1. Medical Officers authorised to arrange maintenance and repairs on Primary Health Centres, Gujarat

Subject Area="Infrastructure and Equipment."	Objective="Maintenance of health facilities."
Details for Reform Option "Medical Officers authorised to arrange maintenance and repairs on Primary Health Centres, Gujarat"	
Summary	**Background**: Minor civil works and repairs (including replacement of window panes and repair of taps) at Primary Health Centres (PHCs) and Community Health Centres (CHCs) were being held up because the power to authorise such work and the funds are held at state, not district, level - with the Roads and Buildings (R&B) Department. The R&B Department is more interested in major, not minor, works, leaving PHC and CHC buildings in a dilapidated state. **Action**: Under the European Commission's Sector Investment Programme (SIP), Medical Officers (MOs) at PHCs and Medical Superintendents at CHCs were given the authority to commission and select contractors and carry out up to INR 25,000 per year of minor repairs (each work costing no more than INR10,000) on buildings. This was initially piloted in two districts and then rolled out to all 25 districts in the State, using funds provided by the SIP, the World Bank-supported Reproductive Child Healthcare (RCH) programme and UNFPA's Integrated Population and Development Programme. Funds are released to the MO by the District RCH Societies who were given the power to appoint local agencies to carry out the work, to authorise works above INR 10,000 with an upper ceiling of INR 10 lakh. A Government Order (GO) to this effect was obtained on the recommendation of the Narmada and Rajkot District Agencies (DAs) on 30 September 2000. **Results:** There has been a quick and appreciable improvement in facilities as well as an efficient utilisation of the funds available. The State Government is now considering a proposal to to sustain this initiative by using the Government funds allocated to the R&B department for repairs and maintenance of health facilities.
Cost	No added cost implication.
Place	Gujarat. Initially in Rajkot district from late 2000 and Narmada district from July 2002. Extended in January 2005 to cover all 25 districts.

Time Frame	Three months but would vary depending on the size of the district.
Advantages	Speed: Minor works are undertaken quickly. Quality: Improved service delivery. Morale: Boosts staff morale and gives district agencies and MOs a sense of ownership.
Challanges	Corruption: Possible abuse of funds - needs careful auditing. Clarity: Proper guidelines were not provided to MOs so not all properly understood the procedures they had to follow. In addition some District RCH societies were not confident enough to release funds to the MOs. Funds flow: Held up initially because there was no bank account for the District RCH society to pay the money into. This has now been rectified.
Prerequisites	GO to empower MOs to take up civil works and identify contractors. Resolution of the DA to implement the GO. Training of PHC MOs to select cost-effective and efficient contractors to carry out necessary repairs. Guidelines for MOs and DAs.
Who needs to be consulted	State Government. District Agency.
Risks	None Identified.
Sustainability	Has functioned for the last six years and it is now planned to extend the decentralisation initiative to Government funds which will make it sustainable in the long term.
Chances of Replication	Judged to be good.
Comments	The Additional Director (Family Welfare) has also been given financial powers of up to INR 5, 00,000 per activity per annum and administrative powers to appoint contractual staff to carry out building works. They can also appoint staff on deputation for project activities bringing more flexibility into the system.
Contact	
Submitted By	Dr Uma Vyas, State Facilitator, Gujarat, for Health and Family Welfare Sector Programme in India, supported by the European Commission. July 2002.
Status	Active
Reference Files	MO describes the work carried out at the PHC.mpg MO describes the work carried out at the PHC

PHC Garudeshwar, Narmada District September 2001.jpg	
Decentralised administrative and financial powers enabled a painter to be employed.jpg	
PHC Medical Officer showing the wall and windows at Samarpada Sub-Centre.jpg	
PROD Gujarat delegated powers.doc	
Presentation AJ Gujarat.ppt	Powerpoint Presentation on Decentralisation, State Government of Gujarat, January 2006.

2. Medical Officers empowered to authorise minor maintenance to Community Health Centres and Block Primary Health Centres, Orissa

Subject Area="Infrastructure and Equipment."	**Objective="Maintenance of health facilities."**
Details for Reform Option "Medical Officers empowered to authorise minor maintenance to Community Health Centres and Block Primary Health Centres, Orissa"	
Summary	**Background**: Lack of minor and routine maintenance of health centres because the work had to be done by the engineering section of the Rural Development Department (RDD) – often situated many miles away. The RDD was unable to cope with both the distance and the numbers (4000 plus) of health facilities it had to maintain in the state. **Action:** The Medical Officer (MO) in charge was given INR 10,000 per year to carry out maintenance and minor repairs of Community Health Centre (CHC) and Primary Health Centre (PHC) buildings. Basic accounting and book keeping training was provided to keep track of spending. After a review of the initial project, MOs were also given training on how to efficiently use these funds and prioritise maintenance needs. The Department of Health and Family Welfare, Government of Orissa, introduced this as a minor maintenance scheme as part of its maintenance policy reform strategy in 1997-98.
Cost	No cost implications.
Place	One hundred CHCs and Block PHCs in Orissa since financial year 1997/98, planned to increase by 100 each year.
Time Frame	Two years.
Advantages	Speed: Pressing repairs can be carried out without too much delay. Visibility: Noticeable improvement in the quality of facilities.
Challanges	Increased workload: Increased burden of responsibility on MOs. Accounting: Necessity to account for funds correctly and

	need for MOs to be properly trained in accounting. Corruption: Possible misuse of funds.
Prerequisites	Training of MOs in general management. Prompt passing of bills for payment. Guidelines for use of funds and accounting. Ongoing management support at district level.
Who needs to be consulted	District Health & Family Welfare Agencies, State Government, heads of facilities, Rural Development Department, CHC / PHC MOs.
Risks	None identified.
Sustainability	Has been extended to cover 600 institutions in the state (August 2004). Similar scheme being undertaken in Gujarat (See PROD link).
Chances of Replication	Has been extended to cover 600 institutions in the state (August 2004). Similar scheme being undertaken in Gujarat (See PROD link).
Comments	None.
Contact	
Submitted By	Dr. Matthew Jowett, Former Programme Adviser, European Commission Techincal Assistance Office, New Delhi. July 2002.
Status	Active
Reference Files	
Reference Links	

3.Maintenance of First Referral Units and Civil Hospitals, Assam

Subject Area="Infrastructure and Equipment."	Objective="Maintenance of health facilities."
Details for Reform Option "Maintenance of First Referral Units and Civil Hospitals, Assam"	
Summary	**Background:** Ten years of under funding at the Public Works Department (PWD) in Assam had led to lack of repairs and poor maintenance of hospital buildings. In order to improve the services in hospitals and to bring about partial modification in the health department, Government of Assam decided to set up a hospital management society for the medical college hospitals, hospitals attached to teaching institutions under the directorate of medical education, Assam as well as the state hospital, district hospitals and sub - divisional hospitals under the directorate of health services, Assam. It was decided that a society be formed in accordance with the provisions of the Memorandum of Association (MOA) and the rules and regulations (bye laws) formed for this purpose. It had to be registered under Society Registration Act XXI, 1860. The Joint Director of Health Services in the District and the Sub Divisional Magistrate (SDM) and Health Officer (HO) of the sub- divisional head quarter, were responsible for taking necessary steps to form hospital management society for district hospital and sub- divisional hospital respectively as per provisions of the scheme within a period of one month. Hospital management society was given the power to exercise autonomy to a large extent, on expenditure to be incurred from the revenue collected by the hospital in the form of donations, membership fees, user charges and government grants. **Action:** After such a Government Order was issued, the responsibility of maintenance of Bhugeswari Phukanani Civil Hospital (B.P. Civil Hospital), Nagaon and the First Referral Units (FRUs) were switched to the District Health and Family Welfare (DH&FW) agency in Nagaon, which was given the funding for the task. It was also authorised to approve repairs and renovations and select the contractor who would carry out the work. It, in turn, formed hospital management societies at a local level and gave them the responsibility to carry out the work by preparing repair and cost estimates and submitting them

	to the DH&FW agency for approval. **Results:** Initially started as a pilot project, the programme has sustained itself. Hospital management societies have been formed in the B.P Civil Hospital and the 4 FRUs (Jakhalabanda, Hojai, Dhing and Lumding) in Nagaon District. The PWD and other government engineers provide technical help for the work. Through the funds from the government and user charges, commendable work is being carried out. The monthly collection from user fees alone in B.P Civil Hospital, Nagaon ranges between INR 2-3 lakhs. A few examples of the achievements of developmental works that have been carried out in B.P. Civil Hospital are: * Repairing and renovation of blood bank and ultra-sonography machine. * Repairing and renovation of medical ward. * New electrification with fans in female medical ward and blood bank. * Repairing of x-ray machines. * Repairing and white washing of administrative building, district medical store, immunization centre and conference hall.* Repairing and renovation of medical paying cabins and surgical paying cabins. * Purchase of 100 beds with accessories. * Purchase of two Maruti Van Ambulance.
Cost	Not specified.
Place	Nagaon District, Assam
Time Frame	Three months. The programme began in 2002 and is continuing since then.
Advantages	Decentralisation: Because financial and administrative responsibility for maintenance is now at a local level, work is being carried out more effectively and efficiently. Improved facility: Improved maintenance and upgradation of hospital facilites. Inclusive: Greater integration of community representatives.
Challanges	Cost: Supervision charges have to be paid to the govt engineers, thus increasing the cost. Decision Making: The executive committee does not have a full say in decisions which poses as a problem at times. Contractual Staff: For cleaning only contractual staff can be hired not permanent. Workload: Extra work is imposed on H& FW (doctors) due to staff shortage.
Prerequisites	* Delegation of powers and availability of adequate funds.

	* Availability of civil engineering support.
Who needs to be consulted	District Health and Family Welfare Agency, Nagaon
Risks	
Sustainability	The program is running successfully since 2002. The activities have been sustainable through community participation like user charges, donation, from other sources like District Rural Development Agency (DRDA), Member of Legislative Assembly (MLAs) funds etc.
Chances of Replication	This option has been replicated already in other health facilities, using outside donations, user charges and other resources for renovating and building new hospital buildings in the state. This was done by the local management committees and not the PWD.
Comments	This reform has been a crucial factor in operationalising FRUs in the State. In conjunction with reforms allowing the District Health Agency to improve equipment supply and ensure manpower deployment.
Contact	
Submitted By	Indrajit Pal, Former Programme Adviser, European Commission Technical Assistance, New Delhi. July 2002. Last Updated: July 2006
Status	Active
Reference Files	IMGP2099.JPG — Maternity ward, Civil Hospital, Nagaon. IMGP2094.JPG — Silent generator bought from user fees, Civil Hospital, Nagaon. IMGP2098.JPG — Mobile medical vans bought from user fees, Civil Hospital, Nagaon.

4. Model Out Patient Door, Himachal Pradesh

Subject Area="Infrastructure and Equipment."	Objective="Maintenance of health facilities."
Details for Reform Option "Model Out Patient Door, Himachal Pradesh"	
Summary	**Background:** It was noticed that utilisation of the services from Out Patient Door (OPD) was severely affected due the limitations of existing infrastructure. For example, patient waiting areas needed to be improved; drainage in few places was poor leading to collection of water, toilet facilities needed facelift for the patients. Labour room for conduction of deliveries at few places were not suitable located. **Action:** To revamp the health facilities, model OPD was constructed by re structuring the existing OPD under European Commission Sector Investment Programme. It meant redesigning existing facility or does minor changes to make place comfortable and convenient for patients. While designing the new OPD care was taken to provide shaded waiting areas to the patients, chairs and couches for their sitting arrangements and public toilets. Space was identified for the labour room so that pregnant ladies can be easily managed at the time of their delivery. Health department staff in the particular premise was responsible to identify the ways in which services could be improved for patients.One health facility was identified from each constituency on the basis of relatively good patients load and strategically good location. Government guidelines, which are situation specific and with emphasis on decentralized decision-making to revamp the health facility. Medical Officer of Health is responsible to identify the needs and submit proposals in agreement with Public Work Department (PWD). **Results:** Service utilization has increased as evident from number of the patients has increased to 140 new patients on an average from 50-60 patients. Also it was noticed that satisfaction among the patients has increased who are availing the services from the health facilities.
Cost	Approximately INR 2 lakh.
Place	68 places across the State.
Time Frame	Six months to one year, depending upon the speed of work.
Advantages	Face lifting of the dilapidated building: Minor changes in the existing infrastructure give a facelift to the facility.

	Increased utilisation of the health facilities by the patients: Satisfaction of the patient after availing the services from the health facilities increases its rate of utilisation over the period of time.
Challanges	Cooperation from PWD: Proposal needs an agreement with the PWD department. To get them involve in the time bound revamping process is big challenge for the health administrator.
Prerequisites	State Government approval.
Who needs to be consulted	State Government, Public work department.
Risks	
Sustainability	Sustainable, though need of a minor repair could arise from time to time.
Chances of Replication	Replicable, in States where infrastructure is in poor condition to utilise it effectively and where funds are available to strengthen it.
Comments	To create environment for the patients with little but basic amenities that provide them basic comfort, access to services with greater responsiveness leads to better patient satisfaction with over all health care interaction experience.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, NIMS, February, 2006.
Status	Active
Reference Files	Notification for release of fund- Model OPD.pdf PHC Amb, Una district1.JPG PHC Amb, Una district6.JPG PHC Amb, Una district4.JPG PHC Amb, Una district27.JPG
Reference Links	

5. User fees for maintenance of medical equipment, Assam

Subject Area="Infrastructure and Equipment."	Objective="Maintenance of equipment."
Details for Reform Option "User fees for maintenance of medical equipment, Assam"	
Summary	**Background:** Assam's medical colleges and health centres have adequate hospital equipment but because of poor funding they could not afford to maintain this equipment or purchase consumables. **Action**: To overcome these constraints the Government of Assam introduced user fees for different investigations and curative procedures in hospitals. The user charges for various facilities vary from hospital to hospital. A few examples of user charges are: admission fee INR 10; pregnancy test INR 80; urine test INR 20; blood grouping INR 40; blood sugar INR 30; normal delivery INR 50; forceps delivery INR 50 and caesarean INR 500. The facilities now raise enough money to regularly service the equipment and purchase required consumables. **Results:** This option is in operation throughout the state and a few hospitals are raising enough funds to run the hospital activities smoothly without government budget allocation for contingencies. There are some hospitals where the collection from the user charges range between INR 1 lakh to INR 3 lakhs. The user charges have helped the hospital in maintaining their equipment and upgrading their facilities. Silent generators, hospital maintenance and expansion, renovation of blood banks, repair of x-ray machine, purchase and repair of mobile vans are some examples of how user charges are being utilised.
Cost	No cost involved.
Place	Medical colleges of Assam, district and sub-divisional hospitals, since 1994.
Time Frame	Initially 5-6 months.
Advantages	Increased quality: People get quality services at lower cost and the staff becomes more accountable. Efficiency: There is less equipment breakdowns and hence the existing facilities are used more efficiently. More facilities: Silent generators, more mobile vans and blood

	storage facilities are being added in the hospitals due to user charges.
Challanges	No general trend in performance of the institutions: Some are collecting sufficient funds to operate medical equipment while other hospitals are not collecting fees efficiently. Lack of guidelines: No definite guidelines are available as to how to use the funds.
Prerequisites	Agreement on an appropriate fee structure, ensuring fees are not higher than in the private sector. Efficient organisation of fund collection e.g. calculating total fund requirements for regular maintenance and operation of equipment; a system for exemption of the poor is desirable.
Who needs to be consulted	State government, health & family welfare department, hospital committees.
Risks	
Sustainability	Since 1994, this option is in operation in medical colleges and civil hospitals of the state. One of the most suitable, acceptable and sustainable reform options in the health sector.
Chances of Replication	User charges have been introduced in Public Health Centres (PHCs) and Community Health Centres (CHCs) too.
Comments	None.
Contact	
Submitted By	Indrajit Pal, Former Programme Adviser, European Commission Technical Assistance Office, New Delhi. Last updated: July 2006
Status	Active
Reference Files	GO No HLD 536-92-Pt-39 (PROD No 6).doc GO No HLD 536-92-Pt-46 (PROD No 6).doc Assam PPT.ppt — Reform initiatives in the health sector- A power point presentation. IMGP2088.JPG — Photo of a blood bank IMGP2104.JPG — Photo of an operation theatre in Jhakla banda IMGP2102.JPG — Photo- Civil Hospital, Nagaon
Reference Links	

6. District level Bio-Medical Equipment Repair Workshop, Himachal Pradesh

Subject Area="Infrastructure and Equipment."	**Objective="Maintenance of equipment."**
Details for Reform Option "District level Bio-Medical Equipment Repair Workshop, Himachal Pradesh"	
Summary	**Background:** A study conducted by GTZ in 5 districts of Himachal Pradesh revealed that about 75% of the equipment inventory was lying unused because it was 'out of order'. The major cause of lack of repairs was non-availability of trained manpower. **Action:** Looking for a long-term solution, it was decided to motivate and train the operator and paramedical staff to undertake possible repairs to simple equipment. Three major categories were identified – (i) Equipment that can be repaired by using simple common sense and basic mechanical understanding. (ii) Electrical and electromechanical equipment that can be repaired by personnel trained on electrical appliances. (iii) Electronic and other equipment that required specialised skills. As a pilot study, a batch of 16 volunteer paramedics was trained in a specially-designed programme for simple equipment: stethoscope, sphygmomanometer, suction machines, weighing machine, autoclave and steriliser. After the course they were allowed to do flexible working at their parent hospital and their performance as a Biomedical Equipment Technician (BMET) was analysed. **Results:** In just one month, about 35% of the 'out of order' inventory of these items was made operational. The scheme was found to be quite satisfactory for simple and electromechanical equipment.
Cost	Estimated cost: Training one person in "Basic Bio-Medical Equipment Repair" at Centre for Electronics Design and Technology of India (CEDTI), Mohali, Chandigarh, costs INR 3000. Cost of setting up a basic biomedical equipment repair workshop (including tools, furniture and fittings) costs not more than INR100,000.
Place	Zonal Hospital, Dharamshala, and district hospitals at Chamba, Una and Bilaspur; since October/ November 2002.
Time Frame	Training takes one week and setting up the workshop (fittings and working table, racks, etc.) takes one to two months.
Advantages	In-house: ensures quicker maintenance of basic,

	frequently-used equipment. Cost and time-effective: in terms of maintenance as well as decreasing the down time of machinery.
Challanges	High workload: In the absence of a dedicated full-time BMET, the workload is very high and the person responsible may not able to cope with the deadline. Increases expectations: of the local authorities and if unfulfilled (ie failure to repair in time) there can be an administrative backlash. Limited: the training only caters to basic and minor problems and there is no alternative to a trained engineer for major problems. Opposition: possible from the person responsible for the workshop if he/she is deployed full-time in maintenance work, as there is an increased workload.
Prerequisites	Budget for purchase of spare parts.
Who needs to be consulted	Chief Medical Officer of the district (for sanctioning budgets), Chief Pharmacist (for procurement), as well as state level authorities for overall sanction and support.
Risks	
Sustainability	Is sustainable if finances for spare parts are provided for by district/ hospital authorities. Sustainability increases if the worker is given a monetary incentive to encourage him/her to find extra time for repairs.
Chances of Replication	Replicable in any health institution with a large volume of basic bio-medical equipment; a person who has interest and motivation to undertake repair job; finances available for spare parts and vendors for spare parts available nearby. In a similar initiative, at Aravind Eye Hospital, Madurai a department was created to do preventive maintenance of medical equipment and instruments of the hospital. This was done by training paramedical staff on preventive maintenance and providing them with the basic tools necessary. (For further information, see link to training of paramedics at Aravind Eye Hospital)
Comments	Totally dependent on the motivation and interest of staff involved in maintenance, support by his superiors in terms of periodically freeing him from regular duties and by providing some incentives.
Contact	
Submitted By	Gautam Chakraborty, Health Economist, BHPHP. June 2004.

Status	Active
Reference Files	
Reference Links	

7. Privatisation of hospital cleaning, Orissa

Subject Area="Infrastructure and Equipment."	**Objective="Clean and hygienic health facilities."**
Details for Reform Option "Privatisation of hospital cleaning, Orissa"	
Summary	**Background:** Cleaning of hospitals by government class IV staff has often been unsatisfactory. It involves huge personnel costs, with unmotivated cleaners and poor outcome, and has compromised hygiene. **Action:** Government of Orissa contracted private providers for cleaning services in a few hospitals. In the beginning, this option involved higher than average costs as existing workers could not be dismissed, but the outcome was well received and more hospitals are now demanding privatisation of their cleaning services. As a consequence, vacancies of class IV staff have been frozen, and staffs are being re-deployed to prepare the way for more outsourcing. **Results:** Proper maintenance of hospitals; proper management of waste and better care for patients and their attendants.
Cost	
Place	Selected government hospitals in Orissa, from July 1997. Firstly as a pilot project in Capital Hospital, Bhubaneshwar, later at SCB Medical College, Cuttack, MKCG Medical College, Berhampur, and subsequently at 4 other district hospitals.
Time Frame	Several months, depending on time taken to identify and engage contractor.
Advantages	Cleanliness: More hygienic conditions leading to fewer hospital infections. Cost-effective: More cost-effective method of cleaning because of the introduction of competition.
Challanges	Costs: May involve higher personnel costs in the

	beginning due to re-deployment of existing class IV staff. Supply: Possibility of insufficient contractors in the remoter areas. Conflict: Possible union opposition.
Prerequisites	Sufficient funds to cover initially elevated personnel costs if current cleaning personnel cannot be re-deployed. Sufficient local skills to negotiate and manage contracts. Establishment of a tender procedure to ensure the best contractor is selected.
Who needs to be consulted	Hospitals, unions, state government.
Risks	
Sustainability	It will sustain if funds are available to pay the contractors.
Chances of Replication	This scheme is currently (August 2004) being extended on an experimental basis in more districts of Orissa and security services in Capital Hospital, Bhubaneshwar, and several other larger hospitals have also been contracted out.
Comments	Orissa State Government has now decided (August 2004) that the costs of cleaning and sanitation are to be made out of user charges. It is proposed that catering and laundry services should also be contracted out.
Contact	
Submitted By	Dr. Matthew Jowett, Former Programme Adviser, European CommissionTechnical Assistance Office, New Delhi. July 2002. Updated August 2004.
Status	Active
Reference Files	
Reference Links	

8. Motivating cleaning (class IV) staff, Tamil Nadu

Subject Area="Infrastructure and Equipment."	Objective="Clean and hygienic health facilities."
Details for Reform Option "Motivating cleaning (class IV) staff, Tamil Nadu"	
Summary	**Background:** Cleaning of health facilities, especially at government hospitals, has been a challenge especially with regard to keeping the class IV employees motivated. To counter this, a number of facilities have started contracting out or privatising hospital cleaning services. However even here there are sometimes problems such as union opposition or a lack of available eligible and efficient contractors. **Action:** A not-for-profit hospital in Madurai, the Aravind Eye Hospital, implemented the following initiatives to keep class IV employees motivated: (i) Incentive schemes linked to number of days present for work and quality of work. It was seen that absenteeism was a big problem at this hospital. To counter this, an incentive of Rs 200 a month was given to any employee who was present for at least 25 days of the month. (ii) Good and appropriate equipment and accessories for cleaning. (iii) Initial training and orientation on their recruitment and regular refresher trainings by senior hospital staff. (iv) A housekeeping supervisor model was adopted. (v) Tours to five-star hotels and hospitality sectors to show the levels of hygiene expected. (vi) A cup of healthy low-cost drink/cereal soup served at 10am to provide them with energy for their hard manual labour since it was found that most of the employees were unable to afford breakfast. **Results:** A boost to employee morale which motivates them to keep the hospital clean at all times - despite 2 million patients and another 2 million attendants visiting the hospital and 200,000 surgeries each year.
Cost	Judged by the Aravind hospital to be cost effective because a small spending improves the atmosphere of the hospital. The place is clean, people are more motivated.

Place	Aravind Eye hospitals at Madurai, (Theni, Tirunelveli & Coimbatore), Tamil Nadu since
Time Frame	Not available
Advantages	Efficiency: Increases the efficiency of the staff and improves their awareness. Cleanliness: Drastically improves hygiene levels, thus reducing hospital infections.
Challanges	None perceived.
Prerequisites	Adequate staff to train the cleaners.
Who needs to be consulted	Hospital managers, trainers.
Risks	
Sustainability	Sustainable as this is a cost-effective intervention.
Chances of Replication	Replicable if there are training staff and facilities as in this case.
Comments	None.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	motivating cleaners.GIF - A cleaner with his supervisor Housekeeping - Administrators.ppt - Powerpoint presentation on housekeeping at hospitals
Reference Links	

9. Healthcare Waste Management, West Bengal

Subject Area="Infrastructure and Equipment."	Objective="Clean and hygienic health facilities."
Details for Reform Option "Healthcare Waste Management, West Bengal"	
Summary	**Background:** Management of health care waste has been a major concern for many states in India. It becomes all the more serious because of its toxic nature posing a threat to public health and leading to pollution of land, water and air. **Action:** Under the West Bengal Health Systems Development Project (WBHSDP), an attempt was made to develop a low cost, effective & sustainable health care waste management system. Since the problem was multi-sectoral, the process was carried out by the Project Management Cell of the WBHSDP, under the guidance of the State level advisory committee. This was headed by the Ministers-in-charge of the Department of Health and Family Welfare and Department of Environment, and in consultation with the West Bengal Pollution Control Board. The first tasks were to identify methods that could reduce the volume and toxicity of wastes and its adverse impact on the environment and to assess the institutional needs and capacity-building measures necessary to implement such methods. A number of pilots were conducted in selected health care units and subsequent to their evaluation, an action plan on Health Care Waste Management (HCWM) was developed. It was also decided to contract out sanitary and scavenging services and provide security in larger hospitals (see entry on Privatisation of cleaning services, West Bengal). The action plan which complies with the Bio-medical Waste Management and Handling Rules 1998 provides all the information needed to implement an HCWM system and its implementation within the existing health structure in West Bengal. A strategy was chalked out for its implementation and it was then replicated in other health care units in a phased manner. A training manual was developed and more than 10,000 staff of health and other related departments have been trained. Capacity building for cleaning (Group D) staff was undertaken and awareness programmes were conducted involving the municipalities, the pollution control board and NGOs. This was backed up with IEC material such as posters and leaflets. Other forums such

	as management and public health engineering institutions were also employed to create awareness amongst stakeholders and students. **Results:** As on February 2004, the action plan was being implemented in 178 secondary level health institutions in 18 districts. This includes 19 district hospitals, 64 sub-divisional hospitals, and 95 rural hospitals (also known as Community Health Centres or CHCs). Medical treatment equipment (three waste autoclaves and two waste microwaves) have been installed and are working satisfactorily. One autoclave and one of the microwaves have also been made available for private health facilities. Revenues earned from this are used for its operation and maintenance.
Cost	Varies from institution to institution and based on technologies adapted. Approximate costs for implementation of HCWM at: 30 bed Rural Hospital: INR 1,37,000 500 bed Rural Hospital(without waste autoclave/ microwave): INR 5,82,000 500 bed Rural Hospital(including waste autoclave/ microwave): INR 23,00,000
Place	State of West Bengal since the year 1998.
Time Frame	Approximately 4 months to issue the Government order.
Advantages	Cleanliness: Drastically improves hygiene levels, thus reducing pollution. Efficiency: Setting up such a system increases the efficiency of the staff and improves their awareness of hygiene standards.
Challanges	Expense: Cost intensive programme. This could pose a challenge to its sustainability. Infrastructure: Needs extensive infrastructure setup. Organisation: It is a complex programme and necessitates close coordination between different sectors.
Prerequisites	Involvement and cooperation of all stakeholders. Extensive training of health staff. Systems required to be implemented for regulatory compliance. Regular supply of consumables. Implementing and monitoring agency (in this case the project management cell of the WBHSDP)
Who needs to be consulted	Officials at the departments of health and environment, Pollution control board, municipalities concerned and NGOs.
Risks	
Sustainability	The World Bank funded West Bengal State Health

	Systems Development Project has come to an end in February 2004, but the Department of Health & Family Welfare has decided to continue with the system and activities are now undertaken by the public health branch of the Health Directorate.
Chances of Replication	Might be a challenge in the absence of an agency such as the WBHSDP as it requires significant funding and technical expertise as well as close monitoring. However certain elements of this system are replicable such as: - the action plan and training manual - common treatment facility in municipal areas - contracting out of scavenging and non-clinical services - the design of storage and disposal facilities - IEC activities
Comments	None.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, November 2004.
Status	Active
Reference Files	
Reference Links	

10. System for standardising medical institutions within the health services department, Kerala

Subject Area="Infrastructure and Equipment."	Objective="Development of norms to ensure a standardisation of facilities and manpower at all levels of the health service."
Details for Reform Option "System for standardising medical institutions within the health services department, Kerala"	
Summary	**Background:** Kerala is noted for its achievements in the fields of health and education. It is the only State in India having at least one health care delivery institution in each of its Panchayath. Moreover almost all Panchayaths have Primary Health Centres. This undertaking makes Kerala Health Services the second largest department under the government, responsible for about 45,000 employees working in about 1,272 institutions. If the grass root level institutions (viz. the 5,094 sub centres) are also considered, the number of institutions increases to about 6,366. In addition, there are presently about 41 different categories of institutions with more than 295 categories of employees. However because there were no standardised norms, there was no uniformity of service provision, bed strength or staff in these institutions resulting in an uneven quality of health delivery. In December 2001, it was decided that to ensure a minimum service delivery to all sections of the population, all institutions needed to be standardised to comply with the needs of the public. **Action:** 1. A committee was constituted by the Director of Health Services in May 2002 to prepare a report on the standard pattern of the Government Medical Institutions under Kerala Health Services Department in terms of infrastructure, equipment and service delivery. 2. A facility survey was conducted using data from the Statistical Wing of the Directorate of Health Services. 3. The collected data was analysed. 4. Key informant interviews were conducted with various stakeholders including the DHS, additional directors, district medical officers, PHC medical officers, service organisations. 5. Data was analysed and final report developed and posted on the Government of Kerala website. **Results:** In July 2005, the committee published a report detailing minimum standards for service delivery; infrastructure; manpower requirements; equipment requirements and laboratory services. It also concluded that the hierarchy of institutions should be changed. It recommended that there should be:

	(i) One Sub-Centre for every 5,000 population in plane areas and for 2,500-3,000 in hilly or difficult areas. (ii) One Primary Health Centre (PHC) in every Gram Panchayath (iii) One Community Health Centre (CHC) in every Community Development (CD) Block in the first phase and then one CHC for every one lakh population in the second phase. (iv) Each taluk, or block, should have a Taluk Hospital. (v) Each district should have a designated District Hospital. The report also includes details of recommended service provision at each facility, bed strength and levels of manpower. It recommends standard building requirements and structural design for any new facilities. For full details see the report in Documents and Illustrations below. The report is now used as the basic framework for developing new health care institutions and upgrading existing institutions. In addition, 10% of institutions in the Health Department have now been selected for standardisation under the Modernization of Government Programme.
Cost	For the preparation of report and its dissemination – INR 2 lakhs.
Place	Kerala.
Time Frame	Twelve months to prepare the report.
Advantages	Uniformity of healthcare provision: Provides a standard pattern for all Medical Institutions within the health services department.
Challanges	Cost: Implementing the recommendations will need a substantial budget. Time: Implementing the recommendations will take time and require consistent political will.
Prerequisites	Political will. Qualified professionals to carry out the report.
Who needs to be consulted	Director of Health Services. Additional Director of Health Services (Planning).
Risks	
Sustainability	Funding for the report came from the European Commission-Project Management Committee (EC-PMC) budget. Funds to carry out standardisation of facilities are now expected to come from a variety of sources including the state budget; Central assistance; health projects; local self government; hospital development committees/societies (ie user charges).
Chances of Replication	Any State could commission such a report. The challenge will be implementation of its recommendations which, as mentioned above, will take time and money.

Comments	Initially it had been hoped that the committee would also develop standardized management and referral protocols. However this was abandoned due to time and budget constraints and because it was decided they could only be accomplished after the physical standardization was completed.
Contact	
Submitted By	Dr K Sandeep, Technical Secretary, Sector Reform Cell, Directorate of Health Services, Thiruvananthapuram, Kerala. September 2005.
Status	Active
Reference Files	List of Institutions (31-12-04).xls — List of Medical institutions in Health Services Department. List of Sub-centers in Kerala.xls — Report on the Standardization of Medical Institutions in Kerala. Report STANDARDIZATION OF MEDICAL INSTITUTIONS IN KERALA.doc
Reference Links	

11. Multi-power operated cold chain equipment, Jharkhand

Subject Area="Infrastructure and Equipment."	Objective="Cold chain maintenance."
Details for Reform Option "Multi-power operated cold chain equipment, Jharkhand"	
Summary	**Background:** Jharkhand, being a newly formed state, leaves much to be desired with regard to electricity supply. Only 15% of the villages are electrified and a village is considered electrified even if there is only one house with electricity. Often, in many places, there is no electricity supply for weeks together. This is not only the case with villages, but also in block towns and district headquarters. This erratic supply of electricity creates problems for maintenance of the cold chain, so necessary for preserving potency of vaccines. Multi-power operated cold chain equipment that function on solar power, battery and electricity, become essential under these circumstances. **Action:** On a pilot basis, Jharkhand government commissioned multi-power operating cold chain equipment in 2005. Ice Lined Refrigerators (ILRs), Deep Freezers were connected with the batteries, which could be recharged with solar power or with electricity, depending on which was available. Thus, even in the absence of electricity battery charge is maintained from an alternative source, in this case, with solar energy. **Results:** Evaluation of the newly introduced system is underway, but it can be said with certainty the shelf life of vaccines has increased and their wastage reduced to a greater extent.
Cost	One time capital cost for setting up the system is very high. Equipment worth INR 6 crore (60 million) was purchased initially for the pilot phase.
Place	131 Primary Health Centres spread across 17 districts.
Time Frame	Nearly 18 months, from planning to implementation including procurement.
Advantages	Reduced vaccine wastage: Increased shelf life of the vaccines has reduced their wastage due to loss of potency. Maintenance: Low maintenance cost and easy to manage. Better immunisation: With increased potency of vaccines quality of immunisation has increased.

Challanges	Commitment: Cooperation and commitment of government officials is needed for smooth functioning of the system. Policy level: Decision making at policy level to introduce the expensive system is a difficult task. Training of workers: Cold chain handlers needs initial training to handle the new system properly.
Prerequisites	Prior approval from competent authority.
Who needs to be consulted	State government.
Risks	
Sustainability	Since maintenance cost is very low, it is highly sustainable.
Chances of Replication	In states where electricity supply is very poor it is a good way to maintain the cold chain.
Comments	Though the initial cost is high, it is easy to maintain and manage; it is highly useful in areas with erratic power supply to deliver quality immunisation services.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, May, 2006.
Status	Active
Reference Files	
Reference Links	

12. Construction of Sub centre building through involvement of Panchayat Raj Institutions, Uttar Pradesh

Subject Area="Infrastructure and Equipment."	Objective="To improve performance of Sub Centres"
Details for Reform Option "Construction of Sub centre building through involvement of Panchayat Raj Institutions, Uttar Pradesh"	
Summary	**Background:** Uttar Pradesh, one of the larger States in India, has fairly large public health care delivery infrastructure. But out of 20,521 Sub Centres (SCs) only 6581 SC were functioning from government building. Whereas 13940 SC were operating from rented building. Most of the SC was operating from poorly maintained buildings. They were facing operational difficulty either due to inadequate space or notice from their landlord to vacate the space in lieu of very low rent. Therefore, it was decided under Sector Investment Programme (SIP) to build new SCs for better functioning. As a traditional procedure, construction of the SCs is the whole sole responsibility of the Public Work Department (PWD), excluding involvement of end users (health care providers and community) in the construction process at any stage. In March 2005, SIP approved the construction of SCs building through involvement of Panchayat Raj Institutions (PRI) and Auxiliary Nurse Midwife (ANM). **Action:** In order to increase ownership in the maintenance of the health facilities, it was decided in the SIP to involve Panchayat Raj Institution (PRI) and Auxillary Nurse Midwife (ANM) together in the supervision and monitoring process of construction of SC building. Randomly 141 SCs in 46 districts were selected for the construction of building. Standard design of subcentre as mentioned under RCH II was approved with some region specific modification. To release money for construction a joint saving bank account was opened in name of Sarpanch and ANM. Chief Medical Officer was made responsible for release of fund. Release of fund was scheduled to be in two instalments. In the first instalment 80 percent of total cost calculated was released and second release of the instalment was on the basis of utilisation of 70 percent fund released in the first instalment. For technical assistance in the construction, a civil engineer posted at block level was appointed. **Results:** From the SIP office, the funds were released in one

	go for all 141 subcentres to respective district (CMO) in June 2005.Till June 2006, the physical progress of construction was as follows: Percent completion Number of SCs 100 percent : 04 76-99 percent: 07 51-75 percent 09 25-50 percent 14 less than 25 percent: 05 Work not yet started 102
Cost	Total fund allotted for construction of 141 SCs is INR 607.45 Lakh.Distribution of fund was based on the type of the soil, found in particular region. Type of soil – Normal – Rs 4.25 lakhs per subcentre (total number – 107) Black soil – Rs 4.45 lakhs per subcentre (total number – 20) Salt peter – Rs 4.55 lakhs per subcentre (total number – 14) Provision was made that unutilised fund could be taken for maintenece of building in future.
Place	One hundred and forty one SCs in 46 district in Uttar Pradesh.
Time Frame	Prepration of district wise priority listing of SCs and development of operational frame work for flexible and decentralised system for construction of government health facilities took 12 months. Release of fund took another six to eight months due to ongoing panchayat election.
Advantages	Decentralised monitoring:Monitoring process is decentralised at the district level. Increased ownership: Involvement of community encouraged their ownership in the health facility.
Challanges	Lack of coordination: Coordination betweem the ANM and PRI members needs to institutionalise through proper guidelines. Ill defined authority: No clear cut guidelines were available for authority of Sarpanch and ANM in the supervision and monitoring of construction process, so decision to sort out local problems used to delay. Lack of PRI capacity: In order to get the involvement of PRI effectively, they need some basic training in the understanding of health care needs of the community and administrative procedures.
Prerequisites	Involvement of PRI Involvement of ANM Involvement of CMO
Who needs to be consulted	PRI and ANM
Risks	
Sustainability	Elements of sustainability are region specific in terms of maintenance of the infrastructure but construction of building do need one time fund allocation.
Chances of	Initiative is under process of replication on larger scale

Replication	provided delineation of roles and responsibilities between Dept of Medical Health & Family Welfare, Dept of PRI and elected representative is completed.
Comments	Construction / strengthening of the SCs building through PRI is a one step forward in the process of decentralised management. But to make their involvement fully accountable the whole process needs to be institutionalised through clear cut guidelines; and need to raise their capacity through training; or else initiative will face a set back as unutilised fund.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, Sept 2006.
Status	Active
Reference Files	
Reference Links	

13. Streamlining drug procurement at appropriate levels of the health system, Tamil Nadu

Subject Area="Logistics."	Objective="Drug supply"
Details for Reform Option "Streamlining drug procurement at appropriate levels of the health system, Tamil Nadu"	
Summary	**Action:** Tamil Nadu State Government set up the Tamil Nadu Medical Services Corporation (TNMSC) in 1994 to be the sole purchaser and distributor of drugs to government medical institutions in the state, in an effort to make significant cost-savings and ensure a regular supply of quality drugs to its health facilities. Items available from TNMSC are listed in a booklet and follow an Essential Drugs List, based on the World Health Organisation model, which is distributed to all doctors, nurses, pharmacists and to post graduate institutions. The items are available from a warehouse designated for each district. In addition, doctors hold an emergency fund to purchase other drugs. The institution is given a pass book which details the funds it is allowed to spend that year on medicines and surgical items, based on the previous year's outpatient and inpatient attendance and also the number of surgeries performed. If they need additional supplies, additional funds can be requested from TNMSC. On a fixed date each month, it can draw drugs from the warehouse and the transaction is noted in its pass book as well as in a duplicate pass book kept at the warehouse. The warehouse also enters the transaction on a computerised database which links directly with TNMSC's headquarters. In this way the HQ knows exactly the quantity of drugs in each warehouse at any one time. Drugs are stored by date order so those closest to expiration date are used first, minimising wastage. Procurement system: The procurement is done through open tender, with certain minimum criteria for eligible bidders and a strict lowest price policy. TNMSC deals directly with the manufacturer or importer of the drug, cutting out suppliers and middle men, and visits the place of manufacture before awarding a contract. It also tests all drugs delivered to the warehouses and does not pay the manufacturer until the tests have been completed. Contract duration is one year. Outsourcing of services: TNMSC makes use of outsourcing wherever feasible. This has included annual contracts for operation of the electronic data processing/software system, transport of supplies from warehouse to hospitals and health centres and drug testing/quality control. **Results:** There have been a number of independent external

	evaluations to confirm the operational and cost effectiveness of the system. These have been financed by DANIDA. TNMSC supplies drugs to 11,059 facilities in Tamil Nadu from 24 warehouses (September 2004). The bulk buying/streamlined/prompt payment advantages of the system have resulted in significant cost-savings (see power point presentation in documents). For example: One Ciprofloxacin tablet cost INR 168 in 1998-99 and cost INR 82 in 2003-04. The cost of a Paracetamol tablet has fallen from INR 13.14 in 1998-99 to INR 12.4 in 2003-04. In the financial year 2003-04, total value of drugs purchased by the TNMSC was INR 12, 14,200,000. Quality control: The percentage pass rate of drugs tested has risen from 96.73% in 1998-99 to 98.9% in 2003-04.
Cost	Dependent on the size of the state and the number and size of the warehouses that need to be constructed. The Tamil Nadu system is completely self-sustaining. All profits are used to improve/extend facilities and services.
Place	Tamil Nadu, functioning since 1995.
Time Frame	One year: to register company, draw up drugs list and construct warehouses.
Advantages	Cost-effective: Generates considerable revenue/ savings through: (i) Rational drug management (introduction of an essential drug list). (ii) Streamlining tender procedures and contract management with manufacturers/importers. (iii) Introducing a comprehensive transportation/distribution system (suppliers deliver directly to warehouses). (iv) Close monitoring and auditing to avoid systemic losses such as pilferage and tampering. (v) Bulk buying for all hospitals in the state rather than each buying their own at different rates. (vi) Outsourcing, including drugs testing; data processing; security. TNMSC is a very lean organisation. Transparency: Clear purchasing system. All drugs labelled with TNMSC logo. Quality control: All drugs tested before they are paid for. Manufacturers who repeatedly supply 'bad' drugs are blacklisted.

	Patient/Doctor satisfaction: Ensures a constant supply of quality drugs to medical institutions.
Challanges	Opposition: Possible opposition from private sector and other groups with vested interests and a threat of legal action by suppliers who lose tenders.
Prerequisites	An independent agency exclusively designed for procurement. Warehouse system. Drugs list. To implement successfully, there has to be a strong political will and commitment to absolute transparency.
Who needs to be consulted	State government, specifically heads of all health and family welfare departments. Government laboratories. Drug controller. Hospitals.
Risks	
Sustainability	Excellent. The scheme is completely self-financing and TNMSC charges a handling fee of 1.5% and laboratory charges on all supplies to cover costs. It is allowed to charge 5% to fund the administration but has to date (2004) never needed to charge more than 2.25%. As the Company's Act does not permit profit orientation, TNMSC finances new initiatives and projects with the revenues it generates.
Chances of Replication	Good with modifications. Several other states are following or learning from the Tamil Nadu model (Andhra Pradesh, Orissa, Rajasthan, Gujarat, Karnataka, Assam).
Comments	The system is so successful that the state government has asked TNMSC to extend its services. It supplied 3,078 items of medical equipment to Government institutions between 2002-04 using a similar procurement system. It also runs several user-fee wards at Government hospitals, charging significantly less than private facilities. The construction department (established to build the warehouses) has constructed 8 Urban Health Posts, 21 Health Sub Centres (HSCs) and upgraded 35 Primary Health Centres and 70 HSCs. See power point presentation for further details.
Contact	
Submitted By	Indrajit Pal, Former Programme Advisor, European Commission Technical Assistance, New Delhi. July 2002. Last updated September 2004.
Status	Active
Reference Files	PROD27-1.jpg — Drug warehouse at Anna Nagar, Chennai PROD27.jpg — BIN Card PROD27-2.jpg — Entering data into the centralised system Reform Ideas at Work.doc

	TNMSC power point.ppt	TNMSC power point presentation 2004.
Reference Links		

14. Passbooks for Drug Logistics, Andhra Pradesh

Subject Area="Logistics."	Objective="Drug supply"
Details for Reform Option "Passbooks for Drug Logistics, Andhra Pradesh"	
Summary	**Background:** Centralised procurement has advantages in terms of price and quality but can result in a mismatch between the facilities' requirements and the actual supplies. **Action:** The passbook system gives the institution powers to select drugs and set the quantity, within an essential drug list. The imbalance between need and supply is thus redressed. Every facility is issued a passbook valid for the financial year, containing an entry showing about 80% of the facility's drug budget for that year. The facility level management draws drugs (and other medical supplies) from the district or state medical stores depending on need. The value of the drug drawn is debited to the passbook. The permitted drugs are specified in a rational drug list and only those drugs can be procured. The facilities are allowed to procure drugs and medical supplies locally up to the balance of the drug budget.
Cost	Information not available.
Place	Andhra Pradesh, since 1998.
Time Frame	No information available.
Advantages	Economical: More flexibility to facilities in type and quantity of drugs procured and consequently less useless inventories and less wastage of date expired drugs. Targeted: Enables better monitoring of the use of drugs and meets the needs of a larger number of clients. Educational: Encourages the use of less expensive generic drugs rather than expensive proprietary formulations. Regulatory: Places a ceiling on the value of drugs used and ensures economy and prioritisation.
Challanges	Inflexible: The facilities are given a budget based on withdrawals the previous year, so if drugs or supplies are unavailable for a period of time they suffer cuts the following year.The budget can also be inadequate in times of epidemic or special campaigns. Unpopular in some quarters: Possible opposition from procuring organisation who resent loss of power to determine which drugs/ quantities they buy. Increased workload: Additional work involved in calculating and

	accounting for drugs used.
Prerequisites	A flexible and responsive central procurement system. Enforcement of rational use of drugs.
Who needs to be consulted	State government.
Risks	
Sustainability	Sustainable as a part of the larger drug procurement and logistics system.
Chances of Replication	Replicable if the political will to reform is there.
Comments	None.
Contact	
Submitted By	Indrajit Pal, Former Programme Advisor, European Commission Technical Assistance, New Delhi. July 2002.
Status	Active
Reference Files	Govt of AP GO No Ms227 dated 12-05-1993 (PROD No 28).doc under_line.jpg xgdgg
Reference Links	

15. Five Disease Treatment, Orissa

Subject Area="Logistics."	Objective="Drug supply"
Details for Reform Option "Five Disease Treatment, Orissa"	
Summary	**Background:** The Government of Orissa has introduced a strategy to ensure that every patient at a public health institution is guaranteed treatment at government cost for the most common diseases: diarrhoea, Acute Respiratory Infection (ARI), scabies, malaria and leprosy - but not every institution had a regular supply of quality drugs to treat these diseases. **Action:** To ensure minimum quality standard treatment protocols have been developed, the required medicines have been calculated, ordered and distributed to the facilities and health personnel have been instructed to provide free treatment for these diseases. In addition, if any patient has to buy medicines from the market he is to be reimbursed. The measures are accompanied by clinical audits and deviations from the guidelines result in penalties. Implementation was accompanied by a media campaign to inform the public.
Cost	
Place	Introduced over the whole state of Orissa in 1999.
Time Frame	Six months to identify the major diseases prevalent in the population.
Advantages	Inclusive: Creates a health entitlement as well as a risk protection guarantee for the poor who will receive free treatment. Prescriptive: Forces doctors to prescribe rationally. Time-saving: Patients are informed of their entitlement and can seek care from the right provider. Cost efficient: benefits a large number of people as it addresses the most common diseases affecting the population.
Challanges	Narrow approach: Focuses resources towards a limited number of diseases at the expense of others. Inflexible: There is no mechanism to change the focus if areas have a different pattern of disease.
Prerequisites	Development of treatment guidelines and guidelines for rational use of drugs. Evaluation of disease prevalence to identify most common diseases. System to ensure sufficient supply of essential drugs to facilities.
Who needs to be consulted	State government, medical doctors.

Risks	
Sustainability	Has been functioning across Orissa since mid 2001.
Chances of Replication	Good.
Comments	Also known as the Pancha Byadhi Chikitsa scheme.
Contact	
Submitted By	Matthew Jowett, Former Programme Adviser, European Commission Technical Assistance, New Delhi. July 2002.
Status	Active
Reference Files	
Reference Links	

16. Streamlining drug procurement at appropriate levels of the health system, Orissa

Subject Area="Logistics."	Objective="Drug supply"
Details for Reform Option "Streamlining drug procurement at appropriate levels of the health system, Orissa"	
Summary	**Background:** Prior to 1998, drugs in Orissa were procured by the districts, with the state government fixing the purchase prices. Drug supply was not tailored to the needs of the district, with drugs being purchased by brand name at high prices and with no quality controls. Districts did give written orders but the information was not used to plan supplies. **Action:** Under the new scheme an essential drug list has been set up, divided into drugs for primary, secondary and tertiary level. A Central Drug Management Unit has also been established. Ordering and payments are centralised, and supplies reach the districts properly packed after quality testing of each batch. Each facility has a budget and a passbook (showing orders and deliveries) and responsible officers in the facility administer 20% of the drug budget for emergency supplies and contingencies. A centralised online inventory control for stock management has been established. Provision for continuing education of doctors for rational drug use and better logistics, etc. has been made. Comprehensive treatment protocols for common illnesses are in place. The procurement procedure is transparent and the tender procedure is comprehensive. Several safeguards are in place to ensure the quality of drugs. **Results:** The new system (which follows the example of Tamil Nadu) has resulted in better value for money through: - lower drug prices as a result of the purchasing of generic drugs in bulk; - improved quality of medicines with the introduction of quality tests and blacklisting of poor quality drugs; - the use of guidelines for rational prescription based on the essential drug lists. Public acceptance of drugs offered through the public system as well as availability of drugs in the facilities has increased.
Cost	Estimated costs: The total budget for drug procurement for 2000-01 was INR 135 million. The 2002-03 budgets were INR 120 million. The budgeted cost is an overview of the cost of medicines to be required for primary health care. Detailed cost including operational cost of procurement system is not available.
Place	Orissa as part of the Orissa Health System Development Project (OHSDP) – World Bank; Bhadralok and Keonjhar District for Department For International Development (DFID).

Time Frame	Information not available.
Advantages	Economical: Lower prices through centralised procurement of large quantities of drugs. Comprehensive: Information costs for medical officers decreased through use of essential drug list. Efficient: Less wastage because institutions order drugs as per requirements. Acceptable: Quality control and appropriate packing has increased consumer acceptance.
Challanges	New skills needed: Managers must be trained to deal with the new budget and passbook system. Corruption: Danger of increased corruption.
Prerequisites	Advocacy to overcome resistance of population who want high profile/ heavily marketed drugs Agency with the technical means and procedures to handle the tendering process for large drug contracts.
Who needs to be consulted	State government, district officials.
Risks	
Sustainability	It is sustainable if a fully streamlined system is in place. Financial support is also required.
Chances of Replication	Proven, as Orissa has adopted the successful model from Tamil Nadu. Other states are in the process of doing the same.
Comments	Took one year to stabilise the programme and overcome opposition from vested interest group resistance.
Contact	
Submitted By	Dr. Matthew Jowett, Former Programme Adviser, European CommissionTechnical Assistance Office, New Delhi. July 2002. Updated August 2006.
Status	Active
Reference Files	
Reference Links	

17. Rational use of drugs, Gujarat

Subject Area="Logistics."	Objective="Drug supply"
Details for Reform Option "Rational use of drugs, Gujarat"	
Summary	**Background:** Doctors were prescribing expensive company brands rather than generic drugs, village health workers were prescribing inappropriate doses and quantities and the public were demanding high-profile but over-priced and unnecessary drugs. Although the Tribhuvanadas Foundation, an NGO concerned with maternal and child healthcare, had been ensuring that sufficient quality drugs were available to village health workers to tackle common illnesses prevalent in rural areas, including TB, the problem still persisted. **Action:** They cut the number of drugs supplied to 20 (including dressing material) and banned expensive company brands and combinations (like combiflan) which inhibit bio-availability. The charges were then subsidised (except for the poorest 20% of the population who were not charged at all). The charges were rationalised so that a course of 5 to 7days of antiseptic or antibiotics was heavily subsidised but the price of vitamins and analgesics were increased to balance out the cost.
Cost	Information not available.
Place	Kheda district of Gujarat, which is split into two districts - Anand & Nadiad, and covers 700 villages. Started 1980 and still ongoing.
Time Frame	Approximately three months for start.
Advantages	Cost-efficient: More effective and cost-efficient treatment. Targeted: Treatment of diseases with a public health impact such as TB is encouraged.
Challanges	None identified.
Prerequisites	Training of village health workers. Motivation of implementers especially if this is to be implemented by the government.
Who needs to be consulted	Provider of the infrastructure and the implementing organisation. Local doctors.
Risks	
Sustainability	Has been working since 1980.
Chances of Replication	Replicable - where cooperative or similar organisations exist (eg. self help groups, micro credit societies).
Comments	None.

Contact	
Submitted By	Dr Uma Vyas Programme Advisor, ECTA. July 2002.
Status	Active
Reference Files	
Reference Links	

18. District budget analysis, Madhya Pradesh

Subject Area="Financial Management Systems."	Objective="Integrated planning and management."
Details for Reform Option "District budget analysis, Madhya Pradesh"	
Summary	**Background:** Several stakeholders are involved in funding health services in Guna District, Madhya Pradesh, including the European Commission (EC), DANIDA, UNICEF and DFID. Furthermore, there are multiple sources of funds from central and state governments for health and family welfare services. **Action:** The development partners, each of whom has its own funding plan (often for similar activities), agreed with the district collector that a single district health plan which reflected all these activities and sources of funds would help to make the planning and delivery of services more effective by avoiding duplication and facilitating pooling of funds where appropriate. The first step towards developing an integrated plan was to map out available funds using a “sources to uses” matrix created in an Excel spreadsheet. Initially, all funds were mapped against the budget lines in the state budget documents. The district budgets referred included those from health as well as other health-impacting departments such as women & child development and public health engineering. Working discussions were also held to produce a larger picture of resources and relate them with the process of formulating a refreshed district health action plan. After discussions, a structure founded on four domains: development of community structures and processes, strengthening of sub-health centres, strengthening of referral services and IEC & training was adopted. It was based on the ongoing district action plan under the EC-supported Sector Investment Programme. This organic approach, which ensures the usefulness and relevance of the information generated, is critical to the success of the process.
Cost	Information not available.
Place	Initially Guna district, Madhya Pradesh. The process began in May 2003 but has now been extended across the state.
Time Frame	Six -12 months.
Advantages	Clarity: A clear picture of total resources facilitates inter and intra-sector coordination and can speed up implementation. Practical: Avoids duplication of activities / funding. Effective: Can improve quality of investments and service

	delivery.
Challanges	Cooperation essential: Possible reluctance to release budget information by some stakeholders. Monitoring: Obtaining data on incomes from user charges, and how this is spent, may be problematic. Complicated: Consolidating a variety of budgets into one framework can be problematic. In this exercise, a general, rather than a very detailed, picture was focussed on.
Prerequisites	Budget documents covering relevant centrally-sponsored schemes and other transfers from central government as well as relevant state budget documents, all disaggregated by districts. Disaggregated budget information from development partners. Data on income from user charges in public facilities. Interest among district officials.
Who needs to be consulted	District Health Officials; also District Collector who can facilitate obtaining detailed budget information, income from user charges etc; development partners (where relevant).
Risks	
Sustainability	It requires a person with computer/spreadsheet skills is required to develop/maintain the spreadsheet matrix, to make it sustainable.
Chances of Replication	It has already been fully replicated to all 48 districts in the state.
Comments	It is critical not to be too ambitious or rigid in this exercise but to ensure that the district officials see value in the budget analysis. Hence the step-by-step approach, doing some analysis, then discussing with officials, then doing more analysis, discussing etc. is important to ensure the exercise is not simply an academic one. Consolidating a variety of budgets into one framework can be problematic. In this exercise, we focus on getting a general picture, rather than a very detailed one.
Contact	
Submitted By	Dr. Matthew Jowett, Former Programme Advisor (Financial Management & Economics), European Commission Technical Assistance, New Delhi. September 2003.
Status	Active
Reference Files	
Reference Links	

19. Auditing Maternal Deaths, Tamil Nadu

Subject Area="Monitoring, evaluation and quality control."	Objective="Performance monitoring to improve services."
Details for Reform Option "Auditing Maternal Deaths, Tamil Nadu"	
Summary	**Background:** Reporting of maternal mortality did not include the direct and indirect causes of deaths. This is essential for deciding the interventions for reduction of maternal mortality and morbidity. **Action:** Systematic reporting and auditing of maternal deaths was first introduced in Tamil Nadu in 2000. All maternal deaths are reported directly within 24 hours to the Commissioner- Maternal and Child Health & Family Welfare by the field health functionaries, Anganwadi workers, Primary Health Centre (PHC) medical officers. This is followed by a detailed investigation report by an obstetrician within 15 days. The multiple reporting is rectified at the state level by the statistical staff. A clear system has been laid down which specifies the person responsible for reporting the death (according to whether it occurs at home, in transit, in a health sub-centre, PHC, public hospital or in a private health facility or nursing home). The Deputy Director of Health Services (DDHS) at the district level is responsible for collecting the relevant information and monitoring the reporting to the Commissioner, the Director of Public Health and the Joint Director of Health Services within 24 hours of the occurrence/ receipt of the information. A district level maternal death investigation team has been formed to improve the quality of investigation. The team, whose obstetrician rotates on a monthly basis, is accompanied on its visit by the local PHC medical and nursing staff. The DDHS makes the logistical arrangements (fixes the dates, arranges the vehicle). To guide its work, the team uses a “Maternal Death Investigation Case Sheet” which collects information on: (i) the location of the death, (ii) the economic, social and educational profile of the family, (iii) the deceased’s obstetric history and record of antenatal, delivery and postnatal care, referral and (iv) the circumstances of death. The team meets the relatives of the deceased and visits the health premises where she was treated to examine case records and interview staff. It is the obstetrician’s responsibility to analyse the direct and indirect obstetrical causes which led to death. The report is also expected to highlight any system failures. The other members of the team examine specifically the non-medical causes of death including

	antenatal care, risk factors and/or complications, delay in referral or in initiation of treatment, non-availability of specialists, equipment, blood, etc. The team feeds back their findings to all the personnel who were involved in care with suggestions as to corrective measures designed to prevent recurrence. The findings are also placed before the maternal deaths medical audit committee on a monthly basis. This committee's minutes are placed before the District Reproductive and Child Health (RCH) Committee chaired by the District Collector, which also receives relatives of the deceased who are invited to give their account of the events. The minutes of both meetings are placed before the Commissioner. The findings are also fed back to the relevant First Referral Units (FRUs) and PHCs. An annual analysis of maternal deaths is carried out at district level to give insight into the corrective measures required. A state level committee, which has responsibility for assessing the quality of maternal death investigations, visits FRUs at random and reports back to the Commissioner every month. A quarterly meeting is held with the Joint Director of Health Services and the DDHS to discuss measures for the reduction of maternal mortality and morbidity on the basis of the district investigation reports. **Results:** No specific evaluation of the impact of maternal death audits has been carried out till now. Anecdotal evidence suggests that it is an effective tool in raising awareness of the preventable and very often non-medical causes of maternal deaths. Now the maternal death audit has been improved further and verbal autopsy of maternal death is being conducted. Two state level training programmes have been conducted- one for the district health managers and another for the district public health nurses to brief them about the new format. The new format includes the community-based survey i.e. interview with the relatives of the deceased and facility-based survey. Following the state level meeting, two district level sensitisation meetings are being held for the PHC medical officers, the obstetric specialists from the hospitals and the officers from the health-related departments. All the maternal deaths reported from April 2004 are being investigated and the first state level meeting was held in August 2004, to review the use of the new formats.
Cost	Apart from the purchase at state level of a computer capable of reading the machine-readable forms at an approximate cost of INR 5 lakh, the main costs are staff time and stationery (paper, etc.). The cost of sensitisation meetings conducted at the state level for the district officers, at the district level for the PHC medical officers and at the PHC level for the female health functionaries is around INR 4,00,000 (€7,154). The entire verbal maternal death audit activity is funded by UNICEF.
Place	Tamil Nadu from 2000. Verbal audit initiated from April 2004.

Time Frame	Total twelve months, including: Development of investigation format – discussion with expert groups: two months. Pre-testing of forms: one month. Printing of forms: one month. State level workshops for the district health administrators and district public health nurses: two months. District level workshops for the PHC medical officers: three months. Conduct of PHC level sensitisation meetings: three months.
Advantages	Focussed: The system focuses attention on maternal deaths and their relatively preventable nature, something which has frequently been ignored. Inclusive approach: Taking a non-judgmental approach, it focuses attention at all levels, including on the bereaved families and on the types of situation and circumstances which lead to maternal death.
Challanges	Fear factor: Some health staff may not be cooperative fearing they will be blamed for a death. Possible opposition: From the investigators who may feel that it is an additional responsibility.
Prerequisites	-- Policy clearance. -- Administrative will. -- Willingness of service providers to investigate. -- Funding support. -- Single department to monitor the collection of reports, analysis and feed back. -- Monitoring system to check the quality of investigation.
Who needs to be consulted	Policy makers to be informed about the process. All programme officers at state level. All district health managers. Hospital administrators. Obstetric specialists of the hospitals. Professional associations. PHC medical officers and paramedical functionaries.
Risks	
Sustainability	The system does not have any major costs attached to its implementation so its sustainability depends essentially on political will and management effectiveness.
Chances of Replication	At present (September 2004) there was no known replication of this specific system but since there are few costs involved, other than staff time, it should be easily replicable.
Comments	Maternal death is a traumatic event and studies proved that a maximum recall period is 8 years for maternal deaths. It is therefore important to conduct the investigation before memories fade and details become blurred.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	go259 GO No.259 dated 30 May 1997 (Public Health &

	(2).doc	Preventive Medicine-C.S.S.M. Programme – Organising Medical audit in the First Referral Units-Orders Issued)
Reference Links		

20. Task Force on Health and Family Welfare, Karnataka

Subject Area="Monitoring, evaluation and quality control."	Objective="Equity, quality and integrity in health care."

Details for Reform Option "Task Force on Health and Family Welfare, Karnataka"

Summary

Background: In December 1999 the then Chief Minister of Karnataka set up a 13-member Task Force on Health and Family Welfare headed by the Project Administrator of the Karnataka Health System Development Project (KHSDP), with the aim of improving the public health care system in the State. The terms of reference for the Task Force were to make recommendations for : i) Improvement of public health ii) Stabilisation of the population iii) Improving management and administration of the Department iv) Changes in the education system covering both clinical and public health It was also required to monitor the implementation of the recommendations.

Action: The Task Force formed subgroups and held extensive consultations with the Ministry of Health and Family Welfare and other government directorates, as well as with representatives of: •professional bodies •voluntary organisations •National Institutes and premier institutions •health organisations •citizens and consumer groups •women's groups •people's organisations •corporate bodies •voluntary, private and corporate hospitals •teaching hospitals •autonomous hospitals In addition, the members interacted with elected State representatives, officials from outside the health sector, the media and guests from within and outside the State. They also visited Primary Health Centres (PHCs), Community Health Centres (CHCs) and District hospitals in all districts of Karnataka, as well as most of the autonomous and teaching hospitals and government medical colleges.

Nine research studies were conducted with the help of the KHSDP. (See Documents and Illustrations section below for powerpoint presentation on list of research studies.). This process formed the basis for the report. The Task Force Interim Report was released in April 2000. (See Documents and Illustrations section below for the recommendations.) In April 2001 the Task Force submitted its final report identifying 12 major issues of concern and an agenda for action to address each problem. (See Documents and Illustrations section below for the recommendations.) They were in summary: I) Corruption ii) Neglect of Public Health iii) Distortions in Primary Healthcare iv) Lack of focus on equity v) Implementation Gap vi) Ethical Imperative vii) Human resource development neglected viii) Cultural gap and medical pluralism ix) From exclusivism to

	partnership x) Ignoring the political economy of health xi) Research xii) Growing apathy in the system **Results:** The report had a very wide mandate but its specific recommendations relate, among others, to: i) re-organisation of the Directorate with a view to streamlining operations ii) creation of a separate cadre of public health specialists iii) mainstreaming of the Indian Systems of Medicine and Homeopathy (ISM&H) doctors for primary health care iv) creation of an integrated set-up at the State level for planning and monitoring v) rationalising the job responsibilities of field functionaries vi) decentralisation of administrative and financial powers vii) Rational use of infrastructure viii) Role of the Panchayat Raj Institutions (PRIs) in the day-to-day management of facilities and services ix) Training, capacity building and skill development. Implementation of between 50 and 60% of the recommendations has been initiated under the guidance of an implementation committee. The latest documentation of this is in progress. The Task Force also developed the draft Karnataka State Integrated Health Policy. The Department of Health had wide-ranging discussions on this through a workshop and a series of meetings in-house and with different departments. It was adopted by the higher committee for health and then by the Cabinet in January 2004. The Karnataka State Integrated Health Policy is comprehensive and includes: •Health policy •Population policy •Drug policy •Nutrition policy •Education for Health Sciences policy •Blood banking policy •Policy on control of nutritional anaemia •AIDS prevention & control policy (draft) •ISM&H policy (draft) •Pharmaceutical Policy It emphasises the role of voluntary and private sectors in public healthcare, with the aim of developing partnerships to provide better care and better use of resources. To curb the problem of spurious drugs, the policy envisages introduction of a rational drug policy by disseminating information on drugs, strengthening the drug control and enforcement machinery, providing adequate staff and modernising drug testing laboratories.
Cost	Approximately INR 10 lakhs on research and publication of the Task Force report. The Task force members, including the Chairman who worked full time, contributed their time on an honorary basis.
Place	Karnataka State.
Time Frame	Three months.
Advantages	Detailed examination of issues: Report offers a rare chance to explore flaws, problems, inconsistencies and failures within the health system, and suggests overhaul of entire system. Provides guidelines: For improvement of all areas, especially

	vigilance and discipline, human resources management, private practice, delegation of powers, planning and monitoring, financial management, drug procurement. Reveals rights to health: Explains entitlement of population to basic services provided by government of which many may have been unaware. Clarifies intersectoral links: Details ways in which health services are strengthened and supported by other sectors. Provides framework for policy making: In short, it provides a pathway for Health Sector reforms.
Challanges	None perceived.
Prerequisites	Co-operation and approval of State Government, including Chief Minister, Minister for Health and Family Welfare, various Secretaries, Directors and officials of related departments.
Who needs to be consulted	As above.
Risks	
Sustainability	The Task Force has served its purpose and has been dissolved. The "Implementation Committee" to implement the recommendations of the Task Force is now monitoring the implementation process.
Chances of Replication	Good, provided State has government co-operation and approval for Task Force, and has a dedicated team willing to commit time and effort not only to researching the report but to implementing the recommendations.
Comments	The Task Force is an example of public-private partnership since 7 out of the 12 members were from NGOs.
Contact	
Submitted By	Tessa Laughton, Research Consultant, ECTA, New Delhi, May 2005.
Status	Active
Reference Files	<table><tr><td>Recommendations of Task Force Interim Report.doc</td><td>Recommendations of Task Force Interim Report</td></tr><tr><td>Task Force Final Report recommendations.doc</td><td>Recommendations of Task Force Final Report</td></tr><tr><td>Health Sector Reforms Powerpoint.ppt</td><td>Powerpoint presentation 'Health Sector Reforms in Karnataka State' by Dr.H. Sudarshan, Vigilance Director, (Health,Education & Social Welfare), Government of Karnataka.</td></tr></table>

Reference Links	

21. Help Line for Health, Jharkhand

Subject Area="Monitoring, evaluation and quality control."	Objective="Empowering the common man with Right to Information."
Details for Reform Option "Help Line for Health, Jharkhand"	
Summary	**Background:** In a low-performing state like Jharkhand, enormous gaps exist between the common man and the authorities with regard to access to information; there are several barriers even when someone wants to register protest on functioning of the healthcare delivery system. Not only that, there was hug information gap on government activities and programmes that were meant for the benefit of the people. There was no channel to access information or to air grievances. Swasthya Help Line (SHL) was an initiative that was designed to overcome these gaps and barriers and create a mechanism for interaction with the common man; it would also serve as a tool for monitoring and quality control. **Action:** Swasthya Help Line (SHL) was launched on 1 December 2005 by the Ministry of Health & Family Welfare, Government of Jharkhand. The main objective of SHL was to overcome problems of hierarchy and administrative delays in solving people's problems and to encourage use of the public health system by putting a check on the ongoing malpractices. Direct access telephone numbers were earmarked and widely publicised. The numbers were advertised through various mass media. These numbers are: 2261857 and 2261487. Issues addressed by the help line relate to malpractices, corruption in the department, non-functioning of a health facility or information related to immunisation drives in local areas, unavailability of staff or health worker in the Primary Health Centres (PHC), non-receipt of salary, stipend, etc. Every call is given a unique code and reference number for its subsequent follow-up. Once a call is received, it is referred to concerned officials with its unique code for follow-up and necessary action. If the caller leaves his or her identity, the department gets back to inform the person on the action taken on a particular complaint. SHL takes the first line of action at the Civil Surgeon (CS) level. The related issues are then transferred to the concerned District Medical Officer (DMO). If problems are not addressed there, it goes to higher authorities at the ministry level. A weekly report is sent to the health Secretary,

	which includes total number of calls received, issues addressed, reference number for the follow-up and action taken. **Results:** In the month of December 2005, 243 calls were received, out of which 152 were from the general public for inquiries related to health services and 91 calls were from the health department itself. Out of these, 142 have been processed, 80 calls are being processed and 21 calls have to be taken up for processing. Similarly, in the month of January 2006, total of 261 calls were received. Out of these 136 were from the general public and 125 were from the health department. Of the total calls received, 97 have been processed, 144 calls are being processed and 20 calls need to be addressed.
Cost	Logistics requirements include a computer, a telephone line and an operator to register complaints and forward them to concerned officials for necessary action.
Place	RCH Directorate, Ministry of Health & Family Welfare, Namkum, Ranchi, Jharkhand.
Time Frame	Approximate time from planning to implementation of the SHL is 3 months.
Advantages	Direct access: Common man has direct access to information. Bypassing hierarchy: Minimum administrative hierarchy involvement for problem solving. Grievance reddressal: Grievances related to the health system are given due hearing immediately. Public perception: People are now beginning to perceive the government health system in a positive light.
Challanges	Unnecessary calls: Difficult to filter calls that are not serious. False complaints: Planted false complaints are registered to get back at officers. Untimely calls: SHL functions only during working hours, but untimely calls are plenty.
Prerequisites	A team dedicated for the helpline with all necessary infrastructure. Ready reference of telephone numbers of the various government officials, hospitals, ambulance services, and Specialist doctors. Support and encouragement of the higher authorities.
Who needs to be consulted	District officials, specialist doctors in the private sector, and officials in the Ministry.
Risks	

Sustainability	Good.
Chances of Replication	Replicable, especially in states with low accountability and high levels of corruption.
Comments	This is a low cost, simple and easy to replicate initiative to bring transparency and accountability in the healthcare delivery system. It also involves the community, which in the long run should increase the demand for efficient public health institutions.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, May, 2006.
Status	Active
Reference Files	
Reference Links	

22. Rural doctors made accountable to Panchayat Raj Institutions, Punjab

Subject Area="Monitoring, evaluation and quality control."	Objective="Performance monitoring and community ownership of public health system."
Details for Reform Option "Rural doctors made accountable to Panchayat Raj Institutions, Punjab"	
Summary	**Background:** Punjab has 1310 Subsidary Health Centres (SHC) and Rural Dispensaries that are meant to take public health services right up to the doorstep of the rural population. However, SHCs were non-functional due to frequent absenteeism of doctors. **Action:** To solve this chronic problem of absenteeism Government of Punjab, from 1 June 2006, handed over management of SHCs and Rural Dispensaries to Zila Parishads (ZP). Now it is the local ZP that engages service providers (Doctors) on contract. The ZP fixed output parameters and benchmarks for each activity to be carried out by service providers. These benchmarks were recommended by a committee of the specialist doctors to make doctors accountable. The committee will also review the benchmarks periodically in the context of local area requirements. The service provider doctors, who fail to meet the benchmarks, will have their contract terminated there and then. (Please see the reference section for: Benchmarks for the doctors engaged by the Zila Parishad on service contract). Service provider (Doctor) will get a consolidated amount as remuneration. The State government will provide the amount to the ZP as grant-in-aid. (For detail Please see PROD entry No 193 on: Management of primary level health facilities by PRI, Punjab). **Results:** So far all the doctors are meeting the benchmarks overwhelmingly. However, it is too early to say how effective the reform is going to be in the long run.
Cost	Only guidelines and a government order are needed to implement the benchmark for accountability of performance of the medical service provides. There is no extra cost incurred in the implementation of the reform.
Place	1310 Subsidiary Health Centres in rural Punjab.
Time Frame	Six months.
Advantages	Accountability: performance of the service providers is monitored objectively.

	Operationalisation: SHCs are made functional by overcoming abseentism among service providers. Decentralisation: monitoring of the performance is decentralised through Panchayat Raj Institution.
Challanges	Service Provider's resistance: Service provider may rebel against the imposition of the PRI on them. Expectation: Service providers expect regularisation of their services on the pattern of Government doctors, including Non-Practising Allowance. Inadequacy: PRI members feel they lack the capacity and technical expertise to handle the work. Political influence: There is pressure on doctors from local politicians to appoint Paramedics of their choice.
Prerequisites	Sensitisation and training of PRI members.
Who needs to be consulted	PRI members.
Risks	
Sustainability	The more well entrenched the panchayati raj system in the state the more sustainable the reform. Political empowerment of the rural populace is crucial to sustainability.
Chances of Replication	Much depends upon government willingness; in real terms, all it requires are guidelines and a government order.
Comments	PRI involvement in the management of rural health facilities may help the government to improve the service delivery, but simultaneously the community should be involved so that a check and balance is maintained against political vested interest.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, August, 2006.
Status	Active
Reference Files	Benchmarks for SHC Doctors.doc
Reference Links	

23. Close Monitoring and Ante-natal Care of Pregnant Ladies, Puducherry

Subject Area="Monitoring, evaluation and quality control."	Objective="To improve sex ratio and to reduce the incidence of female foeticide."
Details for Reform Option "Close Monitoring and Ante-natal Care of Pregnant Ladies, Puducherry"	
Summary	**Background:** The Union Territory of Puducherry is consisted of four districts; Puducherry, Karaikal, Mahe and Yanam. Though the overall sex ratio of 963 per 1000 male children (Year, 2006, IPPI data) children is a respectable sex ratio still there is a need to maintain it and to counter any growing trend towards female foeticide, especially in the districts Mahe and Yanam (701 per 1000 and 920 per 1000 male infants respectively). The couples with first female child may tend to go for pre-natal sex determination in the second pregnancy and are also likely to be misguided by those health professionals who are involved in unethical practice of sex determination and female foeticide. The pre-conception and pre-natal diagnostic techniques (Prohibition of Sex Selection) Act, 1994 is being implemented in the Union Territory of Puducherry with effect from May, 2001. A meeting with an agenda of declining trend of juvenile sex ratio, held at the Directorate of Health and Family Welfare Services, Puducherry in March, 2006 was concluded with constructive steps towards effective monitoring of second trimester scans. Besides, it was complemented with the enhanced supervision of all pregnant ladies having first female baby, by the Auxiliary Nurse Midwife (ANM) and medical officer. Activities: Registration of the genetic clinics and the ultra sonograph scanning centres in the Union Territory of Puducherry has been made mandatory. All the registered ultra sound clinics (government or private) performing the second trimester scan (13 to 28 weeks) are compulsorily recording the indications for performing the scan and forwarding the address proof (ration card/identity card) of the person undergoing scan to the Directorate of Health and Family Welfare. The name of the gynaecologist asking for the scanned dated copy of the ultra sonogram is also furnished. Dated picture of the sonogram has to be maintained by the respective genetic clinics for all medical termination of pregnancy (MTP) cases for cross verification by the enforcing authorities. No nursing home or private clinic is

	allowed to perform more than 12 weeks abortions. The hospitals providing family planning procedures have been accredited. The health authorities are carrying out routine as well as surprise inspection of the ultra sound clinics. To raise awareness about the PNDT act, hoardings displaying messages have been erected at hospitals, bus stand, railway station and beach road. Advertisements in Tamil language on television cable network and auto-rickshaws are also being done. Meetings by Nehru Yuva Kendra and Mahila Swasta Sangh (NGOs on youth and women health respectively) are being conducted in the villages to educate the public about the declining sex ratio. To complement the effective implementation of the PNDT act at both the ends; health providers and the health service seekers, ANMs have been asked to closely observe and provide the antenatal care to the pregnant ladies. Pregnant ladies who have had their first female baby are strictly watched by ANMs for any lapse in their antenatal check up near to the 12 weeks of gestation period. The ANM visits the house of the pregnant ladies and tries to find out the cause of not reporting for the antenatal check up and for any visit to any nearby gynaecologist or ultrasonologist. In case, the ANM gets any clue for sex determination effort, she reports it to the medical officer. The pregnant lady is then counselled by the medical officer to remove any inappropriate health or cultural belief or any mis-guidance she might have recived from any clinician with profit interest. Patients include second time pregnant ladies having first child; a female **Results:** The initiative is in the process of implementation.
Cost	Information not available.
Place	Union Territory of Puducherry
Time Frame	Five months
Advantages	Improved Quality: It has enhanced the quality of the songraphic diagnostic services and outreach antenatal care. Institutional Delivery: With improvement in antenatal care and accessibility to medical officers for qualified opinions, the number of institutional deliveries should increase. Decrease in Maternal Mortality: It will help in reduction of maternal mortality with quality improvement in pre natal, natal and post natal health service delivery.
Challanges	Low Registration of Pregnant Ladies: There have been

	cases where pregnant ladies with an intention of having male child started hiding their pregnancy from ANMs and have not registered with them.
Prerequisites	Baseline demographic and epidemiological data Refresher training of ANMs in foetal well being, antenatal check up, immunization and counselling. Sustained awareness activities against female foeticides, its implications on society et large and the PNDT act Strong will and motivated field health staff.
Who needs to be consulted	Key informants of a community, Pregnant ladies, Health professionals, Directorate of Health and Family Welfare Services.
Risks	
Sustainability	It is sustainable with supportive Information, Education and Communication activities and positive cooperation from the private health sector
Chances of Replication	It can be replicated in similar settings where literacy level is high and outreach health workers are well trained with appropriate skills, knowledge and attitudes.
Comments	It should be well communicated to the pregnant ladies during counselling and awareness campaigns that there are equal probabilities of their being misguided by the profit oriented ultrasonologists and obstetricians who are involved in illegal practice.
Contact	
Submitted By	Dr. Anil Bhola, Research Consultant, National Institute of Medical Statistics, New Delhi January 2007
Status	Active
Reference Files	
Reference Links	

24. Management of Primary Health Centres by NGO, Gujarat

Subject Area="Public / private partnership (including NGOs)."	**Objective="Scope and quality of primary health centre services."**
Details for Reform Option "Management of Primary Health Centres by NGO, Gujarat"	
Summary	**Background:** Jhagadia block of Baruch district is a poor, tribal area which did not have even basic government health services in its rural areas. 95% of deliveries were home-based and done by Traditional Birth Attendants (TBAs) and there were high mortality (IMR 172 & MMR >1500) and morbidity rates. **Action:** NGO SEWA-Rural collaborated with the state government under the USAID scheme to demonstrate a model where the state government and an NGO worked as partners in implementing community health interventions. Consequently, the government decided to entrust the management of the Primary Health Centre (PHC) at Jhagadia to SEWA-Rural for 10 years from 1989-99. Official resolutions were passed by the state government and the NGO took over total healthcare responsibility including implementation of all national programmes. **Results:** During this period (1984 to 1999-2000), there was a reduction in mortality (IMR down from 172 to 46.4) and morbidity rates and immunisation rates increased to 98%. There was an increase in area covered (11 villages and 11,000 population in 1981-82 increased to 30 villages and 40,213 population in 1998-99) and an overall increase in health awareness.
Cost	In a standard government PHC budget, more than 80 per cent is spent on salaries while only the remaining part is available for delivery of services and related programmatic activities, which is found to be inadequate. SEWA Rural saved money on salaries of approved field staff by managing with a smaller number of full-time field staff with relatively low salary and utilising services of more village level workers without compromising the quality of the services. SEWA Rural required additional funds for other important aspects including field operational research studies and documentation, which it believed to be crucial for the success of the programmes and it was able to mobilise extra funding from other sources. Hence, the SEWA Rural experiment demonstrates that if reallocation of budgetary heads is allowed at the local level with organised and

	decentralised planning and management, efficient service delivery by a PHC can be ensured within the existing financial allocations. (For more on the break up of costs over the years see the document below).
Place	Jhagadia in Bharuch District, Gujarat, since April 1984 but formally from 1989-90 onwards for a period of 10 years.
Time Frame	Six months to one year.
Advantages	Decentralisation: Effective decentralisation of powers to NGO running the PHC.
Challanges	Conflict: Problems in the relationship between NGO and the state government could take place. In this case the NGO faced some difficulties in the form of irregular and short supply of medicines, delays in grants and over emphasis on target achievements.
Prerequisites	Government Resolution.
Who needs to be consulted	State Government, NGO, PRI (local Panchayati Raj Institutions).
Risks	
Sustainability	Variable has already been extended to three other community health centres within Gujarat and nine other proposals are under consideration (as of August 2004). The idea has also proved successful in Karnataka where 31 PHCs (August 2004) have been handed over to NGOs or private medical colleges for maintenance. However a similar project in Orissa was unsuccessful, largely because the terms of reference were inadequate and the NGO did not have the resources or the ability to run the institutions.
Chances of Replication	The direct responsibility of managing the PHC was returned back to the government in 2000 mainly because the NGO had been managing the PHC for 15 years (on an informal and later formal basis) and sought fresh challenges. However a hospital run by the NGO was recognised by the state government as the First Referral Unit (FRU) for all 7 PHCs in the Taluk and therefore it continued its association with the area.
Comments	None
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. August 2004.
Status	Active
Reference Files	Corrigendum - management of villages of Jhagadia for providing health services.doc Resolution No MIS-1084-2265 867-b, June 10, 1986.doc Resolution No PHC-1087-8096-88 GH Feb 14,1989.doc

	Resolution No PRCH-1084-590-89-B April 13,1989.doc
Reference Links	

25. Management of Primary Health Centres by Non Government Organisations and Medical Colleges, Karnataka

Post your Comments

Subject Area="Public / private partnership (including NGOs)."	**Objective="Scope and quality of primary health centre services."**
Details for Reform Option "Management of Primary Health Centres by Non Government Organisations and Medical Colleges, Karnataka"	
Summary	**Background:** Although Karnataka has relatively good health indicators and infrastructure, this was found not to be true of remote rural areas. In 1996 two PHCs and their sub-centres were handed over to NGOs by the State Government and after a successful pilot programme, it was decided to extend this reform. **Action:** In 2002, all PHCs were divided into two categories on the basis of their performance, vacancies, building condition and remoteness. The bottom half were offered to NGOs, trusts and medical colleges to manage. A total of 100 were made available in the first phase. The conditions for management were: (i) The initial period of entrustment was 5 years with a review of its functioning after two years. (ii) The government would reimburse 75% of salary payable to government staff, up to a maximum of INR 1500 per month for water and electricity charges, INR 25,000 per annum for maintenance of buildings and contingency and INR 75,000 per annum for drugs. (iii) The proposals were first verified and approved by the Chief Executing Officer of the concerned Zilla Panchayat or ZP (the District Panchayat) and then put to the selection committee. (iv) The NGO/ medical college would be responsible for implementing all National and State health and family welfare programmes. (v) The agency was to employ its own personnel in accordance with the government staffing norms for the PHC and sub-centre but was free to fix the remuneration of its employees. (vi) The existing assets of the PHC and sub-centres were handed over to the agency which they were to maintain and return to the government at the end of the contract period. **Results:** Karnataka is the only State where this initiative has run continuously and successfully long term. For example at PHCs under Karuna Trust -Gumballi PHC, Infant Mortality Rate (IMR) has come down from 75.7 in 1997-98 to 23.6 in 2004-05 and Maternal Mortality Rate (MMR) has been nil throughout the period. At Thitimathi PHC, IMR came down from 45.8 in 1997-98 to 14.21 in 2004-05 and here as well

	there have been no cases of maternal mortality. The RCH and other National Health Programmes are reported to be being implemented with better outcomes. All the staff in PHCs and Sub-centres stay at the head quarters to provide services 24 hours. PHCs under Karuna Trust have also launched various other programmes such as community health insurance; a de-addiction centre; sickle cell anaemia screening programme, and a tribal ANM project.
Cost	On an average it costs INR 10 to 12 lakhs per PHC. The Government (ZP) gives 75% of this amount and Karuna Trust spends between INR 1.5 to 2 lakhs per PHC from its own resources.
Place	Twenty two PHCs in Karnataka since early 2002. Of these, 14 PHCs in 11 districts are run by Karuna Trust and another 8 PHCs by Medical Colleges and other NGOs.
Time Frame	Approximately two to 6 months.
Advantages	Quality: Improved quality of services. Time saving: Enables faster decision making and implementation. Cost saving: Government pays only 75% of staff salaries and a fixed amount for drugs, water and electricity.
Challanges	Possible opposition: Objections from the Panchayati Raj Institutions (PRIs), private practitioners and previously employed government staff were initially faced in some PHCs taken over. Similarly, there could be problems in the relationship between the health authorities and NGO staff leading to payment delays and support in terms of equipment, drugs and training.
Prerequisites	Availability of NGOs and trusts, preferably ones already working in the area who are willing to take on the PHCs.
Who needs to be consulted	Government officials at state and district level, NGOs and Medical Colleges.
Risks	
Sustainability	Karuna Trust is planning to have one “Good Practicing PHC” in all the 27 districts of Karnataka. More NGOs and private medical colleges are coming forward to run PHCs. The partnership between the Government and NGOs has been well established and hence appears to be a sustainable model.
Chances of Replication	Variable. Another example of this kind of initiative by SEWA-Rural in Gujarat (see PROD No. 43) ran for more than 15 years before it was returned back to the government in 2000. However, a similar project in Orissa was unsuccessful - largely because the terms of reference were inadequate and the NGO did not have the resources or the ability to run the institutions.

	The Karnataka experience could be replicated in other states only if there is commitment from both the government and NGOs.
Comments	NGOs and Medical Colleges in Karnataka have been able to take responsibility for just 2-3% of the PHCs, the rest have to be managed by the PRIs (Zilla Panchayats). This is because at present, NGOs do not have the capability to take up more PHCs. Capacity building of NGOs would be necessary to enable them to do so.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. April 2005.
Status	Active
Reference Files	
Reference Links	

26. Public Private Partnership for delivery of Reproductive Child Health services to the slum population of Guwahati city, Assam

Subject Area="Public / private partnership (including NGOs)."	**Objective="Access to facility-based RCH services."**
Details for Reform Option "Public Private Partnership for delivery of Reproductive Child Health services to the slum population of Guwahati city, Assam"	
Summary	**Action:** The urban health intervention in Guwahati, Assam, involves contracting a trust hospital - Marwari Maternity Hospital (MMH) to provide services in eight low-income municipal wards of the city, having a total population of 2 – 2.5 lakh. The state government pays the MMH for providing outreach and referral services, in the identified areas. In addition, vaccines and contraceptives are provided free to MMH. MMH is covering 14 outreach sites in these areas. It is mainly providing RCH services but the outreach team includes a doctor and they can also treat simple ailments or refer patients to the hospital. In the hospital, sterilisation, spacing and abortion services are provided free of cost to patients, while deliveries, operations and diagnostic tests are charged at concessionary rates. The initial contract was for one year (2002-2003). Government of Assam reviewed the performance after one year and renewed the contract. To build up the referral system, the Government of Assam also proposes to upgrade three or 4 health posts/urban family welfare centres to secondary hospitals in the urban limits of Guwahati, within or near the slum areas. The first hospital will be partly funded from the Sector Investment Programme (SIP) of the European Commission (INR 252 lakh) and the others will be funded from the Department of Family Welfare's (DoFW) urban health allocation /other sources. The construction of the first hospital has already begun, under the management of the Kamrup district health & family welfare society. **Results:** The PPP initiative has had significant successes. Apart from direct provision of services, it has induced replication in the public sector. The secondary/ referral system is being strengthened with marginal investment since the staff are already available. The MMH management has started a programme of RCH camps in peri-urban areas at their own cost. Other private and trust hospitals in the city are expressing interest in joining this initiative.

Cost	Estimated cost: Cost of contract: INR 17.91 lakh for the first year, INR 29.07 lakh for the next two years.
Place	Guwahati city, Assam.
Time Frame	Discussions began mid-2000, the MMH - State Government agreement was signed 16 February 2002 and the outreach work formally started 31 March 2002. Once concerned parties have agreed to proceed, things can move very quickly because infrastructure requirement is minimal.
Advantages	Improved access to services: Particularly for the urban poor, floating population and women and children who were previously unserved. Increases use: Of institutional deliveries, immunisation coverage levels, improved management of obstetric emergencies and provision of basic curative care. Popular: Wide community and political support. Economic: Needs little infrastructure, not very costly and can start functioning very quickly.
Challanges	Support: Can be excessively dependant on the commitment and dedication of one person or of a small group. Relies on private sector cooperation: Reluctance of private facility managers to get involved with government programmes (this caused serious delay in this case). Needs government cooperation: Delays and non-cooperation from government officials can kill such initiatives very quickly - particularly delays in funds transfers. Possible opposition: In a similar initiative in Karnataka, the NGO managing Primary Health Centres (PHCs) faced difficulties with a private nursing home which feared a loss of business (See ECTA Working Paper 61 for details).
Prerequisites	Agreement between the government and service providers specifying their respective roles and responsibilities, especially with regard to the areas to be covered, payments, supplies, reporting etc. Prior to implementation, extensive consultations with community and religious leaders, to secure their support.
Who needs to be consulted	State / District health sector managers, the private management, community leaders.
Risks	
Sustainability	Sustainable as long as there is interest on both sides, the Government and the private participant.
Chances of Replication	The service delivery model has now been replicated at another 90 sites in Guwahati city, using available state government staff. The

	staff (both medical and paramedical) were based in various city dispensaries and were under-used. Another 10 sites will also be added. A similar arrangement is reported in rural areas in Andhra Pradesh, Orissa and Karnataka.(See ECTA Working Paper 61 for details)
Comments	The complement of government staff meant for the urban area identified for PPP, if any, would have to be re-assigned elsewhere. This would probably involve moving one or more existing health posts/sub-centres or re-defining the outreach areas for the post-partum centres located at district/sub-district hospitals.
Contact	
Submitted By	Mr. Indrajit Pal, Former Programme Advisor, ECTA, New Delhi. March 2004. Last Updated: July 2006
Status	Active
Reference Files	Case Study_EC program_Guwahati (final version 01 April 03).doc Assam URCH AGREEMENT.doc PPP-Andhra Pradesh Urban Slum Health Project.doc GOA PRESENTATION,2004.ppt IMGP2072.JPG Photo IMGP2057.JPG Photo IMGP2064.JPG Photo
Reference Links	

27. Empowering Non-Government Organisations to run emergency transport services, Tamil Nadu

Subject Area="Public / private partnership (including NGOs)."	**Objective="Access to emergency services."**
Details for Reform Option "Empowering Non-Government Organisations to run emergency transport services, Tamil Nadu"	
Summary	**Action:** Under a pilot scheme, the Tamil Nadu State Government identified NGOs willing to organise and run transport services for emergency obstetric cases and road traffic accidents. After a vetting procedure, the selected NGO, the Seva Nilayam Society, was given two vehicles free of cost, including communication and life saving equipment, drugs and medicines. They are stationed at one of the Emergency Accident Relief Centres (manned 24-hours by an Auxiliary Nurse Midwife) which are located at 50 km intervals along all National Highways in the state. The centres can be contacted on a toll free number. The NGO is expected to take care of vehicle maintenance, driver and paramedic salaries, fuel charges and insurance. It can charge no more than INR 5 per km – Below Poverty Level (BPL) cases must be transported free. The NGO is expected to offer services free of cost to 10% of cases and all accident emergencies are transported free of cost. The NGO must recruit two drivers and two nurses, train them and ensure they are available to provide 24-hour services working in shifts. **Results:** The scheme is monitored by a committee headed by the State Deputy Director (Health), the project director and the director of the NGO. The Deputy Director Health Services at the district level also monitors the programme. In Theni district, 30 to 45 emergency cases are transported every month. Out of the total number of cases transported, 30% are obstetric emergencies.
Cost	Tamil Nadu Government Health and Family Welfare Department budgeted to spend INR 6.5 lakh on the scheme in the year 2003/4 to provide vehicles and wireless network in Theni district. Two (second-hand) vehicles cost INR 5 to 6 lakh. The NGO incurs a cost of around INR 4-5,000 per vehicle per month.
Place	Theni district, Tamil Nadu, since 2002.
Time Frame	Three months to invite tenders from NGOs and vet them.
Advantages	Cost effective: For government because the scheme puts back

	into use old vehicles which are lying idle because of lack of manpower. Saves lives: NGO provides quality service with timely life-saving first aid services. Public awareness: Raises public awareness of available services.
Challanges	Not self-sustaining: The NGO incurs a loss each month and must find additional funding.
Prerequisites	Suitable NGOs. Government Order. Suitable vehicles.
Who needs to be consulted	NGOs. State Government.
Risks	
Sustainability	Despite the scheme not being self-sustaining, there is a growing demand for vehicles and more NGOs have expressed their willingness to run a similar service in other districts.
Chances of Replication	Following the success of this pilot scheme, the State government plans to extend it over the whole State under the Tamil Nadu Health Systems Project with funding from the World Bank and NGO support.
Comments	The State Government is continuing to encourage more private sector involvement in trauma and emergency care, particularly private hospitals. It has found that 30% of accident deaths occur either during transportation to a hospital or due to lack of emergency care at hospitals. In Haryana, the same problem is being tackled by recruiting ex-servicemen as drivers of ambulances at the block level.The driver is allowed to charge INR 5 per km (private companies charge INR 7 per km) and must maintain the vehicle himself.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	GO.doc — Government Order: GO MS No 166 Dated 29 August 2002: Providing Emergency Transport for Women as a Non-Governmental Organisation. Scheme Implemented through Seva Nilaym Society.doc — Report Scheme Implemented through Seva Nilaym Society in Theni District PROD74.jpg — Staff at Emergency Accident Relief centre, Andipatti PROD74-1.jpg — Ambulance run by NGO
Reference Links	

28. Establishing a Public Private Partnership Policy, West Bengal

Subject Area="Public / private partnership (including NGOs)."	**Objective="Policy development."**
Details for Reform Option "Establishing a Public Private Partnership Policy, West Bengal"	
Summary	**Background:** Following the successful collaboration with the private sector in running a number of services (such as outsourcing of non-clinical services, installation of CT scan machines at government medical colleges by private agencies, NGOs running medical services in remote areas, NGO partnerships in AIDS Prevention and Control Programmes), the Government of West Bengal has made it its policy to encourage public-private partnership within the health sector wherever it is cost-effective and beneficial to improving health for all. **Action:** The National Health Policy 2002 states: "In principle, this policy welcomes the participation of the private sector in all areas of health activities – primary, secondary or tertiary." The policy includes not just private sector companies but also non-government organisations (NGOs), community based organisations (CBOs), Panchayat Raj institutions (PRIs) and other interested parties from civil society. To this end, the Department of Health & Family Welfare (DoHFW) has established a dedicated Strategic Planning and Sector Reform Cell (SPSRC). A policy for public private partnerships in the health sector has been drafted by the SPSRC and is posted on the website inviting comments. Regular advertisements are placed in the local media encouraging private agencies to suggest new services and collaborations. Proposed new areas of PPP include: (i) Establishment of a private medical college. (ii) Establishment of a dental college. (iii) Dialysis units in tertiary level hospitals. (iv) Three mechanised laundry units for hospitals in Kolkata. (v) Establishment of a cancer hospital. (vi) Sale of fair-priced quality drugs, contraceptives etc through socially franchised private shops in block primary health centres and rural hospitals. (v) Outsourcing the management of selected non-functioning primary health centres. (vi) Emergency transport network: management of vehicles for emergency transport in BHPCs and PHCs through NGOs/CBOs/Trusts etc.
Cost	Still to be finalised. Approaches which do not bring an additional financial burden to DH&FW are to be given preference – however

	care will be taken to make sure partnerships deliver value for money and a robust and transparent process for assessing this will be adopted.
Place	West Bengal.
Time Frame	Ongoing process.
Advantages	Mutually beneficial: Helps the Government tackle its resource constraints and allows the private sector to make optimum use of its facilities. Increased accessibility: The community gets better access to quality healthcare services at a relatively low cost to the public sector. Community ownership: In the case of using PRIs, CBOs and NGOs, helps put healthcare back into the hands of the community itself.
Challanges	Possible opposition: From political parties and the community who fear health services will no longer be free-of-charge. Also from other local private competitors.
Prerequisites	Political will. A robust and transparent process for awarding contracts. A similarly robust and transparent process for assessing the value for money of each project.
Who needs to be consulted	State Government. Private agencies. The community.
Risks	
Sustainability	Sustainable if the political will is there and the private partner is able to deliver the quality healthcare service it promises.
Chances of Replication	Replicable most states can show examples of successful PPP projects – see other PROD entries in this sector domain.
Comments	Extensive advocacy measures are required for its successful implementation.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. November 2004.
Status	Active
Reference Files	
Reference Links	

29. Installation of CT scan machines in State medical colleges by private agencies, West Bengal

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved hospital services."**
Details for Reform Option "Installation of CT scan machines in State medical colleges by private agencies, West Bengal"	
Summary	**Action:** Computed Tomography (CT) scan machines have been installed and are being run by private agencies in 7 Government institutions in West Bengal. The terms and conditions state that free services should be given to at least 35 poor patients per hospital and to not more than 615 cases per month at approved government rates. The private agency can then carry out as many scans as it wishes, at its own prices, but the government is then entitled to 25% commission from each scan. The private partners bear all capital and operational and maintenance costs for running the facilities while the government provides rent-free accommodation. The entire system must be made available to undergraduates and post-graduate students for training and teaching purposes at pre-designated times. The private agencies must submit their accounts weekly to officers of the Department of Health and Family Welfare (DoHFW) and make them available to hospital administrators during spot checks. **Results:** No evaluation has yet been undertaken. However, services have been made available to patients at Government hospitals at rates which are much lower than the market rates (Rs. 800/- for brain scan). The number of patients has increased considerably. Therefore the initial tenure of agreement of two years has been extended.
Cost	Most of the cost (both capital and running cost including maintenance and electricity) is borne by the private agency. The tendering procedures cost approximately INR 15,000.
Place	7 Medical colleges including BS Medical College, Bankura; NRS Medical College, Kolkata; Medical College, Kolkata; SSKM Hospital, Kolkata; R.G.Kar Medical Colege, Kolkata; National Medical College, Kolkata; Midnapore Medical College, Midnapore.
Time Frame	As required for tendering procedures and evaluation of the proposals to be completed approximately two months to assign contract and four weeks for private agencies to set up at the

	hospital and a total of 8 months to issue the Government order.
Advantages	Cost effective: ensures fully working equipment at hospital without any major cost to the government.
Challanges	None reported.
Prerequisites	Private agencies willing to carry out such work. Political commitment to private/public partnerships.
Who needs to be consulted	State Government health departments; hospital administration; private agencies.
Risks	
Sustainability	Good. The agreement has been working for three years and is continuing.
Chances of Replication	Assumed good, since it has already been replicated and is now functional in 7 medical college & hospitals.
Comments	The Department of Health & Family Welfare, Government of West Bengal, has brought out a policy document on 'Health Sector Reform' and developed a 'Strategic Framework' which has dealt at length on partnership with private sector and NGOs. It has developed a 'Draft policy for Public Private Partnership in the Health Sector' which is available on their website for public feedback. See entry on "Establishing a Public Private Partnership Policy, West Bengal".
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. November 2004.
Status	Active
Reference Files	
Reference Links	

30. Contracting out diagnostic facilities in rural hospitals, West Bengal

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved hospital services."**
Details for Reform Option "Contracting out diagnostic facilities in rural hospitals, West Bengal"	
Summary	**Background:** In almost all Block Primary Health Centres (BPHCs) the only tests carried out are for malaria and sputum tests. Even at most of the Rural Hospitals (RHs) [also known as Community Health Centres or CHCs] only very basic tests are undertaken. At the same time, referring patients to the private sector or testing could have problems of its own, such as high prices and uncertain quality. **Action:** The Government of West Bengal has decided to set up diagnostic laboratories at RHs and BPHCs through public private partnership. It has developed the Standard Operating Procedures (SOPs) on the basis of which the partnership takes place. The agreement is made between the District Health and Family Welfare Societies (DHFWS) in each district and the private partner. [for more on district societies, see entry on Establishment of District Health Agencies] The DHFWS would provide rent-free ready to use space and free water at the RHs and Block PHCs while the private partner would have to install the furniture, refrigerator and other equipment at its own cost. A separate electric meter would have to be set up by private partners and electricity bills have to be paid by them. The private provider would conduct free tests for patients below poverty line up to a total of 20% of each type of test conducted every month (the criteria for free testing is based on a recommendation from the concerned Block Medical Officer of Health at the hospital). User charges would be collected for the rest of the cases as per the rates decided by the DHFWS. They would be free to charge market rates from patients referred by private practitioners. Nineteen such partners in 123 districts were identified and a government order was issued on 1 April 2004, indicating the same. At present (November 2004) operations have started in one place. Others are in the process of being finalised. **Results:** No evaluation has been undertaken since this is a very new initiative.
Cost	The Government only provides the space; all other costs are borne by the private partner.

Place	Rural Hospitals of West Bengal initiated the reform in April 2004. The next step would be to initiate this at Block Primary Health Centres of the State.
Time Frame	Since this initiative required a lot of evaluation like identification of sub-optimally functioning rural hospitals, selection of private partners, it took the department approximately 10 months for completion of the assessment and issue of the Government order.
Advantages	Improved access: to better quality services for the masses at low cost and free of cost for the poor. Utilisation: better utilisation of existing facilities at the hospitals expected.
Challanges	Possible opposition: from other private diagnostic providers in the locality.
Prerequisites	Issue of Government Order and Standard Operating Procedure. Private agencies willing to carry out such work.
Who needs to be consulted	Officials of the Health & Family Welfare department. RH doctors and NGOs.
Risks	
Sustainability	Expected to be good due to: Large patient turn out at rural hospitals. Non-beneficiaries are also allowed access at existing market rates. Sample collection centres are at PHCs, enabling easy accessibility to patients. Provides greater reach through reference from block samities.
Chances of Replication	Similar initiatives in the private sector in West Bengal were found to be a success: Red Cross societies were running such a service at the district headquarters where the rates charged were less than 50% of the prevailing market rate. An NGO – Jalpaiguri Welfare Organisation also runs a diagnostic centre at rates between one and two thirds of market prices.
Comments	The West Bengal Health & Family Welfare Department has brought out a policy document on 'Health Sector Reform' and developed a 'Strategic Framework' which has dealt at length on partnership with private sector and NGOs. It has developed a 'Draft policy for Public Private Partnership in the Health Sector' which is available on their website for public feedback. See entry on "Establishing a Public Private Partnership Policy, West Bengal".
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, November 2004.
Status	Active
Reference Files	
Reference Links	

31. Privatisation of hospital cleaning services, West Bengal

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved hospital services."**
Details for Reform Option "Privatisation of hospital cleaning services, West Bengal"	
Summary	**Background:** As part of the West Bengal Health Systems Development Project (launched June 1996), the State Government decided to contract out some hospital services to private agencies to improve quality and to allow hospital managers to concentrate on patient care rather than building maintenance. **Action:** Cleaning services were contracted out to private agencies. The agencies are appointed by the Chief Medical Officer on behalf of the District Health and Family Welfare Samiti at each hospital and approved by the Department of Health & Family Welfare (DoHFW). The District Health and Family Welfare Samiti has the authority to change the cleaning schedule/guidelines drawn up by State Government to suit its own facility. **Results:** West Bengal DoHFW report cleaner facilities and greater patient satisfaction. Surveys have shown patient satisfaction to have risen from 25% to 74%.
Cost	Depends on the size of the institution. Approximately INR 500,000 for a 500 bedded hospital. Costs for tendering procedures are separate.
Place	From May 2002 at 5 major hospitals in Kolkata – SSKM Hospital, Medical College and Hospital, RG Kar Medical College and Hospital, NRS Medical College and Hospital and National Medical College and Hospital – and then extended to all tertiary level and secondary hospitals with more than 100 beds.
Time Frame	As long as it takes to secure a Government Order and choose a contractor. In West Bengal, it took approximately 6 months to issue the Government Order. The actual tendering procedure was done by the Institution at the local level.
Advantages	Accountable: The agency must do a good job or it will lose the contract. Patient satisfaction: Cleaner conditions encourage more

	patients to attend facilities. It also teaches important hygiene messages.
Challanges	Possible opposition: From existing government-employed cleaning staff.
Prerequisites	Political will; Capable private cleaning agencies.
Who needs to be consulted	Officers of State department of Health & Family Welfare; Chief Medical Officers of Health (CMOH);
Risks	
Sustainability	Sustainable, provided there is political will and adequate budget allocation. The system is being continued either through renewal of contracts or fresh tenders.
Chances of Replication	Has already been extended from the 5 initial hospitals to all secondary and tertiary hospitals.
Comments	Hospital security has also been outsourced under the same contracting system. Security personnel must be ex-servicemen. Operation and maintenance of generators has also been contracted out. The West Bengal Health & Family Welfare Department has brought out a policy document on 'Health Sector Reform' and developed a 'Strategic Framework' which has dealt at length on partnership with private sector and NGOs. It has developed a 'Draft policy for Public Private Partnership in the Health Sector' which is available on their website for public feedback. See entry on "Establishing a Public Private Partnership Policy, West Bengal".
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. November 2004.
Status	Active
Reference Files	GO_31 01 05.doc — West Bengal DHF&W memo (6 May 2002) specifying the manpower required for security and area of scavenging at the hospitals for tertiary level hospitals.
Reference Links	

32. Contracting out of diet services, West Bengal

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved hospital services."**
Details for Reform Option "Contracting out of diet services, West Bengal"	
Summary	**Background:** West Bengal Department of Health and Family Welfare has entered into a number of agreements with the private sector and NGOs to provide specific services to improve the quality of health care being given in the state. **Action:** Meal preparation at all Government hospitals has been contracted out, mainly to women's cooperatives and women's Self Help Groups, and a diet chart prepared with improved nutritional content. Existing manpower was redeployed in other vacant posts. Meals are provided free of cost to below poverty line (BPL) patients and subsidised at 50% of cost to those in paying beds. Tenders are awarded by the executive committees of the District Health and Family Welfare Societies. **Results:** No evaluation has yet been made of this scheme but anecdotal evidence suggests that patient satisfaction has definitely increased.
Cost	Government subsidy remains the same as before. Meal rate fixed at INR 28.50 per patient per day.
Place	All Government hospitals in West Bengal since November 2001.
Time Frame	As required for selection of private contractor and completion of official formalities -approximately five months to issue the Government order and three months for the tender selection process. The actual tendering procedure was done by the Institution at the local level. The Superintendents/ Principals of the institutions had to deal with local problems before they could implement the process successfully and this time again varies between 1-6 months.
Advantages	Cost effective: The hospital can select the best value-for-money tender and the contractor uses existing kitchen facilities. Quality: Improvement in quality of food due to better regulation and higher expectations.
Challanges	None reported.
Prerequisites	Government Order. Availability of catering agencies that can provide an improved and cost-effective service.

Who needs to be consulted	Officials of the State Health Departments; Principal of medical colleges & hospitals; Chief Medical Officers.
Risks	
Sustainability	Has been working for the last three years.
Chances of Replication	No problems perceived with replicating this scheme.
Comments	The West Bengal Health & Family Welfare Department has brought out a policy document on 'Health Sector Reform' and developed a 'Strategic Framework' which has dealt at length on partnership with the private sector and NGOs. It has developed a 'Draft policy for Public Private Partnership in the Health Sector' which is available on their website for public feedback. See PROD entry on "Establishing a Public Private Partnership Policy, West Bengal".
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. November 2004.
Status	Active
Reference Files	
Reference Links	

33. Contracting sonography and x-ray services, Navi Mumbai, Maharashtra

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved hospital services."**
Details for Reform Option "Contracting sonography and x-ray services, Navi Mumbai, Maharashtra"	
Summary	**Background:** The Navi Mumbai Municipal Corporation (NMMC), which supervises an area of 162 sq km, came into existence in 1992. It is coping with a huge rise in population: 88.91% between 1991 and 2001 from 397,000 to 850,000. The 2004 mid year census projects a population of 850,000. Despite this large population, it has just one First Referral Unit (FRU), 4 Maternal and Child Health (MCH) centres and 14 Urban Health Posts (UHPs) which are also reaching out to villages and semi-rural areas. There was no sonography (ultrasound) facility at any of these facilities and even the x-ray services (available only at the FRU, known as the General Hospital) were understaffed and often services were unavailable due to long waiting times for official procedures to take up maintenance and repairs and recruiting new staff. **Action:** NMMC has initiated a number of Public Private Partnerships (PPPs) in the provision of health services. A successful initiative has been the NMMC's decision to set up sonography and x-ray services at MCHs and the general hospital through PPP. At MCH centres, both x-ray and sonography services are managed by the contractor with his own staff, consumables and maintenance. X-ray equipment belong to NMMC, but are managed and maintained (including the staff) by the contractor. Since the x-ray services were understaffed (both in MCH and FRU), it was decided to shift the x-ray technician from the MCH to the FRU in order to manage FRU services more efficiently and bring in the private partner to provide services in MCHs. The ultra-sonography machines are owned and managed by the contractor. At the FRU, the sonography services are run and managed by private parties while x-ray services are efficiently run by NMMC with its own staff. Rates are pre-decided between the operator and NMMC irrespective of the number of free patients and interest is payable by NMMC on delayed payments made to the operator. However at MCHs where the turnover of patients is comparatively less, a provision has been made to pay higher rates to the contractor to compensate for and provide an incentive to

	stay on with lower turnover. Similarly slightly lower rates are payable for higher caseload (a slight negotiation favouring NMMC as the higher volumes will fetch higher returns even with the lesser rate). For emergency services outside working hours, a higher rate is given to the operator. The NMMC is free to decide its own rates to be taken from patients. However all patients have to come through the NMMC cash counter only i.e. the contractor cannot see his own patients directly. The contract is for a long term - 5 years. This is designed as an incentive for the contractor, as the break even point for such a business proposition would be at least two years. Moreover, the rates availed in this contract are almost 7 to 10 times less then the market rates. **Results:** Prior to this setup, there were no sonography services and the x-ray services were running inefficiently. This contract solved the problem. Antenatal checkups have increased and there is a considerable reduction in pregnancy complications. Other departments can now provide better care in cases where ultrasounds are required. Because the PPP venture turned out to be a win-win situation for both the contractor and NMMC and a considerable demand for colour doppler services with improvement in other supportive services in FRU was identified, the existing sonography contract was upgraded with fresh tender invitations for colour doppler and other services will formally commence from late April or early May 2005.
Cost	There is no cost to NMMC in this venture as all the costs are handled by contractor, once set up. The cost involved in setting up the contract will include salary of individuals involved in planning (number of hours utilised), fuel, survey if any, phone calls, and stationary used. The cost to setup the contract was approximately INR 2, 00,000.
Place	4 MCHs and FRU under NMMC, Navi Mumbai, Maharashtra.
Time Frame	Approximately 5 months to set up the contract.
Advantages	Improved access: to better quality services at low costs and free of cost for the poor and at centres nearer their homes. Utilisation: Optimum utilisation of the existing infrastructure and equipment at these centres. Continuous runtime. Reduced costs: The savings in operational costs will be considerable.
Challanges	Possible opposition: From labour unions regarding retrenchment, issues of utilising existing specialists and employees elsewhere and mixing existing staff with contractors staff (which is not recommended for issues of authority).
Prerequisites	Willingness to experiment by the government, availability of

	operators in the vicinity willing to provide services, setting up standard operating procedures.
Who needs to be consulted	Municipality officials, radiologists and gynaecologists at the FRU and MCHs, private parties willing to offer services.
Risks	
Sustainability	The venture is self sustaining, and the NMMC is earning a small revenue in this department for the first time. There does not seem to be a reason why it should not continue in future. As the venture is contractual with operator funding the same, there is no question of funding problem.
Chances of Replication	Such services can easily be replicated but a few things need to be taken into account: (i) An important issue concerns the staff. Staff levels do not need to be cut – they can be relocated to another unit. (ii) Mixing operational cultures should be avoided. For example care would need to be taken not to mix existing staff with new operator staff. (iii) As far as possible, local operators should be involved to take into account linguistic and cultural issues. (iv) Negotiations should not compromise on quality - even if it is necessary to pay more to the contractor. (v) Standard operating procedures should be set up. (vi) Monitoring by authorities is essential to control quality aspects. (vii) Timely payment to the contractor is essential to motivate him to continue to provide quality services (in this case NMMC has included an interest payable for delayed payments).
Comments	None.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, February 2005.
Status	Active
Reference Files	
Reference Links	

34. Using a private partner to provide round-the-clock laboratory tests at a government hospital, Uttar Pradesh

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved hospital services."**
Details for Reform Option "Using a private partner to provide round-the-clock laboratory tests at a government hospital, Uttar Pradesh"	
Summary	**Background:** The Bal Mahila Chikitsa aum Prasuti Griha (BMC & PG) - Maternity & Child Care Centre Aligunj Lucknow (U P) has its own laboratory but it is only open between 0800 and 1400 hours on working days. As a result, large numbers of pregnant women coming to the BMC & PG after working hours did not have immediate access to investigation facilities. In emergency situations, the patient's attendant had to find a private laboratory to carry out the tests, often incurring a high fee. It was decided that under Lucknow's Urban RCH project, supported by the European Commission, which aimed to strengthen the BMC & PG so that it could provide round-the-clock facilities for normal delivery, emergency caesarean section, neonatal care, family planning and immunisation services to the slum population and other residents in the neighbouring areas, laboratory services should be extended to give 24-hour cover. However because resource constraints meant the hospital could not extend its own laboratory's opening times, a private partner was sought. **Action:** (i) BMC & PG Aligunj started negotiations with 24-hour diagnostic centres located in the neighbouring areas for Public Private Partnership. After negotiation and revalidation of laboratory quality standards, M/S Thukral Diagnostics Centre Lucknow was identified as a suitable partner. The selected diagnostic centre provided three different packages at a reasonable cost for emergency investigations. The packages cover most of the investigations a pregnant woman may be required to undergo after admission to the BMC & PG. (ii) The diagnostic centre sends a laboratory technician to BMC & PG to collect blood specimens after receiving a call from the hospital. The specimens are immediately processed in the diagnostic centre's laboratory. They then communicate the results to the hospital. (iii) Below Poverty Line (BPL) patients receive this facility free of cost. The Chikitsa Sudhar Samiti (CSS) (the hospital's welfare committee) reimburses the diagnostic facility these fees. **Result:** The arrangement ensures that pregnant women and children have round-the-clock access to laboratory investigation

	facilities at an affordable cost.
Cost	No additional cost has been incurred by the BMC & PG Aligunj for this arrangement.
Place	BMC & PG (Bal Mahila Chikitsa aum Prasuti Griha) - Maternity & Child Care Centre Aligunj Lucknow (U P) from March 2003.
Time Frame	Two months .
Advantages	For hospital Improved facilities: Provides round-the-clock emergency investigation facilities. Cost effective: No cost to hospital or to BPL patients. It also provides a saving to other patients because emergency investigation charges are usually much higher in a private laboratory. Time effective: Prompt availability of the investigation report, thereby improving the quality of the hospital care. Convenience: The arrangement saves both time and effort. For private partner Increased custom: Idle capacity of the diagnostic facility is utilised. Revenue generation: Increase in customers.
Challanges	Monitoring required: Hospital must ensure the diagnostic facility meets quality standards.
Prerequisites	Good diagnostic facility in the vicinity of the hospital. Good communication network.
Who needs to be consulted	Chief and Deputy Chief Medical Officers. Diagnostic facilities. Patient welfare committees.
Risks	
Sustainability	The arrangement appears to be sustainable.
Chances of Replication	The arrangement can be replicated in district hospitals, FRUs and CHCs, where private round-the-clock diagnostic facilities are locally available.
Comments	This PPP initiative is no longer there. Now, the laboratory services are provided by the hospital.
Contact	
Submitted By	Dr JN Srivastava, State Facilitator UP, ECTA. June 2005. Last Updated: November 2006.
Status	Active
Reference Files	DIAGNOSTIC PACKAGES.doc — Cost of Diagnostic Packages provided by private partner Pvt Lab charges.doc — Comparative fees charged by private

	labs
Reference Links	

35. Outsourcing of non-clinical services, Punjab

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved hospital services."**
Details for Reform Option "Outsourcing of non-clinical services, Punjab"	
Summary	**Background:** Due to a shortage of manpower in hospitals, many non-clinical services (eg cleaning) were not being carried out, leading to an inefficient delivery of health services. **Action:** Punjab Health System Cooperation (PHSC), which runs health services in Punjab, decided to outsource non-clinical services to ensure efficient and smooth functioning of its hospitals round- the-clock. (i) Ambulance services: 147 drivers are hired on a contract basis. Among these 133 drivers were selected by PHSC with the remaining 36 drivers being provided by the Punjab Ex Serviceman Corporation (PESCO).(ii) Sanitary services: In addition to the permanent staff, sanitary staff are hired on contract basis in 56 health facilities. (iii) Electric and plumbing services: Hospitals which have user charge collections of more than INR 25,000 per month are allowed to hire an electrician and plumber. Monthly retention charges on these services are decided according to the bed strength of the hospital. Functional bed capacity Maximum monthly retention charge Electrician Plumbers 200 beds and above INR 1500 INR 1500 100 –200 beds INR 1000 INR 1000 Less than 100 beds INR 750 INR 750 However, electricity expenses, water expenses and other statutory expenses cannot be paid for from user charges. **Results:** (a) Total annual expenditure on permanent staff- INR 34139067. Total annual expenditure on contractual staff- INR 18137756. (b) Total sanitation staff - 1104 Permanent sanitation staff- 399 Contractual sanitation staff- 705
Cost	No additional cost as the reform and running costs come from user fees.
Place	154 hospitals in Punjab, including Community Health Centres, Sub divisional hospitals and District hospitals.
Time Frame	Approximately one year.
Advantages	Hygienic health facilities: Regular availability of sanitation staff in the hospital and accountability of the cleanliness of the facility in the contract provides hygienic health facilities. Availability of ambulance round the clock: Availability of drivers round-the-clock ensures emergency transport services for

	patients.
Challanges	None perceived.
Prerequisites	Government Order.
Who needs to be consulted	State government.
Risks	
Sustainability	Sustainable as the cost of the outsourced services comes from user charges.
Chances of Replication	Many states have outsourced non-clinical services and found it to be a successful solution.
Comments	Outsourcing has become one of the management strategies to deal with routine problems encountered in the smooth functioning of health facilities. Outsourcing of services has the potential to deliver the assigned jobs with accountability.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, September, 2005.
Status	Active
Reference Files	PHSCMFA2k3728-80.doc
Reference Links	

36. Biomedical waste management at Community Health Centre, Himachal Pradesh

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved hospital services."**
Details for Reform Option "Biomedical waste management at Community Health Centre, Himachal Pradesh"	
Summary	**Background:** Biomedical waste can pose numerous health and safety hazards to patients, health care providers and to the community at large. In response to the threat, the Government of India passed the 'Biomedical waste (management and handling rules) 1999', under the Environment (Protection) Act 1986. However, very few health institutions are implementing them properly because of a lack of awareness and difficulties at the institutional as well as operational level such as lack of resources, including personnel, space and equipment, lack of technical knowledge for scientific waste disposal. In addition, waste disposal is monitored by the Pollution Control Board and Environmental Ministry which has no linkage with the Health Department. **Action:** Keeping in view the potential health and safety hazards associated with biomedical waste and the legal urgency to abide by the rules, a model programme of Biomedical Waste Management (BMWM) was launched at a Community Health Centre (CHC) Daulatpur in Una district in April 2004, under the Basic Health Project of the German development agency GTZ. Selection of CHC in Daulatpur was based on the following criteria: (i) It was an average hospital so other facilities could identify with it and follow its lead. (ii)It was a difficult case to work on because of adverse media reporting and overflowing hospital waste. In order to overcome both institutional and operational difficulties, a Non Governmental Organisation (NGO), the Energy and Environment Group (EEG) was hired by State government for one year. They formed an 8-member committee, which was made responsible for implementing, training and ensuring sustainability of the new programme. The first step was the planning phase which included: (i) Assessment of the waste production in the health institution (ii) Evaluation of the existing practice (iii) Estimation of the required equipment and supplies (iv) Development of formats for

	monitoring, supervision and record management (v) Defining responsibilities of staff. This was followed by the procurement and setting up of equipment and supplies. Simultaneously with the procurement of equipment, in house training of staff at all levels was organised, with special focus on the principals of waste management such as segregation of the waste from the point of generation to point of disposal, disposal method of the waste etc. Training was the vital step in the implementation of the BMWM. After the initial training frequent orientation/refresher training programmes (twice in a month) was required at least for about six months to enable people to get used to the new system. **Results:** Proper disposal of waste generated in the hospital has resulted in clean and hygienic health facilities and has reduced the potential risk of exposure of the staff and patients to nosocomial infections. In terms of visible impact, change in the hygiene of the health facility before and after the programme is seen in the attached photograph (see References). For objective indicators for change, the hospital has data, but has yet to analyse.
Cost	GTZ's Basic Health Project financed this model programme. The cost for setting BMWM was INR 63,000 per annum for a 50-bedded hospital. This includes various equipments, deep burial yard with 4 pits, IEC Material, one time training cost and quarterly supply of the bags.
Place	Pilot programme is in operation in CHC Daulatpur, District Una,Himachal Pradesh from April 2004.
Time Frame	Around two months for orientation of staff, planning and procurement of equipment and supplies.
Advantages	Reduced risk of exposure to potential hazards: The potential risk to all associated with biomedical waste is lowered. Quality of healthcare services: After the initialisation of the Waste Management Programme visible improvement in services was noticed. As a result, the infection rate at the hospital level has gone down. Improved environment: The working environment of the hospital is cleaner and better.
Challanges	Staff dissatisfaction: The system may increase their workload.
Prerequisites	Willingness of the health care institution to participate. Motivated health staff that want to work for a better hospital environment. Committed resources (personnel, space, equipment and supplies) to ensure sustainability. Quality training is a vital step in implementing BMWM. The staff should also accept and be committed towards the new system.
Who needs to be consulted	Pollution Control Board and the relevant authorities from the Health Department.

Risks	
Sustainability	Sustainability depends upon the commitment of the head of the health institution as well as the staff towards implementing the programme. Provision for the various supplies (such as bleaching powder, gloves, bags) and repair and maintenance of the BMWM equipment has to be taken care of. Close monitoring and supervision (involving effective, efficient and accurate record keeping) by the Project, NGO or by any nodal person for at least a year is required.
Chances of Replication	After the success of the pilot programme at CHC Daulatpur, the programme has recently been taken up in CHC Gagret and CHC Haroli in Una district of Himachal Pradesh.
Comments	Biomedical waste management is an important service area, which needs to be addressed in order to enhance the output from other related departments and reduce the potential risk of exposure to hospital acquired infections. But success of the initiative depends on the stakeholders who are involved in the production of the BMW as well as in its disposal.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, ICMR. March 2006.
Status	Active
Reference Files	bmw visual.jpg CHC Ghumarwin, Bilaspur district30.JPG CHC Daulatpur, Una District5.JPG CHC Daulatpur, Una District11.JPG
Reference Links	

37. Quality Improvement in Government Hospitals, Himachal Pradesh

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved hospital services."**
Details for Reform Option "Quality Improvement in Government Hospitals, Himachal Pradesh"	
Summary	**Background:** Low management capacities at health facilities, lack of policies and guidelines from the State, as well as structural problems of the centralised health system are key problems of the Public Health Sector leading to inefficient use of scarce resources and deficiencies in the quality of services provided. With decentralisation and planned increase in hospital autonomy arise the need for a well-functioning management system in public hospitals. Furthermore, the establishment of Aspatal Kalyan Samities (AKS), or Hospital Management Societies, which generate their own income by levying user charges, makes improvement of services provided in these hospitals a must. **Action:** In mid-2002, a quality improvement initiative was started in one Pilot Hospital of Himachal Pradesh in Una district. In late 2003 this initiative was extended to 4 other Pilot Hospitals (Bilaspur, Rohru, Palampur, Ghumarwin). In these 5 Pilot Hospitals an initial basic assessment was conducted by a trained International Standard Officer (ISO) auditor from Germany and an Indian expert in hospital management. After the assessment, a planning workshop was conducted with participation of hospital staff. The findings of the Basic Assessment were presented to the staff, based on which Quality Circles (QCs) were formed for systematic quality improvement in different areas—Infection Control and Hygiene, Sanitation and Waste Management, Out Patient Department (OPD), In Patient Department (IPD), Surgical Care, Documentation, etc. The Quality Circles were supported to prepare action plans for removing weaknesses identified during the basic assessment and to gradually improve their respective working area. A Quality Core Group (QCG), consisting of the Hospital in-charge, a Doctor, the Matron and representatives of different professional groups within the hospital, was formed to coordinate and support the activities of QCs. A Quality Representative, who received specific training in Quality Management (QM), was appointed to mediate between QCs and the QCG and to do a close follow-up of the work of QCs.

	Results: Though proper evaluation of the QC has not been carried out yet, it definitely has helped in developing standards for hospital maintenance. So far 25 self-assessments and 13 peer reviews have been carried out which are yet to be analysed. But work of QCs has shown that a considerable part of the problems identified during the basic assessment was solved by the QCs.
Cost	Expenses are met from the revenue collected through user charges.
Place	Zonal Hospitals in Una, Bilaspur, Rohru, Palampur, Ghumarwin in 2002-2003.
Time Frame	Approximately one year.
Advantages	Trouble shooting: Hospital staff is encouraged to contribute to problem solving and process improvement within their hospital, instead of waiting for problems to be solved by the higher level authorities. Structural gaps: Identification of structural problems that hinder quality management and have to be solved with support from the State.
Challanges	Lack of resources: The scarcity of resources limits quality improvement activities, especially with regard to infrastructure and equipment. The high patient load and the overburdening of staff in some of the Hospitals limit their capacity and willingness to do “extra work” for QM. Frequent transfers: Trained staff is withdrawn and new staff has to be trained. Therefore, frequent transfer of staff creates an unstable working environment which is not conducive to QM. Lack of incentives: either negative or positive within the government setting leads to low motivation of some of the hospital staff to improve quality of services.
Prerequisites	A prerequisite for the QM initiative to be successful is the willingness of higher authorities to provide support to the Hospitals (e.g. in form of financial support and training). Hospitals should dispose of some funds to finance QI activities either through State budget or AKS funds. Training on QM has to be provided to key staff within the Hospitals and in the Directorate. Time needed to work on QI should be given to the staff without expecting staff to work outside working hours.
Who needs to be consulted	State government authorities. It may require the approval from the state cabinet for the Hospital Standards.
Risks	
Sustainability	Sustainable if the central authorities keep supporting the initiative and if hospital staff receives necessary training and support.

Chances of Replication	In 2003 the counterpart decided to include all public hospitals that have a Hospital Society in the Quality Management initiative. QI activities could also be started in primary and community health centres.
Comments	Identifying areas for improvement and developing solutions for identified problems empower the staff to contribute to the continuous improvement of their working environment. Nevertheless, for solving very complex or structural problems and for continuously improving key processes within the hospital, further technical support and training are needed.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, June 2006.
Status	Active
Reference Files	
Reference Links	

38. Mobile Health Care Service, Sundarbans, West Bengal

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved outreach services."**
Details for Reform Option "Mobile Health Care Service, Sundarbans, West Bengal"	
Summary	**Background:** The Sundarbans (which have a population of more than 3.5 million people living in 1,134 villages) are extremely remote and lack a satisfactory public transport network. Some villages are at least six to eight hours from secondary care hospitals. Even the nearest villages are two to four hours from subdivision or district hospitals. In addition, most of the region's Primary Health Centres (PHCs) were built in the 1950s and 1960s and have since fallen into disrepair – none offer in-patient treatment and many are not staffed properly. **Action:** The Health and Family Welfare Department of the Government of West Bengal conducted a health system development project with funding from the World Bank between 1996 and 2004. It set up links with five NGOs to improve access to primary health care in the Sundarbans and improve the health status of its people. The NGOs reach the islands by boat, carrying x-ray facilities and equipment, and take specialists from Kolkata to conduct regular health camps in different villages. The NGOs were given the following terms of reference: (i) to organise general, ante-natal, post-natal and well-baby clinics: at least four per village per month. (ii) to provide maternal and child health services. (iii) to boost immunisation programme with the help of sub-centre staff (iv) to boost family welfare activities in the area. (v) to organise specialist camps: at least two per month in the area of operation. (vi) to provide common diagnostic services such as x-rays, routine blood, urine and stool exams. (vii) to arrange regular awareness programmes addressing issues such as sanitation and personal hygiene. (viii) to follow-up pregnancy-related complication cases. **Results:** The service was assessed by INSPIRATION (Institute for Planning, Innovative Research, Appropriate Training & Extension), in 2002 which highly commended the NGO's services and recommended their continuation. Under the Mobile Health Care Service (MHCS), 52% of remote villages in the Sundarbans are covered. Total patient attendance at mobile clinics between March 1998 and March 2004 was 2.3 million. The percentage of patients using government health centre facilities has increased from 11% to 21.25%, implying greater awareness and efficient

	referral. A total of 14,3464 pregnant mothers were monitored in 7,386 clinics
Cost	From March 1998 to November 2002: INR 46 million. From September 2002 to March 2004: INR 33 million. The average cost of MHCS per year is INR 25 million.
Place	Covering 351 villages in the Sundarban islands, Bay of Bengal, since 1998.
Time Frame	Eighteen months from the launch of the project to the beginning of services.
Advantages	Extension of services: Provides specialist care to patients who otherwise would not travel to seek help. Awareness raising: Improves health education and knowledge of facilities on the mainland.
Challanges	Mobility constraints: Needs a better network of riverine and road ambulances to ensure timely medical intervention. Cost Intensive: This is an expensive programme and is difficult for the government to sustain without external aid. Limited effectiveness: Quality of health will only really improve in the Sundarbans with a parallel improvement in education and income generation.
Prerequisites	Good network of reliable NGOs to carry out the services. Availability of consultants willing to take part in the scheme.
Who needs to be consulted	NGOs. Local community. Officials of the State Government.
Risks	
Sustainability	State Government has sanctioned the budget to continue the service now that the World Bank programme has finished. It is applying for foreign funding to help finance it.
Chances of Replication	Good, although dependent on funding and available reliable NGOs.
Comments	Participating NGOs are: TSRD, Kolkata Southern Health Improvement Samity (SHIS), Bhangar Sri Ramkrishna Ashram (SRKA), Nimpith Servik Vivekananda Gram Seva Sanstha (SVGSS), Belur Bharat Sevasram Sangha (BSS), Kolkata. The West Bengal Health & Family Welfare Department has brought out a policy document on 'Health Sector Reform' and developed a 'draft strategic framework' which has dealt at length on partnership with private sector and NGOs. It has developed a 'Draft policy for Public Private Partnership in the Health Sector' which is available on their website for public feedback. See entry on "Establishing a Public Private Partnership Policy, West Bengal".

Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. November 2004.
Status	Active
Reference Files	Mobile specialist health camp at Baliara, Namkhana block, The Sunderbans.jpg Registration at specialist health camp, The Sunderbans, West Bengal.jpg Mobile health staff on their way back from a health camp,The Sunderbans.jpg
Reference Links	

39. Model District Reproductive and Child Health Services Project, Pune, Maharashtra

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved outreach services."**
Details for Reform Option "Model District Reproductive and Child Health Services Project, Pune, Maharashtra"	
Summary	**Background:** Despite its position as one of the more advanced states, Maharashtra has a poor record in public health. Reproductive and Child Health (RCH) is an area of particular concern in the state. A high number of women, particularly those living in rural areas suffer from anaemia; the infant mortality rate is high; low birth weight is prevalent and the rate of institutional deliveries low - especially amongst tribal women. **Action:** To improve the coverage and quality of RCH services in Pune District, the Model Reproductive and Child Health District Project has been implemented by the KEM Hospital Research Centre and 11 partner NGOs, since March 2004. All NGOs have developed a Model RCH Programme Action Plan in one selected Primary Health Centre (PHC) / urban slum. This action plan comprises activities to be conducted by the NGOs independently, as well as in coordination with the government staff [Health, Education and Integrated Child Development Service (ICDS) workers] and the Zilla Parishads (District Panchayats). A review of the existing practice and system of RCH care delivery and its infrastructure revealed there was limited trained manpower resource at the Sub Centres (SCs) and PHCs. Thus under the Model RCH project, one of the main activities undertaken was the selection and training of 'Parivartaks' (change agents) from Community Based Organisations (CBOs). These volunteers carry out house-to-house visits which help them generate demand and plan RCH services in their respective areas. The information they gather enables PHC staff to provide needs-based comprehensive RCH care on fixed days and times through 'Health Service Sessions' in every village (261 villages under this project). This is in addition to the fixed-day weekly clinics held at PHCs. Other activities of the NGOs in coordination with health staff include: (i) Forming and attending block level co-ordination committees and village health committees. (ii) Ensuring proper registration of births, deaths and marriages. (iii) Set up of village

	RCH fund to manage emergencies. (iv) Ensuring 100% registration of ante-natal care (ANC) cases and their follow up. (v) IEC activities such as painting wall slogans and conducting dindis (processions with children chanting RCH slogans). (vi) Inter sectoral coordination activities such as refresher training to school and ICDS staff. (vii) Ensuring that there are no dropouts and 100% attendance at primary schools. (viii) Ensuring all deliveries are conducted by trained personnel and where necessary, provide training and reorientation of Dais. (ix) Adolescent health education. To ensure that the programme achieves its objectives, the following four guidelines were adhered to during the selection process for the NGOs; the project should be: (i) Sustainable, (ii) replicable, (iii) Implemented in coordination with the various government departments, and (iv) Avoid duplication of services provided by the government. Results: Since the initiative only began recently, the full benefits will take some time to materialise, but already the following are apparent: (i) Effective coordination between the government staff of various departments and implementing partner NGOs. (ii) NGOs have identified 'Parivartaks' who are willing to participate in the programme without any honorarium. (iii) Improved quality of services from the PHC staff. (iv) Fixed day clinics have been established at PHC level and in almost all villages, health service sessions (lasting 4 to 6 hours) are being conducted regularly. (v) The NGOs have been able to establish Village Health Committees (VHCs) in each village and have set up the village health fund for management of emergency health problems. This activity has not been initiated in urban areas as the need is not so great because there is better accessibility to health services.
Cost	The estimated cost for the project is INR 2.31 crores over two years.
Place	Eleven blocks (rural area) and one urban area of Pune district, Maharashtra covering a population of 3.5 lakh since March 2004.
Time Frame	Depends on the PHC medical officers' (MOs) motivation and involvement of CBOs. After launching the project, it took six months to function smoothly. Should be possible to replicate elsewhere within a year.
Advantages	Needs specific: Provision of services based on the type of the area. Awareness rising: Improves health education and knowledge of availability of health services and facilities. Increases community ownership: by establishing and conducting village health committees, creation of village health funds and involvement of all gram panchayat members and health volunteers from CBOs in RCH activities.

	Demand generation: These put pressure on the government to provide services and improve quality. Inter-sectoral coordination: Effective coordination with state level schemes implemented by various government departments, specifically education and ICDS staff. Complimentary: coordinates with the work of government health staff and enables them to concentrate on provision of quality services.
Challanges	Possible Opposition: From the PHC MO and his/her staff who may not want to cooperate and from other govt officials for example ICDS staff. Community reliant: Relies on the availability of volunteers to work as Parivartaks. Challenging perceptions: Many partner NGOs found it hard to accept that household planning would work or that volunteers would work without renumeration.
Prerequisites	Good coordination between government (both at state & district), PHC staff and NGOs. A good network of reliable NGOs to carry out the services. Community participation and willingness of community members to volunteer.
Who needs to be consulted	Officials at the Government Health & Family Welfare Department, Municipal Corporation, partner NGOs, local community, body imparting technical assistance (in this case KEM Hospital Research Centre)
Risks	
Sustainability	Sustainability and ability to replicate were the guidelines taken into consideration during selection of the NGOs. It was decided to initially implement the project under European Commission-supported Sector Investment Programme for two years and subsequently make it a part of RCH II programme for the next 5 years to cover the entire district. More specifically, a good liaison between government staff and Parivartaks, community awareness and demand for services will ensure the sustainability of this initiative.
Chances of Replication	Replicable, although dependent on funding and available and reliable NGOs in the area. If proper training and motivation of government health providers in both demand generation and quality services is done, then the chances of replication of the project is easy. The role of gram panchayat and VHCs is crucial and if they are made aware of their responsibilities, then the chances of replication of this project are very high.
Comments	KEM has had a long history of delivering rural health services. For more see “King Edward Memorial Hospital Rural Health Project” publication of the Anubhav series.

Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, February 2005.
Status	Active
Reference Files	
Reference Links	

40. *Mini Health Centre scheme, Tamil Nadu*

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved outreach services."**
Details for Reform Option "Mini Health Centre scheme, Tamil Nadu"	
Summary	**Background:** Community health outreach in partnership with the community is the core vision of Voluntary Health Services (VHS) for the healthcare of the rural underprivileged. The model of outreach services through Mini Health Centres (MHCs) found recognition as early as 1969 and served as a forerunner for primary healthcare in India. The aim of the MHCs is to render comprehensive, continuous and co-operative community care. **Action:** The MHC model was introduced in the in St Thomas block of Kancheepuram district of Tamil Nadu by VHS as a pilot project in 1968 -70 for a population of 10,000. The population was later scaled down to 5000 per MHC. To establish an MHC in an area, the community is involved in several ways. At the execution stage it participates by providing constructed building for accommodation and minimal furniture. Recurring cost is subsidised by grants both from government and private donations. Financial participation by the community is also encouraged through the Medical Aid Plan (MAP), the health insurance scheme run by VHS. At MHC level subscribers to the MAP are entitled to free treatment throughout the year and inpatient services at tertiary level are either subsidized or free. (For details of the MAP scheme see PROD entry No 127: Medical Aid Plan for voluntary health insurance, Tamil Nadu). Each MHC model is staffed by two fulltime Multi Purpose Workers (MPWs), one male, one female and a Medical Officer (MO). They are assisted by Lay First Aiders (LFAs) for every 1000 population. After a short and intensive training LFAs provide first aid services and impart health education to the community. They are in direct contact with the families and are constantly

	available, helping the people and understanding the need for health services and advising them accordingly. A regular medical officer, residing in an urban or semi urban area, attends the clinic for three hours a day, three times a week. The availability of the medical officer is imperative since he or she guides and leads the team of health workers. To improve the capability and resources of the MHC core staff, additional provisions are provided in the form of supervisory staff (one male and one female) for every four MHCs and a referral link where specialised care could be provided. The referral hospital is also expected to provide technical support and manage a cluster of MHCs through supervisory staff. All the above categories of workers, including the doctors, undergo compulsory prescribed training and on the job training while working at VHS. Services provided include: i) Medical examination of every family and preparation of 'at risk' register; ii) Nutritional assessment of each family member; iii) Maintenance of records; iv) Maternal services including antenatal and post natal care. Each mother is visited approximately once a month during the period of pregnancy and lactation; v) Child welfare services, including maintenance of growth cards, immunisation, nutritional assessment and treatment; vi) School health services; vii) Family welfare and planning; viii) Medical care; ix) Domiciliary treatment for tuberculosis and leprosy; x) Laboratory investigation for screening of preventable diseases; xi) Referral of cases for specialist consultation or admission to a referral hospital. Results: In 14 MHCs in 2004 the following results were achieved: Maternal care: 89.3% of women registered for ANC services 89 % of women received three ANC check ups 75.4% of women received immunisation 58.2% of deliveries were institutional Nutritional care to children: 69%% of children (0-5 years) registered Expected malnourishment was 13%
Cost	The Government by their G.O. Ms. No. 437 dated 13th March'84 have sanctioned a budget of INR 27,000 per annum for each of the MHC run by VHS. The cost to be share on 1:1:1 basis by the Central Government, State Government and Voluntary organisation.
Place	Kancheepuram district,Tamil Nadu
Time Frame	Six -8 months
Advantages	Community partnership: Making the community provides the accommodation and minimum furniture free of cost and motivating the community to become member of the MAP scheme. Efficient functioning of the referral services: MHCs have well-established linkage with VHS hospital for the referrals. Government has also issued clear instructions in G.O. No. 94890/P&D I/ 78-SI dated 27.5.78 to Directors of Medical education and medical services to give special attention to the

	referred cases from MHCs and maintaining its records. Increased utilisation rate: Facility used more frequently due to availability of continuous and comprehensive services to the community on permanent basis rather than sporadic visits or camp drive. Strengthened curative care at peripheral level: Provision of medical officer at the peripheral level strengthens the delivery of curative services on continuous basis.
Challanges	Continued need of co-operation from the community: Sustained motivation of the community to participate in the MAP scheme and ensuring their involvement in the health care activities. High turn over of the medical officers due to lack of motivation to serve in rural area.
Prerequisites	Local action committee consisting of local leaders, panchayat members, officials and other residents. It helps to generate awareness of ownership of the MHCs by the people. Community participation in providing free accommodation and minimal furniture for accommodating the MHC. Identification and linkage with the referral hospital for specialized services as Hospital and Medical Centre under VHS.
Who needs to be consulted	Local leaders, PRI members, NGO, State Government and Hospital for referral linkage.
Risks	
Sustainability	Sustainable, but depends upon the raising of funds from the community through their continued involvement as subscribers in the MAP.
Chances of Replication	. Results have shown its success in terms of improved health indicators. . The model was adopted in 1977 by TN government as a prototype for the voluntary bodies to assist the government functioning. Since June 1993- 261 MHCs are running in the TN by various voluntary organizations. Out of them 14 are under VHS in Kancheepuram district.
Comments	The mini health centre scheme was started in 1970 when the concept of primary health centres was very new in India. The core idea was to involve the community in their own healthcare activities, which there is much need of today owing to resource constraints. But its success depends upon the continued involvement of the community.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, IRMS, July 2005
Status	Active
Reference Files	health-Lok Satta.pdf — Ensuring a Healthy Future - Lok Satta MHC-TN.jpg

Reference Links	

41. Community Midwives Programme, Uttar Pradesh

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved outreach services."**
Details for Reform Option "Community Midwives Programme, Uttar Pradesh"	
Summary	**Background:** One third of all deliveries in Uttar Pradesh are by untrained providers and patients have to travel on average further than in any other state in India to reach a delivery centre. There are insufficient numbers of Auxiliary Nurse Midwives (ANMs) and the existing ones are overworked. As a result there is a high maternal mortality rate MMR (707/1,00,000 live births) and infant mortality rate IMR (82/1000 live births). **Action:** State Innovations in Family Planning Services Agency (SIFPSA), with funding from USAID and technical assistance from PRIME/IntraHealth, have established a new cadre of private community midwives in rural areas. To do this they recruited 239 women aged 18 to 35 and educated to a minimum 10th class pass, to train as community midwives (CMWs) at government training centres over a period of 18 months. The CMWs are then expected to go back to their communities and set up in private practice. The programme included: (i) Developing an 18-month training curriculum for CMW trainees and their trainers using the existing ANM training and adapting to meet international standards. (ii) Assessing and improving existing training centres. (iii) Training master and district trainers, mentoring these trainers and assessing their performance. (iv) Developing a business management module for CMWs. (v) Developing post-training certification by the State Nursing and Midwifery Registration Council (SNMRC). (vi) Providing logistical support for clinic set-up plus key equipment at completion of course. **Results:** The CMWs who passed the course were due to set up in their communities from September 2004. Four ANM Training Centres were strengthened. UP State Nursing Council has recommended that the developed curriculum be used for all its ANM training.
Cost	INR 83,070 per trainee: although this figure includes the cost of strengthening the centres which is a one-off cost.
Place	Uttar Pradesh: Varanasi, Sitapur, Agra and Meerut. First course ended August 2004.

Time Frame	One year.
Advantages	Qualified: Uses the GOI-approved basic health worker syllabus so that CMWs are certified into an approved health care cadre. Comprehensive training: Course includes practical, on-the-job training as well as a business management plan. Improves training for all: Improves existing training centres to benefit a wider group. Extends healthcare cover: Adds a qualified provider in places where there is no ANM.
Challanges	Introduces user fee: CMWs must convince the community of the need to pay for services which they are entitled to free-of-charge from ANM. However no CMW was set up in a village with a sub-centre or ANM coverage. Limited expertise: CMWs still not trained in advanced midwifery skills so do not have the capacity for improving emergency obstetric care such as antibiotic injections, IV fluids and oxytocine. Lack of incentives for trainers: ANM tutors were not additionally compensated for training and were therefore very unmotivated. New, unfamiliar scheme: Means CMWs need the respect of doctors and ANMs (where the community respects their ANMs) to gain the trust of the community.
Prerequisites	Co-operation of state government and the SNMRC. Strengthening of ANM training centres before the course begins. Training package for trainers and curriculum (available from SIFPSA). A business plan for CMWs.
Who needs to be consulted	State government and SNMRC. ANM training centres. The community.
Risks	
Sustainability	As yet unknown. Training depends on funding availability and the cooperation of the state government who part-funded the upgrading of training facilities (INR 2.5 Crore).
Chances of Replication	To date unknown. The project's success will largely depend on the progress of the first cadre of CMWs. USAID and SIFPSA will be monitoring this.
Comments	A number of lessons were learnt/recommended from the first course: (i) The selection criteria for CMWs must be strong and give a bias to those with health service experience. Recommendation that they pay a deposit for the course ensuring they do not drop out, repayable after they serve their community for a certain

	time. (ii) Community should be involved in selection process and the applicant's residency there should be verified by an independent authority. (iii) CMWs should be re-certified every two to three years to ensure on-going quality of service.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	CMW Delhi report-final.doc Community Mid Wives Program.doc Scope of Work of CMWs.doc
Reference Links	

42. Involvement of private sector in providing reproductive and child health services, Uttar Pradesh

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved outreach services."**
Details for Reform Option "Involvement of private sector in providing reproductive and child health services, Uttar Pradesh"	
Summary	**Action:** State Innovations in Family Planning Services Project Agency (SIFPSA), funded by USAID, works with NGOs (voluntary organisations, trusts run by the corporate sector and cooperative societies) to provide family planning services to the rural areas of Uttar Pradesh. After an NGO has been selected, it recruits a network of Community-based Distribution (CBD) volunteers who are trained at a training centre managed by SIFPSA. The CBD worker is a married woman from the village where she is to work. She looks after a population of 2,000 and her work includes: identifying and counting eligible couples, supplying condoms and pills, family planning counselling and referral for sterilisation. She is given an honorarium of Rs. 600 per month and incentives based on the sale of condoms/pills. The CBD volunteer also maintains two sets of records - a daily diary and a family card. She also prepares a monthly progress report to be submitted to her supervisor. CBD volunteers are monitored by a network of supervisors. A supervisor is in charge of 6-8 CBD workers. Supervisors are monitored by a project coordinator and, when the population is more than a lakh, an assistant project coordinator assists him. The project coordinator reports to the project director. The CBD gives her monthly progress report (MPR) to the supervisor who in turn compiles the data and gives the MPR to the project coordinator who gives it to the project director. At the end of the quarter, a physical progress report is sent to SIFPSA along with a quarterly expenditure report. Only then can money be released to the project. In addition to these internal evaluations, there are regular external evaluations. Extensions are based on the NGO's performance. As of January 2004, there were 76 ongoing projects. There are four types of projects under SIFPSA's private sector division: (i) Grassroots NGOs working at block level using CBD approach (ii) Dairy cooperatives in 13 districts, again following the CBD approach but restricted to the villages that fall on the milk route. (iii) The employer sector consisting of two components – the factory component where an employee of the

	factory called the 'factory health motivator' plays the role of the CBD worker on the factory premises and the community component where CBD volunteers work in the vicinity of the factory. (iv) Indian Systems of Medicine Practitioners (ISMPs) are trained as family planning counsellors. Though they are given supplies for distribution, unlike the CBD volunteers, the ISMPs are not given any honoraria.
Cost	Estimated cost: A typical two year project of one block comes to about INR 25-30 lakhs.
Place	Thirty three districts of Uttar Pradesh, since 1994.
Time Frame	Information not available.
Advantages	Uses private sector capacity: Involves the private sector in providing RCH services to the masses. Community-friendly: Because the CBD workers are women from within the community or from other community-owned institutions such as the dairy cooperatives, they are accepted by the community. Empowerment: It enhances the confidence of rural, illiterate women who, once trained, often encourage others to do the same.
Challanges	Cost: Tends to be slightly expensive as door-to-door service delivery is involved. NGO reliant: There is a lack of credible NGOs to take part.
Prerequisites	Capacity building of NGO staff/volunteers. Funds for programme management. Mechanism for monitoring field level activities and feedback.
Who needs to be consulted	Executive Director, SIFPSA
Risks	
Sustainability	Ensured by: (i) Charging a fee for services. (ii) The sale of contraceptive social marketing (CSM)/RCH products. (iii) Corpus fund. (iv) Capacity building of private providers in contraceptive technologies.
Chances of Replication	Information not available.
Comments	None.
Contact	
Submitted By	Dr. S. Krishnaswamy, General Manager, SIFPSA, March 2004.
Status	Active
Reference Files	

Reference Links	

43. Community Based Health Posts in remote areas, Himachal Pradesh

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved outreach services."**
Details for Reform Option "Community Based Health Posts in remote areas, Himachal Pradesh"	
Summary	**Background:** The hilly terrain of Himachal Pradesh makes it difficult for government health Sub Centres (SC) to reach basic Reproductive and Child Health (RCH) services to villages. According to the norm laid out by the government, an SC is supposed to cover a population of 3000. The 2001 Census reports, statistically, the coverage is good; on an average, as SC covers a population of 2838. In practice, however, it becomes very difficult for an SC to deliver services when it has to cater to more than one panchayat. In remote areas, many SCs have been non-functional for years. People living in these hard-to-reach panchayats are thus deprived of crucial outreach services such as antenatal care and immunisation of children and pregnant women. **Action:** With a view to extending basic health services to the segment of the population underserved by the government health system, a Community Based Health Post (CBHP) was set up in October 2004 in five panchayats of Chaupal block, sub tehsil Kupvi, district Shimla. The CBHPs were set up by Social Action for Rural Development of Hilly Areas (SARDHA), a Non-Governmental Organisation (NGO), in collaboration with Panchayati Raj Institutions (PRIs). This initiative was part of Basic Health Project of GTZ, the German development agency. The 5 panchayats, where the CBHPs were set up, were among the 11 (comprising 45 villages) that had been identified as backward by the Government of Himachal Pradesh. Between the Primary Health Centre (PHC) of the block and the 7 SCs that fell under it there were just one doctor and 4 health workers. As a result, none of them was functioning properly. The nearest First Referral Unit (FRU) was 96 km (5 hours' drive) away at Rajgarh in district Sirmaur. Space and essential furniture for the health posts were provided by the panchayat while basic equipment, like a haemoglobin meter, weighing machine, and blood pressure apparatus, were provided by the project. Supplies and consumables that were meant for the non-functioning SCs were redirected to these health posts by the state government.

	These included Oral Contraceptive Pills (OCP), Iron and Folic Acid (IFA) tablets, condoms, Oral Rehydration Salts (ORS), safe delivery kits, in a list of about 14 routine items. The CBHP accepts a donation of INR 2 from patients for services rendered. It is a voluntary payment made by patients who wish to. Community health workers, identified by the panchayat, are trained by the project to provide basic health services like antenatal care, diarrhea management. They also give first aid and treat minor ailments at these health posts. A health worker is paid an honorarium of INR 500, from the money collected from patients. Panchayat health committees and SARDHA monitor and supervise the activities of these CBHPs. **Results:** (i) The delivery of preventive and minor curative outreach services have improved in the remote and underserved areas. People now have greater access to health care, including ante-natal services, first aid and treatment of minor ailments. They are also being exposed to Information, Education, Communication (IEC) campaigns. An evaluation is underway to assess the impact of a CBHP on the community. (ii)About 12% of the population of the five panchayats, that is, 1011 patients, were treated at the health posts in the months of January and February alone. (iii) People save on opportunity cost involved in travelling and accommodation as some their problems are addressed by the health post. (iv) The Panchayat Level Health (PLHC) committee was strengthened when it got involved and took ownership of the health posts. The PLHC, on an average, collects INR 800 to INR 1000 per month.
Cost	The cost involved in setting up five CBHPs was INR 163,000. Recurring cost of about INR 1000 per month was met by the PLHC through money collected from patients.
Place	Pilot programme launched in five underserved panchayats of sub tehsil Kupvi; block Chaupal, district Shimla in October 2004. The CBHPs began functioning in January 2005.
Time Frame	Orientation, through a series of consulting workshops, of the panchayat representative and the authorities from the Health Department takes around one month. Strengthening the PLHCs and identification of interested and committed community health workers take about one month. Initial training of health workers takes about 15 days. The training is conducted by the Block Medical Officer (BMO) and a Medical Officer (MO) of the block. Setting up and equipping the CBHP take another 15 days.
Advantages	Access to health: Enables underserved sections of the community to access services not provided by the government health system.

Challanges	Limited scope: Not all kinds of services can be provided owing to the limited capacity of community health workers. Local opposition: From unqualified Rural Medical Practitioners (RMPs), who have, over the years, built a good rapport with the community. Scepticism at higher levels: Initially, from health managers at district and state levels who might have doubts about the functioning and acceptability of the health posts.
Prerequisites	Clear identification of the health needs of the community. Logistical arrangements and funds for procuring equipment, supplies and consumables required to establish the CBHP. Continuous support and commitment of various stakeholders.
Who needs to be consulted	Opinion leaders from the community and relevant authorities from the Health Department.
Risks	
Sustainability	Sustainability depends upon the commitment of the community health workers and the rapport they can build by providing quality health services, continuous support of the PRIs and other opinion leaders, availability of supplies and consumables from the Health Department and close monitoring and supervision by the project and the NGO for at least one year. It also depends on the community accepting the CBHP and having faith in its services.
Chances of Replication	Can be tried out as an option in any remote area where the government has not been able to deliver basic health services at grassroots level.
Comments	Considering the fact that the government health delivery system has gaps in infrastructure and human resources, making it difficult to provide services to people in remote areas, one solution is involvement of NGOs in delivering these services.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, ICMR. March 2006.
Status	Active
Reference Files	
Reference Links	

44. Quality antenatal care for insured women workers, Gujarat

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved outreach services."**
Details for Reform Option "Quality antenatal care for insured women workers, Gujarat"	
Summary	**Background:** For women working as unorganised labourers in the informal sector, health is the most important asset. Yet it is the most neglected aspect of their life. Reasons vary from affordability to availability of services within easy reach. **Action:** In order to provide quality care during antenatal and postnatal period, Vimo SEWA launched an intervention on pilot basis in March 2003, called Quality Antenatal Care for Insured Women Workers. The project was in partnership with United Nations Population Fund (UNFPA) and was conducted in three phases for a period of 6 months in Ahmedabad city. Vimo SEWA is the insurance scheme for workers in the informal sector (For details please see PROD entry no 137). The target area for the project was chosen on the basis of high concentration of Vimo SEWA members, particularly in the reproductive age group. Beneficiaries under the scheme were restricted to those who were pregnant and were members of the fixed deposit scheme of Vimo SEWA. The first phase mainly focused on the quantitative and qualitative research of the area to understand the existing trends in health care, level of awareness among people on care during pregnancy and average expenses incurred to avail of the services. Simultaneously, mapping of the existing health facilities (both government and private) was done and they were encouraged to form a network. With the help of different stakeholders, who were brought together in a workshop, a standardised antenatal care package was designed. (For the package of services, see reference section) Vimo SEWA would pay the cost of the service, which was fixed at INR 200. Duration of the first phase was 6 months. Based on the learning from the first phase SEWA started the interventions to increase the demand for antenatal care among Vimo SEWA members as well as to ensure that the required services would be available on demand. The strong linkage between the Quality Antenatal Care network and Vimo SEWA insurance scheme ensured affordability of the services. Services were cashless

	transactions, which made it easier for members to access them. To generate the demand for the services, Aagewans, Vimo SEWA-supported field level workers, were trained for spreading health messages and generate awareness among family members, pregnant women, their husbands and also the community in general. Both government and Trust hospitals were roped in to respond to the newly created demand for antenatal care. As it was difficult to render cashless services in the government facilities, it was decided, in consensus with Ahmedabad Municipal Corporation, that an Aagewan would accompany members availing of antenatal care; she would keep record of the number of patients and accordingly make payment to the health facility on the same day for services rendered. The third phase comprised an end line study and a closure workshop. **Results:** Initially two government hospitals and 4 Trust hospitals were involved in the network. After the successful completion of the project networking of the hospitals has increased. Antenatal Care details between August 2003 and June 2004: Number of the pregnant women identified - 138 Number of the women who opted for institutional delivery - 94
Cost	The funding support for project interventions were entirely by UNFPA while the INR 200 per member for the ANC package over and above the cash maternity benefit of INR 300 for each pregnant Vimo SEWA member was borne by SEWA.
Place	Ahmedabad city in 2003.
Time Frame	Approximately one year.
Advantages	Integration: of the health services and insurance. Cashless transactions made access to health services easier. ANC mandatory: A standard protocol is developed and providing basic clinical and laboratory services to pregnant women become binding for health care providers in the network. Referral links: Early detection of complications during pregnancy increases scope for appropriate referral linkage and avert obstetric emergencies.
Challanges	Interaction between Aagewans and service providers: As Aagewan is a link between beneficiaries and healthcare providers there is a need for more open dialogue to promote the services. Cross utilisation of providers: The tendency among patients to utilise more than one health facility poses difficulties in monitoring the pregnancy. Male involvement: Getting male partners to participate in the decision-making process is a complex task.
Prerequisites	MoU between the hospitals and SEWA.

Who needs to be consulted	Government Health Facility. Trust hospitals. Insurance company.
Risks	
Sustainability	Scheme is self-sustainable as beneficiaries are the fixed deposit members of the insurance scheme and they are getting the package of services which is pre-determined in the MoU.
Chances of Replication	Good.
Comments	Providing basic minimum care to pregnant women in the informal sector and encouraging them to go in for institutional delivery is one of the goals of the scheme, but it needs to take care of the members for default, irregular visits as well as involvement of the male partners. In this project, UNFPA's role was that of a funding agency as well as of an advisor. Six monthly review meetings were held with representatives of UNFPA.
Contact	
Submitted By	Dr. Anuradha Davey, National Institute of Medical Statistics, May, 2006.
Status	Active
Reference Files	MOU Kachchi Jain hosp-QOC.doc Service package under the QOC project - SEWA.doc
Reference Links	

45. Chiranjeevi scheme to improve institutional deliveries, Gujarat

Subject Area="Public / private partnership (including NGOs)."	**Objective="Improved outreach services."**
Details for Reform Option "Chiranjeevi scheme to improve institutional deliveries, Gujarat"	
Summary	**Background:** In Gujarat it was realised that simply improving the access to the trained health attendant during delivery cannot ensure reduction in the maternal mortality. Services need to be backed up by provision of the Emergency Obstetric Care (EmOC) facilities to save the lives of women who develop complications during pregnancy and delivery. Availability of services, especially to the poor and tribal people becomes difficult from the government institutions due to lack of adequate staff. Vacant position for gynaecologist in Community Health Centre (CHC) was 65 percent and in District hospital was 30 percent; whereas paediatrician shortage was 67percent in the District hospital. It was noticed that out of approximate 17738 registered doctors (with 2000 gynaecologist) three fourth are working in the private sector. However access of the private health facilities by the poor segment of society was limited due to cost constraints. In order to address the financial barrier and to bring the large private sector in the provision of maternity services Government of Gujarat announced Chiranjeevi Yojna (CY) in April 2005 and operational from December 2005. **Action:** Chiranjeevi Yojna (CY) was initiated as a scheme to increase institutional deliveries and to encourage private practitioner to provide maternity services in remote areas that record the highest infant mortality and maternal mortality rates in the States. Based on low institutional deliveries and low sex ratio five districts were selected for one-year pilot project. These districts are: Banaskantha, Dahod, Kutch, Panchmahal and Sabarkantha. CY is a maternity insurance scheme for the families that are under Below Poverty Line (BPL). Broad guideline for designing and developing a proposal for maternity insurance are: (1) treatment coverage in designated public and private institutions (2) Sum assured would account for compensation in case of maternal death (3) Inclusive of transport allowance and incentives to the Trained Birth Attendent (TBA) (4) inclusion of pre existing condition like hypertension and complication from

	previous pregnancies etc.and (5) Sum of INR 10,000 in name of baby, in case of maternal death. In the process of involving the Private Practitioners (PP) in the five selected districts, meeting was carried out at their respective Zila Panchayats in the convership of District Development Officer (DDO) and Chief District Health Officer (CDHO). Doctors who volunteered to render their services signed a Memorandum of Understanding (MoU) with CDHO. MoU expects a doctor to display a board outside their hospital stating: "This hospital is supported by district RCH society, for providing free delivery and emergency obstetric care to BPL families". On entering the contract each gynaecologist is given INR 15000 as an advance to commence deliveries at their facilities. Though mother receive cash less maternity services, but in the benefit of service providers a package for service charge was developed for a batch of 100 deliveries as capitation payment on fixed rate for each delivery. A batch size of 100 deliveries is taken in to account for case mix i.e. normal or complicated deliveries. Package for service charge was developed in consultation of State representative of Federation of Obstetrics and Gynaecological Societies of India (FOGSI). Service package include service fee for pre-delivery consultation, ultra sonography, transportation and incentive to the accompanying attendant. (For the service package please see the Cost Section). Implementation management of CY is under district health authorities. All empanelled doctors maintain a case file for each beneficiary. Weekly records of the deliveries conducted by the PP are submitted in the local Zila Panchayat by Block Health Officer (BHO). Also random visit is paid by BHO in the community to cross check for cash less services from the PP. A monthly report is sent to State by all district for review and feed back. (For broad structure of CY administration, please see the reference section). **Results:** Since December 2005: 73 percent of total specialist has enrolled with the scheme. 34 percent of expected BPL deliveries are institutional deliveries under the scheme. On an average 116 deliveries took place per doctor during the first six months of scheme implementation. One maternal deaths was reported from five pilot districts during the scheme implementation period.
Cost	Capitation payment for the size of 100 deliveries cost for: In private health facility- 1, 79,500 In Public health facility: 65,900 (For break up of different elements, please see: Package of Service Charges)
Place	Five districts in Gujarat fron December 2005. Districts are: Banaskantha, Dahod, Kutch, Panchmahal and Sabarkantha.
Time Frame	Approximately one year.
Advantages	Cash less services to the BPL families: Community is encouraged

	to visit health facilities by attracting them through cash less services. Wider network for health facilities: Involving private practitioners in the health care delivery system widen the network for skilled services during delivery. Competition for accountable business: To make long term profitable business reputation in the community health care providers are accountable for their services and undue operations are checked. Purchasing power in hands of BPL family: BPL have the ultimate power to decide and choose the private / public health facility to avail services.
Challanges	Monitoring of quality of care: Mechanism to monitor the private health facilities for quality of care provided during pregnancy and delivery is not incorporated. Drift towards private health facilities: Tendency for preference of private health facility would increase, thus lead to under utilisation of public health facilities. Dissatisfaction among Service Providers: Growing dis-satisfaction among few health care providers due to cost package need to address timely otherwise opting out from the scheme contract would leave a set back.
Prerequisites	Networking with private practitioners Management capacity at district officials
Who needs to be consulted	Private practitioners District health Officials
Risks	
Sustainability	Good. Scheme implementation is through established decentralised administrative system and health care providers are practising practitioners in the area.
Chances of Replication	Scheme is a viable option for States where MMR is high and public health infrastructure is not fulfilling the demand.
Comments	As high maternal mortality is the priority concern for policy makers as well as implementers, to devise a mechanism that reaches to the socio economically weaker section, especially in rural area has become a challenge for the nation. In such scenario, Chiranjeevi yozna can be adopted with regional specification to make more successful.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, August, 2006.

Status	Active
Reference Files	Chiranjeevi LBSNAA.ppt
Reference Links	

46. Training of Dais to promote safe deliveries, Gujarat.

Subject Area="Public / private partnership (including NGOs)."	Objective="Improved outreach services."
Details for Reform Option "Training of Dais to promote safe deliveries, Gujarat."	
Summary	**Background:** It was noticed that most of the deliveries of the pregnant women in the informal sector were home deliveries and were conducted by Dais. In a study conducted by SEWA under the guidance of Director of Foundation for the Public Interest in the Gandhinagar district in 1990, it was realised that rural, illiterate, poor women from disadvantaged group have least access to modern medical care at the time of delivery and largely rely on dais as services provided by them are affordable, accessible and with in socio cultural norms. In that context Dais are well suited to provide primary health care in their community. It was noticed that dais often were widow women and poorly remunerated and their skills and hygiene were severely lacking in conduction of safe delivery of the pregnant women. Therefore, with appropriate skill up gradation and support through linkages with the formal health system, especially emergency obstetric care they can make significant contribution to the health care of poor. **Action:** In cooperation with State Institute of Health and Family Welfare, SEWA started informal training of the Dais in 1990-91. Training was conducted by government doctors and was attended by the dais as well as SEWA worker who were involved in the Dais training. Training was in two part, 15 days for theoretical training and 15 days for practical hands on training in Civil hospital. Training helped to sensitise the dais and community for safe delivery practices. With rising demand for formal training amongst dais, SEWA's Dai school was opened in 2000. An Advisory committee for the Dai School was set up consisting of three gynaecologists who developed the curriculum for the school alongwith the admission criteria and duration of the training. Every batch which is enrolled at the Dai School undergo a training of three months consisting of three days per week. Training is imparted in a participatory manner combining modern scientific knowledge and the indigenous knowledge of dais. Besides the theory of human anatomy and physiology being imparted on a blackboard, utilization of IEC material like posters, charts, model of human body and practical demonstration of the use of fetoscope, counting the pulse etc. are an integral part of training.

	After the three month training in the classroom, dais also undergo a two days practical training at SEWA Rural Jhagadia in Narmada district of Gujarat. It gives them an opportunity to observe deliveries in a hospital setting. At the end of the entire training, a panel of Chief District Health officer or District RCH Officer and a gynaecologist from the private sector conducts a viva-voce. According to their performance in the viva-voce, dais are assigned grades. The completion of training by these Dais is formally celebrated in order to provide recognition in the community. They were given white coat, dai kit, identity card and certificate. Course curriculum included: A) Antenatal Care- (i) Pre delivery care (ii) Identification of the danger signs (iii) Nutrition (iv) Detection of the ectopic pregnancy B) Intranatal care: Include management during normal labour and early identification of any complication for prompt referral. C) Post natal care: Include care of the mother and baby after delivery. Breast feeding, Birth spacing. SEWA also developed a monitoring system for the work of Dais. SEWA workers visit the women who had been delivered by the trained dais and ask the procedure used by them. If they find that a dais has not followed some of the practices taught in the training, they make it a point to review those points in the follow up training. This is done without pointing any finger at the dais that have made the errors and it works as a reminder for the entire batch present at the follow up training. With the successful completion of six batches in series, demand of the dais training has increased in other districts also. These training were conducted on door step basis i.e. separately in each taluka so that it become convenient for the dais to attend the traing course. **Results:** 488 dais from six districts have been trained on scientific lines by a gynaecologist uptil now. At present door step mobile dai training has been conducted in Gandhinagar, Ahmedabad, Mehsana, Sabarkantha, Anand, Kheda.
Cost	The Ory Foundation of France provided the financial assistance for setting up the school and has continued with the ongoing support to the school.
Place	Started in Gandhinagar district in 1990.
Time Frame	Approximate One year.
Advantages	Resource person: Places where home deliveries are preferred and convenient, trained dais are important human resource to provide

	assistance to the pregnant women. Skill Improvement: Training of the dais helps in their skill up gradation and early reorganisation of the complication during labour. Community recognition: Training of the dais helps them to acquire respectable position and recognition of the work in the society they serve.
Challanges	Initial reluctance: Reluctance from the dais to get involve in the training programme in the beginning.
Prerequisites	A good coordination between State training institute and local area NGO is necessary. Local area reputation of the NGO to organise training programme successfully.
Who needs to be consulted	Local resources like State Health and Family Welfare Institute. Local NGO with good network.
Risks	
Sustainability	Sustainability needs to be decided in terms of resource personnel and fund available with the planners.
Chances of Replication	Good.
Comments	Considering the fact that maternal mortality is a serious concern for all-planners as well as for implementer, raising the skills of local resource person and bringing them in the main stream of health care delivery is an alternative option where resources are the constraints.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, June, 2006.
Status	Active
Reference Files	Dai training-SEWA.jpg Dai training-2.jpg Dai training-3.jpg
Reference Links	

47. Community Partnership for Safe Motherhood, Uttar Pradesh

Subject Area="Public / private partnership (including NGOs)."	**Objective="Mobilising community participation."**
Details for Reform Option "Community Partnership for Safe Motherhood, Uttar Pradesh"	
Summary	**Background:** The project partners (NGO Shramik Bharti, PRIME, USAID) had identified that the high rates of maternal and infant deaths during childbirth could be drastically improved by teaching simple, home-based emergency life-saving skills. Traditional birth attendants lacked the basic health education they needed to assist and there was extremely low use of local referral centres with emergency obstetric services. **Action:** The Community Partnership for Safe Motherhood (CPSM) project aimed: (i) to teach communities home-based maternal and neonatal life savings skills, (ii) to reduce delays in transport to referral centres for treatment and (iii) to promote post-abortion and post-partum family planning. The project also included strengthening community workers in research, data management and design and implementation of health intervention capacities. Set up: Assessments made of the situation in the community: numbers of maternal and infant deaths; assessment of referral facilities; community self assessment; discovering existing practices, perceptions and beliefs about childbirth and care of newborns. Findings: Questionnaires of women aged 21 to 30 found 60% were illiterate; 97.7% gave birth at home; only 30% had antenatal care; 1.7% of women put their baby to the breast within one hour of birth; two % of pregnancies ended in maternal death; 7% of pregnancies ended in neonatal death. Intervention: Self help groups were established in the villages and stakeholder meetings held. Villages encouraged to set up their own health committees to guide the project and select Village Health Guides (VHGs) – women volunteers from the local community to carry out the training. Training: VHGs were trained as health educators by master trainers (recruited by the NGO) to teach expectant mothers and those planning to attend the birth (eg mother, mother-in-law, sister) basic information and skills about obstetric emergency. The VHGs were taught a 6 module programme of Home-based Life Saving Skills (HBLSS) – initially developed by the American College of Nurse Midwives and then adapted to address local needs - using Take Action Cards (TAC) (see Documents and Illustrations section) as visual aids.

	They were then responsible for identifying the pregnant women in each village and teaching them and their birth attendants these skills. They also advised on tetanus toxoid, the use of iron tablets, condoms and pills and were able to earn money by selling these at a subsidised rate (subsidised by the project managers). Despite an effort to direct women towards a facility with Emergency Obstetric Care (EmOC) in times of emergency, it was found that they or their families repeatedly insisted on contacting the rural medical practitioner (lay practitioners) instead. The anecdotal evidence showed this was because they knew these practitioners, were more comfortable with their style of care and perceived them as more affordable and personal. It was decided therefore to also train these practitioners (who are largely untrained) life saving skills so they recognised danger signs and knew to refer on to EmOCs when necessary. Anecdotal evidence showed that training these practitioners did result in them referring dangerous cases on when necessary Awareness building: The VHGs also worked to make sure the community knew what hospital and clinic facilities (both public and private) were available nearby with emergency obstetric care and what transport was available should they need medical help quickly. Wall writing and traditional theatre shows were used to spread the word and two-day workshops were also held to educate husbands, father-in-laws and brother-in-laws – identified as the decision makers in the community - about when pregnant women should be sent to referral centres for specialist help. Loans: Self Help Groups (SHGs) were given funds to provide emergency loans so that women could get emergency medical help and meet transportation costs immediately. Part of the interest from the loans was used to compensate the time spent by the VHGs training the community. Grain collections were also held to raise funds to pay the VHGs. **Results:** Women who had completed the HBLSS series were more likely to accept tetanus toxoid, 75% said they had put their newborn to the breast feed within one hour (traditional advice was to feed the baby sugar and water for the first three days) and 40% had accepted modern methods of family planning. TACs were demonstrated as an extremely effective tool for spreading messages about HBLSS to the community and as job aids to the home-based attendant.
Cost	Shramik Bharti estimates the programme costs INR 16 lakh to INR 18 lakh per year per administrative block (roughly 150,000 population).
Place	The CPSM project was conducted in north UP covering about 20,000 populations in approximately 10 villages (about 32 hamlets) of Kanpur Dehat district June 1998 – June 2002. Has been continued by NGO Shramik Bharti in more than 150 villages covering a population of 150,000 (information as of August 2004).
Time Frame	18 months to carry out community assessment, develop training programme and select VHGs.

Advantages	Simple and good quality visual aids: because the HBLSS modules were limited and were supported by the TACs, the VHGs and the community found the lessons and procedures easier to remember. Community involvement: this greatly increases the probability of the project's effectiveness and willingness to implement antenatal care and family planning.
Challanges	Necessity for frequent assessment and refresher training: For VHGs. Master trainers also need continuing education. Incentives needed: To keep VHGs motivated.
Prerequisites	Master trainers and a training curriculum. The HBLSS curriculum from this project (written in Hindi but can be translated) is available from Shramik Bharti for adaptation and is particularly suitable for Northern India. Thorough consultation with the community and an understanding of their needs. Intervention must be tailored to meet their requirements if enthusiasm for the project is to be maintained. Key TACs must be designed so they are culturally acceptable.
Who needs to be consulted	NGO (in this case Shramik Bharti). The local community. Local practitioners and both public and private hospital referral facilities.
Risks	
Sustainability	The project is sustainable if intervention is modified to suit the local community culturally and socially and costs are available to meet the training and loan fund.
Chances of Replication	Replicable provided there is a reasonable access to an emergency obstetrics care facility and sufficient funding. Data management and record keeping should be a key component of any replication. Monitoring should occur at field level. Any decision to scale-up the programme should take into account compensation for the community-based trainers (VHGs in this case) and the possibility of finding local financial and human resources to provide emergency funding for transportation and other purposes. Stakeholders should assess the advantages and disadvantages of alternative scale-up models within the context of local circumstances and the feasibility of incorporating the core elements of CPSM and HBLSS interventions within the context of other Safe Motherhood programmes in the public and private sectors locally.
Comments	Shramik Bharti reports a need for a flexible attitude. The programme must be able to change to meet circumstances as they arise. Intervention must address the realities on the ground with a well co-ordinated approach. It is essential to reinforce key messages to ensure retention. Lack of affordable transport to encourage community to use FRUs also remained a challenge.
Contact	
Submitted By	Clare Kitchen, Research Consultant, European Commission Technical Assistance, New Delhi. September 2004.

Status	Active	
Reference Files	CPSMFinalEvaluationReport-executive summary.doc	CPSM Final Evaluation Report - executive summary
Reference Links		

48. Malaria eradication, Maharashtra

Subject Area="Public / private partnership (including NGOs)."	**Objective="Disease control."**
Details for Reform Option "Malaria eradication, Maharashtra"	
Summary	**Background:** Navi Mumbai, a new municipality adjacent to Greater Mumbai, is a city under construction. The need for construction workers has prompted a massive movement of labour with migrant workers flooding in from all over the country. The majority of them have settled in temporary accommodation on the building sites or quarries where there are large water pits. In addition, approximately 40% of the population lives in slums. Slum residents commonly store water in open drums for regular domestic use. Anophelis larvae (malaria-carrying mosquito) breed in clear water in uncovered containers and despite receiving health education, people refuse to empty these drums. Also, because the land in the area is low lying and marshy, there is much stagnant water. This, added to the lack of sanitation in the slums and quarries, creates numerous breeding places for mosquitoes and leads to a high incidence of malaria. In 1992 when the Navi Mumbai Municipal Corporation (NMMC) came into existence, the situation was serious. There was no anti-larval activity and minimal surveillance was carried out. **Action:** IN 1992 NMMC began a programme of anti-larval activities on a contract basis. All manpower and instruments are supplied by the contractors and larvicides by the NMMC. The operations are monitored and supervised by a team consisting of a Medical Officer (MO) from an Urban Health Post (UHP), the contractors' supervisor, an Insect Collector and a Malaria Officer. Operations include: (i) Weekly anti-larval programmes at UHPs, in which breeding places are allotted to workers each day. In the early morning, supervisors distribute larvicides and workers conduct anti-larval activities in their allotted area, covering all the breeding sites. (ii) Minor engineering activities, guppy fish introduction activities and overhead tank inspections in the afternoons. (iii) Fogging activities in the morning particularly in closed drains and a foot pump programme in the afternon. (iv) Cross checking activities by the insect collector of NMMC by calculating larval density, adult mosquito density and conducting an evening survey to judge mosquito nuisance. A review is held fortnightly with the contractors and monthly with Insect Collectors and MOs at NMMC head office. Surveillance activities are monitored and supervised by MOs from UHPs of NMMC. They consist of two types: (i) Active surveillance - where NMMC health workers go from house to house collecting blood smears from

	fever cases and administering presumptive treatment. (ii) Passive surveillance - where patients with fever come voluntarily to hospitals and health centres for blood testing and treatment. One general hospital, five maternal and child health centres and 13 urban health posts carry out this activity. In addition, workers visit construction sites twice a week and areas considered to be less high risk such as villages and slums, once a fortnight Whenever any positive malaria case or suspected dengue case is detected, the following preventive and curative activities are carried out in and around the 100 surrounding houses: (i) House to house breeding places survey (ii) Indoor residual spraying with synthetic pyrethroid (iii) Survey of fever cases, blood smear collection and administration of presumptive treatment (iv) Indoor fogging with pyrethrum. In cases of suspected dengue, fogging is done on three consecutive days to kill any residual adult Ades (dengue-carrying) mosquitoes. Presumptive treatment is given to all fever cases at the time of collection of a blood smear. Radical treatment of five days of primaquine is given to all Plasmodium Vivax cases (one type of malaria), and for Plasmodium Falciparum cases treatment is verified with a follow up and contact smears. There are 124 drug distribution centres in NMMC situated at high risk areas such as construction sites and quarries. All private nursing homes and labs are instructed to give reports of malaria cases and their details. **Results:** Annual Parasite Incidence has dropped from 18 in 1997 (when record-keeping began) to 1.92 in 2004. The slide positivity rate has fallen from 7.87% in 1997 to 1.36% in 2004. The total number of positive malaria cases identified was 9,024 in 1997. By 2004 it had decreased to 1,231. There were 300 suspected cases of dengue in 2003, and 250 in 2004 (dengue was not effecitively monitored in previous years).
Cost	The larvicides and diesel or petrol for fogging machines are procured by the NMMC for use by the contractor. Required equipment is supplied by the NMMC on a rental basis. Annual budgetary provisions under the Malaria Control Programme are approximately INR 4 crores. This is broken down as follows: Anti-larval activity – approximately INR 2 crores. Larvicide purchase and fogging – approximately INR 2 crores Contract workers are paid the mimimum wage of INR 123 per day. Extra necessities, such as uniforms and gumboots are covered in a levy of 46% paid to the contractors.
Place	Navi Mumbai Municipal Corporation, Maharashtra
Time Frame	Three months: Two months to formulate terms and conditions of contract. Another six weeks for tender process.
Advantages	Cost effective: Reduces financial burden of the Corporation by removing necessity of having staff on payroll assigned to malaria control.

	Efficiency: Performance-orientated terms of contract mean output of contractors can be effectively monitored and supervised.
Challanges	None perceived. Since the NMMC only came into existence in 1992, the question of existing employees missing out on job opportunities does not arise.
Prerequisites	Sanction by the General Body of the Municipal Corporation
Who needs to be consulted	State Government technical authorities: To guide local governments in areas such as manpower, necessary equipment, purchasing requirements. Field officers and grass root level health workers, particularly at planning stage: To quantify the workload and availability of manpower. Amounts of larvicides and equipment needed can be calculated accordingly. Standardisation of all anti-larval activities should be ensured to guide the terms and conditions of this type of contract.
Risks	
Sustainability	It is self sustaining and will definitely be continued in the future. Funds come from local government but there is still a need for assistance from State and Central govt for effective continuing of contract services.
Chances of Replication	Good. The initiative has been replicated in Nashik, Aurangabad district, Maharashtra. Difficulties could arise were there are existing staff who could be responsible for antilarval activities
Comments	According to Central and State labour laws, orders of court can terminate the contract system. This means that any legal authority can direct local government to stop the contracting out of services. This is considered to be a hindrance by the NMMC because it can be forced to make workers permanent if they take their claim to court.
Contact	
Submitted By	Tessa Laughton, Research Consultant, ECTA, New Delhi. February 2005
Status	Active
Reference Files	maleriaEradSer exp NMMC.pdf — Malaria eradication budget 2000-2005, Navi Mumbai (PDF) Health Services in Navi Mumbai.doc — Health Services in Navi Mumbai, overview
Reference Links	

49. *Targeted interventions among high-risk group of HIV/AIDS, Tamil Nadu*

Subject Area="Public / private partnership (including NGOs)."	**Objective="HIV/AIDS awareness."**
Details for Reform Option "Targeted interventions among high-risk group of HIV/AIDS, Tamil Nadu"	
Summary	**Background:** The spread of HIV/AIDS is associated with behaviour. Generating awareness and changing behaviour can therefore reduce its transmission. The first case of AIDS in India was detected in Tamil Nadu (TN) in 1986. As the number of infections grew, the AIDS Prevention and Control Project (APAC) was started in TN and Pondicherry in 1995 under a tripartite agreement between Voluntary Health Services (VHS), a charitable Non Governmental Organisation (NGO) in Chennai, United States Agency for International Development (USAID) and the Government of India through its National AIDS Control Organisation (NACO). **Actions:** APAC has concentrated on high risk population groups for targeted interventions, including long distance truck drivers, female commercial sex workers, tourists, slum populations, factory workers, men having sex with men and migrant workers. A network of 72 carefully selected NGO partners delivers the intervention programmes in TN and Pondicherry. The thematic areas for interventions are: Prevention Along The Highway (PATH), Women In Prostitution (WIP), Slum Intervention Programme (SIP), Tourist and Women In Prostitution (TWIP), Industrial Intervention Programme (IIP), Men having sex with men (MSM), Migrants Intervention Programme (MIP). The APAC project is governed by a Project Management Committee (PMC), which is chaired by the Health Secretary of the Government of Tamil Nadu. Other members include representatives from NACO, Tamil Nadu State AIDS Control Society (SACS), Pondicherry SACS, USAID and VHS. This committee sets the policies and guidelines for APAC. Community needs assessment is carried out to establish which materials are required for behaviour change. Strategies adopted are: (i) Spreading culturally sensitive messages through peer education: Peer educators are voluntary members of the community who receive training from the NGO to deliver education on Sexually Transmitted Infections (STIs) and

HIV/AIDS at a small cost. (ii) Promoting condom use: APAC has collaborated with Hindustan Latex Limited (HLL) to supply condoms of improved quality to the areas of intervention. Social workers employed by the NGOs or APAC educate individuals on condom usage. They sensitise potential retailers through appropriately developed training programmes conducted by professional agencies. Retailers are encouraged to increase their stock, display and sell condoms through attractive schemes.

(iii) Street plays: Performances are conducted to convey messages on STIs and HIV/AIDS in overt and covert form. NGOs selected by APAC are provided training at the APAC supported Resources and Training centres in traditional media. A state level meeting for planning was convened to decide the content of the plays. It was followed by script writing on different topics to be covered surrounding the subject of HIV/AIDS. The theme, language, content, and background were carefully selected to produce maximum impact among the audience. Plays were standardised for uniformity. Professionals with specially designed costumes were engaged to participate in the plays. All NGOs funded by APAC are equipped with well-trained instructors who further train local volunteers to continue these activities. After the plays, NGO staff are available for discussion and follow up. (iv) Promotion of quality services: The partner NGOs in their area of operation identify health care providers. They are sent for training to APAC Continued Education and Training Centres (CETC) for delivery of quality care for STIs and HIV/AIDS at the local level. They also provide field supervision and support to the partner NGOs. Social workers, counsellors and peer educators create awareness on STI symptoms and encourage patients to seek treatment from these qualified medical practitioners, thus establishing referral networks. (v) Interpersonal communication (IPC): APAC employs both traditional and non-traditional media to communicate effectively to spread awareness and to remove the stigma attached to HIV/AIDS. IPC is conducted within each thematic intervention through trained counsellors, social workers and peer educators.

Advertising agencies are employed to design and develop print and electronic media messages in line with APAC requirements. Outdoor activities such as mobile exhibitions or campaigns on bus or auto panels are also conducted regularly to address specific issues. (vi) Behaviour Surveillance Surveys (BSS): Research complements the activities of APAC. BSSs have been conducted annually in TN and Pondicherry with the objective of discovering trends in the behaviour of high-risk populations, STI prevalence in the general population and high-risk groups and to understand better the needs of the community. (vii) Creating a healthy environment for People Living with HIV/AIDS (PLHA), so that they and their families can lead normal lives. Results: The Efforts of APAC are monitored every year through Behavioural Surveillance Surveys (BSS). Some of the results among selected

	groups include: Commercial Sex Workers-Female (CSW-F) (i) Condom usage among CSW-F with clients has increased from 56% in 1996 to 85.9% in 2004. (ii) Voluntary procurement of condoms has shown a steady increase to 87.4% in 2004 from 11% in 1996. (iii) Risk perception among the CSW-F has increased from 42% at base line (1996) to 77% in 2004. Truckers and Helpers (iv) Involvement of truckers and helpers with a non-regular partner has declined to 33.7% in 2004 from 48% in 1996. (v) Condom usage of truckers and helpers with paid partners has increased to 88.5% in 2004 from 55% in 1996. Availability of condoms (vi) Increase in condom distribution from 17,000 outlets in 1996 to 55,505 outlets in 2004 (vii) Increase in sale of condoms to 31 million pieces in 2004. The work of APAC has been appreciated by NACO and is now recognised as a Training Resource Group for targeted intervention in the country. Based on the experiences from the first phase of the APAC project, additional funds were provided to APAC by USAID for the second phase of activities (2003-2007).
Cost	APAC was provided with a grant of $10 million (INR 439 million) during the first phase (1995-2002) and $15 million (INR 660 million) for the second phase (2003-2007).
Place	21 districts of Tamil Nadu and Pondicherry are covered by a network of APAC partner NGOs since 1995.
Time Frame	It takes a year from the time of grant allocation to effectively deliver the various program components.
Advantages	Focus on behavioural modification: Through a multi- pronged strategy, behaviour change in the high-risk groups is encouraged. Focused designing of messages: Messages are designed and organised according to the need of the recipient. Quality of services: Availability of services and treatment for STD and HIV/AIDS sufferers by qualified medical professionals, and availability of quality condoms for prevention of infection.
Challanges	No disadvantages perceived.
Prerequisites	Government Order and Legal Agreement between partners.
Who needs to be consulted	State Government, Donor agencies, National AIDS Control Society, State AIDS Control Society.
Risks	
Sustainability	Sustainability of the activities has driven all the strategies of APAC, including: (i) Selection of committed NGO partners who are already working in the field and have their own infrastructure and manpower.

	(ii) Raising the capacity of NGOs to deliver messages more effectively to meet the programme needs. (iii) Spreading awareness of STIs and HIV/AIDS through multiple channels and training of healthcare providers in the area to meet demand. (iv) Collaboration with manufacturers to maintain constant supply of high quality condoms to retailers in intervention areas.
Chances of Replication	The APAC model can be successfully replicated with careful selection of NGOs, planned technical assistance, supportive onsite supervision and supportive referral services.
Comments	The APAC model is unique in the state because it was the first wholly private sector approach to address the problems of AIDS in Tamil Nadu. This model has set an important standard for productive partnership of the government with private sector institutions.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, IRMS, September, 2005.
Status	Active
Reference Files	Tripartite areement between GoI, USAID and VHS.doc — Tripartite agreement between the GoI, USAID and VHS apac-1.jpg apac-2.jpg apac-3.jpg
Reference Links	

50. Partner Sexual Health Project, Gujarat

Subject Area="Public / private partnership (including NGOs)."	**Objective="HIV/AIDS awareness."**
Details for Reform Option "Partner Sexual Health Project, Gujarat"	
Summary	**Background:** Gujarat has moderate scale prevalence of HIV/AIDS and is home for about 1000 HIV positive persons. Its capital, Ahmedabad, is the 7th largest city in India with a population of around 35 lakh (3.5 million). Of them, 12 lakh (1.2 million) live in slums and public tenements, called chawls in local parlance. Most of the latter are migrant population, who have come to the city in search of the employment. Realising that knowledge is the only way to contain the spread of HIV/AIDS, Self Employed Women's Association (SEWA) started Partner Sexual Health Project (PSHP) in Ahmedabad. The thrust was on generating awareness and inculcating responsible behaviour. **Action:** PSHP was initiated in partnership with Lok Swasthya, a health co-operative of SEWA and Gujarat State AIDS Control Society (GSACS) in 2001. Around 20 reputed field Non-Government Organisations (NGOs) were selected and a network established for various interventions. Strategies adopted by the PSHP were to be followed by all partner NGOs. Target areas for the interventions were chosen following a need assessment study. Based on the first study, in 2001, Behrampura was chosen and later on Asarva, Girdharnagar, Meghaninagar and Chamanpura were added, based on the need assessment conducted in 2003. The areas were chosen with the guidance and support of GSACS. The second step was classification of high-risk groups, according to their occupation. In each community they identified community leaders by virtue of their long-standing presence in the community. These community leaders were called Peer Educators and their capacity building was done through short training programmes. The training programmes were of two days at the start, followed by monthly one-day refresher trainings by GSACS. A two-pronged strategy was adopted for the programme. (i) Awareness generation: through various channels like Inter Personal Communication (IPC), group discussion and street plays. Awareness generation involved in-depth survey of the sexual behaviour of the community; it was difficult for people to freely discuss delicate

	issues related to sexual behaviour in a group. IPC proved a very useful tool not only to convey various methods of prevention, but also to win the trust and confidence of the community. It also helped in identifying patients of symptomatic Sexually Transmitted Disease (STD) and in motivating them to avail of medical help. Well-crafted street plays, with relevant Lok Swasthya (public health) messages, were also performed at frequent intervals at various locations and were regularly modified in accordance with the community's response. Peer educators were allocated outreach areas of work and were paid INR 750 a month. Of the 26 peer educators, 18 worked as volunteers. (ii) STD detection and treatment: With the help of well-qualified health professionals suspected cases were examined and treated free of cost by Lok Swasthya. It is a regular activity supported by GSACS as part of its programme. Patients, after being cured, are especially followed up for counselling to adopt safe sexual behaviour. GSACS also provided IEC material and condoms. **Results:** Increased awareness and a growing trend towards responsible sexual behaviour. This is corroborated by the fact that the number of regular condom users in Behrampura increased from 275 in 2001-02 to 1527 in 2003-04.
Cost	There was a 10% organisational contribution for STD detection and training of peer educators. Support for SEWA health workers' involvement and other health service costs were hidden costs. GSACS provided IEC material and condoms.
Place	2001, Behrampura in Ahmedabad.
Time Frame	Approximately one year.
Advantages	Awareness generation: Through various communication channels on modes of HIV transmission. Promotes safe sex: Regular communication with the clientele and making services accessible promotes safe sexual practices.
Challanges	Community mindset: Attitude of the community creates strong barriers to accepting facts and changing high risk sexual behaviour. Misconceptions: Local misconceptions related to the transmission of HIV negatively influence the effect of the communication process.
Prerequisites	Reputation: It is of critical importance the organisation be held in high esteem by the community. Agreement with the State AIDS Control Society
Who needs to be consulted	Exisiting health facility. State AIDS Control Society.

Risks	
Sustainability	Sustainability is dependent on integration and convergence with other health programmes.
Chances of Replication	Replicable as there is support from State Aids Control Societies.
Comments	With so much support available from the government, as well as donors, committed organisations need to come forward to help check the menacing spread of HIV/AIDS.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, May, 2006.
Status	Active
Reference Files	Lok swasthya Programme.jpg Lok Swasthya Programme -2.jpg
Reference Links	

51. Drug Revolving Funds (DRF) to make low price quality drugs available, Himachal Pradesh

Subject Area="Public / private partnership (including NGOs)."	**Objective="Availability of quality drugs."**
Details for Reform Option "Drug Revolving Funds (DRF) to make low price quality drugs available, Himachal Pradesh"	
Summary	**Background:** Buying drugs represent a major part of expenses for patients—more than 80%, according to Baseline Survey, 2003-2004. Due to a shortage in state-supplied drugs, patients often have to purchase branded drugs from private outlets. The quality of the drugs, available in the market, is often uncertain and they are also expensive. The drugs would cost three to 5 times less if an outlet were to procure from a bulk supplier for generic drugs. **Action:** In order to make sure essential drugs are available in health facilities and to demonstrate financial and technical feasibility for a demand-driven system, the piloting of a facility-based Drug Revolving Fund (DRF) for essential drugs was planned with the support of GTZ, the German agency for technical cooperation in India. There was seed money of INR 2 lakh (200,000) for the revolving fund. (Details of expenses are given in the reference section). Health facilities for the pilot were selected based on: (i) Interest shown by the community and the staff to establish a DRF. (ii) High outpatient load (at least 100 new patients per day). (iii) Limited number of private outlets nearby (not more than 6). In the initial phase, it was planned a DRF would be introduced at two Community Health Centres. The initial development costs—provision of the building, equipment, and a starting stock of three months' supply of drugs—were covered by the project. The project also selected and trained two pharmacists for each DRF and paid their salaries, INR 5000 per month (€84.9), for one year. Recurring operating costs and the cost of providing free drugs to below-poverty-line patients were met by levying a profit margin on the selling price. The margin was calculated by factoring in the percentage of registered below poverty line people in the catchment area to estimate recurring costs. One of the most important aspects of the DRF, however, was forming a DRF Society. The societies are composed of two bodies: (i) The Governing Body

	(GB), presided over by the Sub divisional District Magistrate (SDM) and Chief Medical Officer (CMO), who is the patron. The Block Medical Officer (BMO) is member secretary. (ii)Executive Body (EB), headed by the Medical Officer (MO) in charge; two other medical officers, a ward sister and a pharmacist are members. The society functions as a governing board for the DRF; its members, it is stipulated, should meet regularly, at least once every three months. From the second year on, the costs of running the DRF is borne by DRF societies from the profits the outlets make. A drug management software was also developed and used by the project. Suppliers, who could ensure the supply of WHO-GMP certified drugs, were engaged. Supervision of DRF activities by an external expert, for 3 to 5 days per month, was also planned. Results: The success of the initiative from 2002 to 2004 is reflected in terms of the increase in the facilities' profit which has enabled them to: (i) Increase the number of drugs purchased from 46 to 450. (ii) Recruit four more pharmacists, allowing them to provide them 24 hour services. (iii) Provide 9% free medicine to people living below the poverty line (BPL) (iv) Provide INR 10,000 in three months for different activites in hospital welfare. These amounts are to be revised and increased in their next meetings.
Cost	Approximately INR 5-6 lakh for the initiation of the DRF.
Place	One DRF counter was opened at CHC Daulatpur (District Una), a 50-bed hospital, as a pilot in January 2003, followed by the opening of another DRF counter at CHC Jwalamukhi (District Kangra), a 10-bed hospital, in May 2004.
Time Frame	About one year for preparations—selection of facilities and staff, staff training, registration of the society, application for drug licence, etc. Another year of intensive supervision is necessary.
Advantages	Drugs available: Quality drugs available on the hospital premises round the clock. Low cost: Essential drugs available in generic forms are considerably cheaper than the branded ones.
Challanges	Stiff competition: from the market, in the form of apparently cheaper deals, means the DRF counters struggle to survive. Internal non-cooperation: Health officials, entitled to prescribing medicines, may oppose.
Prerequisites	State Government Order.
Who needs to be consulted	State government, funding agency, local government official in the health department, MO and staff of the particular health facility, state and district Drug Inspectors.
Risks	

Sustainability	The model is self sustainable; however, ground realities need to be assessed for cooperation from the health facility staff and for awareness of the patients regarding availability of better and cheaper drugs. The selection of the facility is also very crucial. If the patient load is not enough, the DRF cannot sustain itself. Selection of doctors with the DRF is very important. Doubtful prescription practices leading to a nexus with local chemists shops limit the success.
Chances of Replication	The DRF concept can be replicated. Investments, particularly in supervision and monitoring, are especially high for the first DRF. Having more DRFs and linking them up so that they procure drugs in large quantities can work out to be even more economical.
Comments	Making good quality drugs available around the clock at a cheaper cost is a challenge for health administrators. It needs strong support from the medical fraternity. Consumer awareness and satisfaction with DRF shops is crucial to their viability. So, in order to be successful a lot of effort in areas of supervision, monitoring and training is needed.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, February, 2006.
Status	Active
Reference Files	Investment in establishing a Drug Revolving Fund.doc The quarterly expenses and income statement for DRF.doc CHC Daulatpur, Una District20.JPG DRF Jwalaji CHC, Kangra district8.JPG CHC Daulatpur, Una District23.JPG
Reference Links	

52. Awareness Generation on Vitamin A and Anaemia, Jharkhand

Subject Area="Public / private partnership (including NGOs)."	**Objective="Increase Iron, Folic Acid (IFA), and Vitamin A supplementation among women."**
Details for Reform Option "Awareness Generation on Vitamin A and Anaemia, Jharkhand"	
Summary	**Background:** Jharkhand is a tribal dominated state with poor irrigation; almost 75% of the districts have been classified as being deprived of water. This, combined with other socio-economic factors, has led to extreme food insecurity in the state especially among people living Below Poverty Line (BPL). The government runs several micronutrient supplementation programmes in IFA and Vitamin A; nutrition programmes are also conducted through Anganwadi and Sub Centres for pregnant and lactating women, adolescent girls and children below the age of 6 years. Despite that, the Rapid Household Survey (1998) found that coverage of IFA tablets was very low, ranging from 1.9% to 32.5%; regular consumption of these tablets was even lower at 14.6%. The reason for such low compliance was lack of awareness of the importance of IFA in foetal growth. **Action:** In June 2004, Government of Jharkhand launched an anaemia control project in coordination with Vikas Bharati, a local Non-Government Organisation (NGO) and MOST, a USAID funded micronutrient initiative. This pilot project was started in 5 blocks of the Gumla district, covering a population of 400,000. Government of Jharkhand provided consumables and logistical support while Vikas Bharti focussed on community mobilisation. Technical support to the project was extended by USAID-MOST. The main thrust of the project was to raise awareness among women and adolescent girls of IFA supplementation and its regular consumption.In each village, a central location was selected for the activities, like the Anganwadi centres, Panchayat Bhawan, Sub Centre or the local clubhouse. Anganwadi Workers were chosen as service delivery persons in the villages which had an Anganwadi Centre (AWC); villages which did not have an AWC, a Vikas Bharti Worker (VBW) was selected as the delivery person. A Cluster Resource Person (CRP) was chosen with the help of the Panchayat, whose task was to monitor the activities. The CRP also served as a link between frontline workers and Vikas Bharti.The main responsibility of frontline workers was to raise local support from teachers,

	village elders, both male and female, Self Help Groups, Mahila Mandals, and the like. With their group effort they then mobilised the target segment. Three-day training was given to health service providers and frontline workers on how to counsel for raising awareness and motivation among the target group. The focus of the training was to emphasise the importance of IFA tablets and symptoms and consequences of anaemia. Songs were also composed in local dialects so that IFA gained common currency. **Results:** The average consumption of iron tablets in the 5 blocks increased from 35% in March 2005 to 85% in September 2005 and has consistently remained at that level.
Cost	Low-cost. Since it is a joint project of the State government and USAID-MOST it is difficult to get exact information on the cost.
Place	5 blocks in Gumla district in June 2004.
Time Frame	From planning to implementation it took almost 18 months.
Advantages	Increased awareness: Raising awareness has led to increased compliance with regular consumption of IFA tablets. Health seeking behaviour: Increased awareness led to increased health-seeking behaviour in the community.
Challanges	Mobilisation of women: Difficult to mobilise women out of their busy everyday schedule. Monitoring mechanism: Difficult to devise simple and effective monitoring mechanism for regular consumption of the IFA tablets. Logistics: A lot of planning and effort are required to maintain continuum of services.
Prerequisites	Well trained service providers. Easy- to-understand IEC material. Committed field staff. Effective NGO partners. Logistics management.
Who needs to be consulted	State Government, NGOs Community mobilisers
Risks	
Sustainability	It is an awareness generation programme, which makes the activities self-sustainable.
Chances of Replication	Since the reform is of low cost and since majority of Indian women are anaemic it should be replicated widely.
Comments	Simply diagnosing women as anaemic would not alter their health condition unless their compliance with the standard treatment for anaemia is maintained. This can be achieved only through raising their knowledge about complications related to anaemia and other micro nutrient deficiency.

Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, May, 2006.
Status	Active
Reference Files	
Reference Links	

53. Enforcement measures to control female foeticide, Punjab

Subject Area="Public / private partnership (including NGOs)."	**Objective="To promote birth of female baby and improve sex ratio."**
Details for Reform Option "Enforcement measures to control female foeticide, Punjab"	
Summary	**Background:** As revealed in census 2001 that all the 17 districts of Punjab were among the lowest 34 districts of the country where sex ration was poorest. In district Nawashahr sex ratio in 2001 was 808 per 1000. In another survey conducted by department of Child Development revealed 33 point decline in the child sex ratio in four year span (2004). Though government machinery in the department of Health and Child Development were taking measures against medical centres, which were indulged in the sex determination of the unborn child and pregnancy termination after sex determination. But these measures were proved to be inadequate to control the menace. Therefore, to control the social evil measures were introduced in a campaign mode in district Nawashahr in May 2005. **Action:** (1) Involvement of Non Government Organisation (NGO): All NGOs of the district were brought under a registered society named UPKAR Cordination Society (UCS). Ex officio chief patron of the society was appointed to Deputy Commissioner (DC). 35 NGOs were member of the society and each member was assigned an area of their choice. With the help of NGOs, UCS has developed committee at the block and village level. Block and village committees were the operational units, whereas district UCS has main role as facilitator for all the activities. Personal letters were sent to the lady Sarpanch and wives of the male Sarpanch by DC and UCS for their active involvement. With the special drive, community, especially young couple and adults group, was encouraged to become the member of the society. At present 4000 have already registered with the society as its member. Base line survey was conducted in all the villages under the supervision of all district officers. DC had actively monitored the whole survey process. (2)Monitoring of the pregnant women: Realising the fact that pregnant women need to be monitored continuously and sincerely for outcome of pregnancy, a computerised data base was prepared based on initial survey conducted in the area. Database has information like number of previous live children, age of the women, date of visit paid by Auxillary Nurse Midwife

(ANM) and complete postal address including her telephone number. In case women does not have telephone, telephone number of the Sarpanch was noted.

With the computerised database, a list of pregnant women was generated whose pregnancy was in the third to fifth month of gestational period, because this period is considered most vulnerable period for sex determination of foetus and followed by abortion. The main objective to take out the list was to monitor them telephonically by a lady telephone operator in the DC office. She used to ask about the health condition of the pregnant women and the foetus, thus leaving a invisible impact on the mind of lady as well as her family that they are watched and followed by somebody.

Second list was generated for the pregnant ladies whose Expected Date of Delivery (EDD) had crossed. Telephonic enquiry was also made to them for the outcome of the pregnancy. In case there was none, further enquiry was also made for loss of foetus.

(3) Monitoring of the Sonography centre: With time it was realised that one of the obstacle in the monitoring of the medical centre was to get complete details of sonography conducted during gestational period. In order to make monitoring effective, new software was developed at Suwidha Centre, Nawashahr. All data collected from the scanning centre was feeded in the software by 5th of every month and subsequently medical audit reports were generated for monitoring. These medical audits helped to cross check the social audit conducted telephonically. Disciplinary action was taken against the medical centre that does not comply with the rules.

(4) Focused monitoring: During the baseline survey it was revealed that one fourth villages were worst affected by the sex ratio. It was as low as 411 point as compared to 900 point in the adjoining villages. Focused monitoring was launched in these affected villages to identify the associated reasons for low sex ratio. Careful analysis of the information revealed the fact that a nexus was operating between the ANM / nurses and medical practitioners for their financial gain.

In order to break this nexus, all ANMs Nursus and Anganwadi Workers (AWW) working in the village were identified with their complete postal address and telephone number. A separate seminar was organised for these workers to discontinue their unprofessional act and strong warning was also issued to all of them to restrain from such activities or else case would be registered against them. Midwives of the area were given a toll free number (555501) to provide information for all such couples that come to them for abortion after sex determination.

(5) Involvement of youth: It was observed that without involving youths below the age group 25 years, that is largely to be affected segment by the social evil, enforcement measures against female foeticide can not be made fully successful and sustainable. Therefore, all college students were invited to DC office for a direct meeting with DC. Single Window System (SWS) was also introduced in the DC office to facilitate other related administrative work like driving licence, arm licence, birth certificate, depositing electricity and telephone bills etc.

SWS encouraged the youth to visit DC office. Keeping the objective of SWS as secondary, half hour direct interaction was organised with DC to introduce the problem of female foeticide and drug addiction among youth. As a surprise to note that many youths were not aware about present trend of sex ratio as well as its associated impact. Students were appealed to identify pregnant women in their neighbour and inform in the DC office for the purpose of their registration. To encourage their active participation students were offered INR 100. Among the students, girls took active participation in the enforcement measures. They also submitted memorandum in the hospitals and clinics to stop against the menace of sex determination and female foeticide.

(6) Adoption of villages by government officials: Government officials 5 contagious villages. Simultaneouly they were given other related responsibilities in the villages like inspection of school education, veterinary hospitals, drinking water supply, power supply etc.

(7) Mourning of baby girl: In order to sensitise the villagers for female foeticide, UCS used to do mourning of the baby girl in case where abortion took place after sex determination. (where at clinic or in front of house where abortion occurred for female baby).

(8)Involvement of public personality:Recorded messages of popular personalities were displayed on vehicle and literature were distributed.

(9) Identical names to baby girls: To promote birth of baby girl, function was organised at district head quarter every month, where all the baby girls born in a particular months were honoured and given one identical name like 'Navjot'.'Harsimran' and 'Jaspreet'.

Results: The sex ratio in 77 villages out of 475 have crossed 900 points (in 2006) in some cases has reached 1000 points. All these villages panchayats were honored on 8th March, 2006 on the International Women Day by Mrs. Anjali Bhawra, IAS, Commissioner, Patiala Division, Patiala. (See reference section for further details).

Cost	Information not available.
Place	District Nawashahr, Punjab in 2005.
Time Frame	Approximately one year.
Advantages	Involvement of community: Activities were designed as community based with their active involvement. Youth participation: Youth were encouraged to come forward to take ownership of the programme. Strict social and medical audit: To monitor the ongoing activities and current pregnant women strict computerised audit were devised.
Challanges	Insensitive attitude of medical professional: Incorporation can be perceived from the medical fraternity for their personal benefit. Deep rooted social norm: Social norms and gender based societal culture puts a obstacle to turn the knowledge into the behaviour.
Prerequisites	For organised efforts to bring the entire field NGOs under one umbrella.
Who needs to be consulted	Community District officials NGOs
Risks	
Sustainability	Sustainability component need to be judged according to the awareness generated among youth and their active involvement in the measures against female foeticide, as it is the large segment, which would be affected by the deep-rooted social evil.
Chances of Replication	Good, but need modification based on local constraints.
Comments	Down with the sex ratio is growing as a social menace. Making a law and providing a guideline to follow would not solve the problem unless it would be enforced in the society to get implemented.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, ICMR, September 2006.
Status	Active
Reference Files	
Reference Links	

54. Integrated Rapid Intervention and Care Project, Manipur

Subject Area="Public / private partnership (including NGOs)."	**Objective="To minimise the spread of HIV infection among injecting drug users."**
Details for Reform Option "Integrated Rapid Intervention and Care Project, Manipur"	
Summary	**Background:** Manipur is a victim of illegal international drug trafficking. It is geographically very close to the notorious "Golden Triangle" which is geographically composed of northern Thailand, northern and eastern Myanmar and western Laos. Heroin from Myanmar began to appear in Manipur in the mid seventies. By early eighties it became a "User State". Drug traffickers often indulged in self testing of heroin and consequent needle sharing with traders in Mandalay or Kalewa town in Myanmar as part of their drug purchasing behaviour and in the process they got infected with HIV. People thought that HIV/AIDS will never come to Manipur and Manipur's conservatism will protect them from HIV/AIDS. But, Manipur with hardly 0.2 % of India's population is contributing to about 8% of total HIV positive cases. The first HIV positive case in Manipur was reported in February 1990 from the blood samples among a cluster of Injecting Drug Users (IDUs). It has the largest problem of HIV infection associated with injecting drug use in India. Sharing of needles and syringes among the injecting drug users is one of the fastest methods of spread of HIV infection among the IDUs and from them to their sexual partners, their children and even to the general population in the state of Manipur today. The estimated number of IDUs in Manipur is between15, 000 to 20,000 of which 67.66% are unmarried and 40% have sexual partners. The implication is that 10,148 to 13, 530 IDUs are likely to marry in the near future and equal number of females is likely to be infected with HIV in the near future and from them, again to 3,300 to 4050 children. The integrated Rapid Intervention and Care Project (RIAC) was launched on 7th November 1998. It is being implemented, at present, in collaboration with 45 NGOs covering all the 9 districts of Manipur. The objectives of the programme are: (i) To minimise the spread of HIV infection among injecting drug users by making the IDUs accessible to clean needles, syringes and other injection works; education, counselling, skill development and referral network to

drug treatment and other social support networks. (ii) To minimise the spread of HIV infection from IDUs to female sex partners through condom promotion, education and counselling. (iii) To monitor and evaluate the change in the behavioural pattern of the IDUs. (iv) To help and support the people with HIV/AIDS and to initiate community mobilisation so that the families and community can take responsibility for care of people with HIV/AIDS. (v) To ensure effective linkage between community and hospital through formation of "Thoudang Marup" (community action groups) at the community level and Layengshangee Marup (hospital action groups) at the hospital or Community Health Centres and Primary Health Centres. (vi)To provide home based care services for the needy patients and to produce a "Home Care handbook".

Action: i) Rapid Assessment and Response (RAR)survey and Needs Assessment Survey done through questionnaires, focus group discussion among IDUs, sexual partners of IDUs, primary health care teams, private practitioners, hospital doctors and nurses, police officers, chemists and pharmacists, opinion leaders in the community, Non Governmental Organizations(NGOs) and Community Based Organizations (CBOs).

ii) Sensitisation of the community and facilitating them in the formation of 'Thoudang Marup' comprising of family members, carers of people with HIV/AIDS, community members, primary health care teams, medical practitioners, nurses, police officers, teachers, religious leaders and networking with other NGOs, CBOs, local clubs and women's organisations.

iii) Recruitment of 'Marup' (friends, volunteers or peer counsellors) with consideration from among the ex or current drug user, people with HIV or commercial sex worker.

iv) Formation of 'Layengshangee Marup' at the major hospitals comprising of members of medical, nursing and paramedical professions, community representatives and volunteers so that the relationship between community and hospitals is strengthened and sustained.

v) Training of outreach workers, peer educators, volunteers, carers, family members and all those who were going to be involved in the project in the pre-induction training in medical and nursing management, counselling, communication skills, management concepts and evaluation techniques as appropriate for each category of workers.

vi) Outreach work comprising of risk reduction education including free supply of IEC materials to IDUs and their sex partners.

vii) Voluntary confidential HIV antibody testing accompanied with

	pre- test and post test counselling. viii) Distribution of supply packs: The clients are given a pack of 8 disposable syringes (insulin syringes) with 4 condoms per week and educational materials on 'Supply Drug Use' and safer injection practice including how to use condoms with a puncture proof container. On subsequent visits needles are exchanged on one to one basis. The number of condoms and syringes in the packets varies as per the demand. They are also given free supply of bleach (5%) and taught how to sterilise the needles. ix) Monitoring of changing of risk behaviours. x) Referral services to drug treatment and other supportive network. xi) Home care of IDUs who developed opportunistic infections or AIDS. **Result:** By December, 2002 the project could render services to 15401 IDUs. A mid term evaluation conducted by an independent organization-ORG Marg showed the performance index as 92%. It also showed that 59% of the IDUs had stopped the practice of sharing, 46% of the IDUs were regularly using condoms which was only 4% when the programme had started and 89% of IDUs know how to sterilise the syringes with bleach and 83% of the patients have received home care services through the NGOs. The RIAC project is being implemented, at present, in collaboration with 45 NGOs covering all the districts of Manipur. The prevalence rate of HIV infection among IDUs is showing a decreasing trend from 76.9% in 1997 to 30.7% in 2003 and 21% in 2004- 2005.
Cost	Cost of the program is fixed as per the target. The cost for a quarter for different number of target are : 300 people INR 1,91800 500 people INR 2,44,100 800 people INR 3,19,800 1000 people INR 3,72,950
Place	The programme started in 1998 and is now running in all the 9 districts of Manipur.
Time Frame	1 year
Advantages	Wide coverage: The programme is covering the estimated 20,000 IDUs in all the 9 districts of Manipur. Rapid Intervention: As the very name of the programme suggests, the RIAC is a programme of rapid actions and which aims to bring about rapid results. Reduction in HIV prevalence rate: Infection rate has gone down from 76.9% in 1997 to 21% in 2004-2005. Community Involvement: The program involves community at different levels. There is a community action group called the 'Thoudang Marup', and then there are 'Marup's' who are

	volunteers or peer counsellors and hospital action groups called the 'Layengshangee Marup'.
Challanges	Shift in trend of infection: Though the infection rate has gone down amongst drug users but it is now shifting to the spouses and children of drug users. Lack of focussed program for spouses: There is also a need for addressing the spouses of the IDUs. No substitution program: No drug substitution programme has been started for drug users.
Prerequisites	Proper surveys. Mapping of prevalence rate and identification of areas. NGOs with experience in HIV/AIDS.
Who needs to be consulted	State Government. Manipur State Aids Control Society.
Risks	
Sustainability	The programme is sustainable and is continuing since 1998 and the next phase of the programme is being launched in April 2007.
Chances of Replication	A similar programme is running in Tamil Nadu and Puducherry.
Comments	None.
Contact	
Submitted By	Prabha Sati, Research Consultant, European Commission Technical Assistance, New Delhi, March 2007.
Status	Active
Reference Files	
Reference Links	

55. Involving National NGOs in Health Service delivery, Arunachal Pradesh

Subject Area="Public / private partnership (including NGOs)."	**Objective="To functionalise remote PHCs of Arunachal Pradesh"**
Details for Reform Option "Involving National NGOs in Health Service delivery, Arunachal Pradesh"	
Summary	**Background:** Due to Arunachal Pradesh's peculiar topography and difficult terrain, there is widely dispersed settlement pattern of the population that applies to both rural and urban areas. The rural population constitutes around 80% of the population. There are 16 Districts and around 3862 villages in the state. The health sector is weak in different remote inaccessible areas in almost all districts of the state. Availability of manpower in such areas is a big challenge. Common people had been shouldering the burden of poor healthcare delivery system. **Action:** Government of Arunachal Pradesh handed over the management of 16 PHCs of 16 districts to 4 non-profit organisations: Karuna Trust (Karnataka), Voluntary Health Association of India (VHAI), New Delhi; Prayas Juvenile Aid Centre (JAC) Society (New Delhi) and Future Generations (Arunachal Pradesh). Name of NGO Name of PHC District No. of PHCs Karuna Trust Bameng East Kameng 9 Mengio Papum Pare Sangram Kurung Kumey Jengging Upper Siang Dambuk Lower Dibang Valley Etalin Dibang Valley Walong Anjaw Khimyong Changlang Wakka Tirap Voluntary Health Association of India Lumla Tawang 5 Thrizino West Kameng Nacho Upper Subansiri Deed Neelam Lower Subansiri Gensi West Siang Prayas Juvenile Aid Centre (JAC) Society Wakro Lohit 1 Future Generations Arunachal (FGA) Sille East Siang 1 In January 2006, a pilot case study for three years was conducted. A State level Steering Committee on PPP Project was formed to monitor the progress of this pilot. Results: Following the implementation of PPP programme in the state, the manpower position tremendously increased from the past position when the State Government ran the health facilities. The accessibility of the health services has increased from near nil to full accessibility in 16 selected PHC areas. The details of this change is as follows: Designation Before PPP implementation After PPP implementation Medical Officer 14 32 SN 5 32 ANM 16 128 HA 9 32 Lab Technician 4 16 Pharmacist 10 16 Driver 9 16 Grade IV 63 64 LHV 0 16 Total 130 352 The main services that are delivered by the NGOs are as follows: 1. 24 hours Emergency / Casualty Services. 2. OPD service for six

	days per week 3. 5 to 10 bed inpatient facility. 4. 24 hrs labour Room and Essential Obstetrics facility. 5. Minor Operation Theatre facility 6. 24 hrs Ambulance facility 7. Make available essential medicines 8. Participation in and implementation of National 9. Programmes of Health & Family Welfare including the National Rural Health Mission. 10. Outreach / IEC activities by conducting medical camps. This has led to an increase in the availability and utilisation of the health care services by the people. As this is a fairly recent initiative quantitative evaluation is yet to be recorded.
Cost	Estimated around INR 23 lakhs per year per PHC and 10% contribution (whatever the amount) from the NGO with which the PHC is.
Place	16 PHCs in Arunachal Pradesh.
Time Frame	One year to review & decide the NGOs to be involved and allocate the PHCs
Advantages	1. Availability of manpower under management control of NGOs, regular service delivery to the community. 2. Opportunities of the project can be counted, as sizable populations are becoming the beneficiaries of the project. 3. Community is now gradually becoming aware about modern health facilities and also started adopting preventive measures for healthy life. 4. Availability of ASHA (Accredited Social Health Activists) is crucial for effective coverage of deliveries, institutional/home and immunisation especially in remote areas. 5. The fusion of management skill of NGOs and reformed work frame of RKS can turn a PHC as a model PHC. 6. Demand of quality health care has increased as the awareness levels have also improved.
Challanges	1. Population density: average population density per square kilometre is 13 people. 2. Communication problems: Due to difficult geographical terrain, communication with the remote and distant villages is a major challenge.
Prerequisites	The national NGOs should have experience in managing health care delivery system
Who needs to be consulted	PPP program managers of NGOs, Nodal Officer (PPP) of Govt. of Arunachal Pradesh.
Risks	
Sustainability	Cost benefit analysis is required before deciding

Chances of Replication	There is chance of replication to more PHCs and even to few CHCs in Arunachal Pradesh. Chances of replication are there in hilly states of India.
Comments	Securing ownership by all stakeholder (State Govt, NGOs, Local Community) will be the key to the success of this PPP.
Contact	
Submitted By	Dr. P. J. Sarma, State Facilitator (NRHM) Manisha Ghose, Research Consultant, CBHI Paromita Ukil, Research Consultant, ECTA January 2007
Status	Active
Reference Files	
Reference Links	

56. Devolution of financial and administrative powers to districts, Haryana

Subject Area="Management structures and systems."	Objective="Decentralisation."
Details for Reform Option "Devolution of financial and administrative powers to districts, Haryana"	
Summary	**Background:** The State Government of Haryana decided that to meet the rising cost of healthcare and rising expectations of the community it must bring in a programme of decentralisation to increase local ownership and community participation and make it more responsive to local needs. **Action**: Decentralisation and devolution of financial and administrative powers at district and sub-district levels with the aim of simplifying administrative and financial procedures. Powers at different levels have been devolved as follows: (i) Civil surgeon Transfer and depute all categories of staff within the district. Employ specialists, staff nurses, Auxiliary Nurse Midwives (ANMs), Lady Health Visitors (LHVs), drivers, etc. on contract basis. Purchase drugs, material and equipment. Delegation of financial powers of Director General of Health Services (DGHS) for sanction and incurring expenditure under the scheme/project. Get buildings repaired /constructed from appropriate agency.* Responsible for disciplining class III category employees. Readjust/reallocate sub-centre population to ensure effective health care delivery. Assign additional job responsibilities to different categories of health staff in the district. Ability to delegate administrative or financial powers to the most senior district program officer. (ii) Medical superintendent Purchase drugs, equipment, consumable or non-consumable materials and get any repairs done up to INR 50,000).* (iii) Senior Medical Officer (SMO) Redistribute/depute the class III and Class IV staff within his/her area with the approval of the civil surgeon. Carry out minor disciplinary action to class IV staff. Procure medicines, equipments, materials, consumables and non- consumables up to INR 10,000.* (iv) Medical officer Redistribute/depute class III and class IV staff within his/her area with the approval of SMO/civil

	surgeon. Recommend minor disciplinary action. Purchase/repair up to INR 5000. (v) Health supervisors & health workers Purchase/repair up to INR 500. Employ helpers from local area for sub centre. As per the district action plan approved by the state reform cell) **Results:** Visible improvement to infrastructure (particularly district hospitals). See pictures in References section. Shared authority between the centre and local units has improved their ability to meet national health objectives and respond to local health needs.
Cost	Costs met from user fees.
Place	Yamunanagar district, Haryana, since May 2001.
Time Frame	Six months for implementation.
Advantages	Efficiency: More efficient district and sub-district management of resources. Speed: Swifter management decisions.
Challanges	Power struggles: Understanding of roles and responsibilities needs to be provided to facilitate the transfer of power from one agency to another. Flexibility: A decentralisation programme must be flexible enough to adapt during implementation to meet unexpected needs. Capacity building: Health personnel must be trained to understand how best to use their new powers.
Prerequisites	Decentralisation accepted as state policy and a government order from state government. Strengthened monitoring and supervision at state, district and sub-district levels.
Who needs to be consulted	State Government
Risks	
Sustainability	Good, if political will persists. This project is being run until the end of the EC-Supported Sector Investment Programme in December 2006 and will then be reviewed.
Chances of Replication	No information available.
Comments	Haryana State Government is committed to a programme of decentralisation but a significant unfinished agenda remains (as of January 2006). This includes the physical merger of societies and formation of a management andmonitoring cell as well as capacity building of senior officers at the health directorate, 17 districts and PRIs.

Contact	
Submitted By	Dr K B Singh, Programme Advisor, European Commission Technical Assistance, New Delhi. July 2002. Updated February 2006.
Status	Active
Reference Files	

20-98-2001-4HB-III dated 19-06-2001 (PROD No 35).doc	
EC SIPO C-1-2001-275-280 dated 02-05-2001 (PROD No. 35).doc	
EC SIPO C-1-2001-282-287 dated 02-05-2001(PROD No 35).doc	
Decentralisation2.ppt	Powerpoint presentation on Decentralisation, State Government of Haryana, January 2006.

Reference Links	

57. Decentralised planning for RCH services, Uttar Pradesh

Subject Area="Management structures and systems."	Objective="Decentralisation."
Details for Reform Option "Decentralised planning for RCH services, Uttar Pradesh"	
Summary	**Background:** The centralised blanket strategy used in UP for the last 50 years in family planning was failing because the use of contraception is an extremely personal issue, interwoven with religion, tradition and societal values. For the strategies to be successful they need to be tailor-made for each district. **Action:** In March 1998, after four years of planning, SIFPSA (funded by USAID) launched 6 District Action Plans (DAPs) which would involve all stakeholders from the public and private sectors in decentralised participatory planning using an integrated approach (ie using all resources available in the district). They conducted baseline surveys, workshops and a census of facilities in the districts. The districts set their own objectives and evolved strategies. Each plan was implemented by a district level registered society chaired by the district magistrate and called the District Innovations in Family Planning Services Project Agency (DIFPSA). DIFPSA included representatives from the public and private sectors and is supported by the Project Management Unit (PMU) which monitors the programme and reports back to SIFPSA. The objectives were to: •Facilitate access to reproductive health services (through RCH camps). •Improve quality of reproductive health services (through skill development programmes for health workers). •Generate demand for reproductive health services (through communication campaigns). Strategies also included: •Gaining the support of religious leaders and village heads. •Involving the non-governmental sector including Private Voluntary Organisations (PVOs) and cooperatives, identifying potential partners for project implementation, assisting in formulating projects and monitoring of project implementation on a regular basis. **Results:** After the first year an assessment was carried out by an external agency POLICY Project. USAID has also carried out an evaluation. They found: •Average increase in Contraceptive Prevalence Rate (CPR) of 1.2% per year in

	DAP districts. •Increase in sterilization (per 1000 population) from 19.8 (1997-98) to 30.3 (2002-03) – compared to 23.5 in non-SIFPSA districts. •Decrease in population growth by 3.33 % compared to an increase in 0.25 % in non-SIFPSA districts (from 2001 Census conducted February 2001).
Cost	Total costs for Varanasi district ranged from INR 26,189,886 (€464,000) in 1998-99 to INR 10,288,900 in 2000-01. Total costs of Mirzapur district ranged from INR 10,266,850 in 2001-02 to INR 7,945,950 in 2003-4.
Place	Thirty eight districts in Uttar Pradesh, from 1998. Six were added 1998-99, 9 between 2001 and 2002, 18 between 2002 and 2003 and 5 in 2003 and 2004.
Time Frame	Four years from programme conception to implementation of DAPs. It took almost one year to develop the DAPs through the participatory process. One year to implement the DAP model.
Advantages	Participation: DAPs help reverse the management process from a 'top-down' approach to a truly participatory one. Responsive: Local needs are identified and 'fed forward' to project management at the central level, making the system more responsive to local priorities and concerns. Increased sense of ownership: By the community and by stakeholders who are involved at all stages of the planning and implementation bringing a greater level of commitment to the programme.
Challanges	Time consuming: It took four years to develop and implement the DAP model. Management intensive. Government cooperation needed: Greater integration with government public health system is required.
Prerequisites	Cooperation of state government. Readiness of NGOs, PVOs, private sector and public sector to work together.
Who needs to be consulted	State government; public health facilities; private sector; NGOs; PVOs; local community.
Risks	
Sustainability	Sustainable, provided the funding is there. The development of the DAPs and the creation of the PMUs under the IFPS project has, in effect, resulted in the strengthening of the health and family welfare sector at the district level. It has brought in non-health resources for promotion of

	family welfare and lays the foundations of a robust management system. As the PMU is a unit outside the health department, it retains flexibility of operation but at the same time is accountable to DIFPSA, thereby ensuring that it does not operate in isolation of the public sector. Such a mechanism makes for long-term sustainability.
Chances of Replication	Good. After the initial pilot in six districts (1998-99), the DAP model of SIFPSA has now been implemented in all 38 districts (where SIFPSA is operating). In addition, seven more DAPs (also known as Decentralised Participatory Plans(DPP)) were set up under the Empowered Action Group Scheme of Government of India between 2004 and 2005.
Comments	SIFPSA found that systems improvement was a more successful way of tackling the problem than by grafting a completely new structure and that participatory planning created ownership. However there needs to be good quality data to highlight client needs and infrastructure gaps and a strong monitoring mechanism in place.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. June 2005.
Status	Active
Reference Files	Extract from GP report.doc — Extract from Report on Good Practices and their Cost Effectiveness (Reproductive and Child Health) Volume III (GOI, Department of Family Welfare; European Commission) March 2004
Reference Links	

58.Rogi Kalyan Samiti, Meghalaya

Subject Area="Management structures and systems."	Objective="Decentralisation."
Details for Reform Option "Rogi Kalyan Samiti, Meghalaya"	
Summary	**Background:** Rogi Kalyan Samiti / Hospital Management Committee is a simple yet effective management structure. This committee, which would be a registered society, acts as a group of trustees for the hospital to manage the affairs of the hospital. It consists of members from the local NGOs, local elected representatives and officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre / FRUs/PHCs. RKS / HMS is free to prescribe, generate and use the funds with it as per its best judgement for smooth functioning and maintaining the quality of services. **Action:** Ganesh Das Hospital, which is exclusively a maternal and child hospital in Shillong is a pilot case study wherein RKS was introduced that is also being extended to the PHCs, CHCs and other district Hospitals. This government run hospital provides free health care delivery services to the mothers and children. A Memorandum of Association was signed with the State Government by the 8-member society including 2 women. These women are from 'Sengkynthei', a community-based women's organisation, tribal tradition of Meghalaya society. Four meetings by this society have already been held in one year following the formation on 22 February 2006. Objectives of Society: Ø Maintenance & upkeep of the hospital ØAcquiring of equipment for the hospital ØExpanding the hospital building ØImproving boarding and lodging for the attendants accompanying the patients ØEntering into partnership with the private sector for the improvement of the support services such as cleaning, laundry, diagnostic facilities and ambulance services. ØDeveloping and leasing out vacant premises for generating funds ØAdopting sustainable and environment friendly measure for management of the hospitalIn this 400 bed hospital, which conducts an average 20-30 deliveries daily and around 2000 caesareans operation and around 2000 tubectomies annually has 9 double private rooms , along with 5 single rooms & 19 three bedded rooms. Shops were rented out for setting up phone booths for the convenience of the people visiting the hospital. A shopping complex is also under way on the hospital premises. Earlier private wards were the only source of income for this government run hospital and this was to be returned to

	the State government. Now the money generated from the private wards along with the additional sources like user fees, donations etc is to be kept with the society. In fact the government encourages the hospital to generate funds now that RKS is in place. This has empowered the hospital to manage the funds for buying medicines, oxygen cylinders and carrying out minor repairs among other things for which they do not have to wait for government's approval for the day to day running of the hospital. Money for the Jananai Surakha Yojana (JSY) scheme given under the National Rural Health Mission (NRHM) is being released directly to Ganesh Das Hospital Management Society by an account payee cheque from the State Health Society, facilitating them for quick and smooth disbursal to the beneficiaries. At the PHC level also, RKS has taken shape. A case study of Mawphlang PHC, approximately 20 kms from Shillong, is one such example. It caters to 65 villages and 3 sub centres. It is a 10-member society with the village headman as the member chairperson. This society has representation from the church, school and community based organisations (CBO). All the members contribute towards the society in their own capacity. The church leader has provided the ambulance for this PHC and the CBO, 'Sengkynthei' has provided the dustbins. Similarly the chairperson, who also works with the Public Health Engineering Department (PHED) in the State government, has donated the benches for the PHC. His involvement with the PHC management has proved doubly beneficial because now he uses his position in PHED to prioritise road building in the area. This has made a great difference in transporting patients from far flung areas. **Results:** 1. Generation of money through additional sources. 2. Community Involvement leading to ownership. 3. Improvement in the overall management and services of the hospital. 4. Increase in the number of patients visiting the hospital. 5. Increase in the number of referral patients to the PHC and further to the district. 6. Under JSY, 2234 beneficiaries have been compensated since May 2006 till January 2007.
Cost	Information not available
Place	Shillong, Meghalaya & Mawphlang PHC, approximately 20kms away from Shillong.
Time Frame	1-2 months to set up the committees
Advantages	1. Community involvement & ownership 2. Additional income generation 3. Quick Disbursal of money 4. Quick Remedial Steps

	5. Increase in the standard of the hospital
Challanges	1. Increased patient load 2. Lack of support staff 3. Maintaining Quality Health Care Services
Prerequisites	None
Who needs to be consulted	State government, RKS management bodies and staff of hospitals
Risks	
Sustainability	Sustainable but requires commitment and close monitoring and supervision
Chances of Replication	Can be replicated.
Comments	MOA between the RKS of the Mawphlang PHC & State government
Contact	
Submitted By	Manisha Ghose, Research Consultant, Central Bureau of Health Intelligence Paromita Ukil, Research Consultant, ECTA
Status	Active
Reference Files	
Reference Links	

59. Financial autonomy to hospital through Chikitsa Prabandhan Samiti, Uttarakhand

Subject Area="Management structures and systems."	**Objective="Decentralisation."**
Details for Reform Option "Financial autonomy to hospital through Chikitsa Prabandhan Samiti, Uttarakhand"	
Summary	**Background:** Decisions in the better functioning of hospital as well as for welfare of community were delayed due to lack of financial power to the hospital management. Therefore, government of Uttarakhand promulgated the concept of hospital autonomy through government order in March 2003. **Activities:** In order to provide greater flexibility to the hospital management in solving facility level problems through local level decision-making Chikitsa Prabandhan Samiti (CPS) was constituted in all 29 major hospitals (district hospitals & Few Community Health Centres) in Uttarakhand. CPS has been constituted at two levels. One is Executive Committee (EC) under the chairmanship of District Magistrate (DM). The Chief Medical Superintendent (CMS) functions as the secretary of the CPS of Executive Committee as Co Chair Person and of Management Committee as Chairperson. The second level is management or functional committee headed by CMS. CMS is made responsible for utilization of user charges to improve and smooth functioning of the hospital. The EC has been empowered to review the financial account at least once in a financial year, review income & expenditure statements and approve the budget for the next year. It also have powers to appoint chartered accountant and can constitute sub committees for specific purposes such as new construction & commercial use of land. **Results:** Though evaluation of the functioning of CPS has not been conducted but it has definitely given financial flexibility to the facility manager and has increased sense of ownership among them.Performance monitoring of the CPS need to be evaluated in due course of time to improve its functioning.
Cost	Need to provide government order and clear-cut guidelines to take decisions. Resources are generated locally through user charge and community participation
Place	29 major hospitals in the State of Uttarakhand. List of hospital is given under reference section.

Time Frame	Approximately one year.
Advantages	Decentralised decision-making: Financial power at the hospital facility level has given decision-making authority up to a limit. Efficiency: Quick decision at the facility level has inbuilt arm to improve efficiency.
Challanges	Accountability: In terms of expenditure for the income generated, accountability can be checked through financial audit.
Prerequisites	Government order.
Who needs to be consulted	State government
Risks	
Sustainability	Samiti formed at the hospital level are self-sustainable due to income generated at the local level.
Chances of Replication	Good, as has been replicated in other state also successfully.
Comments	Initiative has received a welcome note from the providers as well as from public but need a continuous quality circle and monitoring cell to improve client satisfaction.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, NIMS, February 2006.
Status	Active
Reference Files	
Reference Links	

60. Transfer of rural Sub-Centres to Panchayati Raj Institutions, Haryana

Subject Area="Management structures and systems."	Objective="Link with PRIs (local councils)."

Details for Reform Option "Transfer of rural Sub-Centres to Panchayati Raj Institutions, Haryana"

Summary

Action: Administration of a total of 347 rural sub-centres was transferred to Panchayati Raj Institutions (PRI) on a temporary basis as a pilot project in three districts of Haryana in 2001. It is still being attempted in these districts (as of October 2004) but has not been successful due to perceived management weakness of PRIs in the state. Under the project, existing health workers keep their status as government servants and the terms and conditions of their service is protected.

They continue to receive salaries and perform the standard job responsibilities. However vacancies from retirement/ promotions/ other eventualities are filled by PRIs on a contract basis from candidates available in the local area, as per guidelines issued by the state government and not exceeding 25% of the posts. PRI-appointed staff are paid out of sector investment programme funds during the first two years.

Responsibilities of PRIs: (i) Management & day-to-day functioning of sub-centres. (ii) Provision and maintenance of sub-centre building. (iii) Review of all national health programmes. (iv) Levy of user charges with the approval of the District Health & Family Welfare Society. (v) Ensuring that health workers posted to sub-centres maintained their headquarters by providing rent-free accommodation out of funds generated by PRIs. (vi) Enforce discipline amongst staff. Role of government: (i) Supervision of health workers. (ii) Review of all national health programmes. (iii) Medicines, equipment etc shall continue to be supplied during this period through Zila Parishads/ Panchayats.

Results: Yamunanagar District Health and Family Welfare Society handed over 112 health sub centres to PRIs during the month of September 2001 and trained 160 male and 83 females PRI members about various state and national Health programmes. The training took two days and was held at block level. As of October 2004 the PRIs were still in charge of the subcentres and the DH&FW Society reported that the scheme was working well. It is also still functioning in Ambala (October 2004), where 101 sub centres were

	handed over.
Cost	Estimated costs: Ambala DHF&W gave each Panchyat INR 2,500 for minor repairs for each subcentre and the State Government contributed INR 10,000 per sub-centre.
Place	Ambala, Karnal, Yamunanagar (districts of Haryana) from 2001.
Time Frame	Three months.
Advantages	Organisation: Better accessibility to services (through possible relocation of sub-centres) and better provision and supervision. Accountability: Auxiliary Nurse Midwives in sub-centres accountable to local community body. Local community body is in turn accountable to electorate for maintenance of sub-centre building and equipment.
Challanges	Needs an able PRI: Doesn't work if there is a lack of interest/ commitment/ poor management by PRI. Cooperation dependent: Risk of poor working relations between PRI officials and health officials. Possible opposition: Risk of opposition from district health authorities who may see it as an infringement of their powers.
Prerequisites	Decentralisation accepted as state policy. Government order from state government.
Who needs to be consulted	State government; PRIs; state and district health officials.
Risks	
Sustainability	The scheme did not prove to be sustainable due to a weakness in the management skills of the PRIs.
Chances of Replication	The programme managers feel the scheme would be replicable in states where there are strong PRIs.
Comments	None
Contact	
Submitted By	Dr K B Singh, European Commission Technical Assistance, New Delhi. October 2004.
Status	Active
Reference Files	Haryana Health Dept Memo No 20-98-2001-5B-III(PROD No 33).doc
Reference Links	

61. Establishment of State Sector Reform Cells, various States

Subject Area="Management structures and systems."	Objective="Integrated planning and management."
Details for Reform Option "Establishment of State Sector Reform Cells, various States"	
Summary	**Action:** Establishment of a state Sector Reform Cell (SRC) with a mandate and authority to drive health sector reform processes and, in particular, to produce well-articulated policy and operational options based on sound analysis. An SRC consists of: (i) An empowered committee/board/council/bureau to direct and oversee the reform activities; (ii) A secretariat; (iii) Technical capacity (especially through contracts with local institutions). An SRC is concerned with the management of both internally and externally financed schemes across the whole health & family welfare sector and not just with one development partner (donor). An SRC does not duplicate an existing similar body (such as the strategic management bodies of the State Health Systems (SHS) project funded through the World Bank). An SRC manages a sector reform fund (or similar) as a channel for funds from government or development partners for the development of services.
Cost	Information not available.
Place	Himachal Pradesh, Uttar Pradesh, Gujarat, as well as 22 states under the European Commission's Health and Family Welfare Sector Programme.
Time Frame	Three months.
Advantages	Unifying: A single body is responsible for managing the entire state health sector reform process. Logical: There is now a capacity to develop sound and well-researched policy and operational options. Coherent: Sector reform fund provides a mechanism for funds from many sources to be channelled into a coherent plan for sector reform.
Challanges	None perceived.
Prerequisites	Government Order. Political will.
Who needs to be	State Health & Family Welfare Authority, NGOs, private sector.

consulted	
Risks	
Sustainability	Fair to good, the secretariat and technical capacity could be funded from the regular state budget.
Chances of Replication	Good, although the name, form and membership of SRCs will vary according to local circumstances.
Comments	None.
Contact	
Submitted By	ECTA PROD team, ECTA, New Delhi, July 2002.
Status	Active
Reference Files	
Reference Links	

62. Establishment of District Health Agencies to manage health services: various States

Subject Area="Management structures and systems."	Objective="Integrated planning and management."
Details for Reform Option "Establishment of District Health Agencies to manage health services: various States"	
Summary	**Action:** Establishment of agencies to manage Health and Family Welfare (H&FW) services in the districts through a State Government Order (GO). The agencies can take a variety of forms, eg. the Zilla Parishad itself; a committee set up by state executive order; a statutory body created by the state; corporation or company; society. Most of the current agencies are extensions of existing societies chaired by the District Development Officer (DDO) with the District Health Officer (DHO) as secretary. It is not recommended that an additional society be created and in fact the creation of the agency can be an opportunity to amalgamate a range of existing societies with similar memberships. Membership includes representatives from Panchayats, H&FW department, NGOs and private sector. Powers may include, for example, recruitment and dismissal of staff; schemes to generate income for local use; construction and maintenance of health facilities; procurement of emergency drugs. Each agency manages a Sector Reform Fund (SRF) as a channel for funds from government and development partners (donors) for the development of local services. In Haryana, District Health and Family Welfare Societies have been functioning successfully since January 2002. The societies, which have a governing council and an executive body, also spend user fees and have been able to make significant improvements to both infrastructure and services.
Cost	Information not available.
Place	Andhra Pradesh (Nalgonda, Khammam) -- Assam (Nagaon) -- Gujarat (Rajkot, Narmada) -- Haryana (Ambala, Yamuna Nagar, Karnal) -- Himachal Pradesh (Kangra) -- Kerala (Kollam) -- Madhya Pradesh (Guna, Sidhi) -- Maharashtra (Satara, Aurangabad) -- Orissa (Phulbani, Bolangir, Balasore) -- Rajasthan (Jalore, Barmer) -- Uttar Pradesh (Ghazipur, Jalaun) – West Bengal
Time Frame	Four months.

Advantages	Decentralisation: Decisions can be made quickly without waiting for State Government to respond. Accountability: Responsibility for all H&FW services in a district clearly rests with one management body. Streamlined: Brings a number of different society's less than one management team so services are better coordinated. Communication: Strengthens links between Panchayats, district H&FW services, NGOs and the private sector.
Challanges	None perceived.
Prerequisites	Cooperation of state government and existing community organisations/societies. State GO.
Who needs to be consulted	District Panchayat, District and State H&FW Authority, NGOs, private sector.
Risks	
Sustainability	Fair to good: the agency may well require a small secretariat which could be funded from a variety of sources such as the District H&FW budget or the District Panchayat budget. Haryana reports the system to be functioning successfully.
Chances of Replication	Good: although the constitution, name, form and membership of district agencies will vary according to local circumstances.
Comments	This reform option, which gives a local management focus for effective decentralisation of H&FW services, will facilitate other reform options to take place.
Contact	
Submitted By	ECTA PROD Team, New Delhi, July 2002. Updated October 2004.
Status	Active
Reference Files	Constitution of District Health & Family Welfare Society, Yamunanagar.doc District Health & Family Welfare Society, Ambala.doc
Reference Links	

63. Punjab Health System Corporation, Punjab

Subject Area="Management structures and systems."	Objective="Integrated planning and management."
Details for Reform Option "Punjab Health System Corporation, Punjab"	
Summary	**Background:** Hospital services at the secondary level play a vital and complementary role to the services provided at the primary level of healthcare. However, various gaps were found in the Punjab healthcare system making it impossible to deliver these services efficiently and effectively. These were: (i) Lack of basic medical equipment (ii) Critical lack of infrastructure (iii) Lack of basic diagnostic services. **Action:** To revamp the services at secondary level hospitals, the Punjab Health System Corporation (PHSC) was set up in 1995 to implement the World Bank-sanctioned Second State Health System Project for secondary level health care services. The Secretary to the Government of Punjab, Department of Health and Family Welfare, heads the PHSC with a managing director. The PHSC is fully autonomous and has the administrative flexibility to make rapid decisions for efficient and effective delivery of the health services. Policy decisions were taken by the PHSC in the following areas between 1995 2002: (i) Retention and utilisation of user charges at the point of collection: Under government notification, PHSC were allowed to retain the revenue at the point of collection and were allowed to use it in definite proportion in different heads. (See PROD entry No 146: Retention of User fees at the health facilities) (ii) Decentralised financial power for emergency local purchases Financial powers were assigned to the Senior Medical Officer (SMO), Deputy Medical Commissioner (DMC) and Chief Medical Officer for direct purchase and with quotations. (See PROD entry No 147: Devolution of financial powers, PHSC, Punjab) (iii) Benchmarking of specialist doctors for their performance: To monitor the performance of the specialist doctors from the revamped health facilities, monthly benchmarks were assigned as per the bed strength of the hospital. (See PROD entry No 144: Benchmarking to improve performance of the specialist Doctors, Punjab) (iv) Outsourcing of non clinical services: Non clinical services such as sanitary services, electricity and plumbing services and ambulance services were outsourced to maintain the continuity of health care efficiently and effectively.(See PROD entry: Outsourcing of the non- clinical services,

	PHSC, Punjab) (v) External and internal quality checking system for clinical laboratories. Serum containing 13 biomedical parameters, which have been tested at the department of clinical biochemistry, CMC Vellore, are sent by post every month to the participating clinical laboratories under PHSC. These laboratories test the sample sera. The estimated values are conveyed to the CMC Vellore, which in turn sends monthly feedback. **Results:** By 2002 (i) Civil works such as repairing of the existing building and construction of infrastructure as per requirement was completed in 154 hospitals. (ii) Major and minor medical equipment supplied and installed where required. (iii) 324 existing ambulances repaired. (iv) 133 additional ambulances and 17 surveillance vans positioned. (v) 32 blood banks in the state revamped by providing buildings, equipment and infrastructure.
Cost	World Bank sanctioned US$106.10 million (INR 4670.5 million) to upgrade the selected hospitals, in the following proportions: Loan: INR 252.00 crore. Grant: INR 127.00 crore. State government share: INR 45 crore.
Place	One hundred and fifty four hospitals in Punjab, including Community Health Centres, Sub divisional hospitals and District hospitals.
Time Frame	Approximate time from planning to implement the reform was one year.
Advantages	Administrative flexibility: Power assigned to the Corporation has given it the flexibility to take rapid decisions in favour of patients' welfare. Efficient health service delivery: Maintenance of infrastructure and equipment and setting of benchmarks for specialist doctors promotes efficient service from the health facilities.
Challanges	None perceived.
Prerequisites	Government Order.
Who needs to be consulted	State government, funding agency.
Risks	
Sustainability	The strategies adopted by the corporation are sustained by the user fees.
Chances of Replication	Replicable, but need strong political will to initiate the process.
Comments	Though setting up a corporation with the necessary political

	will is a difficult process, once it starts it helps in the making of speedy decisions for the welfare of the patients.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, IRMS, September, 2005.
Status	Active
Reference Files	
Reference Links	

64. District Health Action Plans, Madhya Pradesh

Subject Area="Management structures and systems."	Objective="Integrated planning and management."

Details for Reform Option "District Health Action Plans, Madhya Pradesh"

Summary

Background: The Government of Madhya Pradesh (GoMP) decided it was impossible for the State to respond adequately to the health needs of its people with purely centralised planning because of its large geographical area. It proposed a policy of decentralised planning and implementation to make the health system more responsive and accountable.

Action: The GoMP established the Rajiv Gandhi Mission (RGM) for Community Health in 2001, situated within the Department of Health and Family Welfare. The mission seeks to converge health-related resources and prioritize the needs of the poor in service delivery through strengthening and decentralizing authority to district decision-making structures. In 2004, it developed planning guidelines and provided technical support to the districts to help them prepare Integrated District Health Action Plans.

The planning process drew extensively upon the experience of District Action Planning in Guna district which had been undertaken in 1999 under the European Commission-supported Sector Investment Programme. As well as the guidelines, the districts were told what funding to expect from both State and development partners so that they could plan realistically and not merely produce a wish list. The planning guidelines included: (i) Objectives (ii) Resources (iii) Restrictions tied to funding resources (iv) Indicative guidelines pertaining to Component Management Protocols (v) Common principals. A core group of 4-6 people from government departments, private sector, Non Government Organisations (NGOs) and Community Based Organisations (CBOs) was formed in each district to facilitate the planning process.

The group was selected by the District Collector (DC) who was advised to only choose experienced people willing and committed to planning. A nodal officer was selected within the group to ensure coordination within the Core Team and between State and district. A team of 7 external experts and a few departmental officials were also deputed to provide technical assistance to the districts because it was a new exercise.

Each expert worked with 5 or 6 districts and was specifically

	told not to develop the plan herself/himself but to coordinate and facilitate the process. Steps for developing a district plan: (i) A two-day district level workshop to identify problems in the health sector and disseminate the purpose of having a district plan. Attended by all stakeholders including community leaders, representatives from Panchayat Raj Institutions (PRIs), line department and private sector, field level workers. (ii) One-day workshops at block level for all stakeholders to discuss problems identified at district level and identify priorities and possible interventions to deal with these problems. (iii) The core group worked on recommendations received from these workshops to finalize the list of interventions. The final plan was placed before the District Health Society for discussion and approval. District plans which had a high level of attendance at workshop level were found to be of better quality. District level workshops were completed by July 2004. Block level workshops completed by August 2004. Plans sent to the State Directorate for approval by October 2004. However, it was found there were significant gaps and lack of coordination in these first plans and major modifications were necessary. It was decided to review all the district plans the following year in the light of Reproductive Child Healthcare 2 (RCH2) and National Rural Health Mission (NRHM). In April 2005, districts were given an improved set of specific guidelines, using the lessons learnt from the previous year's exercise. They were again provided with a team of resource people to facilitate the planning work, with special regard to RCH2 and NRHM. Revised plans were finished by August 2005. These District Plans were then appraised at State level before disbursement of funds and each plan was discussed with three different evaluation committees headed by the Commissioner for Health, the Commissioner/Director of the Information Education Communication (IEC) Bureau and the Mission Director. Following this process, plans were approved and funds made available to the District Health Societies. Local representatives of development partners provided technical assistance in the development of planning guidelines and facilitated the district core teams in developing their plan documents. **Results:** Four Area Health Managers (AHMs) at Regional Headquarters have been made responsible for ensuring coordination between the State and the districts. Since October 2005, they have observed the following: (i) Micro planning of each activity under the District Plans in most districts has been completed and activities have started.

	(ii) The Chief Medical & Health Officer (CM&HO) and DCs feel more accountable following the planning process. (iii) There is more coordination between the CM&HOs and DCs who are more willing to work together to achieve implementation of activities. (iv) A greater sense of ownership amongst the stakeholders for health services and activities.
Cost	INR 24 lakhs in first stage planning process @INR 50,000 per district INR 9.60 lakhs in the second stage @ INR 20,000 per district. In addition, at State level meetings/consultations, an estimated expenditure of INR 25000 was incurred.
Place	Madhya Pradesh, since October 2005.
Time Frame	Twenty months.
Advantages	Encourages ownership: The process makes districts realise their own potential in managing health care delivery. Simplicity: Special care was taken to make sure the guidelines were simple to understand.
Challanges	Continuity: Guidelines need to be specific enough to ensure all districts produce similar plans. Inclusiveness: Important to encourage all the stakeholders to attend planning workshops which ensure a more detailed and comprehensive plan.
Prerequisites	State Government commitment to decentralisation.
Who needs to be consulted	All stakeholders: PRIs, field level workers, private sector providers, NGOs, Government officers at state and district level.
Risks	
Sustainability	The process is sustainable throughout the State. For example, in Guna, improved coordination is now perceptible between Integrated Child Development System (ICDS) and health. A Nutrition Rehabilitation Centre is now functional at the district hospital for severely malnourished children up to the age of 5 years.
Chances of Replication	Judged to be good.
Comments	Further decentralisation is now planned in the State in the form of Village Health Plans via the National Rural Health Mission (NRHM) agenda. The process is planned to be taken up in year 2006-07.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. March

	2006.
Status	Active
Reference Files	

District Health Planning.ppt	Powerpoint presentation on District Health Planning
District Workshop Process-Refined.doc	District Planning workshop process guidelines
District_Health_Planning.doc	Report on District Planning process, 2004-2006
DPG English Version.doc	Guidelines on District Planning and Monitoring (Revised) in English
DPG Hindi Final.doc	Guidelines on District Planning and Monitoring (Revised) in Hindi
Draft letter addressed by Health Commissioner to local DPs.doc	Draft letter addressed by Health Commissioner to local Development Partners
Integrated District Health Action Plans- Roadmap, Roles and Responsibilities of Partners.doc	Integrated District Health Action Plans - Roadmap, Roles and Responsibilities of Partners

Reference Links	

65. Giving functional autonomy to secondary and tertiary level government hospitals through Hospital Welfare Societies, Himachal Pradesh

Subject Area="Management structures and systems."	Objective="Effective decentralised management of services."
Details for Reform Option "Giving functional autonomy to secondary and tertiary level government hospitals through Hospital Welfare Societies, Himachal Pradesh"	
Summary	**Background:** In 2000-2001 the state of Himachal Pradesh was faced with an acute financial shortage, which particularly affected the health system, as there was a shortage of drugs and supplies and meagre funds for maintenance. The government could not take the decision to levy user charges as it had come to power with the promise of providing free health services. So it decided to create autonomous 'societies' at secondary and tertiary level government hospitals, which would decide their own mechanism of financing through means such as charges, or donations. **Action:** In May 2001, societies were formed at district and medical college hospitals in the state. The focus was on generation of resources through charges, donations and other fees. Initially, directions regarding rates for hospital services, ways and procedures of spending the money collected were not very clear. There was also opposition from political parties who wanted to protect the poor. In May 2003, the societies were named as Aspatal Kalyan Samities (AKS), through a government order. These samities have a two tier structure comprising a Governing Body (GB) and an Executive Committee (EC). The Chairperson of the GB is the Deputy Commissioner and the Vice Chairperson is the Chief Medical Officer (CMO). In the EC, the Chairperson is the CMO. In both tiers, the member secretary is the Medical Superindendent. Other members of the committee are President of the Zila Parishad, two senior most doctors and Assistant controller (finance and accountant). The society is registered under the Society Act 1860. The GB is the decision-making authority. It formulates policies and provides directions, whereas the EC is responsible for the day-to-day functioning and implementation of decisions taken by GB. At the end of the

	financial year, the annual report on the working of the samities and work undertaken during the year is prepared by the EC for the GB and copies are sent to the Director of Health Services and Secretary, Health and Family welfare. **Results:** Within around one year (2003-04) the societies, put together, generated an amount of INR 2 crore 72 lakh, which was around 10% of the state recurrent cost budget. The money generated by these hospitals was first used for giving a face-lift to the hospitals, which involved white-washing and cleaning, repairing furniture and other facilities for patients, minor civil repair works. This was followed by purchase of reagents for diagnostic tests, x-ray films and equipment like auto-analysers, which allowed the hospitals to conduct more diagnostic tests and give quicker results. Income and expenditure of user charges under AKS in Hamirpur district from January to September 2005 was as follows: Total income – INR 10, 20, 385 Total expenditure- INR 10,08,325 INR 2 lakh to 5 lakh (for 50 to 300 bedded hospitals) to make the services functional (for example, the purchase and repair of equipment and furniture in the out patient department, whitewashing, building repairs).
Cost	Two Medical College Hospitals (state level), three Zonal, four referral hospitals, eight regional hospitals, 19 civil hospitals and two community Health Centre. At the Medical College, Zonal and District Hospitals since May 2001 and at the Civil Hospitals since January 2002.
Place	Two Medical College Hospitals (state level), two Zonal and 10 District Hospitals (district level) and over 30 Civil Hospitals (sub-division level) in Himachal Pradesh. At the Medical College, Zonal and District Hospitals since May 2001 and at the Civil Hospitals since January 2002.
Time Frame	Takes three to 4 months to register the society with the Registrar of Societies, after this government notification to this effect is needed, Then comes orientation of the hospital staff, formation of the society with the members and convening of the first meeting. It takes almost a year after the creation of the society to make it credible and acceptable to the clients, to make the hospital staff comfortable with independent decision making, to streamline administrative procedures for procurement and purchases.
Advantages	Accountability: Hospital Welfare Societies enjoy administrative and financial autonomy meaning decisions are taken more quickly, are needs based and have greater potential to take into account the wishes of staff and patients.

	Management flexibility: decentralised financial power at the health facilities level helps the authority to by pass the traditional procedure to make decisions.
Challanges	Promotes disparities: As the hospitals are independent in decision making, disparities arise in the standards and quality of care, rates charged for similar services, financial and administrative procedures, etc. This calls for a coordinated effort at the state level. Staff opposition: Staff might feel that the society could make them redundant by employing cheap workers on a daily-wage basis from the open job-market.
Prerequisites	Government Order to create Hospital Welfare Societies.Guidelines for administrative and financial procedures need to be clarified. ood quality services: As generation of funds depends on public support, minimum basic services must be of acceptable quality. This may require giving some seed money to the hospitals to start with.
Who needs to be consulted	State government authorities. It may require the approval from the state cabinet. Rules and regulation of society operations can be decided at the society level.Hospital staff and local administration.
Risks	
Sustainability	Highly sustainable if rates cover the recurrent cost of providing the hospital services. Also, if the money is spent judiciously, it brings about a visible change from the patients' perspective and thus public support is also gained.
Chances of Replication	Replicable in hospitals providing curative care, with no immediate competition from private sector. Was extended to sub-divisional hospitals in 2002.
Comments	If the facilities or the providers do not enjoy the respect of the public, the initiative will face public and political backlash.
Contact	
Submitted By	Gautam Chakraborty, Health Economist, BHPHP, June 2004. Updated in October 2005 by Dr. Anuradha Davey, Research Consultant, NIMS.
Status	Active
Reference Files	Cost Recovery HP.ppt Experience of HP Societies.ppt GO-Aspatal Kalyan Samiti, HP.pdf Income and Expenditure of User Charge Under AKS.pdf CHC Ghumarwin, Bilaspur district17.JPG

	CHC Ghumarwin, Bilaspur district20.JPG CHC Ghumarwin, Bilaspur district.JPG
Reference Links	

66. Setting up a Vigilance Cell for the health sector, Karnataka

Subject Area="Management structures and systems."	**Objective="Control of Corruption in Health Services."**
Details for Reform Option "Setting up a Vigilance Cell for the health sector, Karnataka"	
Summary	**Background:** In order to improve the public health care system in the State of Karnataka, the then Chief Minister set up a "Task Force on Health and Family Welfare" in December 1999. The Task Force was required to make recommendations regarding improvements necessary in the management and administration of the department and to monitor the impact of the recommendations. One of the major concerns of the Task Force report (published in 2001, see documents and illustrations) was the issue of corruption in the health sector. Corruption was found at various levels of the system and in all aspects and sectors of health care. The Task Force recommended the setting up of an institutional mechanism in the Directorate of Health. A Vigilance Cell was established in the Department of Health in 2002 to investigate minor complaints on Class II, III and IV group of health staff received by the department directly and also cases referred to it by the Lokayuktha (literally 'people's representative'- see comments box for more information). However, since the cell had very limited powers to control corruption, it was found to be not very effective. When the report was shared with the Lokayuktha, Honourable Justice Venkatachala, he requested the Chairman of the Task Force, Dr H. Sudarshan, to assist him in dealing with corruption in the Health Department. **Action:** Dr Sudarshan was appointed Vigilance Director (Health) under the Karnataka Lokayuktha. He was to assist the Lokayuktha and Upalokayuktha (deputy Lokayuktha) in investigations and also accompany them during field visits to various blocks and districts. (For a list of the Vigilance

	Director's purview see documents and illustrations.) The Vigilance Director under the Karnataka Lokayuktha (KL) stepped up inspections of all institutions, from sub-centres and PHCs to district and State level medical colleges and super speciality hospitals, the Directorate of Health Services, Directorate of Medical Education, Drug Control Department and General Drug Store. To combat corruption amongst hospital staff, anti-corruption officers employ various methods including grievance redressal for complaints. Accused staff will be publicly asked to pay back bribes, humiliated using press coverage or, in some cases, traps will be set. The Police wing of the KL also operates 'traps and rides' where a police team uses chemically-treated currency which when given as a bribe will stain the bribe-taker's hands and so reveal them. The suspects are then placed in Judicial custody and jailed for 24 to 48 hours pending an investigation. The media has played an important role in publicising and creating awareness about the Lokayuktha and its role. The media accompanies the Lokayuktha during his visits. Display boards at institutions provide information about corruption along with the Lokayutha address to encourage sending in of complaints. The following reforms for good governance in health were suggested: i) Creating a proactive Lokayukta (anti-corruption cell) ii) Strengthening the Consumer Forum iii) Implementation of the Transparency Act iv) Using the Right to Information Bill v) Training in Health and Hospital management vi) Leadership training vii) Health Management Information systems and e-Governance viii) Hospital and Health Committees **Results:** The number of demands for bribes has reportedly dropped. A study conducted by the Public Affairs Centre has shown that the bribes have come down in Bangalore City hospitals. Awareness among patients of corruption within the health services has increased, as illustrated by an increase in the number of complaints. Between 50 and 70 complaints were received at the initial stage and now more than 425 cases have been received (February 2005). The Lokayutha office receives 10 to15 phone calls and 5 to 7 written complaints every day. There is also a plan to start a helpline with the help of an non-governmental organisation (NGO). The procurement of both drugs and equipment has improved. The State government has formed the Karnataka Society for Promotion of Rational Use of Drugs and can now provide good quality essential drugs to all health centres. It

	is also able to purchase good quality equipment at reasonable market rates, whereas previously it was paying more than double the market rate. The presence of doctors and paramedical staff in PHCs and Subcentres has reportedly improved and absenteeism has reportedly been significantly reduced. Most of the suggested reforms for good governance mentioned above have been implemented by the Government but need to be further strengthened. According to Dr Sudarshan, the intervention of the Karnataka Lokayukta has succeeded in saving at least INR 100 crores (€18,057,178) of the State budget which was being pilfered at various levels.
Cost	The total budget of entire Lokayuktha institution is about INR 8 Crores per annum which is less than 0.02% of the total expenditure of Karnataka Government. The total cost of the Vigilance Director's office is 0.05% of the total Karnataka Lokayuktha budget of which about 70% is spent on salaries and 30 % on travel. The Vigilance Director works with a token salary of INR 1 per month.
Place	Karnataka State.
Time Frame	The final report of the Task Force was submitted in April 2001. The Vigilance Director's post was created in January 2002. It took about a month to create the post and set up the office. (The Honourable Lokayuktha wrote to the Government regarding the appointment and he issued the Order to appoint the Vigilance Director.)
Advantages	Improved access: Patients who would have stayed away, unable to pay bribes, can now use the facilities with the assurance that if bribes are demanded they can report those concerned. Strengthens the delivery system: Good quality services, drugs and equipment are ensured in public hospitals. Public awareness: People learn that bribery is not a prerequisite of healthcare. They also understand the need to register a complaint and how and where to make it. Reduces misuse of funds.
Challanges	Fear factor: Some doctors who supplement their salaries with small bribes refuse to conduct operations for fear they will be reported. Harassment: In a few cases, harassment of doctors by false complaints was observed. However, under the Lokayuktha Act, complainants who give false complaints are liable to punishment.

Prerequisites	Strong political will and good leadership in Lokayutha institution and Health Department.
Who needs to be consulted	KL, State Government, Health department of the State.
Risks	
Sustainability	Sustainable, as long as anti-corruption team remains vigorous and the Health Department implements necessary measures.
Chances of Replication	Replicable, but depends on a progressive Anti-Corruption Act and Lokayukta. Requires strong political will.
Comments	Lokayukta is an autonomous institution set up at the State level for redressal of citizen's grievances by investigating into administrative actions taken by or on behalf of Central or State Government or certain public authorities. It is intended to serve as an institution independent of the Government concerned, to supplement the judicial institutions and is headed by Chief Justices or Judges of Supreme Court of India or High Court of the State. 19 States of India have Lokayukta institutions. The Karnataka Lokayuktha was established in 1986. The Vigilance Director (formerly Chairman of the Taskforce) is a person from an NGO background. In fact, 6 of the 12 members of the task force were from NGOs.
Contact	
Submitted By	ECTA Delhi, August 2005
Status	Active
Reference Files	
Reference Links	

67. Efficient Management of Community Health Centre, Rajasthan

Subject Area="Management structures and systems."	Objective="Improve the quality of service delivery."
Details for Reform Option "Efficient Management of Community Health Centre, Rajasthan"	
Summary	**Background:** Sadri Community Health Centre (CHC) is located in the southeast region of Pali district, about 90 kms from the district headquarters. Six Primary Health Centres (PHCs) and 4 sub-centres are directly providing outreach services under this CHC. It serves a population of 28,000 that is pre-dominantly poor and tribal. The CHC also caters to the needs of patients from adjoining districts such as Udaipur and Rajsamand. The CHC is housed in a building largely constructed in 1931 but with later additions made through contributions from various donors. The campus is located in a 35,000 sq. ft. area. The staff at the CHC are sanctioned for a 30-bed hospital. They include 5 doctors, 7 male nurses, two staff nurses, one radiographer, one assistant radiographer, two clerks, one lab technician, three Lady Health Visitors (LHVs), one driver, 10 ward boys, two sweepers, one sector supervisor and two Male Multipurpose Workers MPWs. The CHC does not have sanctioned posts for gynaecologist, paediatrician and anaesthetist though the existing doctors are trained in the same and are providing services to people. The three main departments are Medical, Surgical and Gynaecology and Obstetrics. The sanctioned beds are 30 but the CHC has added 34 more beds. There are 22 beds in the medical ward; 8 surgical; 18 beds for gynaecological patients; 6 cottage beds (paid beds for INR 50) and 10 beds in in a room which was until recently not being used. The CHC also runs a TB outpatient department (see PROD entry ref no 141). Due to availability of a trained anaesthetist, the CHC is able to undertake major surgery including caesarian section delivery. However, blood must be brought from Pali the district headquarters since the CHC is not declared as a First Referral Unit (FRU). Since 2001, Rajasthan Medicare Relief Society (RMRS) has become operational (see PROD entry ref no 134) and from July 2005 life line drug store has become operational (see PROD entry ref no 135).

	Action: In order to effectively manage all the services, the following activities were undertaken fifteen years back by the current Medical officer in-charge: (i) A Personnel Management System developed including the following steps: All decisions are taken jointly by the staff. The staffs are divided into categories- ancillary, nursing and doctors. For each category, a team leader is selected who is totally responsible for all the services provided by that category of staff. In each of the categories, the personnel have demarcated geographical areas of work for which they are responsible. Penalties are jointly decided. If staff fails to complete their work, then two compensatory holidays are deducted. The CHC in charge interacts with team leaders for progress and problems/gaps instead of talking to all personnel individually. The CHC in-charge has tapped human resources available among the staff by identifying interest and skills for staff within ancillary category. The staff was effectively used for maintenance, minor repairs and for this each month some incentive was given for the extra work they did through available RMRS funds. Currently, the CHC has contracted out services pertaining to repairs of overhead tank and pipe for minimal honorarium. The payments have been made through RMRS funds. Instruments requiring repairs are sent by local bus to Pali or Jaipur and are sent back the same way after repair. (ii) Personnel are sent for training organized at state and district level. Recently, staff had undergone computer training and doctors have participated in training on management of RMRS arranged for one day by State Institute for Health and Family Welfare, Rajasthan on medico legal issues. (iii) Community Participation: As the CHC serves tribal and poor people from far-flung areas the institution undertook the following activities: (a) Catering: staff did need assessment. Raw materials are procured without charge from local donors. Cooking is done in the hospital and food provided to patients, relatives and all the CHC staff for one rupee. The money collected is used to pay the cook. A local donor was given the responsibility of managing the food. (b) Accommodation for relatives: A dharmashala (rest house/ Shelter) adjacent to the CHC is constructed by local donors and is freely available to relatives who come along with the indoor patients. Maintenance of the dharmashala is the

	responsibility of the local donor. Infrastructure development: The local donors have contributed for construction of wards, furniture, equipment, renovations, operation theatre, toilets, room for life line fluid store, underground and overhead water tanks etc. Eg. Ranakpur temple trust donated one 15 kv generators. (c) Camps: For good quality specialist services, camps are organized – two eye camps are organized with support donors; 4-5 family welfare camps every year. The CHC is also planning a mega mobile surgical camp for December 2005, where all types of surgeries will be performed. (d) Communication: Public Call Office (PCO): As patients come from far-flung areas, a coin facility PCO was started in 2004. A telephone was installed early 2005 through funding from sector investment programme of European commission. (iv) An autonomous society (Rajasthan Medical Relief Society) was started in 2001 to manage the smooth functioning of the CHC by collecting user fees and through donor contributions. (v) Strengthening Management Information Systems (MIS) through computerization of all data and financial transactions including laboratory and drugs. (vi) For provision of good quality and low cost drugs, a lifeline fluid store was opened in July 2005. (See PROD entry ref no 135). Result The CHC is well maintained and clean. Every month 50 deliveries are conducted and on an average the CHC conducts 5 caesarian sections. The CHC in-charge informed that the X-ray machine and ECG machine available with the CHC has been working very well for last 15 years without major problem. In the last three to four years RMRS has made a collection of 4 to 5 lakhs and most of it is spent on repairs and maintenance of CHC. There has been increase in the utilization of the services.
Cost	Sector Investment Programme European Commission gave INR 1 lakh for RMRS and provided a computer system including UPS, scanner and furniture (through national informatics center). In addition, INR 3000/ was also provided for installing a telephone connection.
Place	CHC Sadri, Pali District, Rajasthan.
Time Frame	One to three months.
Advantages	Cleanliness: Well-maintained and clean facility. Efficient: Good use of human resources without outsourcing ancillary services. Better services: Provision of quality of services and

	availability of good and cheap drugs within the CHC premises. Incentives: Motivated staff. In addition, Medical Officers do not request transfers as they are from local area. Community Participation: Support of local donors in improving the quality of services. No political interference.
Challanges	Transfer: Shifting of motivated staff from the CHC to other facilities. Limited service: Not designated as a First Referral Unit so the CHC does not have a blood storage unit and blood has to be brought from far off place.
Prerequisites	No political interference from local leaders. Financial support from local donors. Finance available with CHC and authority to use it for improvement of services. Motivated leader.
Who needs to be consulted	CHC In charge, Sadri, Pali.
Risks	
Sustainability	Yes, if the above mentioned prerequisites are in place.
Chances of Replication	Participatory procedures adopted to manage human resources can be adopted in any health facility. Similarly, other strategies adopted by CHC can also be replicated elsewhere.
Comments	The CHC reports a real need for a blood storage unit to meet the needs of the community it serves. It also serves three adjoining mountainous regions which are also places of piligrimage (Ranakpur, Parsuram Mahadev and Desuri). This increases the trauma caseload during festive season. This caseload increases significantly during religious festivals.The CHC is now being developed as an FRU with Indian Public Health Standards (IPHS) norms and INR 20 lakhs have been sanctioned under NRHM.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, NIMS. September 2005. Last Updated: Prabha Sati, Research Consultant, ECTA, December 2006.
Status	Active
Reference Files	scan.pdf Workdivisionchart.pdf F1040019.JPG
Reference Links	

68. Restructuring of the Health & Family Welfare Department at sub-district level, Rajasthan

Subject Area="Management structures and systems."	**Objective="More effective administration and implementation of programmes at sub-district level."**
Details for Reform Option "Restructuring of the Health & Family Welfare Department at sub-district level, Rajasthan"	
Summary	**Background:** In Rajasthan, the Chief Medical Health Officers (CMHOs) were overburdened with a large workload and huge geographical area making it impossible for them to operate effectively. In addition, the Medical officer in charge of the block (sub-district) Primary Health Centre (PHC) was overburdened with administrative tasks. Therefore, the staff and the Medical Officer (MO) in-charge of block PHC found it difficult to effectively function, i.e., cater to the needs of population and overseeing the administrative tasks. Consequently, changes were introduced in the roles and responsibilities of district level officials for effective implementation of health care programmes. **Action:** In order to reduce the workload of CMHO and block PHC, following changes were introduced at district level. In 1999, the districts were notified of the changes with respect of the work distribution of district level officials. The government directed the districts to incorporate following changes within one month. It was decided that the deputy CMHO (Dy CMHO) should look after all programmes at sub-district level as well as being responsible for administrative issues of the block. The Dy CMHO was previously responsible only for specific programmes such as malaria control, health and family welfare etc at district level. The deputy CMHO (Family welfare) office was to be relocated at sub-district area and the official was given responsibility for implementation of all family welfare programmes at the district level as well as their area. The drawing and disbursing authority was given to Dy CMHO instead of block PHC. The responsibility included looking after all the programmes, establishment, pension cases, court cases, private institutions, prevention of food adulteration, pre-conception and prenatal diagnostic tests and other administrative responsibilities. The Dy CMHO was responsible for developing the block action plan and targets for each Auxiliary Nurse Midwife (ANM) was determined by

	community need assessment carried out by them. For performing these duties, the Deputy CMHO was given three to four clerical staff. The Dy. CMHO was responsible for coordinating with panchayati raj institutions and inter-sectoral coordination at block level. The reproductive and child health officers (RCHO) at district level who were formerly functioning independently were directed to be working under CMHOs. The staffs of urban malaria scheme are to be shifted to the office of CMHO. Each Dy CMHO was given responsibility for three to four blocks, depending upon the size of the district. No separate funds are available with Dy. CMHO to meet the mobility and communication requirement for overseeing the health programmes at block level. In order to tackle the shortage of Dy. CMHOs' positions, some of the Senior Medical Officers were transferred from districts which were relatively well-staffed to the districts which were most under-staffed. In 2002, the post of Dy CMHO malaria and health was dissolved. **Result:** The initiative was put in place in 1999. However it has taken some time for the districts to set-up office, furniture and functioning. Therefore, it is too early to assess the outcome of this administrative restructuring. The Dy CMHO was given more than one block, often two tehsils (sub-district administrative unit) depending upon the size of the district. However, discussion with Dy CMHO revealed that though the concept is good, there are many operational problems. Such as, lack of adequate infrastructure including furniture, office space and adequate personnel; no telephone connections for getting information from the MOs at PHC level (this becomes an acute problem during epidemics when the district administration and state authority require day-to-day reporting) and, no adequate mobility funds were provided. Since this office was an administrative unit, no donors have been forthcoming to meet infrastructure needs. The reporting mechanisms have also become difficult because they have to report to three-to-four Sub-divisional Magistrates (SDM), one per block. The responsibilities have increased manifold, as they are now responsible to work as food inspector of their sub-division. Also, the Dy CMHO holds a number of meetings for block level functionaries leading to a large amount of his working days being spent on meetings and court cases. Due to shortage of Dy.CMHOs, the existing ones are responsible for more than one sub-division.
Cost	Budget needed to set up offices and meet recurring costs is not available. It was mentioned that some of the office

	furniture was given in kind by local stakeholders. The European Commission through Sector Investment Programme has approved INR 3000 towards installation of telephone connection in the Dy. CMHO offices at Bali, district Pali.
Place	Rajasthan – state wide.
Time Frame	One to two years.
Advantages	Workload: It reduces the administrative workload of CMHO. Effective monitoring: Better administration as well as implementation of all national and state level programmes. Utilisation of services: Sector PHC MO can spend more time on providing preventive and curative services to people. Nearness to the community: Now it has become easier for the people to approach the health officials.
Challanges	Administrative: It is necessary to have a Dy CMHO for each block to work with each SDM. Cost: Creates an additional cost as it is necessary to set up an office for the Dy CMHO. Workload: Increase in the workload of Dy.CMHO. Time consuming: Most of the Dy CMHO's time is spent on attending meetings at block, district and state level at the expense of other programmes.
Prerequisites	Infrastructure is required for Dy CMHO to function effectively such as space to hold meetings and a place for other block level administrative staff to sit. This should also include funds for telephone usage. Personnel required for undertaking administrative, legal and financial matters. Mobility and communication facilities must be available before posting the deputy CMHO if they are to monitor programmes effectively. Necessary to fill-up the posts of Dy. CMHO for the efficient management of sub-division.
Who needs to be consulted	Dy CMHO. CMHOs. Director Public Health. Community.
Risks	
Sustainability	Yes. The changes have been made within the existing structure and therefore it is sustainable if above pre-requisites are ensured.
Chances of Replication	It can be replicable if recurring costs are put in place for effective functioning including space, telephone and mobility.
Comments	The changes in roles and responsibilities of Dy. CMHO will improve the quality of health care services. However, the

	bottom line is still the requirement for effective monitoring of programmes. Proper understanding of need assessment by field staff will ensure that the targets are met. Accountability is an important issue that needs to be addressed by involving the staff from block to PHC level staff. Additional CMHO is currently responsible for all Family Welfare programmes for the district including Jan Mangal. Therefore, for FW Dy. CMHOs have to report to Add. CMHO.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, IRMS, New Delhi, September 2005. Last Updated: Prabha Sati, Research Consultant, ECTA, December 2006.
Status	Active
Reference Files	Binder3.pdf
Reference Links	

69. Devolution of financial powers, Punjab

Subject Area="Management structures and systems."	Objective="Effective decentralised management of funds."
Details for Reform Option "Devolution of financial powers, Punjab"	
Summary	**Background:** As traditional administrative procedures regarding release, utilisation and control of funds can be time consuming and inefficient, services at health facilities are sometimes hampered due to delays in the repair and maintenance of the infrastructure or equipment. **Actions:** To overcome the routine obstacles involved in these administrative procedures, functional autonomy is decentralised to the hospital in charge by allocation of adequate financial powers to staff. (i) For local repair of equipment and other related expenses: Senior Medical Officer (SMO) is authorised to spend: - Up to INR 2000 without a quotation from approved sources. From INR 2000 to INR 5000 with a single quotation by approved source/ manufacturer/public sector undertakings. From INR 5000 to INR 10,000 with minimum three quotations called by a committee comprising of Deputy Medical Commissioner (DMC), SMO and two specialists. Above INR 10,000 with sanction by headquarters. (ii) For necessary single sanction – Single sanction is the spending power at a time for emergency purposes. It varies according to the officer in charge as well as to user charge collection per month. User charge- Less than INR 50,000 More than 50,000 SMO- Up to INR 5000 Up to INR 10,000 DMC Up to INR 10,000 Up to INR 15,000 Civil Surgeon Up to INR15,000 Up to INR25,000 (iii) For stationery: spending power varies according to the bed strength of the hospital as follows-. 30 bedded hospital- Upto INR 500 per month. 50 bedded hospital Upto INR 750 per month. 100 bedded hospital Upto INR 1000 per month.
Cost	Only issue of the government order is needed to implement the power as financial autonomy is based on the revenue collected from the user fees.
Place	One hundred and fifty four hospitals in Punjab, including Community Health Centres, Sub divisional hospitals and District hospitals.
Time Frame	Approximate time from planning to implement the reform is one year.
Advantages	Administrative flexibility: Decentralised administrative power

	helps in making speedy decisions at the lower level. Efficiency: Resources are efficiently managed as per requirements of the health facilities.
Challanges	None perceived.
Prerequisites	Government Orders.
Who needs to be consulted	State government.
Risks	
Sustainability	Sustainable, but political will is necessary to make the process successfully sustainable.
Chances of Replication	Replicable, devolution of financial and administrative powers has been already proven successful in Haryana.
Comments	Devolution of administrative powers helps the corporation to revamp the healthcare facilities structurally as well as functionally.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, IRMS, September, 2005.
Status	Active
Reference Files	PHSCMFA017850-74 dated 23.10.2001.doc — GO:PHSC/MFA/01/7850-74 dated 23.10.2001. PHSCGMFA044855-93 dated 02.09.2004.doc — GO: PHSC/GMFA/04/4855-93 dated 02.09.2004.
Reference Links	

70. Regional Resource Centre for North Eastern States, Assam

Subject Area="Management structures and systems."	Objective="Technical assistance for implementation of health care programmes."
Details for Reform Option "Regional Resource Centre for North Eastern States, Assam"	
Summary	**Background:** The North Eastern States are of special importance due to their diversity of culture, language and ethnicity. Despite receiving increased funds for health in the second phase of the Reproductive and Child Health programme (RCHII) and the National Rural Health Mission (NRHM), these 8 'focus' States have shown no significant improvement in vital health indicators. This was due largely to a lack of managerial and technical capacity, not only at the State level but also in the field, meaning that the increased allocations were not effectively absorbed. **Action:** In November 2005, a collaboration of development partners, the European Commission (EC), the United Nations Populations Fund (UNFPA) and the Department for International Development (DFID) assisted the GoI in establishing a Regional Resource Centre (RRC) at Guwahati, Assam, with the aim of improving the technical and managerial capacity of the north eastern States at all levels. When completed, the RRC will consist of a team of experts in the following fields: i) Public Health ii) Programme Management/ Management Information Systems iii) Financial Management and Accountancy iv) Social Science v) Architecture/ Civil Engineering The centre will provide technical assistance to the State Health and Family Welfare Departments and help them in the implementation of NRHM. Its main tasks will be: i) To produce situational analysis on various aspects of the health sector and to prepare policy proposals. Key areas include: a) Organisational restructuring at the State, district and sub-district levels (including integrated societies at State and district levels and autonomous societies for management of hospitals). b) Institutionalisation of integrated planning and management. c) strengthening and streamlining of financial and managerial systems d) devolution of financial and administrative powers e) strengthening and streamlining of procurement and logistics f) standardisation of norms (services, staffing and infrastructure) at the primary and secondary levels g) strengthening and streamlining of Health Management Information Systems (HMIS) and

	Monitoring and Evaluation (M&E)as per GOI guidelines, integration of disease surveillance within the HMIS i) development of drug policy ii) To facilitate in the preparation of district and State health plans. iii) To coordinate the logistics of the training programmes including assisting in the development of training modules for the implementation of NRHM iv) To facilitate development of the institutional mechanisms for local planning and community participation, including training and orientation of Panchayati Raj Institutions (PRIs) and other local government structures, such as autonomous councils v) To undertake studies on the health problems of the tribal peoples of the northeastern region. vi) To facilitate mainstreaming of the tribal medicine systems vii) To assist the States in establishing a) Integrated District Health and Family Welfare Societies; b) Autonomous hospital management societies; c) Programme Management Units for the State and District Societies. The RRC will ultimately be monitored by a Governing Council and an Executive Council. Until these councils are constituted, an interim body, the Executive Committee, will begin the process by preparing a plan of action and reviewing the centre's work every six months. It will take time to set up the RRC with a full compliment of staff, so it was decided to use an intermediary organisation – the Hindustan Latex Family Planning Promotion Trust (HLFPPT) which is already providing technical assistance to the EC-assisted Sector Investment Programme (SIP) - to initiate the work. The agreement includes financial provision for the RRC until December 2006. However the HLFPPT may be required to help develop the RRC into a legal or corporate entity well before the current arrangement expires. The European Commission Technical Assistance team (ECTA) has agreed to help in this process. A State facilitator will be appointed to each State and will be located in the State Directorate. This person will be the link between the state and the RRC. The Resource Centre will be pre-programmed to 'work itself

	out of a job', meaning the organisation may be dismantled as soon as the State Governments in the region attain the adequate managerial capacity – expected to be by 2012. **Results:** The North East Regional Resource Centre is still very much in its infancy, having been inaugurated only on November 9, 2005. It will take at least a year for any results to be visible.
Cost	Around INR 30 lakhs on hiring staff, buying equipment, and on building rental charges. The European Commission provided about INR 2 crores initially to support the RRC under the ongoing SIP. The estimated expenditure on the RRC for a seven year period is likely to be INR 18 crores. Other development partners, such as UNFPA and DFID have also expressed willingness to share costs.
Place	Guwahati, Assam. Operational with five consultants since November 2005.
Time Frame	Six to 8 months.
Advantages	Focussed: The RRC will identify and focus on key areas in need of technical and managerial assistance. Locally available resource: Will speed up and simplify methods of providing support to north eastern States. Programme supervision: Will allow GoI continuous monitoring of the progress of programme implementation, planning and monitoring
Challanges	Donor coordination: Could be problematic bringing together all the donors supporting the institution to make decisions
Prerequisites	Commitment from donors and GoI
Who needs to be consulted	GoI and donors.
Risks	
Sustainability	The RRC is designed to be dismantled once it has achieved its goal of raising the level of managerial capacity in the north eastern states.
Chances of Replication	The RRC could be replicated in other areas of the country, with the assistance of a nodal agency from the government.
Comments	None.
Contact	
Submitted By	Tessa Laughton, Research Consultant, ECTA. November 2005 Last updated: October 2006
Status	Active

Reference Files	RRC-Concept Note final.doc
Reference Links	

71. State Health Resource Centre, Chhattisgarh.

Subject Area="Management structures and systems."	Objective="Facilitate formulation, implementation and monitoring of health reforms in Chhattisgarh."
Details for Reform Option "State Health Resource Centre, Chhattisgarh."	
Summary	**Background:** Carving out the new state of Chhattisgarh in 2000 from Madhya Pradesh led to splitting up of resources between the two states including human resources. During this transition a considerable gap was felt in terms of states' capacity for planning, implementing and monitoring health reforms. In order to ease the situation, the state envisaged a State Health Resource Centre (SHRC) that would give technical inputs to the State on structural changes in the health sector so that the health services became more accessible. The SHRC was also needed to make the health programmes more community centered, a key element of the health sector reform agenda. Parallel to setting up of the SHRC, a state advisory committee was also formed. **Action:** Initially, a memorandum of understanding (MoU) was signed between the existing Reproductive and Child Health (RCH) society and Action Aid, India (AAI) in March 2002 for a period of three years. At the end of the MoU period the performance of SHRC was reviewed and in March 2005 the State Health Society signed a contract with SHRC, now registered as a society for next three years. A management team and operational guidelines for starting the resource centre was put in place by Action Aid, India at the start. The management team included the Director and three programme coordinators, who were supported by an accountant and two office assistants. Currently, the SHRC has 11 regular staff—the director, three programme coordinators, three programme associates, two accounts staff and two office assistants. The following manuals were developed for smooth functioning of SHRC: •Accounting and auditing standard •Human resource policies and procedure manuals •Operations manual •Gender policy manual •Terms of reference for consultancy contract with individuals and institutions A workshop was organised to identify the initial work domain of SHRC jointly by Government of Chhattisgarh (GoC) and Action Aid, India in consultation with leading health activists and NGOs working in Chhattisgarh as well as in other parts of India. The workshop identified 15 reform areas clearly specifying the role of SHRC. **Results:** Assisted formulation of health sector reform

	programme. SHRC developed the training modules and programme design for Mitanin programme, involving a community-based health activist. It formed a state training team, helped evolve an operational strategy and has been providing monitoring and evaluation support for the Mitanin programme. (See PROD entry no. 49.) Today, the Mitanin programme has reached all the 54,000 hamlets in the state; it serves as a precursor to the Accredited Social Health Activist (ASHA), a village-based health worker, who is a key component of the National Health Rural Mission (NHRM). The SHRC has also done a series of studies, some of which are: 1. Human Resource Development Policy 2. Behavioural Change Communication Implementation Framework 3. Integrated State Health and Population Policy 4. Draft Drug Policy 5. Standard Treatment Guidelines 6. State Drug Formulary 7. Essential Drug List These have led to a number of policy changes in workforce management, human resource development and rationalisation of services. The SHRC has fostered partnership between various stakeholders, including government and non-government organisations, panchyati raj institutions, public health system and development partners in designing and implementing community based interventions and other projects. During the last three years, SHRC also provided technical support to the government in formulating the RCH-2 programme and in negotiating new projects with Government of India and development partners.
Cost	Operational cost of SHRC, including salaries, workshops, office equipment, travel and contingency, is given below: First phase budget covering a period of three years: INR. 82, 75,756. The current annual budget is INR 40 lakhs (4 million).
Place	State Health Training Centre Campus, Kalibari, Raipur.
Time Frame	4 months. SHRC was established in March 2002, but it became fully functional around October 2002.
Advantages	Think tank: Provides the state with requisite support to develop programmes. Pooling strengths: The institution fosters unique civil society partnership that brings together special capacities from diverse groups to provide additional technical support to the directorate. Also, brings special capacities needed for a large community participation and social mobilisation programme. Building hype: Considerable advocacy and synergy for health sector reforms.
Challanges	Autonomy: SHRC needs to ensure autonomy so that it can effectively function as advisor for health initiatives.

	Implementation: Pursue the goals of health sector reforms by taking into account the political environment and constant change of leadership at different levels. Orientation: The line department staff at different levels needs orientation for implementing the reform programme. Ownership: SHRC does not belong to the system and therefore its recommendations may not be followed by the government.
Prerequisites	Government support. MoU. Capacity building in SHRC team.
Who needs to be consulted	Secretary, Health and Family Welfare, GoC. Directorate of Health Services, GoC. Director, SHRC. Development partners.
Risks	
Sustainability	Good as both the government and non-government sector depend on it for vital support for implementing health reforms.
Chances of Replication	NHRM has approved a proposal to establish an SHRC in the focused states and also a National Health Resource Centre. (Core document National Implementation framework on NRHM).
Comments	The SHRC can rope in civil societies and assign them a larger role to improve delivery of health care services.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Consultant, NIMS, May, 2006.
Status	Active
Reference Files	Binder4.pdf Binder3.pdf
Reference Links	

72. Management of Public Health Information System, Rajasthan.

Subject Area="Management structures and systems."	Objective="Establish web-based health management information system."
Details for Reform Option "Management of Public Health Information System, Rajasthan."	
Summary	**Background:** The State Government planned to harness the potential of Information Technology (IT) for efficient and cost-effective management of health programmes in Rajasthan. This initiative was started with financial support from the European Commission's Sector Investment Programme and technical expertise of National Informatics Centre (NIC), Rajasthan. The aim of the project was to facilitate a reliable and cost effective mechanism for better decision making, monitoring and efficient service delivery. **Action:** (i) With assistance from NIC, Rajasthan, the Department of Health and Family Welfare identified the necessary requirements for setting-up an IT network. A detailed plan to link the directorate to district and sub-district office of health and family welfare was prepared and approved. (ii) Identification of an appropriate place in Swasthya Bhavan (Directorate of Health Services Headquarters) to establish the central computer system in the state capital (Jaipur city). (iii) Established local area network in Secretariat and Swasthya Bhavan (directorate office) with 20 and 150 nodes respectively. (iv) The central cell housed in Swasthya Bhavan has two central servers and 55 client computers set-up. In addition, 15 computers to different sections of secretariat, 12 computers for all 6 Joint Directorates (2 each) and 104 computers for all 104 Deputy CMHO offices. (v) High speed leased line for Internet at Secretariat and Directorate. E-mail connectivity for Secretariat, Directorate, 6 Joint Directorates, 32 Chief Medical Health Officer and 32 Reproductive and child health officers. The state is now sustaining it through NICSI. (vi) Developed web-based health management information system (HMIS) for the department with suitable customization for different levels. (vii) Deployment of a team of computer professionals in the department for application development and technical support. (viii) The web site of the department (http://rajswasthya.nic.in) has been developed and is maintained by NICSI. This site contains all information regarding the state including grievance redressal. The site was launched by the Chief Minister. (iix) Six resource persons given extensive training to run the central cell.(ix) In order to facilitate operationalising web-based HMIS, NIC provided training to all the district officials on the use of

	computers including HMIS. About 300 officers up to deputy CMHO have so far been trained. (x) Nineteen software packages have been developed so far by NICSI called HEALING. It is a part of a website called www.rajmedical.nic.in. This is only for internal use of the department. Each given officer can access the website through the given password. The data is entered at the district level and is accessed at the State level in the Central server room. (xi) Integrated formats for monitoring developed for mobility and Eligible Couple Register (ECR) have been developed. Software for the same (xii) NICSI has been made responsible to provide technical support for the next 5 years. (xiii) HMIS system was developed in phased manner. The pre-testing of proposed system has been completed. **Results:** The HMIS is being used by the districts to send the requisite information to the Directorate of Health Services on a regular basis. The Central computer cell was established in the directorate, where in monitoring is being done through reports collected via internet in the prescribed formats. The computer cell is maintained by NICSI and all data is compiled by staff recruited for the cell. The software for monitoring for mobility and ECR is to be developed soon. Though NICSI is providing internet connections in the districts, there is need for broadband connection at district and block level office of Deputy Chief medical health officer. Video-conferencing through NIC network between the district officials and for training is planned to take place more frequently. It was observed during a HS-PROD field visit to a Sanjivani camp at Sethia Hospital (Community Health Centre (CHC)), Sardarshahr, Churu, in September 2005 that the HMIS was being used consistently. Even though an internet connection was not available at the CHC, the requisite data was recorded in the existing e-based HMIS format available in the hospital computer and then emailed from the district headquarters (which does have an internet connection) to the directorate office at Jaipur.
Cost	Rs. 200 lakhs.
Place	Rajasthan, 2003.
Time Frame	2 years.
Advantages	Paper less: Information from the district can reach faster to the state headquarter. It is easily to store the information. Monitoring the programme: The e-system will facilitate better management of data on public health care delivery system.

	Transparency: Easy availability of information on health services in public domain will improve people's participation.
Challanges	Feedback: The feedback mechanism needs to be in-built into the website (state to district and district to health centres) needs to be strengthened. Update: The culture of sending information through internet by District and DHS has to be evolved for success of e-based HMIS. Infrastructure: Regular electricity supply, internet facility and maintenance of facility.
Prerequisites	Internet connections. Computer and peripherals. Trained staff to handle the information flow. Regular electricity supply.
Who needs to be consulted	Directorate of health of services. Rajasthan. National Informatics Centre, Rajasthan.
Risks	
Sustainability	State has taken it up.
Chances of Replication	Yes.
Comments	There is a need to continuously monitor the functioning of e-based HSMIS.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, NIMS, May, 2006.
Status	Active
Reference Files	HMIS Rajasthan.ppt Binder1.pdf
Reference Links	

73. Decentralised Management of Primary Level Health Facilities, Punjab

Subject Area="Management structures and systems."	Objective="Effective decentralised management of services."
Details for Reform Option "Decentralised Management of Primary Level Health Facilities, Punjab"	
Summary	**Background:** Punjab rural health facility was facing operational difficulty due to the fact that day to day complexity were not managed by the State government as health facilities are scattered in location and logistics and medicine to run the health facilities were not available on time. Realising the operational difficulties to manage the health facilities, it was decided by the Punjab Health Service Commission in June 2006 that management of the Subsidiary Health Centres (SHC) would be decentralise to the Zila Parishad (ZP), district level body of Panchayat Raj Institution (PRI). **Action:** Contractual appointment: On lump sum package of INR 0.36 million per annum, Service Provider (SP)-doctor will be contracted in each SHC. SP (doctor) engages the services of the para medical person to assist him for proper delivery of the national health programmes. Package includes INR 30000 per month. Out of the package the doctor also meet the recurring expenses of electricity bill, water supply, sanitation services and maintenance of building and furniture's etc. Salary of one paramedics and one sweeper-cum-attendant that may be around INR 5000 pm and electricity bill is in between INR 500-1000 pm. The balance amount will be retained by the SP (doctor) as his/her service charges. Performance of the SP(doctor) is reviewed on the basis of set benchmarks. Based on that contract is renewed for every three year. (For the benchmarks of SP in rural area: please see PROD entry no 192 on accountability of performance of rural doctors by panchayat raj institution, Punjab). Availability of medicines: Based in the list, finalised by expert committee of the doctors, vital and essential drugs are made available in the SHCs. Special cell is created in the ZP which coordinate the placement of demand and indents for the drugs to PHSC. Whereas PHSC has a role for calling the tenders and distribution of the medicine on the basis of indents placed by ZP. Dispensing of the medicine at SHC is kept under the control of

	Gram Panchayat (GP) of that ZP. GP will issue the medicine to the doctor concerned on weekly / fortnightly basis and record is signed by Sarpanch and one of the Panchayat member jointly. Finance department of State Government also provide INR 7500 per month to each SHC for the purchase of medicines. This is the value of basic medicines which will be purchased by the Punjab Health System Corporation and given to the service provider through the Civil Surgeon of the district. A provision of INR 90 million for the current financial year has been made by the Finance Department of the State Government. **Results:** The scheme has become fully operational with effect from Ist June 2006. The recruitment of SPs (doctor) has been made and 90 % of them have joined for their work. The out door patient attendance has shown positive increase. Earlier it used to be 15-20 per day now it is over 100. This has happened partly due to availability of medicine which earlier was not available.
Cost	The Break up of the budget is as under: Package cost of Service Providers @ INR 3.60 lakhs per annum for 1310 SPs; total INR 471.60 million. Medicine cost @ INR 7500 pm for 1310 SPs; total INR 117.90 million for one year. One time Repair and maintenance of 1310 health institutions INR 150million
Place	1301 subsidiary health centres in Punjab. These are located in rural areas including border and remote locations.
Time Frame	Six months.
Advantages	Decentralised management: Management at the district level provide a better control on the operational aspect of the health facilities. Functional: Availability of manpower and medicine at the health facilities make then functional for the benefit of the patients.
Challanges	Political element: Direct control of the PRI in the management of health facilities has increased chance of their favouritism in the recruitment process as well as in the delivery of services.
Prerequisites	Involvement of PRI.
Who needs to be consulted	PRI membersState government.
Risks	
Sustainability	Sustainability depends on the capacity of the PRI and management ability to make health facilities functional.
Chances of Replication	In remote areas where day-to-day monitoring of the health care delivery services is difficult, involvement of PRI can facilitate functioning of the health facilities.
Comments	Though involvement of PRI in the management of health

	facilities is an encouraging step in the process of decentralisation, but care need to be taken for mixing of political influence in the health care delivery.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, August, 2006.
Status	Active
Reference Files	Existing model of Health Care Delivery, Punjab.doc
Reference Links	

74. Better Communication via Satellite, Madhya Pradesh

Subject Area="Management structures and systems."	**Objective="Improved communication links between state and districts."**
Details for Reform Option "Better Communication via Satellite, Madhya Pradesh"	
Summary	**Background:** With a terrain as vast and difficult as in Madhya Pradesh, it is difficult to quickly and simultaneously reach out to the huge healthcare workforce and the community at large. Field functionaries in particular need to understand instructions and their job responsibilities, which cannot be communicated to them through the written word alone. Likewise, they too have useful feedback to provide. **Action:** Initially, SATCOM, or SATellite COMmunication, was introduced in Madhya Pradesh to impart training via satellite on any

	programme, not just on public health, by distance learning mode. The satellite communication node is established in Bhopal via Indian Space Research Organisation (ISRO), Ahmedabad. A total of 44 dish antennas have been installed in the districts under European Commission's Sector Investment Programme (SIP). These are linked to the SATCOM centre located in the Academy of Administration, Bhopal. The antennas at the districts have been installed at district training centres and in 3 Regional Family Welfare Training Centres. Fixed days and time slots are allocated to the departments by the State SATCOM Centres every month for undertaking communications with their target audiences. These include programme communication and feedback sharing on programme

	performance. The communications also help in clarifying doubts and misgivings with regard to specifications of the schemes. This is a unique two-way communication, wherein the remotely located district personnel can see the State officials while listening to their presentations through television sets. With the help of STD telephone lines, questions can be put to the panel of presenters. Adequate preparation for SATCOM sessions is required, both at the studio and at receiving stations. **Results:** It is a good medium of communication between the state and district officials for monitoring the progress of programmes and for the purpose of training. The quality of reception at SATCOM centres is very good. Now this medium is being augmented by video-conferencing facility, whereby

	those in communication can see each other. Encouraged by the effectiveness of this mass communication, the State Government initiated use of Video Conferencing System in 2005. The system is installed in the secretariat and affords two-way audio-visual communication with district teams. The video conferencing studio network is parallel to that of SATCOM affording an overall wider coverage.
Cost	INR.21 lakhs (2.1 million) have been spent so far on installation of dish antennas and TV sets (at the receiving points) from an approved European Commissions' Sector Investment Programme allocation of INR.25 lakhs (2.5 million).
Place	Madhya Pradesh, since 2001.
Time Frame	2-3 years.
Advantages	Interaction: Effective two-way communication

	between policy makers and programme mangers with field functionaries and community. Quality: Enhances quality of programme communication. People's participation: Useful mechanism for obtaining direct feedback from people.
Challanges	Mode of Communication: If presentations are not well planned or done in intense lecture mode, it fails to capture the attention of the people at the field. Documentation: Process documentation and storage needs careful attention. Preferences: Some people prefer video-conferencing to SATCOM. Infrastructure cost: Capital cost is huge as it requires space, electricity and equipment to make this initiative operational.
Prerequisites	Adequate preparation for SATCOM sessions is required, both at studio and at receiving stations. It is also necessary to document the

	process so that effective follow-up action may be taken.
Who needs to be consulted	Commissioner, Health Director, Public Health & Family Welfare Joint Director, RCH & SIP.
Risks	
Sustainability	Once established, it is self-sustaining if it is effectively used for planning, implementing and monitoring of the programmes.
Chances of Replication	Excellent, because of the efficacy enabled in programme communication.
Comments	It has become very popular with the State Government in disseminating policy and spreading the word regarding new programmes.
Contact	
Submitted By	Sara Joseph, Research Consultant, ECTA. May 2006 &Dr. Nandini Roy, National Institute of Medical Statistics, July, 2006.
Status	Active
Reference Files	
Reference Links	

75. Manipur State AIDS Policy, Man

Subject Area="Management structures and systems."	Objective="Policy development."

Details for Reform Option "Manipur State AIDS Policy, Manipur"

Summary

Background: The first cluster of HIV infection was detected in Manipur in February 1990. Today, the HIV infection and AIDS has taken firm roots in Manipur. Further analysis of the data shows that the infection is now no longer confined to a particular group of people; rather it has spread to the general population. The social, economic and developmental consequences of AIDS in Manipur in the near future will be very grim unless an immediate planning is started.

The State Government of Manipur considers the AIDS problem as a grave public health problem, a matter of great urgency and top priority, requiring immediate Government action. Therefore, in 1996 Manipur State AIDS Policy was formed. Till date Manipur is the first and only State in India having a clear cut Policy statement based on Harm Reduction. According to National AIDS Policy announced on 2nd April 2002, the most important strategy to combat the problem of intravenous drug use and its serious consequences in transmission of HIV/AIDS would be Harm Minimization approach, which is being accepted worldwide as an effective preventive mechanism.

Harm Minimization aims at reducing the adverse social and economic consequences and health hazards by minimizing or reducing the intake of drugs leading to gradual elimination of their use. The objectives of the Manipur State AIDS Policy are: (i) To prevent the spread of HIV infection, both at the community level and in the health care environment. (ii) To promote better understanding of HIV infection in order to protect and support those who are at risk of or vulnerable to infection. (iii) To ensure that treatment and support services both for those infected with HIV and for their family are easily available and accessible. (iv) To ensure that services are efficient, effective, and are well evaluated. (v) To mobilise and unify inter-sectoral action, community initiatives and Non Government Organizations (NGO) and Community Based Organizations' (CBOs) support networks are there for better co-ordination and co-operation among the participating agencies against AIDS.

Action: The Manipur State AIDS Policy: (i)The State Government of Manipur considers the AIDS problems as a great public health challenge, a matter of great urgency and

	top priority, requiring immediate Government action. (ii) The State Government is fully committed to effective and efficient implementation of the AIDS Control Programme as a part of the overall health care system in the State. The State Government shall provide adequate budget for proper implementation of the programme at state, district and community levels. (iii) The department of health is designated as the State AIDS Authority, empowered to monitor the progress of implementation of the State AIDS Policy. Under the Manipur State AIDS Policy, following policies have been made: i) Multi-sectoral action and programme management ii) Information, Education and Communication. iii) School AIDS education iv) Blood Safety v) Medical Care vi) STD and Reproductive Health vii) Drug Abuse Treatment Service viii)Hospital Infection Control ix) Intervention measures x) Employment xi) Antibody testing xii) Confidentiality xiii)Prisons/jails xiv) Social service provision xv) Training and research xvi) Non Discrimination xvii) Appropriate legal framework. The government adopted the Policy based on: (i) Provision of accurate information and education to make people aware of and to protect them selves from HIV infection. (ii) Voluntary participation of people with HIV/AIDS (iii) Safeguard of confidentiality (iv) Respect for privacy, human dignity and individual human rights. (v) Avoidance of discrimination and stigmatization. (vi) Provision of quality medical care. (vii) Provision of social benefits and social support systems for people with HIV/AIDS. (viii) Creating a helpful, supporting and enabling social environment in the community so that people who suspect themselves to be infected with HIV can come forward for voluntary HIV testing and for seeking help so that they can live peacefully with other members of the society. (ix) Avoidance or removal of fear psychosis in the minds of people. **Results:** Policies have been formed and are being implemented. But external evaluation is yet to be conducted.
Cost	Not specified.
Place	Manipur State. The policy was formed in 1996.
Time Frame	1 year.
Advantages	Benefits the State: Helps the Government to tackle the HIV/AIDS situation in Manipur Sate more effectively and efficiently. Budget allocations: Allocates budget for various programs on HIV/AIDS. Conducive for reducing discrimination and stigma: The Policy

	safeguards privacy, human dignity and individual human rights and is designed to reduce discrimination and stigma. Provision for social benefits: The policy includes social support system for people with HIV/AIDS.
Challanges	None Perceived.
Prerequisites	Political will.
Who needs to be consulted	Government of Manipur. Manipur State Aids Control Society.
Risks	
Sustainability	It has sustained since 1996.
Chances of Replication	Replicable, Nagaland has also drafted a State Policy on HIV/AIDS.
Comments	None.
Contact	
Submitted By	Prabha Sati, Research Consultant, European Commission Technical Assistance, New Delhi and Mr. S.Sahoo, Deputy Director, Field Survey Unit, CBHI, Bhuvneshwar, Orissa, March 2007.
Status	Active
Reference Files	
Reference Links	

76. Manipur State AIDS Policy, Manipur

Subject Area="Management structures and systems."	Objective="Policy development."

Details for Reform Option "Manipur State AIDS Policy, Manipur"

Summary	**Background:** The first cluster of HIV infection was detected in Manipur in February 1990. Today, the HIV infection and AIDS has taken firm roots in Manipur. Further analysis of the data shows that the infection is now no longer confined to a particular group of people; rather it has spread to the general population. The social, economic and developmental consequences of AIDS in Manipur in the near future will be very grim unless an immediate planning is started. The State Government of Manipur considers the AIDS problem as a grave public health problem, a matter of great urgency and top priority, requiring immediate Government action. Therefore, in 1996 Manipur State AIDS Policy was formed. Till date Manipur is the first and only State in India having a clear cut Policy statement based on Harm Reduction. According to National AIDS Policy announced on 2nd April 2002, the most important strategy to combat the problem of intravenous drug use and its serious consequences in transmission of HIV/AIDS would be Harm Minimization approach, which is being accepted worldwide as an effective preventive mechanism. Harm Minimization aims at reducing the adverse social and economic consequences and health hazards by minimizing or reducing the intake of drugs leading to gradual elimination of their use. The objectives of the Manipur State AIDS Policy are: (i) To prevent the spread of HIV infection, both at the community level and in the health care environment. (ii) To promote better understanding of HIV infection in order to protect and support those who are at risk of or vulnerable to infection. (iii) To ensure that treatment and support services both for those infected with HIV and for their family are easily available and accessible. (iv) To ensure that services are efficient, effective, and are well evaluated. (v) To mobilise and unify inter-sectoral action, community initiatives and Non Government Organizations (NGO) and Community Based Organizations' (CBOs) support networks are there for better co-ordination and co-operation among the participating agencies against AIDS. **Action:** The Manipur State AIDS Policy: (i) The State Government of Manipur considers the AIDS problems as a great public health challenge, a matter of great urgency and

	top priority, requiring immediate Government action. (ii) The State Government is fully committed to effective and efficient implementation of the AIDS Control Programme as a part of the overall health care system in the State. The State Government shall provide adequate budget for proper implementation of the programme at state, district and community levels. (iii) The department of health is designated as the State AIDS Authority, empowered to monitor the progress of implementation of the State AIDS Policy. Under the Manipur State AIDS Policy, following policies have been made: i) Multi-sectoral action and programme management ii) Information, Education and Communication. iii) School AIDS education iv) Blood Safety v) Medical Care vi) STD and Reproductive Health vii) Drug Abuse Treatment Service viii)Hospital Infection Control ix) Intervention measures x) Employment xi) Antibody testing xii) Confidentiality xiii)Prisons/jails xiv) Social service provision xv) Training and research xvi) Non Discrimination xvii) Appropriate legal framework. The government adopted the Policy based on: (i) Provision of accurate information and education to make people aware of and to protect them selves from HIV infection. (ii) Voluntary participation of people with HIV/AIDS (iii) Safeguard of confidentiality (iv) Respect for privacy, human dignity and individual human rights. (v) Avoidance of discrimination and stigmatization. (vi) Provision of quality medical care. (vii) Provision of social benefits and social support systems for people with HIV/AIDS. (viii) Creating a helpful, supporting and enabling social environment in the community so that people who suspect themselves to be infected with HIV can come forward for voluntary HIV testing and for seeking help so that they can live peacefully with other members of the society. (ix) Avoidance or removal of fear psychosis in the minds of people. **Results:** Policies have been formed and are being implemented. But external evaluation is yet to be conducted.
Cost	Not specified.
Place	Manipur State. The policy was formed in 1996.
Time Frame	1 year.
Advantages	Benefits the State: Helps the Government to tackle the HIV/AIDS situation in Manipur Sate more effectively and efficiently. Budget allocations: Allocates budget for various programs on HIV/AIDS. Conducive for reducing discrimination and stigma: The Policy safeguards privacy, human dignity and individual human

	rights and is designed to reduce discrimination and stigma. Provision for social benefits: The policy includes social support system for people with HIV/AIDS.
Challanges	None Perceived.
Prerequisites	Political will.
Who needs to be consulted	Government of Manipur. Manipur State Aids Control Society.
Risks	
Sustainability	It has sustained since 1996.
Chances of Replication	Replicable, Nagaland has also drafted a State Policy on HIV/AIDS.
Comments	None.
Contact	
Submitted By	Prabha Sati, Research Consultant, European Commission Technical Assistance, New Delhi and Mr. S.Sahoo, Deputy Director, Field Survey Unit, CBHI, Bhuvneshwar, Orissa, March 2007.
Status	Active
Reference Files	
Reference Links	

77. Outreach and referral services for slum populations contracted out to private organisations, Orissa

Subject Area="Social marketing and franchising."	**Objective="Availability of basic health products in rural areas."**
Details for Reform Option "Outreach and referral services for slum populations contracted out to private organisations, Orissa"	
Summary	**Background:** Availability of basic health products limited in rural areas. **Action:** Population Services International (PSI) covered the State of Orissa by distributing basic health products such as contraceptives; oral rehydration salts (ORS), safe water systems and clean delivery kits to the rural population through existing commercial networks – in this case, mostly pan shops. The initiative was supported by a state-wide mass media campaign, with the pan shopkeepers' social contribution at the forefront. PSI staff visit outlets once and then relies on traditional distributors/wholesalers to carry out the restocking. In the process, the project may lose up to 80-90% of the outlets visited but it is still considered that the approach is cost-effective and sustainable. The link between the project and the retailers is kept through mailshots - which allows for some feedback from the field. **Results:** A single visit to rural vendors, counseling them on health product promotion and teaching them about the products (eg. how to take pills and use condoms correctly) is cost effective. However referring them to wholesalers for restocking is problematic and sustainability fell to just 10-20% because most of their queries on clinical needs of products remained unaddressed. A study on rural retailers of Orissa clearly indicates that 30-40% vendors would be interested in restocking if their key clinical products needs could be addressed. Therefore repeat visits/counseling can no doubt increase the numbers of sustainable vendors.
Cost	
Place	Twenty-one districts of Orissa.(March 2004) (Puri, Cuttack, Kendrapara, Jajpur, Bhadrak, Balasore, Mayurbhanj, Jagatsinghpur, Khurda, Nayagargh, Ganjam, Rayagara, Koraput, Malkanagiri, Nawarangpur, Angul, Dhenkanal, Pulbani, Boudh, Balangir, Kalahandi). It was started in January 2001.
Time Frame	A blitz team of 10 members and a supervisor could cover the entire state (if budget is not a constraint) in around 500 days.

Advantages	Extended coverage: Increased access to social marketing products in the rural areas. Education: Improves knowledge, attitudes and beliefs concerning HIV/AIDS, family planning, clean delivery practice, diarrhoea etc. among the rural population.
Challanges	Limited reach: Does not help the poorest of the poor as they cannot afford to use the shops. Lack of support: Wholesalers are ill-equipped to deal with queries on clinical needs of products, leaving shop-keepers unsupported. Communication constraints: In states with limited literacy/ multiple languages/ low ownership of televisions and radios (like Orissa) the reach of mass media is limited. Cost: Low population density and a scattered rural population and make the project comparatively costly.
Prerequisites	Area-specific baseline information. Heavy support for IEC.
Who needs to be consulted	State government and local donors - in this case, UNFPA, State Aids Cell, UNICEF, PSI India.
Risks	
Sustainability	Poor, given that only 10-20% of the rural outlets will survive. However, repeat visits/counselling rural vendors could increase numbers of sustainable vendors.
Chances of Replication	Easily replicable and more cost-effective in areas with higher population density and more developed network distribution.
Comments	The programme is still on-going but, due to lack of funds, is on a much smaller scale. However this has enabled the organisation to collate information on rural markets for social marketing through their survey reports. A similar kind of project in 16 districts of Jharkhand has found that more than 55% of outlets will put in an order for more contraceptives after a repeat visit by trained field staff.
Contact	
Submitted By	Dr Jean Patrick Duconge, Former Programme Director, PSI, New Delhi. November 2003.
Status	Active
Reference Files	
Reference Links	

78. Jan Mangal: Community-based contraceptives distribution intervention, Rajasthan

Subject Area="Social marketing and franchising."	Objective="Access to family planning."
Details for Reform Option "Jan Mangal: Community-based contraceptives distribution intervention, Rajasthan"	
Summary	**Background:** From 1951-1991, a high rate of population growth was recorded in Rajasthan. The absolute growth in population was coupled with low acceptance of spacing methods, high infant mortality rates and lack of adequate knowledge of permanent and, particularly, reversible methods of contraception. Poor contact between the community and Auxiliary Nurse Midwives (ANMs) meant that the community did not perceive her as a source of reversible contraceptives (Oral Contraceptive Pill (OCP) and condoms). The Jan Mangal Project was therefore developed to generate awareness in community, create demand for family planning products and address socio-cultural barriers. **Action:** The programme was carried out by unpaid volunteer husband and wife (in most cases) teams known as Jan Mangal Couples (JMCs), recruited by the ANMs after consultation with community members using a pre-decided selection criteria. Their role included: (i) Supply of contraceptives (OCPs and condoms). (ii) Contraceptive counselling as well as referral for other contraceptive methods. (iii) Providing information on the needs and benefit of use of spacing methods. The JMCs have three days of training, mainly at the PHCs. Topics covered include: (i) Ill-effects of child and maternal health due to frequent pregnancies. (ii) Need and benefits of using spacing methods. (iii) Information on spacing methods and their side-effects, as well as management of side-effects. (iv) Record maintenance. (vi) Counselling skills. JMCs also attend bi-monthly meetings called Milan Baithak at the PHC. The JMCs bring with them the village register in which they record details of the users of OCPs and condoms. Their performance is assessed and discussed in these meetings. Quality issues such as discontinuation, incidence of side effects etc are discussed and the meetings used as continuing education sessions. **Results:** After seven years, TNS MODE Pvt. Ltd. (New Delhi) carried out an evaluation study in two districts of Udaipur and Sawai Madhopur into service coverage and quality; the profile and competence of the volunteers; the system support;

	and community perspectives on Jan Mangal intervention. [Findings can be found in the documents section.] Generally, the programme has ensured ready availability and accessibility of OCPs and condoms in remote villages and has facilitated the creation of a large community-based volunteer cadre. As of March 2003, there were 28,303 JMCs in 32 districts catering to a total of 2,41,817 uses of OCPs and condoms.
Cost	From 1999 to 2002, the programme cost INR 2.45 Crore. Cost-effectiveness has been calculated by comparing the cost saving of providing contraception under the Jan Mangal initiative against the equivalent cost of sterilisation in the country under the family planning programme (which is funded by the state). The cost of sterilisation in Rajasthan under the programme was less than half the cost in the country and about a third of the cost in the state (where the programme was not being implemented). (See TNS MODE report in Documents section for more details).
Place	Initially two districts of Alwar and Udaipur in Rajasthan. Later up-scaled to seven districts, then to the whole State. June 1993 – ongoing.
Time Frame	Six months.
Advantages	Increased availability of contraceptives: in remote areas. Widens health coverage: Creates a sizeable workforce (of JMCs) in remote areas to assist in any other national health programme or allied activities, e.g. during epidemics etc. and can be used to piggyback other interventions, such as HIV/AIDS. Cost effective.
Challanges	Threat perception: The ANMs sometimes perceive the JMCs as competitors rather than facilitators and do not keep them supplied with contraceptives. Corruption: Strict adherence to the eligibility criteria during JMC selections has not always been followed due to political interference. Needs support: MOs holding the Milan Baithaks are sometimes unmotivated and do not provide the JMCs with the support they need. Needs good management: Delays in paying honoraria to/ lack of regular contact with JMCs does lead to a lack of motivation and use of contraceptives falls if the JMCs do not maintain regular contact. Training: JMCs need regular re-training.
Prerequisites	Training programme and available trainers for JMCs. Clearly articulated selection process. A sound programme

	management structure.
Who needs to be consulted	State government, ANMs, MOs.
Risks	
Sustainability	Has been working in Rajasthan for more than 10 years. Because contraception awareness has been generated in the community and demand has been created, men and women are increasingly approaching ANMs for contraceptives. The existence of local depots with supplies is likely to improve accessibility of the supplies which is in turn likely to ensure the sustainability of the Jan Mangal intervention if donor agency stops funding. However, coordinating the functioning of the local depots will be important for achieving sustainability.
Chances of Replication	Good. The Jan Mangal intervention was piloted in two districts of Alwar and Udaipur in 1993 and later up-scaled/ replicated in all districts in the state. UNFPA supported the programme in 7 districts in the state (Alwar, Udaipur, Bhilwara, Bharatpur, Chittorgarh, Karauli and Sawai Madhopur).
Comments	The project was innovative and involved active participation by community volunteers. The findings of the TNS MODE evaluation suggest that the Jan Mangal intervention has potential to increase use of family planning methods, particularly spacing methods. The intervention has been found to be useful in increasing education and counselling of couples to use family planning methods and make services accessible in the villages.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. August 2004.
Status	Active
Reference Files	
Reference Links	

79. Using Rural Health Practitioners for social franchising, Bihar, Jharkhand & Madhya Pradesh

Subject Area="Social marketing and franchising."	Objective="Access to family planning."
Details for Reform Option "Using Rural Health Practitioners for social franchising, Bihar, Jharkhand & Madhya Pradesh"	
Summary	**Background:** A number of studies have shown that: (i) The Rural Health Practitioner (RHP) is consulted as the first provider for any health problem that cannot be handled at home i.e. he is preferred to the Primary Health Centre (PHC). (ii) There are an estimated one million RHPs in India of which 48% have had absolutely no training in medicine. (iii) His main (in most cases, only) source of medical information is the town chemist, whom he meets three to 4 times a month. (iv) All serious illnesses and gynaecological problems have to be referred onwards. Therefore there are two important issues: (i) the under utilisation of RHPs in that they do not provide any reproductive health or family planning services (ii) the danger posed by untrained and unqualified persons who are the first level of health personnel to be consulted. **Action:** An NGO Janani set up a network of more than 21,000 Titli (butterfly) centres and more than 500 Surya (sun) clinics in the states of Bihar, Jharkhand and Madhya Pradesh. Surya clinics are referral clinics run by formally qualified, state-registered doctors in the towns. Titli centres are situated in villages and run by RHPs who have been trained to provide family planning counselling and sell non-clinical contraceptives. Since RHPs are male, they work with a Woman Health Partner (WHP) who is generally a member of their family (in most cases, wife). RHPs and their female counterparts undertake a two-day training programme on family planning counselling. Female partners help reach out to the village women who are hesitant to approach male health providers on reproductive health matters. Once trained, detailed protocols along with counselling cards and IEC materials are made available to the RHP trainees and a contract is established with Janani: the franchiser. This contract stipulates that in exchange for benefiting from free training, IEC materials, the promotion of a common logo and for having access to cheap drugs, they are to provide specific reproductive health services of standard quality and at fixed rates. The network's name, logo, franchised services and corresponding rates are being widely advertised throughout the three states by the franchiser. Networked rural providers are met and monitored at regular

	intervals by the project field teams. Besides replenishing their stocks of contraceptives, which are made available by Janani at subsidised rates, service providers are given a packet of printed IEC material to be used in their centre and catchment area. This kit also includes newsletters and magazines on general health to update them with developments in this field. Second phase (from mid 2003): The rural network was expanded to cover every village of Bihar and Jharkhand (targeting about 60,000 Titli centres). Janani took over administration of the Surya clinics through specially-trained administrators so that quality issues (a source of concern in the first phase) can be addressed. Each Surya clinic had to have, besides the administrator, a trained Auxiliary Nurse Midwife (ANM), a counsellor and a lab technician. This expenditure has to be borne by the doctor to remain part of the franchisee network. Thus the number of Surya clinics targeted for this phase was reduced to 360. **Results:** Janani monitors the performances of its Titli and Surya Clinics through sales data and regularly conducts market research through reputed organisations. It claims to account for 5% of the total contraceptive coverage in Bihar and Jharkhand, of which only 10% are clinical services and the rest social marketing.
Cost	Estimated cost: Cost per couple protected annually by clinical methods like sterilisation: INR 230 Cost per couple protected annually by non-clinical methods like condoms, oral pills, INR 117. Costs on setting up of Surya clinics, Titli centres and Surya clinic rates are available as Excel sheets from ECTA office.
Place	At present, in three states - Bihar, Jharkhand and Madhya Pradesh. The networking component of the Janani programme (Surya clinics and Titli centres) started on a pilot basis in 1996 and the scaling up happened late 1999. At the latest update (August 2004) 39 Surya clinics and approximately 31,000 Titli centres were functional.
Time Frame	Janani hoped to complete the network of 60,000 Titli centres and 360 Surya clinics within three years (from the beginning of the 2nd phase). The basket of services at the Surya clinics will go beyond family planning to all aspects of reproductive health and even some parts of health care.
Advantages	Increased access: To family planning services in the rural areas. Education: RHPs educated on family planning services which they would earlier refer onwards, reducing pressure on PHCs/sub-centres. Self-sustaining: The clinical services have the potential to become self sustaining. The same networks can address the needs of the poorest if financial mechanisms (like coupons and vouchers) are

	set up.
Challanges	Needs government backing: This approach will work even better if government's enforcement of norms is adequate. Administration: The programme needs a strong administrative framework and the ability to consistently value add to the networks to make the approach sustainable. Set-up costs: NGO must have substantial funds to be able to set up the clinics and framework. Then the programme is extremely cost efficient. Possible opposition: From PHC medical officers and other private sector providers outside the franchise networks who find that the prices they charge come under pressure.
Prerequisites	Existence in the state of an NGO comparable to Janani.
Who needs to be consulted	State government. NGO.
Risks	
Sustainability	Good because it is based on an existing dominant health care system (of first health care providers).Non-clinical services can be sustained if various services are bundled with the delivery channels. Clinical services through doctors are fully sustainable.
Chances of Replication	Good where there is an existing network of first health care providers. There may be a need to tailor the providers' networks differently but it should not pose any major difficulty.
Comments	None.
Contact	
Submitted By	J.P Mishra, Programme Advisor, European Commission Technical Assistance, New Delhi. April 2003.
Status	Active
Reference Files	
Reference Links	

80. Vanita: Low-Cost Family Planning Clinics, Andhra Pradesh

Subject Area="Social marketing and franchising."	Objective="Access to quality family planning products in slums and rural towns."
Details for Reform Option "Vanita: Low-Cost Family Planning Clinics, Andhra Pradesh"	
Summary	**Background:** Social franchising of contraceptives and family planning services employs available resources, particularly retail shops and rural medical practitioners, to respond to India's huge unmet family planning needs. Though the demand is high, public facilities are either not functioning or unpopular thus dissuading potential users of family planning products and services. Private practitioners, on the other hand, charge prohibitive fees. The social marketing programme in Andhra Pradesh had so far focused only on over-the-counter products like condoms and oral contraceptive pills. It did not provide clinical family planning services like insertion of inter-uterine devices (IUDs) and female sterilisation, for which there is a great demand. To fill this gap, a pilot project aimed at providing quality family planning services at affordable rates was initiated in Andhra Pradesh by establishing a chain of franchisee clinics brand-named Vanita Clinics. **Action:** The project was implemented by Andhra Pradesh unit of Hindustan Latex Family Planning Promotion Trust (HLFPPT) with financial assistance from the European Commission. The project was initiated April 8, 2001 and concluded after three years in December 2003. Criteria of selecting the clinics were two-fold, one was location specific and other was based on popularity of the doctor. The scheme franchises with maternity hospitals that operate 24 hours a day and are owned by Obstetrician-Gynaecologist. Memorandum of association is initially signed for one year between HLFPPT and the doctor of the clinic and it is renewable depending on the performance of the clinic. Each franchisee pays INR 500 for registration for the first year only. The franchisee gets payment for the services and products sold to the customers and they in turn pay royalty to HLFPPT. Initially, a model Vanita clinic was set up in the Government Maternity Hospital, Hyderabad. A training centre was also set up at this hospital to equip doctors to start such clinics in rural towns. To give these clinics a customised look so that clients identified it with low-cost quality service, a uniform signboard was put up before each one of them with the price board prominently displayed. Publicity was done extensively to popularise the clinics by placing humorous advertisements in local newspaper and on Andhra Pradesh State government buses. The Vanita Franchisee Clinics (VFC) established a network with chemist shops, bangle

	stores, sari shops and beauty parlours to spread the word about their services. The identified doctors underwent training on IUD insertion at Central Resource Centre, Hyderabad. A senior medical consultant from Federation of Obstetrics and Gynaecological Societies of India (FOGSI) was appointed by HLFPPT for the purpose. The paramedical staff at each clinic was trained in-house by a master trainer from HLFPPT. The user charges for family planning services are uniform across all franchisee clinics. The emergency contraceptive pills and urine pregnancy card (Dipstick urine test) was introduced to meet the needs of the clients and help the clinics sustain themselves through their sale. The franchisee clinics also provide comprehensive services such as medical termination of pregnancies (MTP), tubectomy and antenatal check-ups. Various social marketing strategies were adopted to popularise the clinics. One example was the 'Double Benefits, Double Happiness' scheme for women who sought the clinic's services and referred others to the clinic. She was given an incentive of either 4 gm silver coin or free health check-up at home for herself and her children below 3 years. Besides, each clinic, for every 1000 IUD insertions, drew at a Lucky Draw contest and silver and gold coins were given to the winners. Monitoring was done by going through the records maintained by the franchisee clinic (client record, client card for IUD insertion, Clinic bill book and service utilisation report). Every month, information was sent to HLFPPT about the users. Getting feedback from franchisees and customers was also used as a monitoring tool. **Results:** Under the social marketing programme, 57 Vanita Clinics were set up in Andhra Pradesh, of which 26 were in Hyderabad. By the end of the project period there were only 38 Vanita clinics operational in 5 districts of the state; 50 % of the revenue came from the model Vanita Clinic in Hyderabad. The minimum patient load at the clinics ranged from 3 to 15 a month. The project was evaluated by Administrative Staff College of India (ASCI), Hyderabad and the World Bank (WB). For excerpts see Reference. According to the WB report, doctors reported franchising has led to increase in the number of people seeking family planning services in their clinics. The ASCI report mentions that initial enthusiasm was considerably high, but gradually it waned due to lower client inflow than expected.
Cost	The total value of the Project is INR 50, 00,000 for 3 years. For setting up a franchisee clinic total investment required is INR 5000.
Place	Andhra Pradesh.
Time Frame	6-9 months.

Advantages	Quality: The franchisee clinics could offer family planning services hitherto offered by untrained providers. Affordable: By providing free and wide-ranging publicity the patient load of each clinic increased making it possible for them to keep costs low.
Challanges	Doctors: The challenge is to retain private doctors in the network. Monitoring: Continuous monitoring for quality and uniform cost of service delivery. Management: Scaling up, as it will require considerable managerial talent. Publicity: Lack of adequate publicity in smaller downs and inadequate referrals from rural medical practitioners and Auxiliary Nurse Midwives (ANM) affected the franchisee clinics to really take off especially in smaller towns/villages.
Prerequisites	Government support. MoU. Private Clinics. Advocacy. Referral from Rural Medical Practitioner.
Who needs to be consulted	District health administration. Local medical practitioner. Medical Council of India. Local chemist shop. Franchise Medical doctor.
Risks	
Sustainability	The benefit of the project is sustainable as the doctors who have been trained in IUD service provisioning continue to practice even after the closure of the project.
Chances of Replication	The initiative could be replicated in other parts of India as well as there are no major barriers to its implementation.
Comments	The criteria of selecting the location of Vanita clinic differed in rural and urban areas. In urban areas, the suitable location was adjacent to slums with a population of 1000. While, small towns adjacent to rural areas were identified as locations for establishing rural franchisee clinics.
Contact	
Submitted By	Dr. Nandini Roy, Research Consultant, National Institute of Medical Statistics. May 2006.
Status	Active
Reference Files	
Reference Links	

81. Border District Cluster Strategy: accelerating the reduction of maternal and child mortality, Gujarat

Subject Area="Inter-sectoral links."	Objective="Improved outreach services."
Details for Reform Option "Border District Cluster Strategy: accelerating the reduction of maternal and child mortality, Gujarat"	
Summary	**Background:** Government of India (GOI) has a Border District Cluster Strategy (BDCS) for accelerated implementation of the RCH programme. With the support of UNCEF, BDCS is developing new models and tools to achieve these goals in the poorest districts of the country - two of them are in Gujarat. The purpose of developing such tools is to measure 5 key determinants of the basic services: availability; access; utilisation; effectiveness; adequate coverage. The programme has the following key components: (i) A Minimum Intervention Package including immunisation, Vitamin A supplementation, Ante-Natal Care (ANC), safe delivery, Post-Natal Care (PNC), prevention against nutritional anaemia, newborn care, management of diarrhoea and pneumonia. (ii) The expanded intervention package including Integrated Management of Neonatal and Childhood Illnesses and Safe Motherhood interventions through emergency obstetric care. **Action:** The BDCS aims to improve general access to quality services by: (i) Increasing human resource capacities to provide preventive and curative primary health care. (ii) Strengthening the role of the supervisors to effectively monitor and manage health workers. (iii) Improving the sub-centres. (iv) Reinforcing the availability and accessibility of essential drugs by improving logistics system. The key approach to greater success is to achieve greater inter-sectoral collaboration between Auxiliary Nurse Midwives (ANMs), Anganwadi Workers (AWWs) and the Male Health Worker (MHW) in the form of a Health and Nutrition Team (HNT). At the same time, micro-planning exercises ensure that sub-centre clinics remain open regularly and their outreach activity to the distant hamlets is improved through mobility support. Key activities included: (i) Information, Education and Communication (IEC) for Healthy Babies: Traditional healers were trained in newborn care at home and timely referral of high-risk pregnant women. In the remote, inaccessible areas, key messages were communicated through folk performances. (ii) Micro-planning for ANC with mobility support from UNICEF ensured better demand for ANCs. (iii) Adolescent Girls Anaemia Control Programme with weekly in-school Iron Folic Acid (IFA) tablets distribution. (iv) Skilled delivery and PNC by ensuring the presence of ANMs at the sub-centres. (v) Formation of a HNT made up of

	ANM, AWWs and MHW. The HNT ensured necessary ANC and PNC to lactating mother. The ANMs visited the Anganwadi Centres (AWCs) to verify ANC registration. (vi) Formation of Village Health Committees (VHCs) and Self Help Groups (SHGs) to support community mobilisation for routine activities including immunisation and ANC. (vii) Immunisation and Vitamin A supplement. (viii) Collaboration with the forest department for the use of wireless sets and vehicles for maternal and newborn emergencies. **Results:** (Baseline data is monitored quarterly. The data is collected and validated from sub-centres and the PHCs.) 87 out of 145 sub-centres refurbished. Outreach proportion increased from 75% to 86%. 86% children received BCG and 59% fully immunised in earthquake affected area as compared to 77% and 41% respectively in rural Gujarat Demand of ANC increased in Dangs from 60% in 2001 to 90% in 2002. 50% increase in the number of timely complicated maternity cases admitted as compared to the baseline data. 70% of targeted villages have VHCs formed with 87% have quarterly meetings. 75% of the 377 sub-centres offer daily curative services with three-fold increase in 2002 in number of children treated. Vaccines and Vitamin A supplements availability was 90 % in Valsad district. Improvement in measles vaccines from 73% to 85%.
Cost	The budgeted amount for reaching out to two districts in Gujarat for two years is INR 448,550. Additional funds for the expenditure of existing programmes would be met through funds from the state budget.
Place	Dangs and Valsad districts, Gujarat. From 2003 - ongoing.
Time Frame	Information not available.
Advantages	Comprehensive: Sound design of a service package combining reduction of infectious diseases through immunisation with reduction of maternal and infant deaths. Inclusive: Integrated process including national and international financial and technical resources so that advocacy reaches out to the vulnerable groups.
Challanges	Training needed: Data collection and analysis by the Medical Officers (MOs) needs to be strengthened so that they are able to use it as a supervisory tool. Acceptance essential: Institutionalising the monitoring and evaluation process is an immediate need.
Prerequisites	The IEC design tool has to be developed to ensure community empowerment and health awareness.
Who needs to be consulted	State government; PHCs; ANMs; AWCs; the community.

Risks	
Sustainability	It can be sustained if the supportive supervisory tools are institutionalised and the MOs are able to use its analysis as a supervisory tool.
Chances of Replication	It is being replicated in 19 districts in 7 states. It shows different but, effective, results in all the states.
Comments	Sub-centres can provide more effective clinical services with the help of one of the HNT members. Validation of data collected through a peer group increases their understanding of supportive supervision so that mid-course correction can take place.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	
Reference Links	

82. Integration of mother and child health services at village level

Subject Area="Inter-sectoral links."	Objective="Improved outreach services."

Details for Reform Option "Integration of mother and child health services at village level"

Summary

Background: Over 70% of children in India are born without malnutrition but by about 12 to 18 months of age about 60% or more are malnourished. Even in homes with sufficient food, young children become malnourished. The vast majority of these children can be maintained in the 'normal' grade through improved feeding practices, micronutrient supplements and better care and feeding during and just after illnesses.

Action: The Integrated Nutrition and Health Project targeted children under 6, pregnant women and women with children under two. The following programmes were implemented under the project

(i) targeted supplementary feeding for children aged 6 – 24 months and pregnant and lactating women (ii) iron and folic acid supplements for pregnant women (iii) complete immunisation of children under one year and pregnant women (iv) promotion of improved infant feeding (early breastfeeding, exclusive breast feeding, complementary feeding) These programmes were implemented in the following ways: (i) Advisory groups were formed at the block level consisting of Child Development Project Officer (CDPO), Block Medical Officer (BMO), Block Development Officer (BDO), Non-Government Organisations (NGOs) etc. for co-ordination. (ii) Volunteers from the community, known as 'change agents', were trained to monitor and promote positive nutrition and health behaviour among 15–20 families. (iii) In intervention sites, Anganwadi Workers (AWW) and Auxiliary Nurse Midwives (ANMs) made contact with families with pregnant women or children under one year of age. They checked about exclusive breast feeding, nutritional behaviour of mothers and children and focussed on weight gain. They emphasised feeding as part of treatment for Acute Respiratory Enfections (ARI), diarrhoea and fever. ANMs and AWWs reviewed the status % of 'normal' grade children.

(iv) Community-Based Monitoring Systems (CBMS) were designed to help empower communities to manage the health and nutrition status of women and children through village-level social maps depicting key indicators and family-based self-monitoring tools. The social maps helped define catchment areas with target populations.(v) Nutrition and Health Days (NHD) were made fixed days, occurring at least once a month, when take-home rations were distributed and immunisation and/or antenatal care services were offered. (vi) Key messages were also spread through street

	theatre, songs, wall writing, healthy baby competitions, and radio programs. **Results:** The percentage of women receiving three or more antenatal check-ups during their pregnancy increased in 5 of the 7 project states (AP, Bihar, MP, Orissa and Rajasthan). •There was an increase in the indicator "pregnant women receiving two or more doses of Tetanus Toxoid" in all states. Only 4 out of 7 states achieved the iron and folic acid targets, apparently partly because of supply problems. •There was in all states except West Bengal, a general increase in the % of pregnant and lactating women receiving food from AWCs. All states except Uttar Pradesh showed an increase in the % of children fully vaccinated. •There was a general increase in the % of children receiving breast milk in the first 8 hours of life. Five states (Bihar, MP, Orissa, UP and WB) showed an increase in the number of infants under 4 months who were exclusively breastfed. Five states (AP, Bihar, Raj, UP and WB) showed a decline in the percentage of malnourished children.
Cost	INR 4,785 per Anganwadi Centre per year.
Place	Andhra Pradesh, Rajasthan, Madhya Pradesh, Orissa, Uttar Pradesh, Bihar 1996 - 2000.
Time Frame	Information not available.
Advantages	Broad approach: This project has a broad approach to the health/nutritional problems of mothers and infants rather than merely targeting specific aspects of health care. Inclusive: It also ensured coordination between ANM, AWW and the community.
Challanges	Supply dependent: It is dependent on efficient drug, vaccine supply from Government for the components of Iron and Folic Acid (IFA) supply and immunisation. Unreliable: The results were in some places discouraging in proportion to the efforts invested.
Prerequisites	Information not available.
Who needs to be consulted	State Government (specifically the Department of Family Welfare DFW); ANMs: Anganwadi Centre; local community.
Risks	
Sustainability	•The programme depends upon the convergence of staff of the DFW, the ANM and the AWW and community ownership. •It is debatable whether such a programme would continue to exist after withdrawal without further financial support.
Chances of Replication	It has already been replicated in 7 states.

Comments	The take-up of IFA tablets was severely limited by supply problems in several states.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. June 2005.
Status	Active
Reference Files	Good Practices Entry.doc — Extract from report on Good Practices and their Cost Effectiveness (Reproductive and Child Health) Volume III (GOI, Department of Family Welfare; European Commission) March 2004.
Reference Links	

83. Extending role in RCH of Anganwadi workers, Madhya Pradesh

Subject Area="Inter-sectoral links."	Objective="Improved outreach services."
Details for Reform Option "Extending role in RCH of Anganwadi workers, Madhya Pradesh"	
Summary	**Background:** There are 51,000 villages in the state of Madhya Pradesh and according to state government legislation; each village requires at least one trained birth attendant and one Jan Swasthya Rakshak (JSR). However less than three per cent of JSRs are female and so there is a need to extend services to women. **Action:** There are already Anganwadi workers (AWWs: female community-based workers) working in the villages who are trained in health and nutrition education. They are given wider training (a three-month module) so they can also provide women with preventive and simple curative services as well as promote better health practices.
Cost	Information not available.
Place	Pilot study in Guna district, Madhya Pradesh, ongoing (Aug 2004).
Time Frame	One year (April 2001 onwards).
Advantages	Improved: Maternal and Child Health (MCH) care. Empowerment: Of AWWs. Increased availability: Of trained female JSRs. Informative: Improved preventive and promotive health education.
Challanges	Limited: The proposal would miss out new women entrants to community health work.
Prerequisites	Review of AWW training to include JSR training.
Who needs to be consulted	Directorate of Women & Child Department, Public Health & Family Welfare Department.
Risks	
Sustainability	Moderate.
Chances of Replication	Highly replicable. There are plans underway to replicate the pilot across the state.
Comments	Practical experiences of the AWWs who now function as JSRs need to be documented.
Contact	
Submitted By	Dr.S.K.Shrivastava, Member Secretary, Sector Reform Bureau and

	Mr.G.S.Sachdev, EC State Facilitator.
Status	Active
Reference Files	
Reference Links	

84. Aapni Yojana: Safe Drinking Water in villages of Rajasthan.

Subject Area="Inter-sectoral links."	**Objective="Availability and management of safe drinking water to semi-arid areas."**
Details for Reform Option "Aapni Yojana: Safe Drinking Water in villages of Rajasthan."	
Summary	**Background:** Availability of safe drinking water is a pre-requisite for good health. Churu, Hanumangarh and Jhunjhunu districts of Rajasthan, lacked surface water and the ground water was saline. The situation worsened during summers when drought was common. To tackle the water shortage in these districts the Aapni Yojana scheme was designed in 1994 to supply drinking water from Indira Gandhi Canal to 1000 villages and 11 towns at an affordable price. The overall objective was to improve the health status of the population. The challenge was to convince a mostly illiterate user community to own and manage the local system and to contribute to the general cost of its operation and maintenance. The work started from 1997 and the first phase of the project was completed in March 2006. By then the project had expanded to 370 villages and two towns, covering, 20,000 square kilometres and 900,000 people. It is benefiting mainly those engaged in agriculture and animal rearing. Funding for the first phase of the project was provided by the Government of India (GoI) and the German government, through its development bank, Kreditanstalt fuer Wiederaufbau (KfW). The project had two main components, technical and complementary. The technical component was overseen by the Public Health Engineering Department (PHED) through its Project Management Cell (PMC), headed by the Chief Engineer. It included construction of treatment plants, pumping stations, reservoirs and laying pipelines. The complementary component aimed to ensure sustainability and enhance benefits, and was implemented by the Community Participation Unit (CPU), a consortium of five leading Non-Governmental Organisations (NGOs) of Rajasthan. The Indian Institute of Health Management Research (IIHMR), Jaipur was the nodal agency of the consortium. **Action:** A year prior to the commencement of construction of

infrastructure inputs, health education programmes were organised. Various strategies were used to mobilise the community such as media channels, personal contact with women's groups were made by project field workers, through Aganwadi workers, health workers and Panchayat (local self government) members. The project area was separated out according to topography and water demand.

Norms of water supply per person were decided upon and following the local method, the payment model was made. Thereafter, began the construction or installation of the following:

i) four water treatment plants

ii) two raw water reservoirs

iii) pipeline

iv) eight pumping stations

v) dedicated electricity grid

vi) Drainage system

vii) voice communication system

viii) Public Stand Points (PSP) In urban areas there are two types of connections, either individual or PSP for poorer localities. In villages, each cluster has a PSP. The project ensured that women were involved in identifying the location of the PSP in the village clusters. For the management and maintenance of facilities, the project developed various mechanisms such as the formation of Water and Health Committees (WHC) in each village with members elected by villagers.

Before the work began the WHC and PMC signed a legal agreement defining rights, responsibilities and accountability of both parties. The WHC oversees all activities such as determining the water requirement, the model for and collection of water charges, selection of sites, water troughs for cattle, PSP, record keeping, ensuring participation of women and voluntary trench digging in the villages. Water Management Group (WMG) was formed in each village comprising of members of the WHC and PSP attendants. In addition, from 2000, the project formed Paani Panchayats (local water bodies elected by the people) to manage disputes over water distribution between two or more villages.

The Pani Panchayat was also involved in organising free health camps for children and planting trees. The project networked with government to sanction a special tariff structure for the Aapni Yojana. It organised capacity building programmes for local stakeholders, users and caretaker training on minor repairs to the

	existing village pipeline. Villagers have devised an innovative billing system for individual households depending on the number of units ('angas) in the household. For example, one 'anga' for human being, one 'anga' for cows or buffaloes and one 'anga' for every 5 sheep or goats. **Result:** The project has been able to reduce the drudgery of women as they had to carry water over long distances. The project had achieved the following by March 2006: i) Water provision round the clock to 370 villages and two towns. ii) Water availability in 92% of targeted villages. iii) 98% of village clusters have legalised WHCs to represent beneficiaries, and they have entered in contracts with the PMC for planning, operations and maintenance. iv) 13 Paani Panchayats have been formed to protect the interest of villagers. v) Reported water loss is in range of only 2 %. vi) Over 90% pay regularly towards user charges and contribute towards repair and maintenance. vii) The end line evaluation report shows 91% of the PSPs were functional and 84% of them had attendants to take care of them. Of these 94% attendants were found to be trained. Soak pits were found in about 50% of the PSPs visited. A general feature that was noticed in all villages was that after the commission of the project, water consumption increased manifold with correspondingly high water bills. This was the result of severe drought conditions after which people believed that water would not be available continuously. The villagers maintain the internal water system and no villages have defaulted paying bills. The villages have actively participated in trench digging for pipe laying and participation in all works of the project. Self Help Groups (SHGs) have also been formed to enhance income generation of the community.
Cost	The first phase of the project was funded by the government of Rajasthan (25%) and the government of Germany through KfW. The cost of the technical component of the project was approximately INR 364 crore. This excludes the community participation activities carried out by the CPU to complement the technical activities.
Place	The first phase covered 370 villages in Churu, Hanumangarh and Jhunjhunu districts of northern Rajasthan and two towns (Taranagar and Sardarsahar) from Churu.
Time Frame	Preparatory phase: 3 years. Programme implementation phase: 8 years The project was approved in 1994. The initial phase was preparatory and was spent on developing mechanisms for making the project operational. The project work started in 1997 mainly to garner support for the programme and the actual construction of sanitation units started in January 1998. The first phase of the project was completed in March 2006.
Advantages	Constant supply: Water is available 24 hours a day in the villages.

	Simple payment methods: Villages have one meter and villagers pay their dues. Health benefits: More awareness of health and hygiene. Economic prosperity: Women have started income generation activities in the villages. Improved community participation: Maintenance of the safe drinking water facility by villagers.
Challanges	Management: Coordination and integration between social and technical wings of the project is crucial for successful implementation of the project. Negotiation and agreement on institutional arrangement for O&M and project governance needs to be done. Systematic water quality control at the tail end villages. Illegal connections in the villages. Water Tariff: Water tariffs need to be revised from time to time to cover O&M cost and for maintaining the level of service. Cost recovery in semi-urban systems is a challenging issue. Community Participation: An innovative institutional set up for the construction or maintenance and sustenance of the efforts. Payment of bills: Support drought-proof Income generation activities to ensure ability of the poor to pay the water bills. Sustainability: Sufficient time to assess the mechanisms set-up by the project to ensure availability of water and payment of bills. Contract agreement between service providers and community on the level of responsibility and commitment to the project. Cultural ethos: In the villages, the customs and traditions of target communities should be respected and addressed before starting the work.
Prerequisites	Community participation, especially that of women as they are not involved in community decision making process though they are responsible for fetching water. Initial capital for construction of water distribution. Availability of skilled construction workers. Good rapport of project staff with community. Inter-sectoral and inter-department coordination. Availability of spare parts and tools of specified quality near pumping station.
Who needs to be consulted	Chief Engineer, PMC, District:Churu. Project Director, CPU, District:Churu. Kfw Office, New Delhi. NGO consortium for feedback: Director, Indian Institute for Health Management & Research, District: Jaipur; Vice chancellor, Gandhim Vidya Mandir, District: Churu; Project Director, Bhoruka Charitable trust, District: Churu; Executive Director, IIRM, District: Jaipur & Secretary, URMUL Setu Society, District: Bikaner.
Risks	

Sustainability	The project is likely to continue, provided there remains an institutional set up for the maintenance of the project ensuring community participation, especially of women and ensuring that water charges are paid regularly. It is sustainable if the mechanisms built for managing water in the village and between the villages stays operational.
Chances of Replication	The program is replicable in areas where there is scarcity of water. Presence of committed NGOs to oversee community participation in distribution and management of water will be beneficial. On similar lines, a project entitled 'Churu Visau project' was sanctioned in 2000 by central government to make water available to towns. GoI sanctioned 119 crores.
Comments	Delay in project implementation (Phase one), which was supposed to be completed by 2003 was completed until the end of March 2006. Staff fluctuation in PHED may have affected the working of PMC. The feeling of ownership amongst community makes the project sustainable. However, the sustainability in urban areas is doubtful. No follow up plans made after the CPU support is over for villages – many village committees and Pani Panchayats still need back up support
Contact	
Submitted By	Dr. Nandini Roy, Research Consultant, National Institute of Medical Statistics, June 2005. Last updated : July 2006.
Status	Active
Reference Files	

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Technical Measures in Aapni Yojana- PP presentation by Devesh Bhardwaj.ppt	" Technical Measures in Aapni Yojana" a power point presentation by Devesh Bhardwaj

	Ayp 1.jpg	photo
	Ayp2.jpg	photo
	Ayp 3.jpg	photo
Reference Links		

85.Mano Netra Programme, Andhra Pradesh

Subject Area="Inter-sectoral links."	Objective="To empower the visually challenged students with a comprehensive eye care service."
Details for Reform Option "Mano Netra Programme, Andhra Pradesh"	
Summary	**Background:** It has been really hard to meet the needs of the visually challenged such as reading material scribes and eye care services in the remote coastal areas of the Andhra Pradesh. Mano Netra is a programme for the empowerment of the handicapped in general and the visually challenged in particular. It is an initiative of the Seva Bharathi organization and in operation since the year 2000. Seva Bharathi is a nationally networked agency. Seva Bharathi Western Andhra Pradesh Agency is a part of the proud network, servicing the needy and remotely located tribals and rural people of western Andhra Pradesh. The organization is active in 4 of the 11 government hostels for the blind in the cities of Telangana and Rayalaseema region. **Action:** In the year 2000, the Seva Bharathi's Mano Netra team surveyed the hostels of the visually challenged persons in the Telangana and Rayalaseema cities. Initial target was to reach the 770 inmates of the hostels in the two cities. The inmates were deprived of the reading material; the scribes to pen the examinations of the visually challenged and any eye care services. The full-fledged activities for the visually challenged in the two cities hostels came into progress for last two years. In 2005-06, Mano Netra has taken up campaign with a series of eye camps in the government hostels at Dar-ul-Shifa, Malkpet as well as government and private schools to check blindness through series of camps. The programme involves the following activities: (i) The Audio books containing the recorded lessons are distributed in free among the visually challenged (ii) Audio books library (iii) Writing Club (iv) Raising awareness about eye care and training the visually challenged, their teachers as well as their parents. (v) Counselling sessions (vi) Eye screening camps (vii) Eye screening awareness/ training programmes with LV Prasad Eye Institute (viii) Medical facilities at the hostels in particular and at the office of Seva Bharathi (ix) Providing nutritious food to blind students in hostels in collaboration with the Vivekananda Sevika Samithy (Committee). (x) Eye collection centre (xi) Slow learners awareness programmes in association with BODH school (xii) Computer training for blind students (xiii) Medical transcription training for blind students (xiv) Spoken English vocation course (xv) Volunteering programme for eye camps and to record lessons for the blinds. The beneficiary visually challenged students are not charged for any of the service they receive. Clients: visually

	challenged students **Results:** The campaign in the year 2005-06 in association with the LV Prasad Eye Institute has benefited around 1000 children and has been able to educate government and private school teachers effectively.
Cost	INR 25000 per annum. Volunteering by the health professionals and donation of audio cassettes has significantly reduced the expenses involved.
Place	Telangana and Rayalaseema regions of Andhra Pradesh.
Time Frame	Six months.
Advantages	Building up self-esteem: it helps the visually challenged students in developing their personality by winning over the physical incapacities. Raising awareness about eye care: screening through eye camps provides opportunities to raise awareness and sensitize about eye care. Prevention and control of blindness: early case detection and its timely treatment help in preventing the blindness.
Challanges	Supportive environment: persistent advocacy campaign is required. Continuous involvement of sighted people has been a tough challenge. It requires a lot of patience. Availability of service providers: the service provider's loss interest in the activities if they need to cover a large distance. Intermittent transfer of important volunteers also affects the programme. Fear: fear of loss of reservation and facilities among few students; if their vision acquity improves and they shy away from follow up medical check up.
Prerequisites	Baseline data,need assessment, supportive environment, advocacy Audio cassettes and voice recorders Eye specialist and equipped health facilities Expert counsellor, child psychologist Public Awareness and donors to support Motivation and enthusiasm
Who needs to be consulted	Visually handicapped students, parents, teachers, hostels wardens, schools authorities, state education and health departments, social welfare department, eye specialists and Seva Bharathi for programmatic assistance.
Risks	
Sustainability	Fair: Persistent support from the donor agencies, continuous capacity building and good coordination with the education department is required.
Chances of Replication	Good: The audio cassettes and the vocational training for the visually challenged were being practised in the education sector in

	different states but coordination with the health professionals under this initiative gives it a comprehensive facet in context of the rehabilitative services.
Comments	Mano Netra programme is a good example of development of specific services for the visually handicapped students. It can be further improved by time-to time need assessment of the client population and evaluation of the programme.
Contact	
Submitted By	Dr. Anil Bhola, Research Consultant, National Institute of Medical Statistics, New Delhi November, 2006
Status	Active
Reference Files	Visually challenged beneficiaries.JPG Eye check up.JPG Eye care education.JPG Activities in details.doc
Reference Links	

86. Inter-sectoral approach to Family Counselling Centres, Madhya Pradesh

Subject Area="Inter-sectoral links."	**Objective="To promote psychosomatic health of women through empowerment."**
Details for Reform Option "Inter-sectoral approach to Family Counselling Centres, Madhya Pradesh"	
Summary	**Background:** In the Country Report for the Fourth World Conference on Women at Beijing in 1995 Indian government accepted the fact that domestic violence on women in the society is a hidden menace. Two Indian States i.e. Madhya Pradesh and Maharashtra together account for 29.7 % of total registered crime against women. Domestic violence in any form harasses women and increases their vulnerability for ill health, ultimately leading to psychosomatic disorders like depression, anxiety, hypertension, high suicidal tendency. Realising the fact that mental health is a neglected issue in India, Family Counselling Centre (FCC) were established by the Institution of Family counselling Support Services in 1999 in five districts- Satna, Rewa, Sidhi, Chattarpur and Panna. FCCs are supported financially by United Nations Fund for Population Activities (UNFPA). **Action:** Regular Counselling Services: The victims of domestic violence are counselled respecting their confidentiality and privacy. If the women are driven out of the home or family and does not have any place to stay then she is referred to the Short Stay Home

	run by an NGO or social welfare board, for some time. In the mean time the FCC sends an advance note of invitation to the clients accused one (spouse or the relative or second party) on a fixed date. The FCC interacts with and counsels the accused and the grieved client separately and then together in a family setting and tries to resolve the problem from their point of view. The counsellor tries to cure the psychological stress and trauma and helps the women in restoring to normal mental health. Counsellor, Social worker and legal advisor forms a team of FCCs. All the social workers and the counsellors of the family counselling centres of the five IPD districts have been provided training in the area of counselling by the Indore School of Social Work organized by the IPD project. Department of Health and Department of Women and Child Development plays a proactive role in the promotion of FCCs activities and restoring the psychosomatic health of women as well as family. For monitoring of the FCCs locally, an agreement was signed between the Chairperson of District RCH Society, the implementing agency of the UNFPA supported the Integrated Population and Development (IPD) project in Satna and the Chairperson of the Police Welfare Society, Satna. Advocacy Campaign: Some of the FCCs have adapted to the local settings and have got printed advocacy material in the local language. The community receives legal literacy skills relating to women's rights and child marriages. Legal Awareness Camp: The FCC team along with the police department officials organise legal awareness camps in the urban and rural areas of the districts wherein; the advocates, police officials and officials from the department of women and child development and health address the women on issues concerning to violence, reproductive health, and employment generating activities. **Results:** Total number of cases registered for the period 2001 to 2005 is 1062; out of which 849 cases were settled. The data for the period January 2003 to June 2003 are not available. However, there is clear evidence of positive impact of the FCCs on resolving of the family disputes, addressing violence against women and thus improving their mental health. The type of crime reported to FCCs are problem of dowry, domestic violence, Tension, Depression, illicit relation, alcohol / drug related, maladjustment between wife and husband.
Cost	The running cost of one FCC is rupees three lakh sixty six thousand per year (INR 3,66,000/- per year).
Place	FCCs are established under UNFPA supported programme in the five districts of MP in 1999: Satna, Rewa, Sidhi, Chattarpur and Panna.
Time Frame	It took around one and half year starting from the review, need assessment to a functional family counselling centre.

Advantages	Integrated approach: It follows a system approach to resolve the family and mental health issues and provides an inter-sectoral platform among the RCH Society, Police Department and Women and Child. Confidentiality: Privacy, confidentiality and individual rights of the client are respected. Focus on mental health: Preventive and promotive approach for psychosomatic disorders, especially among women. Women' right: Legal counselling is also made available to generate awareness among women for their own right.
Challanges	Liaison with Health department: Involvement of district health society, family planning and welfare unit for a comprehensive family care. Delayed impact: Inclusion of sensitive issues related to sexual and reproductive health that may demand slow transitional positive change in the cultural norms. Insufficient fund/ logistics: Operational difficulty in running the FCCs due to financial crunches.
Prerequisites	Expressed need for a FCC in the community, a furnished building having rooms for confidential counselling, expert team members, coordination and cooperation among health, police, social welfare, tribal welfare, IEC departments and NGOs.
Who needs to be consulted	Community (key members, marginalised sections like women, elderly, tribes), women welfare NGOs, Police Department, Social Welfare, Family Planning Unit, Naree Niketan (Short Stay Houses for Women), private sector and the project officer, UNFPA, Madhya Pradesh.
Risks	
Sustainability	Good: The Family Counselling Centres have been in operation under the Central Social Welfare Board scheme in states such as Delhi, Kerala, Maharashtra, Karnataka, West Bengal and Punjab and other states and with this new approach also it is sustainable.
Chances of Replication	The FCCs have been upscaled by the State Government of Madhya Pradesh to cover all the districts. The Department of Women and Child Development has committed funds for upscaling, strengthening and sustainability in all the districts of the state.
Comments	This reform option is good enough to empower women for legal, gender equity, equality and to assert their reproductive rights decision making; still an evaluation study is needed for statistically sound results. The issues on reproductive health and family planning require a comprehensive approach to add on the utility of the FCCs.

Contact	
Submitted By	Dr. Anil Bhola, Research Consultant, National Institute of Medical Statistics, New Delhi, November, 2006
Status	Active
Reference Files	Training Need Assessment Study.doc Terms of Reference.doc Training Module.doc Results.doc Family counseling centers in Madhya Pradesh-Manish.ppt
Reference Links	

87. Decentralised Wastewater Treatment System, Karnataka

Subject Area="Inter-sectoral links."	Objective="Better sanitation in slums."

Details for Reform Option "Decentralised Wastewater Treatment System, Karnataka"

Summary

Background: Access to good sanitation facilities is cause for concern, especially for those living in slums. Shrinking urban spaces makes defecation difficult and unhygienic. Most slum dwellers usually live without proper toilet facilities and it is women who suffer the most, as privacy is hard to come by during daylight hours.

Action: Gram Swaraj Samithi (GSS), a local non-government organization (NGO), partnered with Bremen Overseas Research and Development Association (BORDA) with funding from European Commission and the Federal Ministry for Economic Cooperation and Development, Germany. The project involved building two sanitation complexes for the peri-urban population of Ullalu Upanagara, on the outskirts of Bangalore. The sanitation complexes were fitted with Decentralised Wastewater Treatment System (Dewats); this made the wastewater suitable for reuse.

It was the first community-based sanitation (CBS) project in India that treated wastewater and harvested rainwater for use in toilets, bathrooms and for laundry. The biogas produced by the treatment plant was used for heating water, which was used by the community for hot water baths. The facility is operated by the women's Self Help Group (SHG), which is nurtured by GSS. The amount earned from the two units is INR 17,000 to INR 26,000 per month; it is used for the operation and maintenance of the facility. Surplus amounts are transferred to the SHG's bank account. The SHG is now registered as an NGO. At the outset, GSS initiated education and awareness programmes on critical issues like health, environmental hygiene and sanitation.

Thereafter, following a community needs assessment, it was found the there was willingness to own and run the sanitation project. BORDA undertook a technical feasibility study. Concurrence from the community on the proposed CBS facility was taken and important stakeholders from the community were sent to Dewats units for a hands-on experience. This enhanced the community's practical understanding of such units and their supplementary benefits. GSS involved the local government (Panchayat) from the very beginning. Community members mobilised contributions from the people of the slum area for the project.

They were also instrumental in land acquisition, supply of water and

	electricity. The project also provided political mileage to the local self-government. In 2002, initiative were taken to propagate the success of Ullalu Upanagara's Dewats by a consortium consisting of a network of institutions, authorities and organisations concerned with wastewater treatment in Bangalore with the objective to encourage adoption. **Results:** The project does not have quantitative data to show documented improvement in health status of the people who benefited directly from the project. However, in a place where no sanitation facility existed and people lived in extremely unhygienic conditions, construction of sanitation complexes provided over 700 people with toilets, bathing and laundry facilities. The utilisation of the facility has increased appreciably over the months. In addition, 18 people from the community are now employed to run the sanitation complex.
Cost	Infrastructure cost at Ullalu Upanagara was approximately INR 12 lakhs (1.2 million) for one unit. The costs involved are case specific – based on both, social and technical issues like waste water characteristics, cost of construction material, topographical conditions, existing infrastructure, land cost and demands of the beneficiary.
Place	Ullalu Upanagara, a peri-urban slum in Bangalore, Karnataka.
Time Frame	One year.
Advantages	Low Cost: The investment and maintenance cost of running eco-friendly sanitation facility are not high and the benefits are many. Environment friendly: Converting sewage to irrigation effluent is efficient waste management. Low Maintenance: Minimum skills are required to run the project. Viable: Income generation and savings through use of treated water and biogas.
Challanges	Community participation: Taking the consent of the community for setting up, operation and maintenance of the facility, a necessary step taken for the project, at times slowed things down. Legal issues: Acquiring land, agreements between involved parties, agreement for operation and maintenance are time consuming. However, once accomplished, these legal documents ensured sustainability of the project.
Prerequisites	Demand and felt need for basic sanitation services (demand-based intervention). Genuine interest of stakeholders. Good working relationship of the NGO with the community. Consent and support of the local panchayat. Government support for provision of land, water and electricity.
Who needs to	Local NGOs. Technical agency, in this case, BORDA, Consortium for

be consulted	Dewats Dissemination (CDD). Gram Panchayat and Zilla Panchayat. Revenue Department Women's groups and other Community Based Organisations (CBOs).
Risks	
Sustainability	Pay–and-Use system ensures income, employment and a sense of ownership. Earnings from pay toilets bathing rooms and sale of water (heated by biogas) are used for the maintenance of the new facility. Financial viability reduces dependence on external or government funds. The system itself is competitive and affordable (minimal maintenance cost) and can be put up with locally available material and expertise; it is also reliable. Community involvement from the very conception of the project ensures that people own the new infrastructure. And once the community gets used to its advantages it makes efforts to make it sustainable.
Chances of Replication	Being replicated by Partner network in many places—East Devadhanam,Tirucherapalli; Mahajan Nagar-Nagpur; H&A Block, KGF-Kolar, Karnataka; many other projects are underway at Tamil Nadu, Karnataka and Maharashtra. Corporate leaders like India Tobacco Company (ITC) are considering Dewats for wastewater management of their hotels while institutions such as the Aravind Eye Hospital, Madurai, are highly satisfied users since the last two and a half years. Central Pollution Control Board (CPCB), the premier environmental protection authority in India, has recognised Dewats as an effective means of pollution control. In collaboration with Rajiv Gandhi Rural Housing Corporation Pvt. Ltd. (RGRHCL) and Consortium for Dewats Dissemination (CDD) it has integrated a Dewats unit in a low-income housing colony (120 houses) in Bangalore. The Government of Karnataka has instructed all districts to integrate Dewats into all future sanitation projects under the Nirmala Nagara Scheme. The scheme is aimed at improving basic sanitary infrastructure and sanitation in all urban areas with a population of more than 100,000. Foundation for education and innovation in Asia (FEDINA) and BORDA have received an award from the President of India for their 'innovative work'.
Comments	Dissemination activities and exposure visits to this pilot project have formed a base for initiation of many sanitation projects with involvement of Government, civil societies, private parties and beneficiaries. For more on the Dewats BORDA India programme, please refer to the attached annexure.
Contact	
Submitted By	Dr. Nandini Roy, National Institute of Medical Statistics & Sara Joseph, Research Consultant, ECTA, Bangalore, July, 2006.
Status	Active
Reference	

Files	
Reference Links	

88. Nutrition Rehabilitation Centres, Chattisgarh

Subject Area="Inter-sectoral links."	**Objective="Controlling severe malnutrition among the children."**
Details for Reform Option "Nutrition Rehabilitation Centres, Chattisgarh"	
Summary	**Background:** Acute malnutrition is an extremely common condition associated with the high rates of mortality and requires specialized treatment and prevention interventions. As per the National Family Health Survey III, the prevalence of malnutrition in Chattisgarh is 52.1 percent and of stunting is 45.4 percent. Thus, almost every second child in the state is chronically malnourished. Anganwadi centres lack specialised care that is needed for treating severe malnutrition. They only provide spot feeding, monitor weight and nutritional status of the children and refer severely malnourished (Grade III and IV) children. **Activities:** The (NRC) initiative is a program for severely malnourished (Grade III and IV) children of the age 1 to 5 years. It is presently organized in a tent on raised platform in Dhornapal area of Dantewada district. The Unicef- Raipur branch office provides technical assistance in terms of knowledge sharing and facilitation. The department of women and child development (DWCD) has purchased utensils for cooking and serving. The cooking is done by aanganwari workers and their helpers (from the Integrated Child Development Scheme). Medical Officer from the nearby primary health centre evaluate every child and follows up the children requiring critical care. Auxiliary Nurse Mid-wife (ANM) and community volunteers of CARE organization facilitate maximum attendance of the children and their mothers at the nutritional rehabilitation centre. Nutrition Rehabilitation Centres are providing: (i) Medical Care (ii) Timely, adequate and appropriate feeding to the children (iii) Training on preparation of low cost nutritious diet from locally available stuffs (iv) Enhancement of mothers' skills on child care and feeding

	(v) Special diets (prepared by cooks) for severely malnourished children according to their age and condition (vi) Monitoring of the health and nutritional status of the child during the stay at the nutrition rehabilitation centre (vii) At the time of discharge, the parents or care-takers are given a follow-up card, through which a child is followed up four times up to six months **Results:** The NRC is in its initial phase and the results are not yet very evident. However, its feeding services are being implemented properly
Cost	Establishment cost: Tent Supply INR 34000 Utensils: INR 10000 (provided by DWCD) Technical Support: INR 18000 (provided by UNICEF). Recurring Cost: Fuel cost varies on day to day basis Approximately INR 24 per day and per child enrolled.
Place	Dhornapal area of Dantewada district in Chattisgarh
Time Frame	One week
Advantages	Specialized focus care: severely malnourished children get proper medical and nutritional care. Greater Sensitization: mothers and caregivers will be more sensitized towards nutritional needs, balanced diets and safe feeding practices. Inter-sectoral involvement: the close coordination of the welfare department and community increases the effectiveness and utility of the initiative.
Challanges	Coordination and cooperation: maintaining a continuous commitment from the DWCD is a huge challenge. Erratic food supply: Food supply often is erratic. Its streamlining is a challenge.
Prerequisites	Baseline data need assessment, supportive environment, and advocacy. Government or private building near to the district hospital or block community health centre. Minimum 20 bedded ward with latrine-bathroom at district level and a 10 bedded ward at block level. Kitchen with enough space for feeding demonstration and child friendly environment. Essential Staff: one paediatrician or any doctor trained by a paediatrician, one feeding demonstrator, one cook, three nurses, three care takers and one cleaner.
Who needs to be consulted	State government. Department of women and child development. Health and family welfare department. UNICEF. Health professionals working in the field of paediatrics. Anganwari workers and health workers. NGOs working in the field of child

	care
Risks	
Sustainability	Project can be sustained through persistent coordination and cooperation among the collaborative partners
Chances of Replication	The initiative can be replicated in similar settings. Unicef is planning eight nutritional rehabilitation centres in the year 2007 in collaboration with department of health and family welfare and department of women and child development; in blocks with high malnutrition.
Comments	It is a good initiative involving collaboration among health, woman and child welfare, NGOs and social sectors.
Contact	
Submitted By	Dr. Anil Bhola, Research Consultant, National Institute of Medical Statistics, New Delhi, December, 2006.
Status	Active
Reference Files	
Reference Links	

89. Sishu Sanraksan Maah, Chattisgarh

Subject Area="Inter-sectoral links."	Objective="To promote child survival and to reduce under five child mortality and morbidity"
Details for Reform Option "Sishu Sanraksan Maah, Chattisgarh"	
Summary	**Background:** A national workshop on micronutrients was organized by the Indian Council of Medical Research (ICMR) in November, 2003. It recommended that the biannual child health and nutrition promotion months be held six months apart which would offer a package of child health and nutrition services with Vitamin A supplementation to target children as an integral part. The recommendation is in line with the globally used REACH (Regular Events to Advanced Child Health) strategy which focuses on providing contact points for delivery of child friendly health services to pre-school children.According to the National Family Health Survey III, only 12.7% children (of age 12-35 months) in Chattisgarh received a dose of Vitamin A in the last 6 months, 81% children (6-35 months) are anaemic and 52.1% (under 3 years of age) are underweight in the state. As per the Coverage Evaluation Survey, 2005, the immunization coverage of BCG, DPT 3, OPV 3, measles and fully immunized children (12-23 months) was 89.2%, 65.5%, 46.4%, 72.0% and 44.4% respectively. In order to promote better child survival and reduce under five morbidity and mortality rate, the Government of Chattisgarh announced October and April as the health and nutrition promotion months in the name of “Sishu Sanraksan Maah (Child Protection Month)” in all the district of the state. The first “Sishu Sanraksan Maah” was celebrated in October, 2006 (on all Tuesdays and Fridays of the month excluding holidays).This inter-sectoral initiative is a collaborative effort of the state Department of Health and Family Welfare, Department of Women and Child Development (DWCD), State Health Resource Centre, Micronutrient Initiative, Child in Need Institute and Unicef. **Activities:** The Sishu Sanraksan month involves delivery of service package on health, nutrition and immunization days. It includes: (i) Administration of Vitamin A doses to eligible children (aged 9 months to 3 years) who have not received Vitamin A in the past 6 months. (ii) Administration of vaccines to eligible beneficiaries-focussing on never or partially vaccinated. (iii) De-worming of children (aged 1 to 5 years) having signs or symptoms of worm infestation. (iv) Weighing of all children upto 3 years of age and referral of children with severe malnutrition. (v) Salt testing at the household of pregnant women, school (mid day meal) and anganwari centre (spotfeeding) for iodine content. **Results:** It is a new initiative and so far only one ‘Sishu Sanraksan

	Maah' in October, 2006 has been celebrated. The impact of this initiative is yet to be studied.
Cost	The initiative received financial support of INR 26.5 lakhs from the Micronutrient Initiative and UNICEF for activities like IEC, training of health workers, mobility and accommodation support, printing and supply of recording and reporting formats.
Place	All the districts of Chattisgarh.
Time Frame	Two months.
Advantages	Enhances child survival: The focussed approach on child health, nutrition and immunization will have a positive and promotional impact on child survival. Inter sectoral Coordination: Inter-sectoral coordination among various departments, NGOs, private and public sector institutions will yield high dividends in terms of improved visibility and coverage.
Challanges	Leadership and commitment: Strong leadership and administrative commitment at district levels are critical to the success of the initiative. Involvement of DWCD needs to be enhanced. Delay in submission of reports: There was a delayed submission of concurrent evaluation report from the districts to the state. Difficulty in identifying children with worm infestation: It was observed that the health workers were finding difficulty in identification of children with worm infestation. The guidelines need revision for the April, 2007 round.
Prerequisites	Vaccine, nutrition and supply requirements. Identification, categorization and prioritization of villages and urban units in the area. Identification and mobilizing of left-out/drop-out children IEC and social mobilization plan. Supervision Plan.
Who needs to be consulted	State Health Directorate Chief Medical Officer Deputy Commissioner Panchayat Body Members
Risks	
Sustainability	The coordination and cooperation among the collaborative partners requires persistence.
Chances of Replication	The initiative can be replicated in similar settings. The operational plan is based on the routine immunization area microplan; already in practice.
Comments	None
Contact	
Submitted By	Dr. Anil Bhola, Research Consultant, National Institute of Medical Statistics, New Delhi, January, 2007
Status	Active

Reference Files	
Reference Links	

90. *Institutional Service Monitoring Report, Tamil Nadu*

Subject Area="Health information systems."	**Objective="Performance monitoring to improve services."**
Details for Reform Option "Institutional Service Monitoring Report, Tamil Nadu"	
Summary	**Background:** There was no consistent reporting of institutional activity within Tamil Nadu's health system, especially with regard to Primary Health Centres (PHCs), prior to 1999. **Action:** The implementation of an Institutional Service Monitoring Report (ISMR), funded initially by DANIDA. PHC staff are asked to fill in a computer-readable form every month which gives details of: (i) Outpatient and inpatient attendances, (ii) Deliveries, (iii) sterilisations, (iv) minor surgery, (v) laboratory investigations, (vi) vaccines administered, (vii) Indian system of medicine out patients etc. The form was designed after careful consultations at all levels including PHCs and considerable effort was invested in sensitisation and training of all those concerned. These record forms have been produced as bound registers in different colours and numbered. Similar registers are also maintained at the Sub Centre and First Referral Unit (FRU) levels. The form is filled out monthly and sent to the statistical section of the Public Health Directorate of the State Department of Health and Family Welfare for analysis. They use an "Optimum Mark Reader" (OMR) which scans each form and permits, by means of a computer link, the tabulation, consolidation and analysis of a number of parameters. The information is analysed for each level of the health care system: PHC, health unit district, health district and state. By the 10th of the month, the data for the previous month is submitted by the districts to the statistical department. By the 15th, it is scanned, consolidated and analysed and sent to the Chief Minister and to the Health Minister and his senior officials. By the 20th of the month, feedback is provided to the District Collector and field level staff through the district. **Results:** The Institutional Service Monitoring Report (ISMR) has proved to be an excellent tool for constructive criticism leading to better service. Since its introduction, there has been much greater awareness of performance levels which are discussed in review

	meetings at both district and PHC levels. Substantial improvements in activity levels have been recorded which appear to be directly linked to the implementation of monitoring. Between April 1999 and April 2004, the proportion of PHCs (out of 1,413) carrying out deliveries rose from 40% to nearly 90%. Average daily outpatient attendances at PHCs rose from 68 to 116 (60% of this increase took place in the 8 months following the introduction of monitoring).
Cost	Total Costs: INR 2,000,000 including: Printing of OMR sheets: INR 100,000 Printing of registers: INR 700,000 Training of staff: INR 200,000 OMR scanning machine (a one-off cost) and annual maintenance cost: INR 1,000,000 (€17,915)
Place	Tamil Nadu. Autumn 1998 - December 2003 under the DANIDA project. This has since been continued by the State government and is now part of their regular reporting process.
Time Frame	Formation of expert group to decide the selection of indicators: one month. Proposal to funding agency: one month. Proposal to government for getting orders: one month. Discussion with stakeholders: one month. Pre-testing forms: one month. Printing of forms: two months. Procurement of OMR equipment and computer accessories: one month. Procurement of software for analysis: two months. State level training of the use of forms: one month. District level training: one month. PHC level training: one month.
Advantages	Simplicity: The monitoring forms are easy to fill in. The process at PHC level is manual so that no computer skills or equipment are needed. However, the forms are computer readable so even the analysis is very simple and easy to implement. Speed: The system allows quick and comprehensive analysis and feedback. Shortfalls and lapses are highlighted and queries are raised. Reasons for good or bad performance are elicited through query and discussion. Information: Knowledge of the workload has also permitted more rational allocation of staff.
Challanges	Accuracy essential: As with any statistical system, the information obtained is only as good as the accuracy of the input. It is therefore important to monitor regularly the quality of the data recorded. Increased workload: Possible opposition from PHC medical officers and district officers who may see this activity as an additional responsibility.
Prerequisites	-- Funding support to sustain the activity. -- Willingness of the department to internalise the activity. -- Availability of trained personnel.
Who needs to be consulted	Programme officers. District health managers. State & district level staff. PHC medical officers and statistical staff.

Risks	
Sustainability	The Danida funding support was withdrawn from December 2003 onwards but the ISMR monitoring system was taken on by the Directorate of Public Health & Preventive medicine department from 2002. Now ISMR is part of the regular reporting system of the directorate and functioning very well. Based on its success, a PHC outreach services monitoring format (OSMR) is also being developed (August 2004) and is expected to become operational soon.
Chances of Replication	This simple and effective system would appear to be easily replicable. Andhra Pradesh also runs a Health Management Information System.
Comments	Securing ownership of the scheme through careful preparation of personnel at all levels is an important contributory factor to the success of the scheme.
Contact	
Submitted By	Sara Joseph, ECTA, New Delhi. September 2004
Status	Active
Reference Files	PROD69.jpg Registers filled in by the Village Health Nurse at sub-centre level
Reference Links	

91. Performance rating of Primary Health Centres, Andhra Pradesh

Subject Area="Health information systems."	Objective="Performance monitoring to improve services."
Details for Reform Option "Performance rating of Primary Health Centres, Andhra Pradesh"	
Summary	**Background:** The existing Health Management Information System (HMIS) was failing to provide an adequate communication link between Primary Health Centres (PHCs) and state government, resulting in ineffective monitoring and evaluation of public sector health programmes in the community. **Action:** In order to improve the primary health care services, the Government of Andhra Pradesh's Department of Health and Family Welfare introduced a Performance Rating System (PRS) first at Community Health Centres (CHCs) and later at PHCs. The PRS used measurable outcomes of a PHC as indicators: (i) total number of out-patients treated, (ii) number of women given ante-natal care, examined and counselled for HIV/ Prevention of Mother to Child Transmission (PMTCT), (iii) number of institutional deliveries at the PHC, (iv) number of children immunised, (v) number of at-risk pregnant women referred, (vi) number of maternal and infant deaths audited. Various expected levels of achievement as a percentage of the population covered are determined as benchmark measures and performances are measured against them. Different weightings are given to each indicator. They are aggregated and graded as A, B, C and D.
Cost	This addition to the existing HMIS does not require additional cost except for the additional stationery and time required to calculate performance rates.
Place	Andhra Pradesh. 1998 – 2002.
Time Frame	Three to 6 months.
Advantages	Incentives: (Non-monetary) to PHC staffs who wants to achieve a high grade for their centre. Even stronger if the results are made known to the community. Service: Encourages a higher rate of institutional deliveries. Simplicity: It uses primary health care indicators and is easy to calculate.
Challanges	Misleading statistics: The performance ratings cannot be looked at in isolation. Other factors eg number of staff working at PHC/drug supply etc should be taken into account to assess the

	real situation.
Prerequisites	-- Government support. -- Development of performance rating tool. -- Statistical personnel services at various levels. -- Supply of reporting formats. -- Time schedule for submission of reports. -- Provision of computers.
Who needs to be consulted	State government. Officers looking-after the MIS including the PHC Medical Officer (MO), Chief Medical Health Officer (CMHO) at the district level.
Risks	
Sustainability	Is cost effective, easy to implement and provides an incentive to each PHC.
Chances of Replication	Each state can devise its own performance rating tool to suit its requirements.
Comments	The PRS was developed as part of the multi-sectoral Andhra Pradesh Economic Restructuring Project, in cooperation with the World Bank.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	
Reference Links	

92. Rationalised and computerised Health Management Information System (HMIS) for Public Health Information, Himachal Pradesh

Subject Area="Health information systems."	Objective="Performance monitoring to improve services."
Details for Reform Option "Rationalised and computerised Health Management Information System (HMIS) for Public Health Information, Himachal Pradesh"	
Summary	**Background:** The existing information system (mostly running as part of the vertical disease control and Reproductive and Child Health programmes) was inadequate for the changing needs of the health system. Also for reasons of poor data quality it was neglected as a tool to support and improve decision-making and lacked the necessary ownership and commitment of its users. In addition, recording health activity data and merging the various registers was a time consuming process, which overburdens health workers. It involved completing 13 registers and preparing monthly reports. **Action:** A modified Health Management Information System (HMIS) system was started in 2002 as a pilot project in three districts (Hamirpur, Bilaspur and Kangra district) with the help of the German Agency for Technical Cooperation in India, GTZ. The basic theme was of “Reliable Data for Informed Decisions” specifically aimed at public health and NOT hospitals. In the new system the following modifications were introduced: (i) Family Health Card (FHC): Health workers gave an FHC to each family at the time of annual survey. It has 22 sections. Each section has information related to the 13 different registers maintained by the health workers (See References). The basic data captured in the FHCs not only related to the RCH programme, but also to other vertical programmes like RNTCP, Blindness, Leprosy etc. In the FHC, the wife of the earning member is considered the household head. The card is kept by her and is brought every time a family member visits a health facility where it is filled by the Auxiliary Nurse Midwife (ANM). (ii) Family Health Register (FHR): For each village one register is maintained by the ANM. This register includes information on all the sections covered by the FHC. (iii) Monthly report compilation: This is prepared by the ANM in a format assigned by the Reproductive and Child Health Programme (Form no. 6) for each sub centre. The major departure from the earlier existing Form-6 was the inclusion of other vertical health programmes. An other “new” feature was that Form-6 was to be filled by all the health institutions, whereas earlier, it was filled only by Sub Centres.Services related to RCH and other

	vertical programmes, that were delivered by Primary Health Centres (PHC) but not captured in Form-6, were captured in Form-7.Similarly, services of hospitals at sub-division and district level that were not captured in Form-6 were captured in Form 8. (iv) Computerisation of data entry and analysis at the block level: Sub Centres report monthly through Form-6, PHCs through Forms 6 and 7, and hospitals (sub-district and district level) through Forms 6 and 8. These forms not only capture service statistics (related to vertical programmes) for each facility, but also include "input" statistics like supplies and consumables, staff, etc., related to these vertical programmes. The lowest level of computerisation is at the Block level, where data captured in Forms 6, 7 and 8 by all the health institutions in the Block is entered in a tailor made HMIS software (Front-end – "Visual Basic", and Back-end – "Access"). After data entry, aggregate reports at PHC level and Block level are generated by the software, which is used for monthly feedback meetings at Block level. The aggregate data is transferred (through Floppy) to District level computers, where data for institutions above Block levels are also entered, and then an aggregate district report (Form-9) is generated by the software. This report is used in monthly meeting at district level. The data is then transferred from the district to the state level server, where various state level reports are generated. Also, in the software, there are checks and cross-checks for data entry, which helps in weeding out unscrupulous data. **Results:** Evaluation of the modified reporting system is underway but it has definitely reduced the health worker's workload in filling in records and reports by reducing the number of registers. Authentic data in the form of disaggregated information (for each individual health facility) and also aggregated form (at PHC, Block, District and State level) exists for all vertical health programmes. The software also generates ranking reports and graphs for easy and quick performance monitoring at all levels of health facility.The generation of feedback to the sub centre has also helped the PHC Medical Officer (MO) monitor the reasons for poorly performing ANMs in different sub centres. This information is used for review and action at all levels in monthly review meetings.
Cost	A revised format of Family Health Cards was from UNFPA, printing of which was supported by the Basic Health Project HP. After initial installation of hardware and software along with basic training in the handling of computers and software, approximately INR 10,000 per annum per block is required on average to meet out the variable costs.
Place	The new HMIS was piloted in three districts namely, Hamirpur (computers at Block as well as District), Bilaspur (computers only at District) and four of the twelve blocks in Kangra (computers at pilot Blocks and District), starting in 2002. After successfully piloting for more than a year, it was decided to roll out to all the

	remaining districts, with computers at all the Blocks. At present (October 2005) the new HMIS is functional in all 12 districts of Himachal Pradesh.
Time Frame	Development and modification of the data entry forms (Forms 6, 7 and 8) took around nine months through a series of consulting workshops with users at all levels. Development and stabilisation of software took around a year, although adding new features is an ongoing activity. Installation and orientation of users takes around two days per site, with additional "Basic Computer Training" of two weeks.
Advantages	Saves time: Number of registers maintained by the ANM is reduced from 13 to one. It has eliminated the duplication of information in many registers as well as saving worker's time filling them. Performance monitoring: Comparison of the performance of the ANMs by sub centre helps to provide a better understanding of reasons and gives ways to improve them. Improved managerial decision making: Quick access to reliable information and visual graphical display on the health facility's performance helps identify problems and possible solutions with the existing constraints. Rationalised allocation of the resources: It is possible to rationalise and reallocate resources in almost real-time, to address any emerging health problem (like sudden increase in infant deaths, communicable diseases, in some particular areas).
Challanges	Maintenance of software: Training was not given at the CHCs for maintaining software so every time there was a problem the headquarters at Shimla had to be approached. Cards lost: Around 5-10% of FHCs are lost in each district. For this reason and because there is a migrant population, cards must be redistributed periodically every 5 years. Sceptical users at field level: Some view computerisation as additional burden.
Prerequisites	Training: ANMs need one day's orientation training from their supervisors / MO to maintain the FHC and FHR.Statisticians also need training in additional software (Excel, Access, Windows) and in same basic hardware maintenance. Identification of users need and projection of the financial resources: clear identification of the needs of the users in the foreseeable future is needed, along with the funds for procuring hardware and development of the software (either in-house or through outsourcing).
Who needs to be consulted	Users at all levels and technical experts.
Risks	

Sustainability	It is easy to implement and cost effective in terms of finance and time. But it does depend on the level of commitment of managers at district and state level, availability of funds for procurement, development, maintenance and trainings.
Chances of Replication	Can be replicable in any other states of the country. However the reporting hierarchy of health institutions have to be defined and mapped before adopting the HMIS software.
Comments	It can form the base for decentralised health plans, involving public health and national health programmes. For smooth running, it is essential to have commitment towards the new system at all levels; along with a problem solving attitude, rather than fault finding attitude. But care now needs to be taken that a dual reporting system does not evolve during the establishment of the State's new HMIS system which itself is in the transition phase.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, April 2006.
Status	Active
Reference Files	HMIS-HP.ppt
Reference Links	

93. Health Management Information System, Kerala

Subject Area="Health information systems."	**Objective="To improve the quality of healthcare services by providing a state-of-the-art reporting system using e-connectivity."**
Details for Reform Option "Health Management Information System, Kerala"	
Summary	**Background:** Kerala is widely regarded as a model state within India because of its high achievements in the field of health and family welfare at low cost. However despite its relatively low infant mortality rate and high life expectancy, recent studies have found that the cost of health care is increasing while the quality and quantity provided through the public sector is decreasing. As a result the Government of Kerala decided to set up a state-of-the-art Health Information Management System (HIMS) in order to monitor the effectiveness and performance of the health care system using e-connectivity and to provide a more meaningful, time-efficient reporting system from grass-roots level up. **Action:** In November 2003, the Centre for Development of Advanced Computing (CDAC), Trivandrum, was engaged by the Sector Reform Cell of the Directorate of Health Services (DHS) to prepare a master plan for setting up a HMIS in Kerala. Accordingly, CDAC conducted a year-long study of the information requirements and the existing reporting system. To do this, the CDAC project team interviewed officers from DHS, District Medical Offices (DMOs), Primary Health Centres (PHCs) and Community Health Centres (CHCs). It produced a report of the findings, inferences and conclusions of the team, with recommendations for maximising the effectiveness of the HMIS. The report recommended: i) Hosting the Administrative applications and Health Services Data Collection & reporting module centrally in one server for remote access. All software developed for this project will be loaded onto the central server and PHCs and other healthcare institutions will enter data and send it to the central server via the internet. If a computer is not available at the PHC, the data is to be sent to the DMO who will then enter it on their behalf. ii) Computerisation of 14 DMOs of the DHS. Data which is currently entered by hand onto a paper report will now be entered by browser-based data entry. DMOs will be given training under phase 2 of the project. There is no provision for additional staff. iii) Networking of DMO Offices to DHS. The two have already been connected by the internet under the RCH programme. iv) Development of Software. **Results:** See References for the full masterplan. The project is not yet up and running but is in Phase 2 (implementation). This entry will be updated once the HMIS is in place.

Cost	Phase 1 (development of masterplan) – INR 8 lakhs. Phase 2 (implementation) – INR 169 lakhs
Place	Kerala.
Time Frame	Phase 1: One year. Phase 2: Expected to take one year.
Advantages	Time efficient: A centralised system with online access across the state will enable quick collection and dissemination of information. Improved planning: Up-to-date information will enable more informed decision making.
Challanges	None perceived.
Prerequisites	A review of the existing computerisation and reporting system across the state.
Who needs to be consulted	Director of Health Services. Additional Director of Health Services (Planning).
Risks	
Sustainability	The central server will be maintained by the state government. There is also an additional budget provision from the Government of Kerala of INR 25 lakh to the Directorate of Health Services (2005-06) but this budget is expected to vary from year to year.
Chances of Replication	Good if the funding and political will is there. CDAC is willing to share the software – cost to be negotiated.
Comments	None.
Contact	
Submitted By	Dr K Sandeep, Technical Secretary, Sector Reform Cell, Directorate of Health Services, Kerala. March 2006.
Status	Active
Reference Files	

HMIS Master Plan.doc	Masterplan for the Health Management Information System, Kerala: Report of the study and recommendations; CDAC, Thiruvananthapuram.
HMIS Kerala revised.ppt	Powerpoint presentation: HMIS, Kerala, by State Government of Kerala, January 2006.
Appendix to Report Templates.doc	Appendix to Annexure I, Report Templates.
Acronyms.doc	Acronyms used in Master Plan.
Anneure III GIS Integration.doc	Annexure III: GIS Integration.
Annexure I Requirement Specification for HMIS.doc	Annexure I: Requirement Specification for HMIS.
Annexure II Generation	Annexure II: Generation of a typical

	of a Typical Report.doc	report.
	Annexure IV Human Resources Portal .doc	Annexure IV: Human Resources Portal.
	Annexure VI Akshaya Project .doc	Annexure VI: Akshaya Project.
	CoverPageReport.doc	HMIS Master Plan cover page.
Reference Links		

94. Integrated Diseases Surveillance Project, Goa.

Subject Area="Health information systems."	Objective="Optimum utilisation of the resources by timely collection of data to control epidemic of the diseases."
Details for Reform Option "Integrated Diseases Surveillance Project, Goa."	
Summary	**Background:** Integrated Diseases Surveillance Project (IDSP) was started by Government of India to detect early warning signals of any impending outbreaks. Goa was included in the second phase i.e. from 2005. **Activities:** In order to operationalise the IDSP in Goa, MoU was signed between State of Goa and centre on August 2005. Goa State Surveillance unit and Goa State Surveillance Committee were formed under the chairman ship of the Secretary (Health). State Epidemiologist was appointed as State Surveillance officer as well as member secretary for both the committees. At district level, District collector is the chairperson whereas district surveillance officers are the member secretaries. IDSP cell in Goa became fully operational from 1st April 2006. The reports are received by the District Units from the Primary Health Centres. In order to encourage the peripheral medical officers for timely reporting, INR 1000 is given to them at a time. They are allowed to pay bus fares for the informants and medical officers are asked to keep a record of the payments made in a register. On exhausting the amount, the record is submitted to the District Unit to get a further amount of INR 1000. This has a dual effect- 1) Though the informants, who are usually the peons or other Class IV staff, are entitled to get TA/DA for their tour, it is a cumbersome process and so they are happy to receive an on-the-spot payment of bus fare. 2) The Medical Officers in charge of the PHC are anyway authorised to make payments of upto INR 1000 without being questioned by any other authority, so they find this sum handy. Thus in one stroke we achieve two results- The staff is happy to feel important (as they feel that someone has the consideration to pay them in cash for their efforts) and the Medical Officer is also happy that he does not have to request or beg the informant to take the report to the district. It is seen that this small gesture (incidentally, the amount involved for the whole state is less than INR 10,000 per month, which, when seen as an investment towards preventing many diseases, is very meagre) leads to richer dividends, since the informants feel encouraged and work better in the implementation of other National Health Programmes as well due to the change in their attitude.

	Results: Since the weekly reports are received regularly, the needed action is possible to be taken well within the time to show the maximum impact on the outcome. For example, there are many instances where a PHC has reported a little higher number of cases. The Surveillance Unit could alert the respective PHC to this fact and monitor the situation from the District or State to tackle the suspected outbreak in time. Moreover, the fact that the reports are received within a week's time adds to the effectiveness of the control measures by tackling a disease within its incubation period.
Cost	Capital cost incurred in the establishment of the IDSP cell was approximately INR 50 lakhs and recurring cost is about 15 lakhs per annum.
Place	Goa State
Time Frame	Approximately one year from planning to implementation.
Advantages	Timely collection of data: The above system of Data Collection helps in the timely collection of data from periphery. Zone wise analysis: Computerised analysis gives an opportunity to take out zone wise information to take decisions.
Challanges	Coordination with other programme official: To get coordination with the programme officials for reporting of a particular programme may pose unnecessary problems in smooth functioning. Frequent transfer: Frequent transfers of the trained staff create a hindrance.
Prerequisites	Training to medical officers at PHC. Computer infrastructure up to the peripheral level
Who needs to be consulted	State Surveillance officer Health secretary
Risks	
Sustainability	Good. Instalment of the computers and training of the concerned official to operate it is one time capital cost but system provides cost benefit in terms of efficiency and timely decision for impending outbreak.
Chances of Replication	Good.
Comments	Timely collection and analysis of data helps in taking rational decision with available resources before a disease become a menace.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, ICMR and Ms P.T. Subha, Dy Director, FSU Bangalore, CBHI. Feb, 2007

Status	Active
Reference Files	
Reference Links	

95. District Mental Health Programme, Tamil Nadu

Subject Area="Access to service and coverage."	Objective="Mental health."
Details for Reform Option "District Mental Health Programme, Tamil Nadu"	
Summary	**Background:** There are an estimated 70 million mentally ill people in India, but only 4,000 psychiatrists and 200 psychologists, meaning that just 10% get treatment. **Action:** A mobile psychiatric team, consisting of a psychiatrist, social worker, statistician and Medical Officer (MO) was established in three districts in Tamil Nadu, to visit each hospital and Primary Health Centre (PHC) in a district once a week. The team's aims include treatment, training and Information Education and Communication (IEC) as well as rehabilitation. The programme also organises mental health festivals and trains PHC staff. MOs are given 15 days training, paramedicals 10 days training and non-medical personnel [eg Panchayat (local council) members and teachers] three days training. It has also set up self help groups for the relatives (mostly wives) of the mentally ill. **Results:** (Madurai and Ramnad districts, Tamil Nadu) Number of patients treated rose from 210 in July 2002 to 1,209 in July 2004. In 2002-3 100 PHC MOs were trained to diagnose and supervise treatment. In 2003-2004 50 PHC MOs were trained.
Cost	For 2003 to 2004 INR 62,600 was spent on drugs. INR 98,000 was allotted for 2004-2005. The District Administration allocated INR 24 lakhs or the construction of a rehabilitation centre for the mentally ill. Training, IEC activities and stationery costs (2002-2003) INR 7,50,000 (€13,327) in both districts. Funds allotted for 2003-2004: 4 lakhs (€7,103) (two lakh for each district).
Place	Trichy district since 1998 and Madurai and Ramnad districts since 2001, Tamil Nadu.
Time Frame	Information not known.
Advantages	Access: Increases access to care for the most needy and vulnerable. Training: Extends training into the community. Integrated: Decentralises care from hospital level down to community level. Public awareness: Educates/raises public awareness in the community.
Challanges	None perceived.

Prerequisites	Availability of psychiatrist. IEC materials.
Who needs to be consulted	State Government health services departments. Primary Health Centres and MOs.
Risks	
Sustainability	Has been operating successfully in Tamil Nadu since 1998.
Chances of Replication	Similar schemes are ongoing in Andhra Pradesh, Assam and Rajasthan. The Government of Tamil Nadu has asked the Government of India for INR 10 Crores to extend the programme to 9 more districts in the state.
Comments	None.
Contact	
Submitted By	Clare Kitchen, Research Consultant, European Commission Technical Assistance, New Delhi. September 2004.
Status	Active
Reference Files	DMHP-Madurai.ppt — Powerpoint presentation: District Mental Health Programme, Madurai District. PROD78.jpg — Dr Ram Subramania with patients at the District Mental Health Programme at Chellampatty PHC, Madurai district
Reference Links	

96. Reproductive Child Health outreach camps, Tamil Nadu

Subject Area="Access to service and coverage."	**Objective="Improved outreach services."**
Details for Reform Option "Reproductive Child Health outreach camps, Tamil Nadu"	
Summary	**Action:** Outreach camps are held on a fixed day of the month at the Health Sub Centre to provide Ante Natal (AN) care and child care. Mothers and children are given basic health check-ups and advice on diet and basic healthcare. Pregnant women are encouraged to undergo an institutional delivery and high-risk cases are identified and referred to Primary Health Centres (PHCs) or hospitals. The camps are staffed by: One lady doctor One Village Health Nurse (VHN) One educator One laboratory technician. Each pregnant woman is given a book in which their AN care is recorded. **Results:** Each outreach camp records the numbers who attend; the numbers who receive AN care; the numbers referred; the number of contraception/sterilisation offered; lab tests done.
Cost	Each camp costs approximately INR 300 to 400 (serving an average population of about 4,000 people). Initially funded under the RCH1 scheme which gave INR 2 lakh and INR 2,000 per block per month.
Place	Tamil Nadu since 1997.
Time Frame	One month: Government Order. One month: District micro plan.
Advantages	Accessibility: Provides services to those who cannot afford the time or money to travel to a PHC. Systematic: Always held on the same day of the month (eg the first Tuesday) so patients can easily remember.
Challanges	None perceived.
Prerequisites	Availability of a team to travel to the camp.
Who needs to be consulted	State Government health services departments. VHNs.
Risks	
Sustainability	Requires funding.
Chances of Replication	It is a simple, effective idea for extending coverage but requires adequate funding.
Comments	None.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. September

	2004.
Status	Active
Reference Files	PROD79.jpg — Women queuing at a RCH outreach camp at Thimmarasanaickanur Sub-centre, Madurai district.(15 September, 2004) PROD79-1.jpg — Medical Officer checking a pregnant lady's blood pressure at RCH outreach camp, Thimmarasanaickanur Sub-centre, Madurai district PROD79-2.jpg — Block Extension Educator speaks to women at Thimmarasanaickanur RCH outreach camp, Theni District
Reference Links	

97. Training of Traditional Birth Attendants, Maharashtra

Subject Area="Access to service and coverage."	Objective="Improved outreach services."

Details for Reform Option "Training of Traditional Birth Attendants, Maharashtra"

Summary	**Background:** Training of Traditional Birth Attendants (TBAs) began in Satara in 1978. The eastern region of Satara district is drought prone while parts of the western belt are particularly hilly, with many small villages unapproachable during parts of the year. In the year 2000, home deliveries accounted for 32% of all births, 11% of those were by untrained birth attendants. Two thousand dais had been trained in Satara district by March 2001, but the number of women actually working was only 862. **Action:** The need for safe delivery services was recognised as a high priority in Satara and formed one component of the Satara District Action Plan of the Sector Investment Programme (SIP) supported by the European Commission. It was also taken up under the government Reproductive and Child Health (RCH) programme. The aim was to identify the different skills required by midwives, or dais, at each level, and to train and re-train to develop those skills. The broad strategy involved: (i) Identification of areas where TBAs were not available (ii) Identification and training of previously untrained birth attendants (iii) Involvement of communities to ensure deliveries by TBAs if not institutional deliveries. Suitable institutions - Primary Health Centres (PHCs) or private hospitals – were chosen in which to conduct the courses. Trainers, auxiliary nurse midwives (ANMs), from the selected centres were trained and a training schedule of two weeks was finalised. Taluka Health officers and Medical Officers from the relevant PHCs were called upon to verify all the deliveries conducted by TBAs and also give hands-on training. Course components include: (i) immediate newborn care (ii) instruction on breast feeding practices (iii) prompt referral to First Referral Units (FRUs) when necessary (iv) immunisation (v) family planning advice. Once trained, the dais are given a kit consisting of 23 items of basic equipment necessary for conducting deliveries. These include: plastic sheets, gloves, blades and scissors, kidney tray, soap, forceps, clamp, nail brush, shaving kit, disinfectant, scales for newborn weighing. A follow-up strategy is conducted by the ANMs and, for the first two years, a concurrent evaluation of the scheme was carried out by development NGO, BAIF, appointed by the Health and Family Welfare

	programme in Satara. A delivery status review is given at monthly Village Health Committee meetings. The women are paid a nominal fee of INR 100 (€1.77) on completing the training but since they are not regular health workers they are subsequently not paid a salary, although they do receive payment in kind, such as gifts of food from the family of the newborn. They remain as support to the health system rather than becoming part of it and are responsible only for deliveries. Post-partum monitoring remains the role of the anganwadi workers. **Results:** Between December 2001 and January 2005 the following results were achieved: I. 480 dais were trained II. Hospital deliveries increased from 68% to 84% III. Home deliveries decreased from 32% to 16% IV. Total deliveries by trained birth attendants increased from 89% to 97.6% V. The infant mortality rate (IMR) was reduced from 24.1 to 18 VI. The maternal mortality rate (MMR) was reduced from 0.74 to 0.6 VII. The total fertility rate (TFR) was reduced from 2.3 to 2.1
Cost	First year (September 2001 to March 2003) grant approved: INR 4.55 Lakhs. Total expenditure: INR 608,984 Second year (April 2003 to December 2004) grant approved: INR 7.91 lakhs Total expenditure: INR 572,830 Third year: INR 25.10 lakhs (€44,571) proposed and approved but activities yet to be started Costs for first and second years included: Training: INR 1300 (€23) per dai. 160 trained in first year, 137 in second year. Total (€6,822) Kits: 1850 per kit. (120 bought in first year: INR222,000 (€3,926). 200 bought in second year: INR 370000 (€6,542)) . Total: INR 592000 (€10,472) Delivery disposable packs: INR 20 x 7500 (€2,663) Extra costs were incurred for developing the Dai training module and for duplication of cassettes and provision of incidentals.
Place	Satara district, Maharashtra
Time Frame	One year, 10 months. During which time workshops and meetings were conducted at district level and a District Action Plan (DAP) devised. The DAP was finalised and submitted to the government in March 2000, and finally approved by the GoI and EC-SIP members on 31st August 2001. Implementation of activities began on 1st September 2001.
Advantages	Cost effective: a simple intervention aimed at women already working in RCH. Localised: TBAs selected from areas identified as 'low coverage' . Standardises care of mother and newborn: over-rules use of 'traditional' or superstitious treatments. Increases access to care: in some areas TBAs are the only source of care available during pregnancy and childbirth. Advocacy: One important role of trained dais is to encourage women

	to seek further skilled care if necessary.
Challanges	Low literacy level of TBAs: illiteracy sometimes poses a problem during training.
Prerequisites	No government orders are needed but Village Health Committees must be strengthened so as to create awarness of the benefits of institutional deliveries or deliveries by trained persons. Launching Behavioural Change Communication activities in villages is also integral to the success of the scheme. All deliveries in remote villages must be evaluated. ANMs must support TBAs by offering hands-on training during field visits.
Who needs to be consulted	State Family Welfare Bureau: Assistance needed to arrange training for untrained birth attendants. Women's self help groups: At village level, to raise awareness of dangers of using untrained birth attendants and promote safe deliveries. Medical Officers: Needed to conduct monthly reviews of deliveries in each village.
Risks	
Sustainability	Good. Although success in some areas depends on linking TBAs to a functioning health care system.
Chances of Replication	Good, since lack of TBAs is invariably a problem in India
Comments	
Contact	
Submitted By	Tessa Laughton, Research Consultant, ECTA, New Delhi. March 2005.
Status	Active
Reference Files	trained dai with newborn, Maharashtra.jpg — trained dai with newborn, Maharashtra trained dais outside PHC, Maharashtra.jpg — trained dais outside PHC, Maharashtra
Reference Links	

98. Primary Health Care and RCH Services in urban slums, Uttar Pradesh.

Subject Area="Access to service and coverage."	Objective="Improved outreach services."

Details for Reform Option "Primary Health Care and RCH Services in urban slums, Uttar Pradesh."

Summary

Background: The state of Uttar Pradesh is the most populous in India. According to the 2001 census, Varanasi has a population of 3,138,671 (Rural- 1,878100 & Urban – 1,260,571). The Ramakrishna Mission Home of Service (RKMHS), Varanasi has been working in this area for 124 years. They have a 100-year-old, 230-bedded secondary and limited tertiary care hospital. A Public Private Partnership (PPP) between the State Government and RKMHS was developed to provide primary health care and Reproductive and Child Health (RCH) services in eight identified slums of Varanasi City.

Action: Services are delivered through a mobile medical van and Community Health Workers (CHWs), trained by the RKMHS, thrice a week. The van contains the following:

(i) Gynaecologist, General physician, Pharmacists (two), Nurse and support staff (two clerks and one driver). (ii) Patient examination facility where internal examinations, Intra-Uterine contraceptive Devices (IUD) insertion and minor operations can be conducted. (iii) Medicine dispensing counter (iv) Audio-visual display facility (v) Washing area The following services are provided on a weekly basis: (i) Curative primary health care including provision of essential medicines to residents, (ii) Vaccination of children for prevention of six major communicable diseases, (iii) Routine ante-natal care, (iv) Family planning services: oral contraceptive pills, condoms and IUD insertion, (v) Health education, (vi) Referral services to Ramakrishna Mission Home of Service hospital which provides free consultations, investigations, hospitalisation, operations, medicines and dietary services at a minimal cost. However, the hospital does not provide obstetrics services for which pregnant women are referred to district hospital and medical institute hospital (BHU Varanasi). There are two CHWs who visit the assigned slums regularly and provide antenatal care, family planning supplies and health education regarding primary health care and mother and child health services. They also maintain all the data regarding the various services.

Results: (i) Evaluation survey has been undertaken in the identified slums covered under the project. The survey shows considerable increase in the reach of RCH services in the slums, covered by this project. ANC check-up coverage has touched 91%

	in Baulia slum, from 29.76% at the time of beginning of the project. Iron and Folic acid coverage stands at 89.8% from 31.15% in J.P. Nagar slum area. In Misirpur slum, tetanus toxoid coverage (two doses) is 100%. (ii) Outreach mobile primary health care services and RCH services are being provided to 34571 beneficiary patients in eight identified slums and neighbouring areas, from 30th March 2004 until May 2006. Patients coming from a distance of 50 to 100 km have also benefited. Apparent reason for the popularity of outreach services have been availability of assured quality of primary health services at the minimal/ no cost (for Below Poverty Line patients, the services are free of cost). (iii) Out-reach RCH services have begun in these slums and 6328 women have been treated for gynaecological problems from 8th June 2004 till May 2006. (iv) Transformational Health Education Workshop conducted over 9 days two sessions. (v) Health education group meetings have been conducted by the gynaecologist in the slums with good results in family planning coverage. (vi) In service training workshops held for Community Health Workers.
Cost	Estimated Cost for slum out reach and Health education for five years is INR 20,000,000. The break-up of costs is approximately 46% for slum outreach and 54% for heath education.
Place	Eight identified slums in Varanasi city of eastern Uttar Pradesh
Time Frame	Six months. Approved in Principle: September, 2003; MOU formally signed with Government of UP: Jan. 2004 First cache of funds received: Feb. 2004. Work began in April 2004; it took two months to streamline the whole process. Work could begin very fast because outreach primary and mother and child health care required minimal infrastructure [the old mobile van was used until the new one was ready and doctors and paramedics sat in the open under the shade of a tree or veranda]. It took two months time to custom build a new mobile van and the same length of time to identify the slums and to train CHWs and other staff.
Advantages	Professional community based service coverage: RCH service delivery is done through CHWs. Improved access to professional services: Highly qualified individuals provide services to the underprivileged and poor persons especially women and children in urban areas. Economical: Infrastructure needs minimal and near zero administrative overheads and Popular among the target beneficiaries. Human Resource Development: This is inherent to the entire program.
Challanges	Highly qualified individuals required: Health Care depends on the

	availability of highly qualified individuals. Government involvement: Involvement of government machinery at various levels with its inherent problems of non-responsiveness [barring healthy exceptions] and instability in form of transfers. Potential conflicts with vested interests.
Prerequisites	MOU between government and implementing agency.
Who needs to be consulted	State / District Health Authorities. NGO management. Community leaders.
Risks	
Sustainability	Sustainable and scalable provided mutual respect and trust continues along with flow of funds.
Chances of Replication	Very good chances of replication. However, resource constraint is a major hindrance; especially smooth and timely fund.
Comments	None
Contact	
Submitted By	Dr Arti Bahl, Research Consultant, CBHI, New Delhi, September 2005. Last Updated: November 2006.
Status	Active
Reference Files	
Reference Links	

99. Effective Mini Reproductive and Child Health camps organised by Primary Health Centres, Gujarat

Subject Area="Access to service and coverage."	**Objective="Improved outreach services."**
Details for Reform Option "Effective Mini Reproductive and Child Health camps organised by Primary Health Centres, Gujarat"	
Summary	**Background:** According to the World Bank, about one-third of the total disease burden in developing country women aged 15 to 44 is linked to reproductive health problems, yet health facilities at the community level in Gujarat were poorly equipped to deal with gynaecological and obstetric morbidities because they did not have the diagnostic facilities, the skills or the drugs to treat them. What was needed at the PHC level were facilities for routine diagnosis of gynaecological problems, improved obstetric care, sensitive counselling and sound referral services. **Action:** The Indian Institute of Management, Ahmedabad, (IIM-A) proposed a camp approach as an intermediate solution till regular services were available at the PHC and sub-centres for the reproductive child health (RCH) programme. It would also give a higher level of services closer to the community on a periodic basis. Initially, it organised a RCH camp every three months at each PHC level. The dates were fixed in advance and the community was informed about it by the Auxiliary Nurse Midwives (ANMs) and the Anganwadi Workers (AWWs). The paramedic staff identified women and children requiring this service and facilitated their attendance at the camp. Specialists were arranged from the nearby medical college. PHC ensured adequate privacy and proper sterilisation of equipment needed. Several counters were set up for registration, history taking, laboratory tests, counselling, medicines and health education. The camp offered services like examination of children by a paediatrician, growth monitoring and immunisation, gynaecological examination of women, lab diagnosis of anaemia, urinary tract infection, pap smear for early detection of cervical cancer, examination of high risk ante-natal cases, referral for further diagnosis and treatment, treatment of all childhood diseases and women's diseases. On an average, 141 women and 60 children attended each RCH camp. The camps were then made smaller, but more regular (eg once a month). One gynaecologist attended each camp to ensure a good rapport between the specialist and the PHC staff. Paediatric cases were seen by the PHC's medical officer (MO) and referred if

	needed. The PHC staff conducted most of the activities related to the camp. Most of the camps planned (40/ 55) were conducted in one year. On an average 35 women and 25 children attended. Lastly, the MO in the PHC was given the responsibility of organising a fixed-day RCH clinic at the PHC. The MO was to assure the presence of the specialist and to access additional medicine. A new record proforma was designed which mentioned individual case history, etc. **Results:** On an average, 200 cases were attended to in large camps and 63 in mini camps. Since both the camps had availability of specialist and adequate privacy, RTI problems were detected in about 50% of women complaining about their problems. More than 8% were cases of infertility. The clients were either treated or referred for further investigation and treatment.
Cost	A large camp cost INR 60 (€1.07) per client, while a mini camp cost INR 48 (€0.86) per client, when organised externally (ie by IIM-A). A mini camp organised by a PHC cost INR 19 (€0.34) per client. The medicine cost approximately INR 9 (€0.16) per client in all the above camps. It is clear that 'other costs' incurred for organising large camps are higher than for mini camps.
Place	Sanand Taluka, Gujarat. May 1996 to January 1999. Post 1999, continued by the state government. In September 2004, 150 out of 1068 PHCs in Gujarat were carrying out the camps at a rate of two per PHC per month.
Time Frame	Six to eight months.
Advantages	Manageable: Mini camps are easier to manage by the PHC staff and it increases person-to-person contact between the service providers and the clients. Strengthens the referral system: Patients now meet the specialists from nearby town or from the Community Health Centre (CHC). Training: PHC staff got hands-on training from specialists and specialists learnt the realities of PHC and village level care and became more sensitive to rural patients.
Challanges	Can get marginalised: Mini camps need to be supervised on a regular basis else they run the risk of being sidelined due to several other tasks/ activities of the PHCs. Continuity: Changes in the PHC staff may affect the effectiveness of the mini camp because the new staff have to be trained once again.
Prerequisites	Co-operation of the PHC MO and staff. Availability of willing specialists to attend the camps. Cooperation of the district health officer and district Panchayat.
Who needs to be consulted	District Panchayat; district health officer; state government; PHC medical officers; private medical practices who will be offering their services for free.

Risks	
Sustainability	It is sustainable once the PHC MO is trained to plan and organise mini camps as a routine activity. It can be better implemented if it is conducted under active supervision of an external agency like IIM - A.
Chances of Replication	Good. The state government took over and continued this programme. The National AIDS Control Organisation (NACO) also adopted a similar strategy.
Comments	Large numbers of clients attending the services at the camps indicated a large unmet need of the community. Women prefer female doctors but are prepared to be examined by male gynaecologists if a woman is not available. Overcrowding of a large camp can affect the quality of the service. Medicines like vaginal tablets and higher antibiotics are not in the rate contract list at the PHCs and have to be supplied from outside.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	
Reference Links	

100. Improving access to healthcare in urban areas through re-structuring, community involvement and operational autonomy, Lucknow, Uttar Pradesh

Subject Area="Access to service and coverage."	Objective="Improved outreach services."

Details for Reform Option "Improving access to healthcare in urban areas through re-structuring, community involvement and operational autonomy, Lucknow, Uttar Pradesh"

Summary

Background: Uttar Pradesh (UP) is the most populous state in India. Lucknow, the capital of UP, has an estimated population of about 21.85 lakhs, with (2001 census) with some 500 odd slums accounting for about one-third of its population. However, the existing healthcare infrastructure was set up in 1976 for a population of just 8 lakh. Even now, only about 38 - 47% of births take place in health care facilities. In mid 2000, Lucknow was chosen as one of the cities to be taken up under the national component on urban Reproductive and Child Health (RCH) under the Sector Investment Programme being implemented in partnership with the European Union.

Action: This programme sought to improve the Maternal and Child Health (MCH) indicators by: (i) Using an existing network of resident volunteers in slum areas to provide counselling, first-aid and detection of emergencies. The members of this network, called Resident Community Volunteers (RCVs - one RCV for every 25 families), were given additional training under the project to improve their counselling and organisational skills. After the 6-day training, the RCVs put together a Swasthya Ghar or health home - a small room in one of their homes where they stock supplies given to them and conduct meetings/consultations with the local women. (ii) Strengthening existing maternity homes to provide essential and emergency obstetric and neonatal care on a round-the-clock basis. Merging smaller units and staff re-location were key initiatives to improve sustainability of additional investments made. Enhancing operational autonomy for the Chikitsa Sudhar Samities (facility level management committees set up by the state government before the project started) was another policy intervention. (iii) Setting up of additional facilities to serve the outer parts of the city. Merger of smaller units and staff re-location were again the priority while determining the input needs. These activities are supported by complimentary investments in Information, Education and Communication (IEC), training and capacity building. The project started with the creation of an integrated District Health and Family Welfare Authority by merging existing vertical societies of national

	programmes. Two types of NGOs are involved to support service delivery. (i) The first type of NGO acts as a link between the slum population and the District Health and Family Welfare Agency through the network of RCVs. They provide performance-based compensation to the RCVs. (ii) The second type of NGOs organise service delivery through charitable or private hospitals in slum areas that are not yet covered by the RCV network. The initial task in such areas is to hold health camps. **Results:** The progress has been slow but steady in the last six years. The initiatives are beginning to take root and the performance data indicate early signs of a positive impact.
Cost	Estimated cost: Initial plan (in 2001) outlay of INR 165 lakh followed by roll-over plan (year 2002) outlay of INR 260 lakh and 2nd Roll Over Plan outlay of INR 321 lakh. The funding mechanism is Performance-based Funding (PBF). For every agreed plan cycle, a set of milestones are agreed upon with the values assigned (to the individual milestones) on the basis of an assessment of requirement of funds.
Place	Lucknow City, since early 2001.
Time Frame	Six months.
Advantages	Improved access to services: particularly for the poor, increase in institutional deliveries, increase in immunisation coverage levels and couple protection rate and improved management of obstetric emergencies. Functional autonomy: For programme managers leading to better ownership, community participation in improving their healthcare and involvement of NGOs in service delivery.
Challanges	None perceived.
Prerequisites	Situational analysis, consultations with stake holders, involvement of policy makers in the government and technical assistance to the planners.
Who needs to be consulted	* Directorate General of Family Welfare, Government of Uttar Pradesh. *Chief Medical Officer and Secretary, District Health & Family Welfare Authority, Lucknow. * European Commission Technical Assistance.
Risks	
Sustainability	The programme is sustainable.
Chances of Replication	It has been replicated and similar programmes are running in other states also.
Comments	None.
Contact	
Submitted By	J P Mishra, Programme Adviser, European Commission Technical Assistance, New Delhi. July 2004. Last Updated: November 2006.

Status	Active
Reference Files	Aliganj Bal Mahila Chikitsalaya evam Prasuti Grah (Maternity Home) before repairs.jpg Aliganj Bal Mahila Chikitsalaya evam Prasuti Grah (Maternity Home) after renovations and repairs.jpg Ms Renu Yadav, Community Health Volunteer (CHV) at the Sikandar Pur Swasthya Ghar.jpg Presentation October,2003 URCH Lucknow.zip
Reference Links	

101. Jeevan Suraksha Programme, Gujarat

Subject Area="Access to service and coverage."	Objective="Improved outreach services."
Details for Reform Option "Jeevan Suraksha Programme, Gujarat"	
Summary	**Background:** Self Employed Women's Association (SEWA) has been working in Gujarat to improve the health status of women in the unorganised sector since the mid 70s. However, in its course of work and interaction with members, SEWA realised that simply curative services are not enough to improve the women's health. It needs a change in the mindset of the women, who give the lowest priority to their own health. Therefore, the need was felt for health promotion services, especially in the area of reproductive and child health. **Action:** Under a tripartite arrangement between SEWA, United Nations Population Fund (UNFPA) and Government of India (GoI), Jeevan Suraksha Programme was launched for poor women in November 1999. Geographical coverage of the programme was limited to four districts—Kheda, Patan, Anand and Ahmedabad city. It was based on strengthening of the public system rather than creating a parallel system. The main focus of the programme was to protect the health of the members and their families by improving access to healthcare and also helping women to prevent or detect the diseases at an early stage. Camps were organised for diagnosing Reproductive Tract Infections (RTI) and Sexually Transmitted Diseases (STD), for providing mother and child health and family planning services. Medicines were made available at a very low rate in the camps, subsidised by project funds. Camps were organised in collaboration with private practitioners or Medical Officers (MO) of the Primary Health Centre (PHC) in that area. A total number of 297 camps were organised in 2000, 333 in 2001 and 290 in 2002. The presence of such a large gathering of women at these camps also gave an opportunity to build awareness among women and adolescent boys and girls on issues of reproductive health and gender. This education focused on simple, useful and basic lessons on reproductive healthcare, sexual hygiene. UNFPA provided funding and technical guidance for the project. **Results:** Change in the mindset, which is evident through increased participation of men and adolescent boys in the health programmes and enhanced sensitivity of the government health service providers towards the poor. Figures are not available, but the demand for education on reproductive and sexual health resulted in the formation of a men's cooperative; this cooperative

	plays an active role in immunisation programmes.
Cost	The cost per camp was up to INR 5,000. Government infrastructure was sometimes utilised with SEWA bearing the mobilisation cost. All other support was provided by UNFPA.
Place	In four districts: Kheda, Patan, Anand and in Ahmedabad city in November 1999.
Time Frame	Approximately one year.
Advantages	Awareness generation: Sensitisation of adolescents and pregnant women has helped in creating an environment conducive to delivery of health services. Demand generation: Awareness generation has led to felt need, thus generating the demand for services, especially for treatment for RTI/STDs. Male involvement: Participation of men was encouraged in the reproductive health programme; this makes the decision-making process on reproductive health issues easier for women.
Challanges	Working women: Coordinating with the working women, to make an additional demand on their time, has posed a challenge to involve them in the programme. Quality of service: Only identifying patients who need referral for complicated procedures is not enough. Linkages have to be made with a view to providing quality service to the referred patients. Male participation: Changing their mindset and bringing them into the stream of reproductive health issue needs a lot of effort by health care providers. But once they get involved, they provide a new momentum to the health services delivery.
Prerequisites	Agreement with the involved agencies (UNFPA and GoI).
Who needs to be consulted	Local Chief District Health Officer. State officials. Primary Health Centre Medical Officers. Donor agency representatives.
Risks	
Sustainability	Certain key elements in the programme have been adopted for their lasting impact. For example: Project's linkage with government programme rather than creating a parallel system. Involvement of local private practitioners. Involvement of men in decision-making. Implementation through local associations or cooperatives.
Chances of Replication	The project was extended to all the blocks of Ahmedabad district.
Comments	In the unorganised sector, reproductive health is a neglected issue. Creating a felt need leads to a demand for services. Awareness generation and involvement of men in the decision making process are key factors here.

Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics May, 2006.
Status	Active
Reference Files	
Reference Links	

102. Catch-up Rounds to Increase Immunisation Coverage, Jharkhand

Subject Area="Access to service and coverage."	Objective="Improved outreach services."
Details for Reform Option "Catch-up Rounds to Increase Immunisation Coverage, Jharkhand"	
Summary	**Background:** When the new state of Jharkhand came into existence in November 2000 there was very little to rejoice about on the health front. Clearly, there was much that needed to be done. Routine immunisation coverage was only around 9%. More than 35% children did not receive any immunisation at all. It was also observed that complete immunisation (three doses of DPT and Polio, one dose of BCG and Measles) among the children aged 12-23 months was only 10%, and 8 out of 10 children suffered from anaemia. A base line survey found that there was a huge gap in infrastructure, skilled manpower and logistics. **Action:** Given the poor health infrastructure in the state, the government had to take immediate steps to reach routine immunisation and other preventive medicines to the maximum number of people, particularly infants, children and pregnant women. In July 2004, therefore, the Ministry of Health and Family Welfare conducted a pilot Catch-up Round in 7 of Jharkhand's 22 districts. The Catch-up Round was conceived of to catch up with those who got left out in the normal course of health service delivery. It is a month-long drive that takes a basket of preventive and promotive healthcare services to make it available in the immediate neighbourhood of the community. Catch-up Round is an additional effort over and above the normal routine immunisation and other RCH services. It is a bi-annual operation, each round lasting for one month, followed by subsequent doses of vaccines like DPT. The first round was carried out from 1st to 31st July 2004, covering 75 blocks in 7 districts. It provided only 4 items—measles vaccine, Iron Folic Acid (IFA) tablets, deworming tablets and Vitamin A syrup to boost supplementation of the micronutrient among children and pregnant women. In the second round, in December 2004, Tetanus Toxoid (TT) injection was added and coverage was extended to all 22 districts. The following year, from June 2005 onwards, the basket of preventive and promotive medicines included all antigens, IFA tablets, deworming tablets, measles vaccine and vitamin A supplementation; additional services like counselling for contraception, screening for malaria, sputum collection for tuberculosis were also included. This comprehensive package of

	services began to be provided twice in the year in a camp mode. **Results:** (i) Immunisation coverage increased to 38% in 2005-06 from 9% in 1999-2000. (ii) Provides coverage to 140,000 children. (iii) Provides coverage to 300,000 pregnant women and lactating mothers.
Cost	The total cost for each round is approximately INR 40 to 50 million.
Place	The first Catch-up round was piloted in July 2004 in 75 blocks in 7 districts: Ranchi, East Singhbhum, Lohardaga, Seraikela Kharsawan, Gumla, West Singhbhum, Simdega. By the next round, in December 2004, the entire state was covered.
Time Frame	Planning the programme and programme logistics took around one year.
Advantages	Package of services: Basic preventive and promotive medicines are provided to the community twice in a year. Extensive coverage: The camp mode makes sure services reach the last house of the last village.
Challanges	Cold chain: Especially during summer rounds; maintaining the vaccines at the desirable temperature is one of the most difficult tasks, more so when distances are long and road transport to interior villages almost non-existent. Procurement: Estimation of the demand and getting together the supply of consumables including medicines is rigorous exercise for programme officers. Mobilising the community: Raising the awareness of the community and mobilising them to avail of the services in their locality is also critical for wider coverage. IEC/BCC: As literacy level is very low among the tribal population, they also face language and cultural barriers. Developing user-friendly communication material, to spread the right message, poses a great challenge to service providers.
Prerequisites	Planning and reporting formats. Training of the staff. Stakeholder involvement like NGOs, private sector, faith based organisations. Logistics and material management.
Who needs to be consulted	Donor AgenciesNGOs, faith based organisations, private sector State Government, Community Based Organisations (CBOs)
Risks	
Sustainability	Sustainable, as there are many donors and technical assistance agencies working in collaboration with the state government. NGOs, faith based organisations are also involved in the implementation.
Chances of	Replicable in similar situations, where there is a history of low

Replication	performance.
Comments	Camp mode Catch-up Round can be continued for only a limited period; it has to be taken over by routine immunisation over a period of time. Therefore, there should be a simultaneous strengthening of the routine process as well. The presence of Angan Wadi Workers (AWWs) in the area gives an opportunity to reach the community and creates convergence with the Department of Women and Child Development.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics,May, 2006.
Status	Active
Reference Files	
Reference Links	

103. Provision of essential maternal and child health services in Tribal Areas, Rajasthan.

Subject Area="Access to service and coverage."	Objective="Improved outreach services."

Details for Reform Option "Provision of essential maternal and child health services in Tribal Areas, Rajasthan."

Summary	**Background:** The State of Rajasthan has one of the highest recorded maternal mortality rates (670 per 100,000 births) in India. The situation is due to poor socio-economic conditions, non-availability of trained health personnel in rural areas and traditions surrounding marriage and childbirth. Eighty-five percent of deliveries in rural areas take place at home and most of the communities rely on a dai (traditional birth attendant) or relatives for delivery care (National Family Health Survey-2, 1998-99). Recognising the need for sensitive and affordable health care for women in small towns and rural areas, Non-Government Organisation Action Research and Training for Health (ARTH) started a Reproductive and Child Health (RCH) clinic in 1997 in Kumbhalgarh block, Rajsamand district. The goal was improvement of maternal-neonatal health and survival by providing midwives trained in safe motherhood and neonatal health interventions in a rural community. In addition, it aimed to enhance the role of panchayats (village level government) and men in the family, to contribute to safe motherhood. The clinic served a cluster of 10 villages with a population of 11,500 and was located 5kms from the nearest Primary Healthcare Centre (PHC). **Action:** In 1999, the programme was expanded to cover 27 villages and in April 2003, one more RCH centre was started in Kadiya, Udaipur district with provision of 24-hour delivery services. The programme area has now expanded to cover a total of 50,000 population covering 45 villages in two clusters covering Kumbhalgarh block (Rajsamand district) and Gogunda and Badgaon blocks (Udaipur district). The programme involved: (i) A baseline survey to establish the extent of the reproductive health needs of the community, more than half of which belong to scheduled castes and tribes. This is repeated every 3-4 years.(ii) Establishing adequate staffing at the health centres: Five nurse-midwives for two health centres who provide 24-hour delivery services. Support from doctors including specialists (gynaecologist, paediatrician and public health professionals) who visit twice a week. Two clinic attendants who cleans the premises and linen. This support helps motivate the nurse-midwives to stay in station. Seven health workers/ field supervisors. Two field worker-cum-driver with

	motorcycle who drives the nurse-midwives to emergencies and field visits. (iii) Community involvement: Each village has a tribal woman working as a health volunteers or Swasthya Sakhis who carry out community based education & distribution and accompany women & children to health centres if needed. They are trained to give information on nutrition, newborn & child care, maternal care, safe abortion and contraception. (iv) Training: All the nurse-midwives were from Kerala or Rajasthan and had some basic training in nursing (ANM or GNM). In addition, they were given practical hands-on training on a range of reproductive health issues including antenatal, delivery & postnatal care, first aid for obstetric emergencies; reversible contraception and neonatal and child care; with use of standard guidelines and protocols adapted to Indian setting. (v) In-house Services: Since October 1999, the nurse-midwives have been providing 24-hour delivery and obstetric first aid services. In addition, outpatient services are provided on 6 days a week, while the services by doctors (gynaecologists and paediatricians) continued on two fixed days a week. The clinic provided the following services – ANC, PNC, delivery services, reversible contraception, first trimester abortion, management of Reproductive Tract Infections (RTIs), Sexually Transmitted Diseases (STDs), gynaecological conditions, and Child Health services including immunization & treatment of sick children. The clinic provided subsidies to poor women for obstetric emergencies. When a nurse identifies a problem that is beyond her competence, she stabilizes the patient, arrange transport and accompany her to the referral hospital in city. She also negotiated admission and start of treatment at the referral hospital. (vi) Outreach services: In addition, once-a-month village clinics are held by the nurse-midwives with support from field workers and volunteers on pre-designated days. The village clinics are held in one room of an Anganwadi or the house of ARTH's volunteers. The services provided at village clinic are: antenatal care, counselling, pregnancy confirmation, contraception (oral pills, condoms, follow-up doses of DMPA (this means that if first dose had been given after proper screening under the supervision of a doctor, then subsequent doses of DMPA could be given by nurse midwives), and treatment of minor ailments and childhood illnesses. (vii) Family planning: As a part of its outreach programme ARTH has been running a Community-based Education and Distribution (CBED) programme covering a range of contraceptives. Women volunteers and field workers of ARTH have been distributing condoms and oral contraceptives within the community. They refer those who want a copper-T (CuT 380A or CuT 200B) or injectable (DMPA) to the RCH centre. In the clinic, all women are given contraception counselling. It provides reversible methods of

	contraception. (viii) Referral and transportation: Referral links have been developed with the medical college and a few private diagnostic facilities in Udaipur city. Three local jeep taxis provide quick transport of nurse-midwives accompanying women needing referral to the hospital in Udaipur, at fixed cost. (ix) Service Charge: There is no consultation charge, while the drugs are provided at no profit basis (the drugs are bought at wholesale rate). All services are subsidized, and the subsidy is greater for tribal patients. Services are charged much below the market rate for example delivery is charged at INR 100 (€ 1.74) and INR 200 (€ 3.44) respectively for tribal and other castes women, 'inclusive of all drugs and supplies'. Recently, ARTH has also promoted the development of health funds (Swasthya Kosh) through 20 self help groups in its field area. The health funds range from Rupees 2000-3000 and each has 25% contribution from members of SHG and 75% contribution from ARTH. The members of SHG are required to save every month INR 5 (€ 0.093) to INR 10 (€ 0.186959).The fund is to be used exclusively for meeting the emergency health needs of women and children. (x) Drug supply: A revolving "clinic fund" was established, to procure drugs and supplies, which were sold at a not-for-profit basis. Medicines are procured from whole seller at lowest rates and are sold by adding 10% to cost of procuring it by ARTH. The cost of medicines is displayed in the clinic. (xi) Information, Education and Communication activities: IEC activities are carried out through group meetings of women and adolescents, including SHG meetings, where pictorial booklets are used. In addition, individual counselling of pregnant women and their husbands is also carried out in the villages. Delivery services are publicized through pamphlets distributed by field workers in the project villages and through personal interaction with those that visited the health centre. Both the centres started with outpatient clinics, where doctors provided the services twice a week. The first centre was upgraded to Safe Motherhood Centre (SMC) with 24 hour services in year 1999, while the second centre started providing 24 hour services in year 2003. ARTH also gets supplies from the public health system – ORS packets, iron and folic acid tablets and vaccines. It maintains registers of outpatient treatment, deliveries, contraceptives etc. Safe abortion services were started in the first centre in 1999 after two years wait for a registration certificate for the facility, and in year 2005 in the second centre. Because electricity is a problem in these areas, manual vacuum aspiration (MVA) technique and medical abortion are used for providing safe abortion. **Results:** 1. It took a few months before community started utilizing

	delivery services - only 7 deliveries were conducted in the clinic in first six months. However through continuous interaction of the nurse midwives with the community, the involvement of panchayats and the trust built by the competence of the nurse midwives that women began to use the clinic. In 2004-05, the nurse-midwives attended 311 deliveries, out of which 36 women needed referral for maternal or foetal complications. As their confidence grew, the proportion of women needing referral declined -- in 2000-01, 20% women were referred, but in 2004-5, only 11% were referred. Nurse midwives have also assisted in delivering breech babies. 2. Nurse midwives have also attended to 30 cases of obstetric emergencies in year 2004-05 who came with emergencies related to antenatal or postpartum period or abortion. 3. Nearly 2266 antenatal checkups have taken place last year in RCH centres or field clinics. 4. Nearly 8000 clients have been seen by the 2 health centres in last year with various needs – 94% of them were for reproductive or child health needs. 5. In year 2004-05, 221 women utilized copper-T services, and 104 women accepted DMPA injections on an average per month. 6. The proportion of women delivered by skilled attendants or those receiving ANC has shown significant increase, especially for women of tribal and backward communities.
Cost	INR One lakh for clinic start-up costs (includes equipment, furniture, revolving drug fund etc. for each health centre). It costs approximately INR 500,000 to run each health centre per year, This includes the cost of salaries of service team, rent, water, electricity for health centre, vehicle hire & subsidy for very poor patients & service charges for CBD agents, travel for nurse midwives, doctor & some of IEC costs.
Place	Kumbhalgarh block (Rajsamand district) and Gogunda Badgaon blocks (Udaipur district), Rajasthan since 1997.
Time Frame	Twelve months.
Advantages	Outreach services: Village level clinics are crucial in developing a rapport between nurse midwives and pregnant women. This in turn resulted in a manifold increase in delivery by nurse midwives. Delivery Care: Provision of delivery care at home and 24 hours services at the clinic increases confidence among villagers. Affordability: Availability of cost effective services including drugs near home. Targets: No target set for the nurses in achieving FP targets Since

	there are no targets, clients are being given informed choice about various methods. Similarly, there are no targets given to nurses for delivery services, but they receive encouragement when they have good caseloads.
Challanges	Human Resources: It is difficult to find trained nurse-midwives and doctors ready to work in rural areas. Presence of quacks: Many villagers have more confidence in traditional quacks than in conventional medicine and it is hard to change these traditions. . Replication: With transfer of government officers, continuity can be affected so replication of ARTH model becomes a bit difficult. Accommodation: Difficult to find a reasonable priced and suitable place to house clinic & its staff in rural areas.
Prerequisites	Provision of escort with two-wheeler mobility to nurse mid-wife. Two nurse-midwives at the health centre and assistants. Supportive supervision by doctors & ongoing monitoring & encouragement. Availability of trained nurse -midwife to work in rural areas. Good coordination with the public health systems.
Who needs to be consulted	Secretary ARTH. CMHO, Udaipur. Community. Panchayats.
Risks	
Sustainability	Sustainable if pre-requisites are put into place and there are funds available from various philanthropic individuals and organisations.
Chances of Replication	Replicable, if pre-requisites are put in place. This model is being replicated at 3 different NGO sites in Rajasthan.
Comments	ARTH is also providing the training it gives to its nurse midwives to government Auxiliary Nurse Midwives (ANMs) as well as technical know-how to set-up more clinics with local NGOs. Rajasthan State Government recognised ARTH's initiative in 2001 and the money. An award of INR 1 lakh rupees (€ 1718.09) for recognition of ARTH's contraceptive services, not fro delivery services.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, NIMS, March 2006.
Status	Active
Reference Files	scan.jpg F1040034.JPG Binder2.pdf Workprofile.pdf Binder2.pdf

Reference Links	

104. Delivery huts to promote safe delivery in the rural areas, Haryana

Subject Area="Access to service and coverage."	Objective="Improved outreach services."
Details for Reform Option "Delivery huts to promote safe delivery in the rural areas, Haryana"	
Summary	**Background:** Nearly 78% of women in Haryana deliver at home in the hands of untrained dais that puts both mother and child at risk. Promotion of clean and safe delivery practices in rural areas is a high priority strategy to reduce maternal and infant mortality in the State. In order to provide safe delivery services with in villages, which is equally accessible and affordable, delivery huts were established in the rural areas in September 2005-06. **Action:** Delivery huts are being set up with in the villages for providing services required during labour in the institutions having all facilities required for normal deliveries and referral arrangements. Old buildings of some of the subcentres / Primary Health Centres are being renovated in a phased manner to meet the cleanliness standard of a health facilities. The health department is providing the required furniture, equipments and trained staff to conduct safe deliveries. Positioning of the additional Auxillary Nurse Midwife (ANM) strengthen the delivery of services like ante natal check ups, immunisation of the mother and children, birth registration and referral services. An revolving amount of INR 10,000 has been placed in a joint account of Panchayat Raj Institution (PRI) and ANM as untied fund to meet the routine requirements including referral. **Results:** Though long term effect of the scheme is still awaited to evaluate but response in the four months has shown that – Delivery huts established –258 Deliveries conducted-4193.
Cost	State government has sanctioned INR one crore for the scheme in financial year 2005-06.
Place	All the districts of Haryana.
Time Frame	Approximate time from Planning to implementation is one year.
Advantages	Safe deliveries: Services are made available through trained personnel to the needy people. Accessible: Services are both economic and geographical accessible with in the community. Referrals: First delay in making decision for referral is tried to make shorter in the benefit of the patient.

Challanges	Trained personnel: availability of the trained personnel at the delivery hut for twenty four hour is big obstacle for smooth functioning. Infrastructure: Logistic and infrastructure needs continuous replenishment.
Prerequisites	State government order.
Who needs to be consulted	District officials PRI members
Risks	
Sustainability	Good. Scheme is self sustainable as existing resources are strengthened to deliver the services at the local level.
Chances of Replication	Good.
Comments	In rural areas more than 80 percent deliveries are home based deliveries. Establishing delivery huts and promoting delivery through trained personnel is one step ahead to promote safe deliveries among rural women.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, ICMR, June 2006.
Status	Active
Reference Files	
Reference Links	

105. Telemedicine Project, Chhattisgarh

Subject Area="Access to service and coverage."	Objective="Improved outreach services."

Details for Reform Option "Telemedicine Project, Chhattisgarh"

Summary

Background: Public health is of major concern to Government of Chhattisgarh (GoC) as key health indicators, such as infant mortality rate, maternal mortality ratio and expectation of life at birth, are far below the national average. About 80% of Chhattisgarh's 21-million population live in rural areas, of which one-third belong to scheduled tribes and one-fourth to scheduled castes. The population density is 154, which is much below the national average of 310. The state suffers from acute shortage of healthcare facilities and a lack of trained medical personnel. There are only two medical colleges serving a population of more than 10 million. Delivery of public health services becomes even more challenging where the terrain is difficult with large areas under forest cover; villages in these areas are sparsely populated and remotely located.

Action: Following the formation of the state on 1 November 2000, the government of Chhattisgarh (GoC) in 2002 published the e-government roadmap (included in References), a vision document of GoC, clearly mentioning the opportunities for harnessing Information and Communication Technology (ICT) to improve the reach of health services. One of the e-governance issues taken up by the government was telemedicine project, which aimed to provide quick medical advice and facilities to the rural areas of Chhattisgarh. The specific objectives were to enhance specialised health services, distance Continuing Medical Education (CME) and training; monitoring national health programmes and management of information system.

The GoC commissioned the Indian Space Research Organisation (ISRO) to provide the hardware and software for the project. The first step was to set up a super-specialty node at Government Medical College, Raipur and Bilaspur and link them to premier hospitals across the country. Second, to have telemedicine node at district hospitals. In the first phase, 3 telemedicine centres were set-up: Medical College Raipur, District Hospital, Jagdalpur, Community Health Centre, Marwahi. Now, all the districts have the facility. Each telemedicine centre has a separate room.

The software for communicating information about patients includes data on patient identification number, name, age, sex, location, date of sending the information, electronic medical record and referred doctor. ISRO gave 2-day training to staff identified at telemedicine centres across the state. ISRO has placed a support engineer to facilitate smooth functioning of the network. Pre-determined time slots

	have been shared with users to consult doctors at All India Institutes of Medical Sciences (AIIMS), New Delhi and B.R. Ambedkar Memorial Hospital, Raipur. The telemedicine network of Raipur is also connected to more than 150 telemedicine nodes of ISRO (As on May 2006, ISRO network covers 165 hospitals - 132 remote/rural/district hospitals/health centres connected to 33 speciality hospitals located in major cities) spread across India (see third and fourth website reference given). **Results:** The use of ICT was more frequent at the initial stages of the project. Between 2002 and 2006, Raipur Medical college received 194 electronic medical records; of which 70% cases have been diagnosed and reports sent while the rest are still pending. In addition, the Medical College has been able to conduct simultaneous training programmes for paramedical students at Raipur and Jagdalpur (Bastar district). Fortis Hospital, Noida has also shown interest to provide telemedicine services free of cost to Raipur Medical College. The slow progress seems to be result of technical snags and inadequate trained technical staff to handle the telemedicine network.
Cost	INR 40 lakhs (4 million).
Place	Medical College, Raipur and district hospitals.
Time Frame	One year.
Advantages	Reach: Extends the reach of specialist services to patients living in difficult and inaccessible areas, where it is difficult to find even a general physician in the vicinity. Diagnosis and treatment: Patients usually prefer to visit local doctors for their ailments. Therefore, telemedicine offers local doctors the required assistance for diagnosis and treatment of difficult cases Training: Where local resources are limited, the interactive medium can be effectively used for conducting training programmes. Continued Medical Education: Staff and doctors can keep abreast of ongoing advances in medicine sitting at their office.
Challanges	Staff: The telemedicine centre requires technicians to handle the operations. At the very least, part-time assistants need to be hired who will do the teleconferencing. Training: Inadequate training on maintenance of installations and equipment by ISRO to computer operators working at nodal centres is a major challenge for the smooth functioning of project. Essential facility: The telemedicine centre should have a dedicated telephone facility so as to enable the technical staff to communicate with ISRO on technical problems. Efficiency:Frequent technical snags de-motivate users. Infrastructure/connectivity: The capital cost and maintenance cost

	are considerably high. There is also need to ensure that there is enough bandwidth available for the project to continue. Besides, each district hospital has to have facilities such as X-ray, CT scan, MRI, Film scanner and equipped pathology slides so that the reports can be sent to specialist hospitals. Lack of technical support: It can take weeks for telemedicine equipment in rural areas to be repaired.
Prerequisites	Government support. Broadband connectivity with video-conferencing facility. Computers. Dedicated technical staff to manage the telemedicine centre. Demand for specialist services. Funds to set up such centres. Telemedicine training facility.
Who needs to be consulted	Government of Chhattisgarh.B.R. Ambedkar Medical College, Raipur.District hospitals. Government Doctors. Patients who have received help through telemedicine.
Risks	
Sustainability	It is sustainable if used efficiently.
Chances of Replication	It can be replicable if the government finds it a cost-effective means to improve the quality of training and provide access to specialist services in remote corners of the state.
Comments	
Contact	
Submitted By	Dr. Nandini Roy, Research Consultant, National Institute of Medical Statistics. June 2006.
Status	Active
Reference Files	
Reference Links	

106. Mobile Hospitals in Tribal Bazaars, Chhattisgarh

Subject Area="Access to service and coverage."	Objective="Improved outreach services."
Details for Reform Option "Mobile Hospitals in Tribal Bazaars, Chhattisgarh"	
Summary	**Background:** The minerals-rich state of Chhattisgarh is divided into plains in the north and plateau in the south. The terrain is difficult and it is challenging task for health service providers to reach out to remote villages, particularly the 6 predominantly tribal districts of the state. Maternal mortality rate here is much higher than the national average. The health department has to battle not only against inaccessible terrain, traditional beliefs and superstition create further obstacles preventing it from reaching care to pregnant and lactating women. **Action:** Weekly haat bazaars, or local open-air markets are a centuries-old feature of India's rural economy. This is also true for tribal areas, where on a fixed day, people come to a particular haat to sell and buy essential items such as agriculture produce, equipment, jewellery, utensils, salt and spices, among other things. These haat bazaars are usually located in the vicinity of large villages and are well connected with the outside world. The district health department considered such haats an ideal place to station mobile health clinics whereby a large population of underserved population could be reached and provided basic healthcare facilities, including first aid. The district health department has been using this strategy in Chhattisgarh more or less on an ad hoc basis. However, the state government decided to reinforce the strategy to generate awareness among the tribal population on health issues and also provide basic curative services. Two independent high level bodies were constituted to oversee the course of development in 6 tribal districts of Chhattisgarh in 2003: (a) Bastar Vikas Pradhikaran (Bastar Development Authority) was responsible for three districts located in the southern part of Chhattisgarh, namely Jagdalpur, Kanker and Dantewada and (b) Surguja Vikas Pradhikaran (Surguja Development Authority) was responsible for districts located in the northeast of the state, namely Surjuga, Rajnandgaon and Koriya. (For Role and Powers of the committees please see the reference section.) Funds were provided for the purchase of 10 ambulances, salaries of the doctor, the nurse and the driver so as to make mobile clinics a regular feature of the markets. So far, the progress has been reviewed quarterly by the two committees (see Reference for excerpts of meeting minutes). The doctors recruited under Bastar and Surguja Vikas Pradhikaran

	(B&SVK) have been attached to Primary Health Centres (PHC). The B&SVK mobile clinics serve the tribal population living in 6 most inaccessible blocks spread across 6 districts (62 blocks) of Chhattisgarh. Eighteen ambulances have been procured from funds provided by B&SVK. Besides, the district health department also sends its ambulances to those haat bazaars, which have not been covered by B&SVK mobile hospitals. The haats to be covered by B&SVK mobile clinics were identified by district and block officials based on weekly turnover of tribal population. The visit schedule of mobile clinics was shared with panchayats as well as district health machinery (details in the Reference section). At the grassroots level, it was the health workers' responsibility to publicise mobile hospitals and persuade tribals to go there during their visit to haat bazaars. There were a spurt in visits during immunisation campaigns and school health programmes, especially when done with a lot of fanfare and involvement of Aanganwadi workers and the school administration. In the remaining 10 districts, the mobile hospital project is to be implemented by Non-Government Organisations (NGOs). Ten NGOs have been selected and memorandum of understanding (MoU) signed. The MoU clearly states that NGOs will provide ambulance service free of cost to patients below poverty line (BPL). The user fee is to be decided in consultation with the district administration. Medicines will be provided by the district administration and the NGOs will distribute them free of cost to people coming to haat bazaar clinics; free medicines are for malaria, leprosy, tuberculosis and contraceptives (list attached). **Results:** Posting the 18 mobile clinics at tribal haat bazaars has shown encouraging results. In the last one year (31 March 2005 to 30 April 2006), the B&SVP mobile clinics have provided curative services to 31,524 persons from three blocks of Kanker district. Statistics available show that during the same period, the Kanker district administration, through its own ambulances, was able to serve 38,380 patients; 45 % of them were women and children and comprised 14% of the total attendees (see Reference).
Cost	Cost of 18 B&SVP mobile hospitals (see Reference): INR 78 lakh Cost of 10 Mobile ambulances for NGOs (see Reference): INR 41, 28,700 lakh. The ongoing operational cost of running the mobile clinic was not available.
Place	Bastar, Kanker, Dantewada, Surguja, Rajnandgaon, Koriya.
Time Frame	1-2 years.
Advantages	Understanding the local epidemics: The administration can get an indication of the type of health problems currently faced by tribal population living in remote corners of the state. Emergency Care: At times, mobile hospitals stationed at Haat Bazaars could immediately transport a critical patient to the referral

	hospital.
Challanges	Coverage: The doctors may not be able to serve all sections of the tribal population, such as sick persons. Follow-up services: Healthcare workers on a regular basis need to follow up with those who have sought services from mobile clinic. Continuity: Non-availability of funds for fuel can bring the reform to a halt.
Prerequisites	Mobile Van equipped with necessary facilities. Driver. Recurring cost. Fuel Doctor, Nurse and Male health workers. Convergence of Mitanin (village level community health worker), traditional healers, aanganwadi workers. Understanding the tribal culture.
Who needs to be consulted	Directorate of Health Services. Chief Medical Health Officer. NGO.Community. Doctor attached to mobile hospitals.
Risks	
Sustainability	Depends on the government's commitment.
Chances of Replication	Many states have adopted this strategy to reach out to people living in inaccessible and difficult terrains.
Comments	On non-haat days, the doctors were involved in other activities such as overseeing school health programmes, organising health camps, participating in gram panchayat meetings and also teaching traditional healers the benefits of modern medicine. Political support is essential for the progress of such hospitals as also convergence of grassroots health workers, aanganwadi workers, mitanin, traditional healers. The doctors believe their active involvement, combined with proficiency in tribal dialects will popularise mobile clinics.
Contact	
Submitted By	Dr. Nandini Roy, Research Consultant, National Institute of Medical Statistics, June 2006.
Status	Active
Reference Files	
Reference Links	

107. Telemedicine at General Hospital, Arunachal Pradesh

Subject Area="Access to service and coverage."	Objective="Improved outreach services."

Details for Reform Option "Telemedicine at General Hospital, Arunachal Pradesh"

Summary	**Background:** The major health problems causing morbidity and mortality among infants and mothers are diarrhoeal diseases, parasitic infestation, hepatitis, enteric fever and other water borne diseases. Malaria and tuberculosis are the major leading causes of death. Other diseases are leprosy, goiter, anaemia, respiratory diseases and limited HIV screening activities along with asthma. One major problem that concerns the health officials is alcoholism, which is extremely high in Arunachal Pradesh. **Action:** Information and Communication Technology (ICT) is now being used extensively to improve the reach of health services. The Government of Arunachal Pradesh launched the Telemedicine project in April 2004 in Naharlagun, which is about 10 kms from Itanagar. The main objectives of this were: To provide Continuing Medical Education (CME) training for General Duty Medical Officers on various health issues. Quick medical advice Health facilities This facility caters to the rural people in and around Naharlagun and Itanagar. The Government of Arunachal Pradesh commissioned the Indian Space Research Organisation (ISRO) to provide the hardware and software for the project. The North Eastern Council (NEC) provided also provided financial support. The Science & Technology Department of GoAP in partnership with a NGO, Health Foundation. The first step was to set up the infrastructure at the General Hospital, Naharlagun linking them to premier hospitals across the country. Second, to have telemedicine centre at other hospitals. ISRO gave training to staff identified at telemedicine centre and also lends its support to facilitate smooth functioning of the network. The GoAP conducted sessions of CME with Medical Officers at Naharlagun and specialists from Fortis Hospital, NOIDA, New Delhi on topics as follows: Management of Strokes Cardiomyopathy Seizure Disorder Cardiomyopathy Management of head injury In the first phase, one telemedicine centre has been set-up at General Hospital, Naharlagun. Each telemedicine centre has a separate room. The software for communicating information about patients includes data on patient identification number, name, age, sex, location, date of sending the information, electronic medical record and referred doctor. This is a 24-hour telesite. When a patient approaches the hospital and requires a specialist's view, the concerned hospital and doctor are approached. An appointment for

	consultation from both sides is then arranged. The telemedicine network of Naharlagun is connected to the telemedicine centres of ISRO covering more than 10 hospitals in various parts of India for example: Tata Memorial Hospital, Mumbai; Amrita Hospital, Koche Dr B Borooah Cancer Institute, Guwahati and many more premier institutes. **Results:** Encouraging results in terms of patients consulting specialists through Tele-conferencing. In one instance, as per the consultation, two cardiac patients requiring Open Heart Surgery were operated at free of cost at Narayana Hrudayalaya, Bangalore. The hospital has also promised to continue support and assist Arunachal Pradesh for such situations in future also, considering the state's remoteness.
Cost	1.5 lakhs (INR)
Place	General Hospital, Naharlagun, Arunachal Pradesh
Time Frame	Three months.
Advantages	Coverage: This was seen both in terms of increase in patients demanding the use of the telemedicine facility and also increasing the range of diseases that could now be covered in the hospital. Networking: Liasing and networking with specialist doctors at premier institutes in India. Specialist's advice at local level: Comfort level of the people to discuss their problems did not change as they were with the same doctor but in addition receiving a specialist's advice. Affordability: This facility has benefited the poor people of the state who can't afford the cost of super speciality hospital intervention, since the state does not have any cardiologists and cardio thoracic surgeons. Increasing knowledge: Besides, all the resident doctors and nurses utilise the Tele site for weekly Tele conferencing on CME programme on various selected topics and are kept updated on the latest techniques and management.
Challanges	No proper network, increase in network system is required, particularly at the district level, which is under active consideration. The General Hospital, Naharlagun will soon be transformed into a hub station for connecting all district hospitals. Lack of Resources
Prerequisites	- Broadband connectivity with video-conferencing facility.Computers. - Dedicated technical staff to manage the telemedicine centre, 24 hours. - Demand for specialist services. - Funds to set up such centres. - Telemedicine training facility.
Who needs to be consulted	Government officials who have set up the telemedicine centre. Doctors at the hospitals linked to the General Hospital telesite.

Risks	
Sustainability	Good. Telemedicine Centre at General Hospital, Naharlagun, will continue till the GoAP continues supporting. The Programme does not require huge funds so it is easily sustainable.
Chances of Replication	Good. After the positive response from this TC, 2 more new centres are being planned in other districts of Arunachal Pradesh.
Comments	None
Contact	
Submitted By	Manisha Ghose, Research Consultant, Central Bureau of Health Intelligence, and Paromita Ukil, Research Consultant, ECTA. January 2007.
Status	Active
Reference Files	
Reference Links	

108. Telemedicine at Primary Health Centres, Tamil Nadu

Subject Area="Access to service and coverage."	**Objective="Scope and quality of primary health centre services."**
Details for Reform Option "Telemedicine at Primary Health Centres, Tamil Nadu"	
Summary	**Action:** The Government of Tamil Nadu, under the Reproductive and Child Health (RCH) programme, introduced telemedicine at Primary Health Centres (PHCs) thereby linking PHCs with the nearest medical college hospital for patient consultation over the internet. The setup consists of a computer with a printer, speaker phones and a camera which is connected to the internet via cable (broadband connection is expected in rural areas late 2004/early 2005). A couple of PHC staff such as the health inspectors are trained to operate the computer and set up consultation timings with the hospital doctor/specialist. One specialist doctor is available at the hospital between 9 am and 1pm and other specialists can be called on to view a patient over the web if necessary. At other times, the enquiries can be forwarded through e-mail. The hospital can cater to 5 PHCs at a time. This facility is made available from the Health & Family Welfare department's webpage. **Results:** Still to be ascertained at the time of writing as it was still a very new initiative.
Cost	Computer equipment costs Rs. 2 lakh at each PHC. Other costs would involve training of PHC and hospital staff.
Place	Three PHCs in Theni district and 4 in Madurai district, Tamil Nadu since July 2004.
Time Frame	Procurement of computer systems: Two months. Training of PHC paramedics: One month.
Advantages	Economical: In terms of time and cost of travel to a hospital for a second opinion. Service extended: Referral process strengthened and specialist advice available at PHC level.
Challanges	Coverage: Possible only where telephone lines and reliable internet connectivity is available.
Prerequisites	Telephone lines and internet connectivity. Trained manpower. Computer equipment.
Who needs to be consulted	State and district level government staff, PHC and hospital doctors.
Risks	

Sustainability	Sustainable as it is not so costly once the initial equipment is in place.
Chances of Replication	Replicable similar scheme is being implemented in Madhya Pradesh.
Comments	None.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	PROD84.jpg — Health inspector at T. Kallupatty PHC, Madurai district demonstrating telemedicine equipment. (15 September, 2004)
Reference Links	

109. Providing 24–hour delivery services in Primary Health Centres, Tamil Nadu

Subject Area="Access to service and coverage."	Objective="Scope and quality of primary health centre services."
Details for Reform Option "Providing 24–hour delivery services in Primary Health Centres, Tamil Nadu"	
Summary	**Background:** In Tamil Nadu, many Primary Health Centre (PHC) buildings were being under utilised due to a lack of skilled personnel to conduct deliveries round-the-clock and, as in many other parts of India, the number of deliveries conducted in PHCs was very low. The clientele generally went to secondary and tertiary hospitals, the private sector or delivered at home. **Action:** It was therefore decided to provide round-the-clock services at PHCs. This was implemented in two phases. In the first instance, under the Reproductive and Child Health (RCH) Project, a model involving a high degree of medical involvement was envisaged and staffing levels of medical officers were duly increased. However, an examination of PHC performance revealed that these additional inputs in staff had not resulted in anywhere near a commensurate increase in output, in terms of either the number of deliveries or the number of outpatients treated. This was because it was difficult to ensure constant availability of a doctor, even when posted, since they generally live in the towns, not at the PHCs, and the proposed incentive of INR 200 per delivery conducted between 8 pm and 7 am was an insufficient incentive for them to travel back to work during these hours. On the basis of these results, it was decided to implement a modified version of the scheme. Since it is not possible to conduct Caesarean cases in a PHC without a gynaecologist and an anaesthetist, it was clear that the presence of qualified paramedical personnel to conduct normal deliveries was the most important requirement for improving PHC performance. In terms of medical presence, analysis of PHC attendances indicated that the critical hours were between 8 a.m. and 5 p.m. with paramedical staff available thereafter to conduct minor ailment clinics. It was therefore decided to employ three additional staff nurses, two sanitary workers (cleaners) and one driver, all on a contractual basis, to provide 24-hour services. Staff nurses are preferred for this purpose as they are better skilled in conducting deliveries, treatment of minor ailments, provision of obstetric first aid and in early identification of complications and may not require additional training. (Staff nurses undergo 3 1/2 years training with exclusive training in midwifery for 6 months)

	Results: After implementation, these PHCs showed a "vast improvement" in the Maternal and Child Health (MCH) services as shown by the increase in the number of deliveries, including those carried out at night. The number of minor ailments treated outside the outpatient hours in the PHCs have also gone up due to availability of nurses round the clock. Evaluations indicated that the increase in medical staff had little impact on the number of deliveries being carried out. The critical factor was 24-hour availability of skilled female paramedical staff. In the PHCs which instituted this regime, there was a large increase in the number of deliveries being carried out including during the night.
Cost	The monthly employment costs per PHC of three staff nurses, one sanitary worker and one driver are INR 13,500 per month .
Place	Madurai, Theni, Dharmpuri, Krishnagiri, Thanjavur, Thiruvarur and Nagapattinam districts of Tamil Nadu, since the financial year 1999 – 2000.
Time Frame	Approval of the activity by the funding agency: three months. Preparation proposal to state government, getting orders and budget allocation by state government: three months. Recruitment of staff nurses: 6 months. Despatch of orders and joining of staff nurses: one month.
Advantages	Facilitates: Makes better use of existing PHC facilities. Encourages: Institutional delivery by providing an accessible local service. Reduces hospital burden: Relieves secondary and tertiary hospitals dealing with normal deliveries.
Challanges	Possible opposition: From ANMs who may oppose the entry of staff nurses, fearing they will lose the informal payment they get from delivered mothers and fearing a threat to their existence. Nurses may also object to having to work in rural settings and in PHCs rather than hospitals.
Prerequisites	Availability of trained staff nurses. Funding support.
Who needs to be consulted	Programme officers. District officers. Director of Medical and Rural Health services to ascertain the availability of staff nurses.
Risks	
Sustainability	This programme was sustained using the RCH State Implementation Plan funds.
Chances of Replication	Good. Tamil Nadu has already up-scaled from 90 PHCs to 180 PHCs using the balance fund available under the integrated financial envelope of the national component of the RCH Project. Under the second phase of the RCH Project, the 24-hour delivery care activity plans to be extended to 700 PHCs in the state in two phases. The staff nurses who will be posted in these PHCs will also be empowered with skills to provide obstetric first aid e.g. post

	partum haemorrhage, premature labour, sick newborn etc.
Comments	None
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	
Reference Links	

110. Round the Clock Primary Health Centres, Andhra Pradesh

Subject Area="Access to service and coverage."	Objective="Scope and quality of primary health centre services."
Details for Reform Option "Round the Clock Primary Health Centres, Andhra Pradesh"	
Summary	**Background:** The 1998-99, National Family Health Survey 2 (NFHS) for Andhra Pradesh showed that non-institutional deliveries constituted 50% of all deliveries. Only 30% of the non-institutional deliveries were attended by a doctor or other health professional. Since all pregnant women are at risk of complications, they need to have access to obstetric care. Therefore, encouraging institutional deliveries conducted under the overall supervision of trained health professionals is essential to ensure better health of the mother and child. The infant mortality rate for Andhra Pradesh for the five-year period immediately preceding the survey is estimated to have been 65 per 1000 live births. This means that 7 out of every 100 children did not survive until their first birthday. **Action:** (i) 470 Primary Health Centres (PHCs) were converted into Round the Clock Women Health Centres – providing 24 hour services for normal deliveries – from 1996 in Andhra Pradesh. (ii) These PHCs have one additional ANM employed on contract basis. She is given an incentive to be available for 24 hours and is assisted by a helper. (iii) Specialist clinics are held at the PHC for women and children on a fixed day. Gynaecologists and paediatricians are hired from private or public sector to conduct these clinics. They identify and refer high-risk cases of pregnancy and childhood illnesses. (iv) These PHCs have better facilities for communications and transport - a labour room with essential medicines and equipment and a telephone facility for prompt communication. Vehicle for quick referral is also made available on a hire basis at the PHC. (v) Traditional Birth Attendants (TBAs) or Anganwadi Workers (AWWs) are given INR 50 as an incentive for motivating pregnant women to go for institutional deliveries. **Results:** There was a 6-fold increase in institutional deliveries in Andhra Pradesh during 2002-03. Institutional deliveries increased at the district level by two to 6 times during the same period. (See Table 1 in Documents and Illustrations.)
Cost	Additional cost of converting a PHC into a round-the-clock PHC: INR 471,600 (€8,489) per year (as per budget submitted to Government of India). Therefore, every additional institutional delivery required INR 3,103 . (Table showing unit cost as pre the additional budget for year for Round the Clock PHC given below.)
Place	470 PHCs in Andhra Pradesh. Initiated in 1996.

Time Frame	Around six months.
Advantages	Flexible and comprehensive: It is a flexible programme and targets remote areas where private services are not available. The package contains staff recruitment, infrastructure development and communication and transportation. Saves lives: Early detection and referral of at-risk mothers and children through frequent specialist clinics can reduce the number of deaths. Widens service reach: Regular clinics help increase the use of other services provided by the PHC.
Challanges	Cost: Round-the-clock PHCs require additional financial resources. Needs infrastructure: It requires some basic infrastructure like roads, telecommunication and electricity. Staff availability: It requires availability of specialists on a regular basis.
Prerequisites	It is important to empower the implementing organisation and maintain the management system including the key stakeholders. It is important to provide greater autonomy for management and supervision, adequate staffing and strengthening management procedures. It is important to pay attention to quality by development of technical norms, referral mechanism, clinical and management training programs and the development of performance indicators.
Who needs to be consulted	Commissioner of Family Welfare at state level and District Medical & Health Officers at district level.
Risks	
Sustainability	Good if state government gives commitment and financial investment in Reproductive Child Healthcare (RCH) is flexible enough to include innovative programmes. It is sustainable if adequate budgetary allocations are made for recurrent expenditures.
Chances of Replication	It is replicable if at the district level, a strong, autonomous implementing agency and an effective monitoring system are in place. It also would require adequate and long-term financial commitment in order to sustain in resource-poor areas. It has been replicated in 450 PHCs and it is planned to increase it to 600 PHCs (March 2004).
Comments	None
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, September 2004.
Status	Active

Reference Files	Table 1.doc	District wise increase in Institutional Deliveries
Reference Links		

111. Training of community health workers, Maharashtra

Subject Area="Access to service and coverage."	Objective="Community health workers."

Details for Reform Option "Training of community health workers, Maharashtra"	
Summary	**Background:** The District of Osmanabad is one of the most underdeveloped regions of Maharashtra. The region is drought prone and impoverished. The caste system is prevalent and the women have a low place in the society. An earthquake rocked Latur and Osmanabad districts in 1993 which left nearly 10,000 dead and another 10,000 crippled for life. **Action:** It was at this time that HALO Medical Foundation (HMF) started training and working with women of the area to provide basic health services. Bharat Vaidyas, as these women are called, were given a basic residential training of 21 days followed by three 7-day refresher courses quarterly. The topics covered in trainings are quite vast- health aspects included the primary health care set up of the government; causative factors and treatment of common diseases like diarrhoea, pneumonia, fever and STDs, HIV/AIDS; antenatal, postnatal and neonatal care; pharmacology of 20 drugs. Other topics include water and sanitation; violence against women; training in formation of self help groups and communication skills. Criteria for selection of Bharat Vaidyas are that they should be literate (educated at least up to middle school -class 8). They are recommended by self-help groups, villagers and the mahila mandal (women's group). Preference is given to widows and women from oppressed classes. She is self reliant because she collects charges directly from the community. HMF purchases drugs from LOCOST Baroda (LOCOST is a public, non-profit charitable trust that makes essential medicines for those working with urban and rural poor in India- for more on LOCOST, see link below). Every year, the list of drugs sold is prepared keeping a margin of 25%. This margin forms part of the women's incentive. Her duties include: Treatment of minor and medium illness. Registration of births and deaths. Antenatal case registration, examination and immunisation. Identification of high-risk cases and timely referral. Conducting deliveries. Conducting health surveys in the village. Organising women and forming self-help groups. Co-ordination with government health services. Promoting micro-insurance in health. In order to empower the village women and enable them to afford the fees of the Bharat Vaidyak, women are formed into self-help groups. The self-help groups generate income through various activities such as kitchen gardening, animal rearing, small businesses such as grocery shops, bangle selling, vegetable selling and tailoring. HMF

	established the Sanjeevani Mahila Bachat Sangh (a collective of women's savings groups). Each group has between 9-15 members where each member saves INR 25 per month and gets an annual interest rate of 10% on her savings. Loans are given to members from this fund for a period of 10 months at an annual interest rate of 24%, the rules and eligibility criteria for which are set by the members of the Sangh themselves. The health programme is connected to other social mobilisation activities. Social education programmes through Kalapathaks (traditional folk dancers) and social animators is another important feature of the programme. Women's self-help groups form the basic unit of mobilisation and community organisation and they act as the nodal points of awareness building and education. Other initiatives undertaken by HMF include: Savali Kendra (Women and Violence documentation and intervention centre). Training of Adolescent girls. Prevention of Mother to Child Transmission of HIV -Jeevanrakshan Project (AIDS awareness). Life and health insurance scheme for self-help group members (see separate entry on the insurance scheme). **Results:** Presently (February 2005) 64 workers are working in 54 villages. Report of the work done by Bharat vaidyas (1 January to 31 December 2004) Total villages covered 42 Total Bharat vaidya workers 47 Total number of patients examined 12,950 Patients referred 474 Total expenditure of treatment INR 46,125 Average cost per episode of illness INR 3.50
Cost	Training cost is INR150 per day inclusive of lodging, boarding, educational aids, hon. & travel for resource persons. Total cost inclusive of bag and drug kit in first 21 days training goes up to INR 5000. Costs are borne by HMF through donor funds -Indian Express Citizens Relief Fund and OXFAM supported the training costs initially.
Place	Tulajapur, Lohara and Omerga blocks in Osmanabad district, Maharashtra.
Time Frame	Six months.
Advantages	Community involvement: Village women selected by the community are trained. Empowerment: Women's empowerment through set up of self-help groups. Acceptance: Because Bharat Vaidyaks are part of the village community, they have access to the people - particularly the women in the village.
Challanges	Possible opposition: Stray examples of opposition from established quacks (also known as Rural Medical Practitioners or RMPs).
Prerequisites	Willingness of the women, availability of an institution (such as HMF) to provide technical assistance and training facilities.
Who needs to be consulted	Government health staff, experts in community health who have practically worked in the area, local community.

Risks	
Sustainability	Initial funds required to set up the training centres and provide training. Once trained the women collect fees for providing services.
Chances of Replication	Good and especially useful in places where there are no government health facilities. The programme should be designed as per the geographic location and local requirement. Linkages with the existing system are essential. It would not work if there is a duplication of services.
Comments	None.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, February 2005.
Status	Active
Reference Files	
Reference Links	

112. Counselling centre for women, Thane, Maharashtra

Subject Area="Access to service and coverage."	Objective="Support and counselling."
Details for Reform Option "Counselling centre for women, Thane, Maharashtra"	
Summary	**Background:** Violence against women is widespread in India (female infanticide; poor care of female children; dowry-related disputes) but there is very little support for victims of domestic violence. Although the abuse cuts across class barriers, the worst affected group are poor, illiterate women and as such the violence goes widely unreported. It is generally considered to be a private matter, requiring no outside intervention, be it legal or medical. **Action:** Aarohi Counselling Centre was set up in March 2001 by a Non Government Organisation (NGO) of the same name in an effort to address the dire need for support services for women in Thane, a densely populated area with a growing slum population. The centre is collaboration with the Tata Institute of Social Sciences and Thane Municipal Corporation's Integrated Population and Development project, supported by UNFPA. Worldwide research and practice has shown that the health system is an important entry point for women facing domestic violence. For this reason the Aarohi Centre is situated in a tertiary level hospital, the Chatrapati Shivaji Maharaji Hospital, Kalwa. An established link between the Outpatient Department (OPD) and the centre means doctors can refer women to Aarohi for counselling after they have been treated for physical injuries. Services at the Women's Centre include: (i) Counselling: providing non-judgemental support, explaining gender inequalities and exploring women's strengths. The process aims to prevent further episodes of violence and also to generate self-empowerment (ii) Working with couples, families and significant others including children (iii) Facilitating medical help (iv) Facilitating police help: registering and filing a complaint (v) Facilitating legal help: explaining legal rights, providing legal aid in cases of litigation (vi) 48-hour emergency shelter within the hospital (vii) Referral services by networking with other NGOs including organisations providing shelter, employment and vocational training. The centre also does outreach work in three phases: (i) Linking with the education sector, where, working with partner NGOs, they reach out to school drop-outs and adolescents from lower socio-economic groups to offer them life skills education, negotiating skills and general health information. Their strategy is preventive, involving workshops and discussion on issues such as

	gender and sexuality. (ii) At district court level. They try to sensitise lawyers by conducting workshops. (iii) Enrolling MA social science students to go out into the community and work with women. Aarohi also runs an adolescent and youth centre with a helpline attended by trained professionals. Results: While no data has yet been analysed, the Aarohi Crisis Centre has counselled more than 300 women in four years and receives two new clients per week on average, although the flow tends to vary according to the season. The response to follow-up services has been good, with some women returning regularly for four years. The number of referrals has also increased, both from within and from outside the hospital and the relationship with hospital staff is good. The helpline receives two to three calls per day on average, during the two hours that it is operational, although following a publicity drive the number of calls increases. Counsellors stress that it is a steady process. Their primary baseline is challenging entrenched beliefs about gender roles. Most women don't want to leave their homes because there is no alternative open to them. The centre's success is measured by the extent to which the women they help learn to negotiate with their husbands, to control their own finances, to assert their own rights with regard to sex or work and most importantly, to believe that they are not responsible for the violence and not to be blamed for it. They say that at all levels they can see transformation in the women.
Cost	Information not available.
Place	Chatrapati Shivaji Maharaji Hospital, Kalwa, Thane, from 2001.
Time Frame	The centre was set up after three years of research in a municipal set up.
Advantages	Support: The centre offers advice and a safe environment for women victims of violence. Education: Women are instructed on their legal rights as well as given information on common diseases such as STDs and stress related illnesses. Awareness of medical staff: Through sensitisation programmes run by the women's centre, hospital staff are made aware of the emotional and psychological damage women have suffered and are encouraged to refer them for counselling Sensitisation of youth Through life skills sessions young people learn about harmonious relationships and how to avoid violence.
Challanges	Limited reach: The crisis centre depends on women coming to the hospital for treatment before they can be referred for counselling. Dependent on referral from doctors: Medical staff concentrating on physical injuries may not know about their cause.
Prerequisites	A hospital or other medical institute with an OPD. Funding from

	donor or other areas. Dedicated team of trained counsellors with a gender sensitive perspective.
Who needs to be consulted	The hospital providing the premises (in this case Chatrapati Shivaji Maharai Hospital, owned by Thane Municipal Corporation). The organisation providing technical support and consultation (in this case Tata Institute of Social Sciences). Funding agency (in this case UNFPA).
Risks	
Sustainability	As long as link with medical staff remains strong and women pass on information by word of mouth the program is sustainable.
Chances of Replication	Prerequisites need to be met.
Comments	None.
Contact	
Submitted By	Tessa Laughton, Research Consultant, ECTA, New Delhi. February 2005
Status	Active
Reference Files	
Reference Links	

113. Adolescent Health Programme, Kerala

Subject Area="Access to service and coverage."	Objective="Support and counselling."
Details for Reform Option "Adolescent Health Programme, Kerala"	
Summary	**Background:** Almost one-third of India's population is young and faces significant risks related to sexual and reproductive health. It is therefore important to influence the health-seeking behaviour of adolescents in order for the next decade to witness rapid improvement in health indicators. The State Government in Kerala had noted that there was a low level of awareness regarding sexual and reproductive health among adolescents and a lack of proper facilities to deal with these problems in the State. **Action:** The State Government devised an Adolescent Health Care Project. The first step was to devise a project manual and teaching module which were completed by June 2005. See both in Documents and Illustrations (below). The State Child Development Centre assessed existing data and reports on Adolescent Sexual and Reproductive Health (ASRH), mapped services available and prepared a directory of resource persons and materials. The Family Life Education (FLE) Module covers Life Skill Education, AIDS Awareness and ASRH with the focus not just on subject content but on social acceptability and appropriateness of language. The FLE components include: (i) Adolescent nutrition – needs and issues relating to obesity. (ii) Personal hygiene – relating to urinary or reproductive tract infections. (iii) Identity crisis – body image, psycho-social competence. (iv) Life skill development – capacity to say "no" to peer pressure. (v) Avoiding alcohol, cigarettes, drug abuse and sexual abuse. (vi) Sexually Transmitted Infections (STIs) and HIV/AIDS awareness, responsible sexual behaviour. In addition, there is a FLE module for Plus-2 School adolescents. This module uses the name FLE rather than 'sex education' – a term which is unacceptable to many Indian parents. It was also decided that it would be better for a doctor or counsellor to be present at the FLE class as pilot experiences found teachers had difficulty talking to their children about these issues. FLE teachers should be experienced in teaching and in conducting adolescent clinics and have a PG Diploma in Clinical Child Development (DCCD) from the Child Development Centre. The project plans to cover 20,000 students from Class-XI who will be tested before and after the course on their ASRH knowledge. The project is planned for a five-year period and includes a number of other activities including:

	(i) Reaching out-of-school adolescents through the Kerala State Literacy Mission Authority (KSLMA). (ii) Formation of teen clubs for out-of-school boys. (iii) Formation of Anganwadi-based teen clubs for out-of-school girls. (iv) ASRH clinics at Taluk Hospitals (v) Outreach approach by proving Adolescent Care, Counselling, Empowerment and Support Services (ACCESS) units at Taluk and private hospitals. (vi) Establishing Adolescent Development Centres (ADC) at NYKS-affiliated Youth Development Centres. (vii) Self employment for below poverty line adolescent girls through Kudumbasree. For further details on each of these activities see Documents and Illustrations (below). **Results:** The project is planned over a five year period. It will be evaluated by an external agency who will prepare a report highlighting lessons learnt for dissemination at State and possibly National level.
Cost	Total cost for the proposed project in all 14 districts: INR 4,09,54,400. This figure includes: District level training for 14 districts: INR 53,34,000 Recurring expenditure for three years for one district: INR 288,34,400 Organisation of Apex training and Resource Centre: INR 41,86,000 Information, Documentation and Dissemination Unit: INR 19,00,000 Behavioural Paediatrics – Scholastic Backwardness Unit: INR 1.5 lakhs Adolescent Care Counselling Unit: INR 1.5 lakhs Guidance and Counselling Unit: INR 1.5 lakhs Family Counselling Unit: INR 50,000. For a detailed breakdown see budget chapter within manual. The preparation of the project manual and the implementation of the Adolescent Health Programme in Trivandrum District is being funded by the European Commission's Sector Investment Programme.
Place	Kerala, intially in one district, Trivandrum. It will be extended to other districts during RCH 2. Programme began July 2004.
Time Frame	Preparation of the project manual and the adolescent health module: 6 months. Implementation: 13 months.
Advantages	Time and resource effective: It is envisaged that it will take a relatively short time to implement the project because it concentrates on making optimal usage of available resources.
Challanges	None yet perceived.
Prerequisites	Government order. A centre for child health or adolescent health: in this case the Child Development Centre, Thiruvananthapuram. Development of Adolescent Health Modules.
Who needs to be consulted	Director of Health Services, Child Development Centre.
Risks	
Sustainability	The programme involves grassroots NGOs and the Panchayat Raj system which should make it acceptable to the community. Included in RCH 2. The Adolescent Care Clinics, counselling and training facilities and speciality services will all charge user fees in an effort to make them self sustaining. External funding will be sought for

	research projects.
Chances of Replication	Unknown.
Comments	
Contact	
Submitted By	Dr K Sandeep, Technical Secretary, Sector Reform Cell, Directorate of Health Services, Kerala. September 2005.
Status	Active
Reference Files	Government Order.jpg — Government Order Details of proposed activies under the Kerala Adolescent Health Programme.doc — Details of proposed activities under the Kerala Adolescent Health Programme Adolescent Implementation model.doc — Adoclescent Implementation model.
Reference Links	

114. Telemedicine scheme for cardiac emergencies, Karnataka

Subject Area="Access to service and coverage."	Objective="Specialist treatment in rural areas."
Details for Reform Option "Telemedicine scheme for cardiac emergencies, Karnataka"	
Summary	**Background:** Studies suggest that Indians are genetically three times more vulnerable to heart attacks than Europeans and Americans. Those living in rural areas run the greatest risk of misdiagnosis of symptoms or delay in receiving treatment. Chamarajanagar, a tribal, border district of Karnataka, is one of the most underdeveloped districts in the State. The District Hospital, Chamarajanagar has 70 beds, 15 doctors and the capacity to treat over 250 out patients a day. The hospital has facilities for general medical and surgical treatments, yet patients with any emergency cardiac condition had to travel at least 60 kilometres to Mysore for treatment, thereby losing the 6 crucial hours after a heart attack when a blood clot can be broken down and the life saved. According to Dr Devi Shetty, cardiac surgeon and managing director of Narayana Hrudayalaya super speciality hospital in Bangalore, 99% of patients do not require operations. In these cases there is no need for the doctor to be physically present, all data can be transferred electronically through a system known as telemedicine. **Action:** The Karnataka Telemedicine Programme was formally launched in April 2002 in association with the Indian Space Research Organisation (ISRO) to provide better emergency cardiac care to underserved areas such as Chamrajanagar. Under the project, remote hospitals and health centres are linked via satellites to super speciality hospitals in major cities, connecting patients with specialist doctors for consultations and treatment. The Telemedicine Cardiac Care Unit (CCU) at District Hospital Chamarajanagar opened its doors in February 2002. One online ECG machine was purchased complete with the computer hardware provided by Narayana Hrudayalaya and ISRO and two other regular ECG machines were supplied by the World Bank-supported Karnataka Health System Development Project (KHSDP). The telemedicine system consists of customized medical software integrated with computer hardware, along with diagnostic instruments connected to the Very Small Aperture Terminal (VSAT) at each location. This facility enables transmission of patients' medical records, including images, and provides a live two-way audio and video link between patient and specialist. VSAT connectivity has no geographical barriers and doesn't require a

	telephone line. Once the patient's history is sent to the specialist doctor, along with investigative data such as interpretation of images and blood chemistry, he can communicate with the patient and attending doctor during a video conference. He can advise on the course of treatment to be followed and can even provide guidance during surgery. **Results:** Between February 2002 and March 2005 the Chamrajanagar CCU has achieved the following: i) Thrombolysed 187 cases with acute Myocardial Infraction (MI) ii) Treated 945 other cardiac cases including MI as inpatients This includes cases such as acute coronary syndrome, congenital and rheumatic heart diseases and arrhythmias. iii) Screened, reviewed and treated 16,668 outpatient cases iv) Organised 10 free cardiac diagnostic camps in Chamarajanagar district, with the help of Narayana Hrudayalaya v) Enabled 74 patients to undergo invasive cardiac procedures at Narayana Hrudayalaya, of which eight were operated upon totally free or for a nominal fee. vi) Enabled more than 338 patients to get higher cardiac evaluation at Narayana Hrudayalaya at its free outpatients department vii) Average occupancy for cardiac care throughout the year 60.32%
Cost	Two computers and accessories: INR 100,000 Scanner: INR 130,000 Conferencing Camera: INR 250,000 Digital camera INR 65,000 The bulk of the cost for technology oriented services goes on software. Narayana Hrudayalaya (NH) has developed its own software which is given to the general practitioners, hospitals or charitable organisations free of charge. VSAT equipment was provided to the District Hospital, Chamarajanagar by ISRO free of cost. (It would otherwise have cost around INR 15 lakh (€) for a 385kbs line.) Computers and tele-conferencing unit were given by NH in association with ISRO free of charge.
Place	Chamarajanagar district, Karnataka
Time Frame	Two weeks to set up the telemedicine equipment (mainly VSAT) and convert the building from a general ward to a CCU
Advantages	Speed: Patients can be diagnosed and treated quickly, without the need for a potentially life-threatening journey to a larger hospital. Economical: In terms of cost of travel to a hospital for a second opinion and in service itself, once facility set up. Service extended: Referral process strengthened and specialist advice available at PHC level. Steamlines referral: Patients are able to see the right doctor without falling prey to ineffectual untrained practitioners. Continued medical education: Staff and doctors can keep pace with ongoing advances in medicine from the convenience of their office. Builds trust: Patients with low level of education are often

	suspicious of visiting a city specialist. Tele-conferencing offers frequent consultation with the specialist, building confidence and improving patients' compliance to treatment.
Challanges	Lack of technical support: It can take weeks for telemedicine equipment in rural areas to be repaired. Staff unwillingness: GPs find problems seeking and accepting advice from a specialist whom they don't know personally. (This could be over come by holding an orientation course for GPs at the hospital giving the specialist consultation). Communication barrier: Patients with little acquaintance with conferencing equipment may find it difficult to talk to the 'video image' of the specialist.
Prerequisites	Broadband connectivity, needed for video conferencing facility though not for data transfer. Computer equipment Dedicated staff. Telemedicine training facility. Funds to set up the facility. Political initiative and backing.
Who needs to be consulted	State and district level government, hospital doctors.
Risks	
Sustainability	Sustainable,since in the context of rural and distant areas, telemedicine-based medical care is highly cost effective once equipment has been installed. Sustainability depends upon maintenance of equipment and upkeep of the CCU facility, including consumables, medicines and staff salaries (if not government employees, as at Chamarajanagar). Chamarajanagar CCU levies user charges for telemedicine services. These exclude consultation and doctor's fee. Current charges: i) ECG 30/-INR ii) Bed charge 100/- INR per day iii) Streptokinase Injection 1,100/- INR iv) Ventilator charges: 500/- per day Below poverty line (BPL) patients are exempt from all charges. Chamarajanagar CCU has so far accrued about INR 400,000 after meeting all its maintenance costs.
Chances of Replication	Very good. There are now about 80 remote district hospitals linked to 29 super speciality hospitals throughout India. There are a further 10 in other countries. Using this technology, Narayana Hrudayalaya says 17,500 patients have been treated so far.
Comments	As in rural areas across India, more than 90% of Chamrajanagar's population is dependent on agriculture. For such people living at subsistence level, health comes as a low priority. Medical staff report that providing adequate health care to them is increasingly challenging. Tele-medicine is proving to be an affordable and reliable method of getting treatment for these people.
Contact	
Submitted By	Tessa Laughton, Research Consultant, ECTA, New Delhi, May 2005.

Status	Active
Reference Files	
Reference Links	

115. Sanjivani Scheme, Rajasthan

Subject Area="Access to service and coverage."	Objective="Specialist treatment in rural areas."
Details for Reform Option "Sanjivani Scheme, Rajasthan"	
Summary	**Background**: Rajasthan has a difficult topography and a largely rural population which is scattered in desert and tribal districts. Therefore, access to public health care services is limited in these districts. Further, most of the Community Health Centres (CHCs) in Rajasthan, which are the first referral units, do not have all specialties and there are also a lot of vacant posts for specialists. To cater to the medical needs of the population, the government of Rajasthan proposed to introduce a novel scheme of providing specialist services periodically at block level, (an area covering a population of approximately 100,000). The scheme provides services to patients suffering from acute and chronic illnesses that need referral by a Medical Officer (MO) at the Primary Health Centre (PHC). The name of the scheme was coined from an epic Ramayana where Hanuman brought Sanjivani booti (herb) from Himalayas to Lanka to save Lakshman, brother of Lord Ram. **Action**: The Rajasthan State Government made their proposal to the European Commission-supported Sector Reform Investment Programme in August 2004. The proposal was developed as per the demands from the districts. A number of meetings were held at state level to develop a scheme and finalise the details of operationalising the scheme. Under the Secretary Medical and Health, a committee was constituted to work out operational details and management. The nodal department was Public Health and the nodal officer was Director Public Health. In each district, the most backward blocks were selected. The Chief Medical Health Officers (CMHOs) and all the officers at the state level were given an orientation regarding the scheme. Each state officer (directors, additional directors, joint directors and deputy director, Officer on special duty, nodal officers of various programmes) was allotted a district. The funding agencies in the state (UNICEF, UNFPA, European Commission) were also allotted districts to monitor the activities pertaining the programme. The first camp was organized as a pilot to test out the operational details, which had been developed. The principal health secretary, secretary health and director public health all participated in the first camp to understand the functioning of the camps. Thereafter, a review meeting was held

under the chairmanship of the principal health secretary, Mrs. Rukmani Haldia. Guidelines Finalized after pilot testing) were developed for the scheme and circulated to the districts. Organisation issues •Nodal officer in each district is the district chief health and medical officer. •Organize two camps with a gap of six months in every district. •Duration of each camp to be for 3 days. •Different colour referral cards were developed for the benefit of the patients as well as for those overseeing the delivery of care. The colour of the card denotes the different place for referral- referral from PHC to sanjivani camp was blue; referral from sanjivani camp to PHC/CHC/SubCentre was white; referral to district hospital from sanjivani camp was yellow; and referral to attached medical college was pink. •Each of the above-mentioned cards has to be filled in duplicate, one of which was given to the patient and another was kept in the institution. •Approximately a month before the camp, the CHMO develops a draft budget and plan of action including the responsibilities, publicity, printing, purchase of drugs, infrastructure provision at camp site, transport facility for people below povery line (BPL) and sterilized patients. Identifying local donors for organizing, tent provision, food, water, taking care of patients, drugs etc.

•Approximately a month before the camp, a meeting is to be organized under the chairmanship of district collector for finalizing the dates for scheduling the camp and all the above issues. The participant include official from all the sectors including Ayurveda, ICDS, district hospital, Treasury officer, social workers, NGOs, local donors, department of water, electricity, PRI, municipalities and health officials. •A meeting is held at the campsite, CHC to finalise the responsibilities purchase of drugs, stationery, formats, printing of IEC materials and nitty gritty details including mapping out the places for service provision, exhibition, registration, waiting places for patients and their relatives, computer room, administration section etc. The participants include all the block level officers, local private practitioners, local donors, NGOs, CHC staff and PHC medical officers. •Letters were sent by CMHO to all concerned people regarding what services they had to give at the camp. 1.Services to be provided •The specialist services to be provided were medical skin diseases, tuberculosis, obstetrics/gynecological, pediatrics, surgical, ophthalmology, E & T, dental, family welfare, immunization, ayurvedic, unnani etc.

•The team of specialist was taken from district hospital, adjoining CHCs and local private doctors. •The camp was to provide minor and major surgical procedures. •The lab investigation for hemoglobin, TLC (total lucosyct count), ESR (Erythrocyt sedimentation rate), urine (albomin and microscopic examination and pregnancy), sputum examination, blood group, ECG X-ray, HIV, pap smear, malaria. 2.Publicity •Before the camps are organised wide publicity was to be carried out in all the villages by the Auxiliary Nurse Midwifes/ Male Multipurpose workers (ANMs/ MPW). The medical officer at the PHC would examine the people suffering from illness and refer only those

	patients who required specialised services. •Organising an exhibition on all the health issues to create awareness among people. 3. Management of Information System was developed for monitor the flow of patients. Software was also developed to facilitate monitoring the progress of the scheme. The camps were then organized in a phased manner to cover all the districts. **Results:** This is a statewide initiative started in 2004 and therefore documentation of its impact has not yet been carried out by the state. On average, two camps have been carried out in each district. A visit to one such camp in Churu district at Seth Chotu lal Sethia Hospital (CHC) Sardarshahr on the eve of 3rd camp revealed that each of the nine PHC MOs were supposed to refer 50 patients to the camp. INR one lakhs rupee was donated by a local donor that was spent on a tent, food, water and even drugs. This was the second camp in the CHC. In the last camp held in March 2005, 2455 patients attended and forty-two referrals were made to district hospital; 248 surgeries were carried out including 243 major surgeries (female sterilization-113; cataract-122; Male sterilization-7; 142 patients were tested and ECG was carried out for 18 patients and X-ray for 44 patients. In September, 2005 –53 X-rays; 120 laboratories; 200 BPL patients were given free medicines (Surgeries 262 patients had been referred from PHC to this camp. At the end of each camp all the voluntary workers including private doctors are given a token of appreciation.
Cost	Under this scheme an amount of INR1.5 lakhs was provided to each CHC in the state. Later the amount was increased to 1.6 lakhs. Besides, each CHMO gets donations from the community. For organizing the said camp CMHO garnered INR 1 lac and it was used for providing food and water for volunteers and patients.
Place	All 32 districts of Rajasthan. In each district, such camps are organized in one to two backward blocks since, June 2004-December 2004.
Time Frame	six months.
Advantages	Doctors: Availability of all specialists under one roof. Access: Coverage of backward areas. Public-private partnership: Involvement of local donors facilitates in organizing such camps for detecting HIV/AIDS, Cancer. Referral: The camps are for patients being referred from PHC. Patient load: Load of the patients decreases in district hospital. Increase in the inflow of patient from nearby villages and town to CHC. Record: Good computerized MIS at Camps. Awareness: Camps have exhibition on various diseases and prevention of the same. The patients/relatives and local community

	get awareness on all health issues. Integration of services: Good coordination with ayurveda system.
Challanges	Few Camps: Organised only twice in a year. Referral: Referred cases may not get priority since local load increases. Commutation facility: Transportation facility is not provided from villages to CHC and back for patients from non-BPL families' especially old and very ill patients. Doctors: Identifying good doctors from the district for the camps can be difficult. Follow-up: Unless cases/patients are followed up by PHC and SC staff the effect of the initiative will reduce. Feedback: Continuous feedback from the PHC/CHC/District/Medical college hospitals regarding referred patients is necessary.
Prerequisites	Good managerial skills of CMHO. Detailed planning of each event. Involvement donors and local community including private practitioners. Adequate space for exhibition, waiting rooms, arrangement for stay of patients and relatives, water etc. Availability of computer and computer operator Availability of generator/inverter.
Who needs to be consulted	Director Public Health. Nodal officer, EC-SIP. Deputy Director, FW. CMHO from respective districts.
Risks	
Sustainability	It can be sustainable through Rajasthan Medicare Relief Services started in all government health facilities and local donors.
Chances of Replication	Good
Comments	Good initiative. However, unless stringent follow-up measures are put into place the effectiveness of the camp will reduce. Camps need to be held more frequently.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, National Institute of Medical Statistics, October 2005.
Status	Active
Reference Files	F1040016.JPG F1040017.JPG F1040018.JPG Binder1.pdf
Reference Links	

116. Delivering Reproductive Health Services to women in rural areas, Rajasthan

Subject Area="Access to service and coverage."	**Objective="Access to reproductive health services."**
Details for Reform Option "Delivering Reproductive Health Services to women in rural areas, Rajasthan"	
Summary	**Background:** In Jodhpur (popularly known as Marwar) district of Rajasthan, most of the villages are scattered in the Thar desert. For poor women, who have limited decision-making power, health care is an economic and community issue. Based on the core belief that only healthy women have the strength to create change in their lives and in their communities, the Veerni project was initiated in the villages of Jodhpur in 1993 in collaboration with Parivar Sewa Sanstha, Delhi, and is administered by local NGO Rajdadiji Badan Kanwar Trust under the aegis of the Maharaja Gaj Singh II of the Jodhpur from 1999. It is funded by the non profit organisation – Global Foundation for Humanity (GFH). The mission of the project is to improve the quality of life in rural areas of Jodhpur by promoting reproductive health services; income generating services; education and mobilization of women. **Action:** Seventeen villages scattered on the Ajmer and Barmer route up to 50 km from Jodhpur are under the Veerni project, covering a population of 20,961. After a baseline survey of each adopted village, a written agreement was made with the local Panchayat Raj Institution (PRI) members. A team called the Veerni team provides services in the villages. The Veerni team consists of a doctor, a social worker, two nurses, two women field educators and one male health educator. Service providers are given training in consumer friendly skills and practices to improve quality of services delivered. Local village women, (called Veernis) are selected based on self motivation to work in a community, effective leadership skill and their ability to read and write. They are trained at their resource centres for 10 days to serve as health promoters. They act as an informed and skilful information disseminator at the community level, thus creating the demand for services. For their services they are paid an honorarium (INR 675). Services provided: (i) Health services: The Veerni team is mobile and visits the villages a minimum of twice a week in rotation. Comprehensive reproductive health care, pre and postnatal care, treatment of anaemia, family planning, treatment of infections, childcare, immunization services etc are provided by the team. Health camps

	(eg eye, skin and venereal diseases, paediatric) are organised from time to time. (ii) Health Education: Village level meetings on hygiene, nutrition, domestic violence, girls education, women's rights and the problem of addiction are conducted from time to time. (iii) Nutrition Programme: A nutritionist counsels mothers on better feeding practices for their children. They demonstrate how to cook local foods safely and nutritionally. Besides the health services, women and girls are trained in sewing to support themselves through income generation. **Results:** Base line results not available] (2003-04)- Infant Mortality Rate of villages under Veerni project- 52.43 per 1000 live births. This compares to an overall rate for India (rural) of 67 per 1000 live births and Rajasthan state of 79 per 1000 live births.
Cost	Start up costs for the project is not available but the current cost (2003-2004) to run the project is approximately INR 36 lakh.
Place	Seventeen villages of Jodhpur district in Rajasthan since 1993.
Time Frame	Six months approximately.
Advantages	Women empowerment: Through education and income generating activities, women feel more able to take part in family decisions. Accessibility to health services: Mobile team services bring health services to women who live in difficult areas and have limited access to health services.
Challanges	Donor reliant: There is too much dependence on the donor agency to run the project.
Prerequisites	Community participation. Donor agency. Good NGO to administrate.
Who needs to be consulted	NGO, Health department.
Risks	
Sustainability	Doubtful if donor agency withdraws financial support.
Chances of Replication	With funding, yes.
Comments	Empowering women through education and income generating activities not only helps them to decide better for herself, but also for her family and a healthy community as a whole. Interactive village participation, listening, learning and sharing information are the keys to success. But the scheme needs to find ways for the activities to become self-sustainable.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, December 2005

Status	Active
Reference Files	
Reference Links	

117. Comprehensive Healthcare Outreach Services to the poor using mobile approach, Madhya Pradesh.

Subject Area="Access to service and coverage."	Objective="Improve access of health care services to undeserved regions."
Details for Reform Option "Comprehensive Healthcare Outreach Services to the poor using mobile approach, Madhya Pradesh."	
Summary	**Background:** In Dewas district of Madhya Pradesh, a baseline survey of the selected population revealed low level of immunization, family planning and antenatal care (ANC) a preference for home deliveries; a high prevalence of low birth weight and malnutrition; low levels of awareness about pneumonia, diarrhoea, Sexually Transmitted Diseases (STDs) and HIV/AIDS. A large section of the population is tribal and the undulating terrain makes it difficult for the poor in Dewas district to access health care services. **Action:** The Ranbaxy Community Health Care Society (RCHCS) is a non-profit registered society set up in 1994 by Ranbaxy Laboratories Ltd, a leading pharmaceutical company. It planned to provide a package of preventive and curative services through mobile vans in Dewas Block in November 2001 with the objective of increasing access to essential reproductive and child healthcare including adolescent health, prevention and treatment of Reproductive Tract Infections RTIs/STIs as well as AIDS awareness and health education on various health issues. The service is very convenient for women and children, who are otherwise dependant on men to take them to hospital to access basic health care services. Even though the catchments area of RCHCS have 4 Primary Health Centres (PHCs - Barotha, Sunwani Gopal, Double Chowki & Vijayganjmandi) and one district Hospital in Dewas town, which is the first referral unit within the service area of RCHCS. Population Foundation of India (PFI), New Delhi funded this project. The RCHCS office at Dewas is located within the campus of Ranbaxy. The service area of RCHCS was identified in partnership with PFI. Once a week on a regular basis two mobile health care vans visit the villages. Two 14-seater vans were procured and converted into 4-seater ambulances with a check-up table suitable for gynaecological use. Sufficient storage space was also included. The van included collapsible furniture including television and CD Player to show educational programmes and had provisions for doing minor procedures like Copper-T, insertion, Non-Scalpular Vasectomy (NSV) operations, gynaecological / ANC check ups, immunisation etc. inside. The first step is to ask permission from Panchayat to set up a

mobile clinic in their village. A team of doctor and paramedical staff manages the outreach services. The 'Gram Swasthya Samiti' members are also given training on health matters and sanitation. They notify the villagers (through the Village Chowkidars) about the visits of a mobile clinic. The Sarpanch is often the Chief Guest at 'Health Camps' and other functions like puppet shows, street plays etc. In addition, the sum of INR18,000/- was given to each Panchayat of 36 village health centres as an advance for providing transport assistance to high risk obstetrical and neonatal emergencies for referral to hospitals.

In order to bring about changes in health seeking behaviour the village community was involved by organising meetings of various groups formed by the project. Examples are Breast Feeding Support Groups, Adolescent Groups for both male and female, Women Group and Health Committees. Distribution of pamphlets, video shows, group discussions and demonstrations are other methods used to promote better hygiene practices as well as street plays, puppet shows, poster exhibitions and workshops.

RCHCS maintains records of all vital events like live births, infant deaths and maternal deaths in its areas to determine the health status of the community and monitor such events on a continuous basis. Information about deaths is obtained from direct home visits by RCHCS staff and also by collating information from Community Health Volunteers (CHVs)/ Anganwadi workers (AWW)/ Auxiliary Nurse Midwives (ANMs). This helps RCHCS to plan specific interventions for preventing deaths.

Medicines are bought from wholesale dealers in Indore according to need and the budget allocated by RCHS and PFI. Some medicines like Iron tablets, Oral Rehydration Salts (ORS), Family Planning measures like condoms, Copper T (CuT) oral pills are obtained from District Hospital, Dewas, which also carries out maintenance of vehicles and general administration. Local Registered Medical Practitioners are informed about all the initiatives started by RCHCS. They are invited to workshops organised by RCHS and educative materials are distributed to them on a regular basis. Linkages have also been established with local charitable hospitals for referral of patients. Poor patients referred by doctors of RCHS are given concessions at private clinics/hospitals.

From the villages, CHVs are identified with the objective of sustaining the efforts started even after the project ends. The CHVs have been given training on how to deal with some common health problems. Besides, they also function as depot holders for family planning methods, ORS, 'Environmental Health and Sanitation', 'HIV/STD/AIDS'. CHVs are identified from the educated villagers (they must have a minimum of 10th standard pass) and who are interested in Social Work. They are paid an honorarium of INR.100 (€ 1.87) per month. The dais (untrained birth attendants) was also given training on safe deliveries. The Chief Medical Officer (CMO) of

	the District Hospital is the chairperson of the Project Implementation Committee (PIC) of RCHCS. The RCHCS takes part in all National Health Programmes like Pulse Polio, Bal Sanjeevani Mission for malnourished children, Malaria Eradication Programme etc. The doctor of RCHCS is a member of District Health Committee. The project also used government buildings like PHCs, Subcentres, Panchayat buildings, schools in villages to hold health care camps. The Dais training was organised by using the Government Hospital, Dewas. The district administration has provided the project with requisite supplies from the District Hospital - vaccines, family planning products and also trained staff on RCH. The project involved Govt. Medical Officers to train village level health workers, specialists and health education material. Results: During 2003-2004, a total of 12,900 beneficiaries used the mobile-based health care services in 301 field visits. A total of 44 untrained Dai, 80 CHVs, 94 AWWs and 30 gram swasthya samitis were given orientation training on essential new born care. In addition, to facilitate normal working at the labour room at Barotha PHC in Dewas block, one 5 KV generator set was installed. All infant and maternal deaths were thoroughly investigated to find out the probable causes of death. Since RCHCS started operating, no malaria death has been reported so far from the RCHCS service area. Other improvements noted are: The immunization coverage has improved among children aged 12 – 18 months. Complete vaccination increased from 61.2% (baseline) in 1998 to 92.2% in 2004. Supplementation of Vitamin A prophylaxis for prevention of nutritional blindness also showed an increase from 59.6% (baseline) in 1998 to 93.4% in 2004. Coverage of family planning methods increased from 56% in 1998 to 76.9% by end of 2004. The coverage of Tetanus also increased from 79.5% in 1998 to almost 100% in 2004. The percentage of malnourished children in the age group 0-1 year showed a decline from 37.6% baseline in 1998 to 13% in 2004. The service statistics of RCHCS show a decline in the number of births and infant / maternal deaths. The birth rate reduced from 23 per 1000 population in 1998 to 17 per 1000 population in 2004. Significant reduction in infant deaths from 45 per 1000 live births (1998) to 20 per 1000 live births. Maternal mortality in RCHCS area declined from 4.5 per 1000 live births (1998) to 1.8 per 1000 live births. They conclude that the overall reduction in mortality has resulted from improved health status including greater health consciousness among the community and speaks itself about the availability, utilisation and effectiveness of the services rendered by RCHCS. The project is now in the process of doing a survey to explore the possibilities of appointing sanitary operators or sweepers in collaboration with the Panchayats.
Cost	A. Capital (Cost of health care van, medical / surgical INR 8 lakh equipment, collapsible furniture (curtain included), Audio- visual

	equipment etc.) B. Recurring INR 7 lakh (€ 13073.62) Cost of personnel (one doctor, one ANM, one Social Worker, one Driver) Total INR 15 lakh (€ 28,011.45) 2nd year Recurring INR 7.5 lakh (€ 14009.22)
Place	Dewas, Madhya Pradesh. This initiative is also operational in Mohali, Beas, Toansa (Punjab), Paonta Sahib (Himachal Pradesh), Gurgaon (Haryana) and Delhi.
Time Frame	About two years. The project was approved on 10 November 2001 and activities were started in January 2002.
Advantages	Coverage: Can reach the un reached and otherwise inaccessible population especially women whose health needs so far had remained neglected by the existing public sector. Behavioural Change: Provision of services at the doorstep coupled with health education through audio-visual means increased utilisation of the services. Outcome: Better results through focussed integrated approach and targeting of precise groups for specific problems. Women friendly: Specialist doctors especially services of lady gynaecologist and paediatrician can be made available even in remote areas.
Challanges	Existence of motorable roads. In many areas there is also no place to set up a clinic especially in bad weather. Cost: In the long run this is not a cost-effective means of providing services.
Prerequisites	Corporate Sector. District Health Administration. Panchayat Raj Members. Community. Non-government Organisation.
Who needs to be consulted	Medical Officers RCHCS Dewas. District health authorities - civil surgeon / Chief Medical Officer CMO / Senior Medical Officer SMO of the respective area. Panchayat Raj Members. Prominent persons from the community like social workers, teachers, dais, Aganwadi workers and volunteers. Medical College (Community Medicine Department) if there is any Social Welfare department. 'Nehru Yuva Kendra' and 'Dept Of Women and Child Development'-run Anganwadi centres (they organise camps for malnourished children, provide 'dalia' (porridge) to pregnant/lactating women and keep records. Population Foundation of India, New Delhi.
Risks	
Sustainability	Partially self-sustainable at grass root level through the availability of trained members of the community.
Chances of Replication	The project has been started in other parts of the country simultaneously – All RCHCS centres provide mobile health care units and run Reproductive and Child Health Programmes.

Comments	The CHVs approach was not very successful as most of them are 'Daughters-in-law' of the village; hence their mobility in the village is restricted. Also they are not always available as they also work in the fields especially during the farming season. Initially the project was meant for a period of three years. There are indications that the project is likely to be extended for next five years, so that the project can make much more of an effect on the lives of the people of Dewas.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, NIMS, March 2006.
Status	Active
Reference Files	
Reference Links	

118. Mobile phone consultation for community health care, Haryana

Subject Area="Access to service and coverage."	Objective="Improve access of health care services to undeserved regions."
Details for Reform Option "Mobile phone consultation for community health care, Haryana"	
Summary	**Background:** The innovation was experimented by Rural Health Training Centre of Postgraduate Institute of Medical Education and Research (PGIMER) Chandigarh, at Naraingarh in Ambala, Haryana during May to December 2005. **Action:** Mobile phone number of the principal investigator (PI) was communicated to general population. People were asked to contact the PI any time for medical consultation. All the telephone calls from people seeking medical advice or treatment were answered by the PI who was responsible for providing medical advice. For this purpose, detailed and structured medical history was taken from the patient and accordingly appropriate advice or treatment was given. Further advice on follow up and contact with the doctor again was also given. Details of the phone calls received were duly recorded. Short Message Service (SMS) was also used to provide correct prescription if the caller was unable to write during consultation (provided he/she also had a mobile phone.) At the completion of each call, permission was sought for a follow-up call to determine the caller's response to the advice/treatment given. Consent for the study was obtained from all the respondents. All data has been kept confidential. **Objectives:** To provide 24 hours, free of cost, mobile telephone consultation to rural community of Haryana, India through a community physician To ascertain the acceptability, feasibility and scope of mobile phone medical consultation in rural areas of north India. **Results:** A total of 660 phone calls were received during the study period. The main results found were: Mean duration of a call was about 2.7 min, around 80% from Males The mean age of callers was 32 years. Gradual increase in the number of calls from 16 in May to 186 by December 2005. Approximately 60% (394) calls were from Naraingarh sub division. Out of 417 calls for advice or treatment, 224 (53.7%) calls were regarding advice on a specific health problem and 193 (46.3%) calls were for treatment of some ailment. Most common morbidities were skin, respiratory, psychological and behavioural, sexual, gastro intestinal or locomotor problems. During the follow up, 387 (92.8%) callers

	were traced and interviewed. About 96% of users were in favour of continuation of the service in future also. About 302 (78.0%) followed the suggested advice. Among these, 275 (91.15) found the advice very useful in tackling their health problems. About 96% (371) users favoured continuation of the service in future also. Among other results, 257 (61.6%) callers had minor health problems, so they were advised to manage it at home (self care) as per the suggested treatment, 74 (17.7%) callers were advised for routine appointment with specialists, 42 (10.1%) callers were asked for urgent local general practitioner visit, 29 (6.9%) callers were referred for emergency department visit, and 15(3.6%) callers were advised to visit some other nearly agency like NGO/Charity hospital for their problems.
Cost	INR 60,000/-
Place	Rural Health Training Centre, Sub divisional hospital at Naraingarh in Ambala, Haryana
Time Frame	One Month
Advantages	1. Speedy advice 2. Savings on time and money spent in travel especially for handicapped, children, women and old people 3. Bypasses hospital formalities for consultation 4. Reduces shyness in discussing the problems 5. Convenient follow up process with increase in the medical knowledge of lay people regarding self-care.
Challanges	A physical examination is crucial to a patient's diagnosis, without which, physicians may miss some important clinical finding. This can unintentionally harm the patient. Many medical problems need physical examination for proper treatment and cannot be dealt on the phone.
Prerequisites	Ø Motivation, commitment and willingness to work for community. Ø Mobile phone Ø Physicians willing to spare few hours from his/ her routine life Ø Provider should be familiar with the customs, belief, language of the area Ø A small pool of funds for recurring costs.
Who needs to be consulted	The head of the Institution for the permission and consent to run such a service and department of communication or any private company for mobile phone connection and willing medical officers who are going to deal with this service. We also need to consult local media persons to disseminate the mobile phone number and ideas and needs of such services
Risks	
Sustainability	Sustainability depends on the interest, attitude and commitment of service provider (doctor) towards community. If doctors can

	spare time and answer the calls and also get their phone bills reimbursed, then this system can be made self-sustainable. As incoming calls are free and most of the doctors have their own mobile phones, they can provide services in their respective places.
Chances of Replication	Replication is not difficult but the only thing is to find a motivated, determined, skilful physician for this services.
Comments	This service can prove beneficial in areas where commuting is a major problem especially in rural, hilly & tribal areas and sometimes in geographically difficult terrains. It can also be life saving in areas where doctors are not easily available and accessible.
Contact	
Submitted By	Dr. Surya Bali, Lecturer, Allahabad University Dr. Amar Jeet Singh, Addl. Professor, PGIMER, Chandigarh Manisha Ghose, Research Consultant, CBHI. March 2007
Status	Active
Reference Files	
Reference Links	

119. Oucher scheme for institutional delivery and immunisation, Jharkhand

Subject Area="Access to service and coverage."	Objective="Promote institutional delivery and enhance immunisation coverage"
Details for Reform Option "Voucher scheme for institutional delivery and immunisation, Jharkhand"	
Summary	**Background:** One of the major concerns of the state Reproductive and Child Health (RCH) Programme, phase II, is the extremely low percentage of institutional deliveries. Among women living Below Poverty Line (BPL) and in remote villages the number of institutional deliveries is almost negligible. In order to promote institutional delivery and to enhance routine immunisation coverage a voucher scheme titled Chief Minister's Mother and Child Health Campaign was launched in the State. It was in line with Janani Suraksha Yojana (JSY), recommended by the Union Government under National Rural Health Mission (NRHM). This scheme was started in December 2005 in all the 22 districts of Jharkhand and is implemented through the Auxiliary Nurse Midwife (ANM), Anganwadi Worker (AWW) and Sahiyya, the village level link health worker. **Action:** Vouchers are issued to BPL pregnant women at the time of registration of pregnancy. These cover services for institutional delivery; the final and last instalment is given at the time of complete immunisation of the newborn. Responsibility for registration of the pregnant women lies mainly with the AWW and Sahiyya as they are both based in the community. At the time of registration INR 100 is given to the pregnant woman in cash as a promotional incentive, and her thumb impression or signature is taken on a receipt by the AWW or Sahiyya. The BPL status of the woman is ascertained on the basis of the red ration card, issued by the revenue department; in the absence of this card, two senior persons of the village can certify the poverty status of the woman. The registered pregnant woman is encouraged to go to the Sub Centre to receive 100 tablets of Iron and Folic Acid (IFA) and two doses of Tetanus Toxoid (TT). On her third visit to the health facility, which is around 8 weeks before the expected date of delivery, she is issued a voucher of INR 700. With this voucher she is entitled to have the delivery at any government facility or at an accredited private health facility. In case of caesarean section she will get INR 1500. After the delivery, the woman is encouraged to visit the health facility or Anganwadi Centre for the immunisation of the new born. After complete immunisation schedule of one year (BCG, three doses of DPT, Polio

	and Measles) the woman is rewarded with a cash incentive of INR 300. There are two more vouchers, one each for INR 100. These are issued to the AWW/Sahiyya and ANM after the process has been completed, beginning from registration of a pregnancy to complete immunisation of the newborn. 5% beneficiaries are monitored by the Block Medical Officer In Charge (MOIC) and 3% beneficiaries by the district's Civil Surgeon (CS). A complete list of private healthcare providers at block and district levels are provided to all ANMs for referrals. Results: As it is a new initiative in the State, its impact will be evaluated at least after six months.
Cost	This initiative is funded by both Union and State Governments.
Place	All over the state.
Time Frame	Six-8 months.
Advantages	Institutional delivery: ensure skilled attendance at birth and safe motherhood. Public-private partnership: Private healthcare sector involvement is encouraged to deliver the services where resources are limited. Routine immunisation coverage: Women are motivated to visit the health facilities and get complete immunisation for their infants. Coordination: Scheme devises a mechanism for better coordination between ANM and AWW/Sahiyya.
Challanges	Mobilising women: Due to illiteracy and ignorance it is difficult to mobilise women to visit health facilities for check-ups and delivery. Monitoring: To monitor the management of the vouchers is a complex job for implementers. Fund flow: Adequate flow of funds from the state for timely payment to the beneficiary to make scheme successful.
Prerequisites	Commitment of State Government. Effective team of service providers. Sufficient resources. Effective management systems and procedures.
Who needs to be consulted	State Government. Private health facilities. NGOs and faith-based organisations
Risks	
Sustainability	State and Union government funded scheme.
Chances of Replication	Good and is already reflected in NRHM.
Comments	Maternal deaths are a serious concern for the nation. Devising a strategy, which is accepted and adopted by the community is difficult task, but even more difficult is the implementation, which is

	reflected by reduction in maternal mortality.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, May, 2006.
Status	Active
Reference Files	Voucher scheme PPP.ppt
Reference Links	

120. Telemedicine at Dr. B. Barooah Cancer Institute, Assam

Subject Area="Access to service and coverage."	Objective="Improve access to cancer care and cancer initiatives in underserved areas."
Details for Reform Option "Telemedicine at Dr. B. Barooah Cancer Institute, Assam"	
Summary	**Background:** Telemedicine (health care delivery system where physicians examine distant patients using communications technologies) has been heralded as one of the several possible solutions to some of the medical dilemmas that face many developing countries. Telemedicine has brought a plethora of benefits to the populace of India, especially those living in rural and remote areas (constituting about 70% of India's population). The North East states have a far higher incidence of cancer than many other regions of the country. The region has for long struggled to deal with the large number of cancer patients. Dr. B. Barooah Cancer Institute (BBCI), Guwahati, Assam, which is one of the largest institutes in the region, has been designated as the Regional Institute for Cancer Research and Training. But, despite the existence of institutions like BBCI in Guwahati, most of the cancer patients from the region, especially those who can afford it, make a beeline to the metropolitan cities for consultation and treatment. Mumbai is a top destination. Apart from being a huge drain of resources, it also means a great deal of inconvenience for the patients and their attendants. But now the patient's sufferings from cancer in the North East have expert help available at their very doorstep. A telemedicine centre has been established at BBCI on December 2003, with the following objectives: * Improve access to cancer care and cancer initiatives in undeserved areas. * Reduce cost of cancer care delivery. * To standardise and ensure practice of Evidence Based Medicine. * Export clinical expertise, increasing the availability of cutting edges cancer protocols and procedures to all affiliate facilities. **Action:** A tripartite agreement was made between the Department of Atomic Energy (DAE), North Eastern Council (NEC) and the Assam Government for funding the Dr. B. Barooah Cancer Institute. The telemedicine centre was commissioned by Indian Space Research Organisation (ISRO), Department of Space and Government of India. It was linked to Tata Memorial Hospital (TMH) and BCCI which is the referral centre for the under served North-Eastern States. It has been linked with other government referral hospitals in the region, including Sikkim. It is a server- based multi channel link. Besides, facilitating point- to point communication, it also enables forward

	and backward linkages. **Results:** Since May 2005 till June 2006 around 60 tele - consultations have taken place in the telemedicine centre. The details are as follows : * Department of Surgical Oncology - 11 consultations * Department of Gynaecological Oncology - 9 * Department of head and neck oncology -16 * Department of Medical oncology – 7* Department of Radiation oncology - 7 * Department of preventive oncology - 2 * Programme transmitted by TMH and participated by doctors from BBCI - 1 * Official meetings (technical committee) and TMH -3 * Planning committee meeting – 2 * Other official meetings- 2
Cost	The full package of entire equipments and connectivity support in case of this facility at BBCI was provided free by ISRO and was implemented in cooperation with TMC. So no separate cost can be assigned for this particular facility.
Place	Dr. B. Barooah Cancer Institute, Guwahati, Assam.
Time Frame	1 year.
Advantages	Improved access: Telemedicine has provided and improved access to cancer care in previously un-served or under-served areas. Reduced Cost: The travel cost of the patients for speciality care to the premier centres, the personnel/equipment cost for not having to keep speciality care facility in rural hospitals and other costs can be reduced. Reduced isolation: Provides a peer and specialist contact for patient consultations and continuing education. It has also been reported that colour, full-motion video is critical to the health professionals for stimulating face to face communication between colleagues in consultations and between patients and physicians. Improved quality of care: It has allowed consultation to take place among the referring physician, the consulting physician, the patient, and the patient's family thought interactive video with critical information of the patient being made available on-line. Telemedicine facilities allows optimal use of resources at both ends of the connectivity; saves time, energy and resources both of the patients, their families and hospitals. Distance learning: The physicians and other personnel at remote locations can be educated during consultations with speciality physicians and other experts, increasing their ability to treat other similar cases in future.
Challanges	Difficulty in Maintenance: Day to day maintenance becomes difficult if there is a lack of technical support. It can take a long time for any technical snag to be fixed.
Prerequisites	Critical mass of patients, who will utilise the telemedicine facility; hardware software and connectivity infrastructure; technical support

	manpower; treaties between linking institutions with support from link providers.
Who needs to be consulted	* Tata Memorial Hospital/Dr. B. Barooah Cancer Institute, Guwahati * ISRO, Govt. of India * State Government of Assam & North Eastern States
Risks	
Sustainability	Telemedicine centres are serving well in the country.
Chances of Replication	Telemedicine centres have been running in other parts of the country also. It's a highly replicable venture. With increasing application of IT in medicine. Such venture will multiply. Apollo is already in telemedicine in a big way.
Comments	None
Contact	
Submitted By	Dhrub Kumar Singh, Consultant, Central Bureau of Health Intelligence, New Delhi. October 2006.
Status	Active
Reference Files	IMGP2078.JPG — Photo IMGP2082.JPG — Photo IMGP2085.JPG — Photo Dr B. Baruah Cancer Institute.doc — Annual Report of Dr. B. Barooah Cancer Institute & BCCI newsletter
Reference Links	

121. Smart Card Initiative for Sex Workers, Karnataka

Subject Area="Access to service and coverage."	Objective="Promoting regular health check-ups of sex workers."

Details for Reform Option "Smart Card Initiative for Sex Workers, Karnataka"

Summary

Background: In the year 2005, it was estimated that 0.1% the female sex workers were HIV positive. The year before 0.07% sex workers were found infected. During the year 2005, the contribution of HIV infection from the sexually transmitted infection afflicted population group has been found to be 1.7 million in comparison to 1.3 million in 2004. An increasing number of persons acquire HIV through high risk sexual behaviour. In order to tackle the problem at its root, Government of Karnataka introduced smart cards to promote regular health check-ups among female sex workers. Karnataka is one of the six high prevalence states in India.

Action: The Smart Card initiative has been developed by the Karnataka Health Promotion Trust (KHPT) in association with Ashodaya Mahila Samanwaya Samiti (AMSS), an association of sex workers of Mysore and Mandaya districts. A pilot project was launched in July 2006 in these two districts; the initiative was supported by Bill and Melinda Gates Foundation and University of Manitoba, Canada. AMSS members were initially given identification numbers for health check-ups which they did not remember.

They were then issued health cards, but these also did not promote regular health check-ups. Pennant Consulting Services, a software company was then approached; it merged the health cards with smart cards, which were then issued to AMSS members. With the smart card a sex worker gets discounts when she shops at the designated stores, but to keep her card valid she will have to go for health check-ups at least once every three months. The smart card also contains confidential medical record of the card holder. The women have to report at the clinic set up by KHPT, Mysore, for sex workers.

Here they undergo a thorough health check-up, for any symptoms of sexually transmitted infections, particularly, HIV. Five business establishments—two restaurants, two garment shops and a provision store—are taking part in the pilot programme. While the vendors can record and read their transactions on these cards, they will have no access to the health data stored on them.

The health data can only be entered and accessed at the clinic, using the main computer. The system is designed in such a way that the Simputers (handheld computing devices developed by Indian

	Institute of Science, Bangalore) will not read cards that have not been updated at the clinic in the preceding three months. **Results:** Findings can be requested from the resource person on the completion of the pilot project. The pilot project has initially involved 500 sex workers from Mysore district and is rolling onto Mandya district.
Cost	Information not available.
Place	Mysore and Mandya districts, Karnataka.
Time Frame	Six to 9 months.
Advantages	Building up self-esteem: The sophistication and confidentiality attached with the card raises the self-assertion and self-recognition among the sax workers. Promoting positive sexual health: It has raised concern among the sex workers regarding their sexual health and shall be accelerating the reduction in STIs and HIV/AIDS. Promoting reproductive health: The regular check-up will further help in interrupting the transmission of HIV virus and STIs from mother to child.
Challanges	Socio-cultural barriers of non-acceptance of sex-workers: the prevalence prejudices and stigma against sex workers itself may resist the initiative. Illiteracy: Smart Card may be difficult to use and taken care by illiterate sex workers
Prerequisites	Baseline data need assessment, supportive environment, advocacy, clinical facility, diagnostic lab.
Who needs to be consulted	Sex workers, health professionals, software companies and business establishments.
Risks	
Sustainability	This initiative is still under trial and needs to be observed further. However, advocacy is crucial to creating a practice of regular health check ups among sex workers.
Chances of Replication	The experience in Mysore district was encouraging enough to extend the initiative to Mandya as well. The detailed nuts and bolts of the implementation process will emerge once the pilot project is complete.
Comments	Monetary incentive can prove an effective strategy to motivate hard to reach high risk population to undergo health check-up on regular basis. The cost involved in attracting them may be far less than the cost spent on treatment and control of STI such as HIV/AIDS.
Contact	
Submitted By	Dr. Anil Bhola, Research Consultant, National Institute of Medical

	Statistics, New Delhi November, 2006.
Status	Active
Reference Files	Smart card.bmp
Reference Links	

122. Kishor Mitra Pariyojana: Life Skills Education Programme for Out-of-School Adolescents, Madhya Pradesh

Subject Area="Access to service and coverage."	**Objective="To improve understanding about relationships, sexual and reproductive health, raising self-esteem and reducing incidence of STIs and HIV/AIDS among out-of school adolescents."**
Details for Reform Option "Kishor Mitra Pariyojana: Life Skills Education Programme for Out-of-School Adolescents, Madhya Pradesh"	
Summary	**Background:** Over 35% of all reported HIV infections in India occur among young people in the age group of 15-24 years. Out of these, the estimate number of young women living with HIV/AIDS was almost twice that of young men. Majority are infected through unprotected sex. Age specific fertility rate in the age group of 15-19 years contribute to 19% of the total fertility rate and only 7.4% of married girls use contraception. The adolescent population in Madhya Pradesh consists of 34.6%. The literacy level is 63.7% out of which male literacy is 76.1% and female literacy is 50.5% Thus many of the adolescents are inaccessible to the sexual and reproductive health, education and services that leads them to early marriage, misperceptions about sex, sexuality and relationship, STIs and HIV; and teenage pregnancies. This initiative is one of the results of the fifth country programme (1997-2002) of the UNFPA-India. It has been implemented by the Department of Health & Family Welfare, Government of Madhya Pradesh in support with the UNFPA as a pilot programme in five districts (under Integrated Population Development Project– IPDP). This initiative has also received support from the Bhartiya Gramin Mahila Sangh, Indore. It was implemented in the year 2002 in the selected villages of each IPD districts and was completed in the September, 2004. Main Activities: The initiative studied the information and counselling needs of the out-of-school adolescents, developed a training curriculum, collaborated with local interested NGOs for capacity building and implemented the life skills education which sensitised adolescents for the following: (i) Awareness of physical changes during adolescence (10-19 years age) (ii) Awareness of emotional changes during adolescence (iii) Awareness of the relationship issues, sexual and reproductive health (iv) Developing understanding about STIs and HIV/AIDS

	(v) Vocational training such as in stitching, embroidery, soft toy making, agarbatti making, to enhance earning resources and orientation to public service offices like Bank and Post Office. (vi) Building up negotiations skills and raising self-esteem (vii) Enhancing the skills of peer educators like leadership quality and communication skills Kishor Mitra Centres also observes special days or weeks like World Population Day and Feeding Week. How was it organised? The programme was implemented in 2002 in the selected blocks of the IPD Project districts. A need assessment was done in the Sidhi district. The Directorate of Health & Family in support with UNFPA prepared a concept note on Life Skills Education Program for out of school adolescents on the line of the IPD Project Output 7 (Knowledge on sexual and reproductive health and life skills of in and out of school adolescent boys and girls improved). The process of organizing this endeavour has been step wise. Clients: Boys and girls of the age 10-19 years. **Results:** The programme reached a total of 3807 adolescent girls and 2253 adolescent boys. The assessment of the programme was conducted by the Preventive and Social Medicine Department of Rewa Medical College, Madhya Pradesh in the year 2005. The programme had better impact in Satna comparing to Rewa districts in terms of the knowledge of the animators and the adolescents girls especially on the sexual and the reproductive health aspects and the type of methodology adopted was quite encouraging.
Cost	Information not available.
Place	Five IPD districts: Rewa, Satna and Sidhi of Rewa division, Panna and Chhatarpur districts of Sagar division.
Time Frame	A period of 14 months starting from September, 2003 to December, 2004.
Advantages	Access and coverage: it met the much sought needs of the out-of-school adolescents and promoted positive sexual health. Building up self-esteem: it enhanced the self-esteem of children through transferring knowledge and skills to lead an economically productive life.
Challanges	Socio-cultural barriers: traditional social barriers about being open to adolescents on sexual and reproductive health issues and the usual tussle among moralists, conservatives and experimentalists school of thoughts. Involvement of females: selection of female animators difficult in a male dominant society as men may not allow women for this activity and for attending any residential training, responsibility of siblings on girls, less interest of females if the project duration is

	too short (as if 3-6 months).
Prerequisites	Baseline data need assessment, supportive environment, Development of training curriculum as per local needs and its pre-testing, trained staff, infrastructure to be used as a place where transferring knowledge, skills and attitudes can occur. Budget allocation as per project area and physical distance from the department head quarter.
Who needs to be consulted	Key people in the community: adolescents, parents and teachers. Local Government bodies, NGOs, health professionals providing STI treatment and counselling services, women welfare organisations, UNFPA field Programme Coordinator and State Government of Madhya Pradesh.
Risks	
Sustainability	Fair, it needs persistent advocacy efforts to maintain a supportive environment and to dilute the social barriers on adolescent sexuality and reproduction which have been existing in the community across generations. Its sustainability can be further enhanced by linking it to the resources available under the national Rural Health Mission.
Chances of Replication	The initiatives on adolescent reproductive and sexual health and on life skills are already being practised in different states as per the local circumstances such as Multi-purpose Youth Centres and Telephone Help-Line in Maharashtra, Better Life Option Programme being run by CEDPA in Delhi, an international non-profit organization for females between the age 12-20 years. Hence, chances of replication are good.
Comments	Considering the deprived conditions of the out-of-school adolescents, their lower literacy level and accumulated life experiences, sensitivity and reluctant acceptance of adolescent sexuality by the society, the training material has to be designed keeping in mind the local epidemiology, culture and social values. There is also a need to conduct 'Training of Trainers' refreshing courses time-to-time to meet the upcoming needs as the programme evolve and develop. Need for involvement of Integrated Child Development Scheme (ICDS) Health Department Need for adolescents friendly health centres in the districts having Kishor Mitra Pariyojana to accelerate the positive impact. Sensitisation of media people to gain maximum support from them.
Contact	
Submitted By	Dr. Anil Bhola, Research Consultant, National Institute of Medical Statistics, New Delhi November, 2006
Status	Active
Reference Files	IPD Project Blocks.doc Need Assessment.pdf Organising Steps for KMP.doc

	Assessment Report.doc
Reference Links	

123. *State Illness Assistance Fund, Madhya Pradesh*

Subject Area="Access to service and coverage."	**Objective="Financial support to BPL families for major surgical procedures in premier hospitals in or outside the state."**
Details for Reform Option "State Illness Assistance Fund, Madhya Pradesh"	
Summary	**Background:** Government of Madhya Pradesh created such a scheme for the benefit of people living below the poverty line. This scheme provides assistance to poor families in case of 13 major diseases, listed by the government, that require surgery and expensive treatment. **Action:** The State Illness Assistance Fund (SIAF) has been created with a grant of INR 10 crores (100 million) (€ 1,723,760). The eligibility criteria for applying for this fund stipulate the person should be a domicile of MP and belong to a BPL family; assistance can be sought for any of the 13 listed diseases. An application form can be obtained from the district collector's office, the district chief medical and health officer's office or from the office of the district civil surgeon or the district hospital. The application has to be submitted to the District Collector and addressed to Director, Public Health and Family Welfare. Along with the form, other attachments that are needed are (1) BPL and residence certificates (will be given by the collector or the sub-divisional magistrate). (2) Certification of the disease, the estimate for the surgery (to be given by Civil Surgeon). The application is then forwarded to the Secretary, SIAF. The application is scrutinised by an SIAF sub-committee before the management group approves it. SIAF sub-committee constituted under chairmanship of the Minister for Health and Family Welfare. Assistance is provided for: (i) cancer surgery, radiotherapy and chemotherapy (ii) Thoracic surgery (iii) Renal surgery and renal transplant (iv) Total hip joint replacement (v) Total knee joint replacement (vi) Head injury requiring surgical intervention (vii) Organ transplant (viii) Comatose condition (ix) Spinal surgery (x) Retinal detachment (xi) Post puerperal complications (xii) Cardiac surgery (xiii) Injuries caused by bomb blast, agricultural machines, industrial accidents and natural calamities. The above-mentioned surgical procedures can be

	performed in 16 recognised institutions or hospitals (see Reference). Initially, a state level committee was formed and registered under MP Societies Act 1973. The committee comprises 10 members, including Chairman and member secretary. The State Minister for Health and Family Welfare is the Chairman. The other members include Director, Public Health and Family Welfare, MP, Principal Secretary, Health and Family Welfare, Principal Secretary, Finance, Director of Medical Services, Director of Medical Education, two members of legislative assembly and two reputed medical experts. The committee is responsible for generating funds for the scheme, assessing the requests and monitoring programme performance. In January 2006, district level committees were formed for prompt service to needy patients far from the state capital. The minister responsible for a particular district is the chairman of the committee. The other members include the District Collector, Civil Surgeon, Chief Medical Health Officer and three persons nominated by the chairman. The maximum amount that can be approved by a district committee is INR 75,000.Assistance ranges between minimum INR 25,000 and maximum INR 150,000. It is provided directly to the government-approved hospital where the patient has been referred to or undergoes treatment. **Results:** Between 1997and 2004, the SIAF Secretary received 5,150 applications; of these only 1, 341 seriously ill patients have been provided assistance for surgical and medical treatment in government recognised institutions. Most of the recipients are from districts of Rajgarh, Mandsaur and Jabalpur. After the formation of district committees, assistance was made available to additional 793 patients (from January 2005 to May 2006).
Cost	The Government of Madhya Pradesh (GoMP) has so far spent more than INR 18 crores (180 million) on 3000 patients.
Place	Madhya Pradesh.
Time Frame	Few months.
Advantages	Life Saving: Treatment, unaffordable by the patient, saves life.
Challanges	Monitoring: Lack of information after the patient undergoes treatment. Time consuming: Bureaucratic procedures can sometimes cause delay in treatment. Rightful recipient: Effective scrutiny so that only the genuinely poor get the assistance.
Prerequisites	Government order.
Who needs to be consulted	GoMP. Directorate of Health Services. SIAF committee members at state and district level.Beneficiaries.
Risks	

Sustainability	Depends on the establishment's will to save the life of a person who cannot afford a certain category of treatment.
Chances of Replication	There is demand for such assistance and the government is in favour of extending it. A similar scheme is in place in Jharkhand, where BPL patients have drawn above INR 1 lakh (100,000) for expensive treatments as in the case of cancer and cardiac surgery.
Comments	Political consideration may also mar the scheme and reduce it to a conduit for granting favours.
Contact	
Submitted By	Dr. Nandini Roy, Research Consultant, National Institute of Medical Statistics, June 2006.
Status	Active
Reference Files	
Reference Links	

124. Amchi- The Tibetan medical system, Ladakh

Subject Area="Access to service and coverage."	Objective="To contribute to the health care system by promoting traditional medical system."

Details for Reform Option "Amchi- The Tibetan medical system, Ladakh"

Summary

Background: Amchi medicine is the communal term used for naming Tibetan medicine in Ladakh. It is found in different regions in the Indian sub- continent, stretching from east to west along the chain of the Himalayan mountains including Himanchal Pradesh (Dharamshala, Lahaul, Spiti) and Sikkim, as well as the neighbouring states of Tibet Nepal and Bhutan, extending until Mongolia and certain regions of Central Asia. This medical model of health systems reflects holistic thoughts in which the sick are treated physically, emotionally and spiritually. Amchi medicine is a conglomerate of science, art, philosophy and religion, each element closely dependent on the others.

It maintains its own ideas about the composition of the universe and the body, in physiology, pharmacology and disease, and is unique in its method of pathological diagnosis and the nature of its treatments. The Amchi text is divided into four major chapters that cover the anatomy, the embroyology, the pharmacology, the physiology, the pathology, the pharmacopoeia, the podiatry, the gynaecology and the treatment.The practitioner or Amchi is considered as an epitome of physical, mental and spiritual values.

Action: There are at present three schemes for Amchi Medicines in Ladakh under the Central Government of India and State Government of Jammu and Kashmir. The main functions of these schemes are research, health care and education. These schemes are:

i) Amchi Medicine Research Unit, Leh: This Unit is part of the Central Council of Research on Ayurveda and Siddha (CCRAS), an autonomous body of the Ministry of Health & Family Welfare. It is concerned with clinical, literary, botanical research and publication on Amchi medicine. An Amchi holding the Katchupa Degree is employed as a Research Officer (on the salary scale of INR 8000 to INR 13000) with other staff assistants. This unit was established in 1976. ii) Health Department, Leh: The Amchi Unit of the health department is under the direction of a Chief Amchi, State Government of J& K. It operates several projects including seminars and supports a total of 40 Amchis which are on Government pay role and promote health care in the remote areas of Ladakh. iii) Central Institute of Buddhist Studies, Leh: This centre is under the Ministry of Human Resources and Culture, Government of India. The medical training wing in this centre was created in 1988. An

	Amchi who holds Katchupa degree is appointed as a lecturer on a salary scale of INR 8000 to INR 12000. **Results:** The above mentioned three schemes are running well in the State. There is one chief Amchi and 40 other Amchis rendering services in the remote and far flung areas of Ladakh. The chief Amchi is on a salary scale of INR 6500 to 12000 and the forty Amchis receive a monthly allowance of INR 300 and INR 1500 annually in raw materials and ready made pills. Besides there are more than 200 Amchis in Ladakh and several active associations of Amchis. They are successfully treating primary and complex ailments and are fully supplementing the allopathic system of medicine in Ladakh.
Cost	Not specified.
Place	Ladakh.
Time Frame	Approximately 6 months.
Advantages	Wide coverage: Amchi practitioners are catering to the health needs of the people in far flung areas and where there are no Primary Health Centres. Conserving the traditional system of medicine: It is also an attempt to conserve the traditional form of Tibetan medicine which was slowly becoming obsolete. No side effects & effective treatment: The Amchi medicines is said to have no side effects. For treatment of broken bones, and some other ailments, Amchis' claim that the treatment is much more effective than Allopathic treatment. Cost Effective: The treatment under this medical system is not at all expensive and well within the reach of poor people also.
Challanges	Declining number of Amchis: The number of students studying Amchi medicine is approximately 6-10 per batch. It is a 5 year course and not many want to opt for it due to limited scope of work opportunities and low payments. Inadequate Government support: Though Amchi medicine has been recognized and supported by the government but the support is far from the desired level. Need for integration: The number of governmental Amchis and their remuneration are severely limited compared to the huge need of public health in Ladakh. It is therefore essential for the practicing Amchis to be integrated under the formal health care system.
Prerequisites	Trained doctors and political will.
Who needs to be consulted	State Health and Family Welfare Department. Chief Amchi.
Risks	

Sustainability	The programme has been running well since it started.
Chances of Replication	Can easily be replicated in States where traditional forms of medical practices exist.
Comments	
Contact	
Submitted By	Prabha Sati, Research Consultant, European Commission Technical Assistance, New Delhi, October 2007.
Status	Active
Reference Files	IMGP2049.JPG — photo IMGP2210-Leh.JPG — photo IMGP2208-Leh.JPG — Photo IMGP2204-Leh.JPG — Photo
Reference Links	

125. Anti-retroviral Therapy for HIV/AIDS patients, Manipur

Subject Area="Access to service and coverage."	Objective="Providing free treatment to people living with HIV/AIDS."
Details for Reform Option "Anti-retroviral Therapy for HIV/AIDS patients, Manipur"	
Summary	**Background:** According to the WHO estimates, of the 40 million People Living with HIV/AIDS (PLHA) in the world, 95% are in developing countries and of the 6 million people currently in urgent need of anti-retroviral therapy (ART), less than 8% receive it. Government of India (GOI) announced a policy commitment to provide free ART on 30th November 2003 with implementation starting from 1st April 2004, in the six high prevalence states - Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Manipur and Nagaland. Later, the Government also added the low prevalence state of Delhi due to its 'high vulnerability'. The GOI plans to provide free ART to 100,000 patients by the year 2007 and 180,000 patients by 2010. This policy development is in line with the declaration of the AIDS treatment gap as a global health emergency and the launch of the WHO/UNAIDS initiatives to provide 3 million people with ART by the end of 2005. Anti-retroviral therapy is no cure to HIV/AIDS. But effective anti retroviral regimens inhibits the efficient replication of HIV virus. Lower frequency of opportunistic infections significantly reduces the cost of management of HIV/AIDS. This helps people lead more productive lives with perceptibly reduced stigma and discrimination. Success achieved in terms of ART delaying the onset of AIDS, has helped in transforming the common perception about HIV from being an immediate fatal disease to somewhat more manageable chronic illness. **Action:** The number of PLHA in Manipur is 23,086 (May 2006). The first ART Unit was launched in April, 2004 at RIMS hospital with a provision for 300 patients. Lots of problems were faced in dealing with PLWHA who demanded more Anti Retro-Viral (ARV) drugs for the needy AIDS patients who were in the waiting list. This was to some extents, relieved after the opening of the second ART Unit at J.N. Hospital on 1st December 2004 with a capacity of 200 patients especially for infected pregnant women their children and spouses. Subsequently, the third and the fourth ART Units were established at District hospital, UKhrul on 1st December 2005 and District Hospital Churachanpur on 15th March 2006. National AIDS Control Organization (NACO) has selected a Regional Paediatrics ART centre at JN Hospital out of the six centres in India as a referral centre for

	North East. One more ART centre is to be established before March 2007 at District Hospital, Thoubal with a target of 200 patients. The main targeted sub-groups given priority for free ART are: (a) Seropositive mothers who have participated in the Prevention of Parent-to-Child Transmission Programme (PPTCT); (b) Seropositive children < 15 years; and (c) People with AIDS who seek treatment at the designated hospitals. The centres are providing: i) ARV drug therapy, follow up and strict maintenance of adherence to treatment to avoid ARV drug resistance. ii) Pre ART cares for Opportunistic Infection (OI), to change the high-risk behaviour and preparation for ART by a team of ART centre. iii) Strengthening of linkages and referral systems with other service providers. Free paediatrics ARV drug formulation is available at ART centres of RIMS and JN Hospital. Paediatrics ARV initiative was launched on Children's Day in 2006. **Results:** The cumulative numbers ever enrolled in the HIV care (till the end of October 2006) are: Males Females Children Total 1. ART RIMS 1,525 796 145 2,466 2. ART J.N. Hospital 1143 746 232 2,121 3. ART, Churachandpur 305 277 85 667 4. ART, Ukhrul 70 55 11 136 The cumulative number of patients who were lost to follow up was 108 at the end of October 2006 and 69 patients transferred out. 118 deaths were reported and the total number of patients alive and both on ART and DOTS treatment is 114. As on 31st October 2006 the number of patients with more than 95% adherence to ART is 2627 patients.
Cost	Not specified.
Place	Manipur
Time Frame	Approximately 4 months to start the 1st ART centre.
Advantages	Comprehensive programme to combat HIV/AIDS: Access to treatment is now perceived as an important component to combat HIV/AIDS. Prolongs the life of patients: By preventing opportunistic infections ART dramatically improves the quality of life and prolongs the life of AIDS patients. Reduction in stigma and discrimination: As treatment options become available, it will help in reducing stigma and discrimination attached to HIV/AIDS.
Challanges	Adherence to ART: Failure to comply with therapy results in the rapid recurrence of viral replications. Limited coverage: The government's programme makes a commitment to cover only a very small percentage of the suffering PLHA, and thus deliberately leaving out a vast number simply because the system cannot afford it. Cost of ART drugs. The price of

	ART drugs have come down but not enough to be within the buying capacity of people infected with HIV. The need for subsidizing the rates of ART is strongly felt as the existing health care set ups have not been able to incorporate free ART for all the people living with HIV/AIDS.
Prerequisites	* Legal agreement between partners.
Who needs to be consulted	Manipur State AIDS Control Society.
Risks	
Sustainability	The programme is sustainable as there are funds available under MSACS, though the ART programme is not covering all the PLHA.
Chances of Replication	The programme is running in Delhi and other states like Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Manipur and Nagaland.
Comments	None.
Contact	
Submitted By	Prabha Sati, Research Consultant, European Commission Technical Assistance, New Delhi and Mr. S.Sahoo, Deputy Director, Field Survey Unit, CBHI, Bhuvneshwar, Orissa, March 2007.
Status	Active
Reference Files	
Reference Links	

126. *Health Awareness Rallies, Rajasthan*.

Subject Area="Access to service and coverage."	**Objective="To create health awareness in the community."**
Details for Reform Option "Health Awareness Rallies, Rajasthan."	
Summary	**Background:** The State of Rajasthan has diversified topography. The wide ranging topography includes rocky terrain, rolling sand dunes, wetlands, barren tracts, river drained plains, plateaus and ravines. The topographical features affect the economic, social and cultural life of its inhabitants. Due to these conditions the benefits of the Government health programmes cannot reach out to the people living in the far flung areas. The health indicators of the state are also not too satisfactory. The growth rate is 22 percent, the birth rate 29 per thousand, Infant Mortality Rate (IMR) 67 and the Maternal Mortality Rate (MMR) is 445. These figures are much higher when compared to the National figures. Health Awareness Rallies or Swasthya Chetna Yatra and free medical camps were organized at the Gram Panchayat headquarters of the districts of Rajasthan from December 1st to 30th December. It was a campaign to spread awareness on health and hygiene among rural people and to benefit the far flung people by free medical camps. This campaign was organized through coordination between various departments like Health, Department of Women and Child Development, Department of Ayurveda, Panchayati Raj Department and Education Department. **Action:** During the course of the Health Awareness Rallies, awareness on nutrition, health, seasonal diseases, infectious diseases, immunization, benefits of small families, total sanitation campaign, Janini Suraksha Yojana, breast feeding and other health related issues was created using simple and locally adapted Information Education and Communication (IEC) materials. For organizing these campaigns, different committees like implementation, monitoring and evaluation committees were formed at various levels. At the State level, Organising and Coordination Committees were formed in which the Chief Secretary and the Secretaries of the respective department were members. At the district level, the District Collector was given the whole sole responsibility of implementation, monitoring and evaluation. Under him a committee was formed which had the Additional Collector as the Nodal Officer and Chief Medical Officer(CMO) as the Secretary and its members were Chief Executive Officer (CEO), district level officials, members from Red Cross Society, FICCI members, Non Government Organizations (NGOs) and representatives from the media. At the Panchayat level the District Collector made the Block

	Development Officer (BDO) responsible for the successful implementation of Health Awareness Rallies. The Block level officials were part of this committee. For 9189 Gram Panchayats falling under the 237 Panchayat Committees of Rajasthan, 334 "Raths" (mobile carts or vehicles) were decorated. These "Raths" were well equipped with audio- visual devices and loud speakers. It was ensured that the Information Officer of the Panchayat Samiti, officials from the Health Department, Department of Women and Child Development and Folk Media team accompanied these "Raths". The inauguration of the Swasthya Chetana Yatra was done in each of the District Head Quarters (except Dungarpur District) on first December 2006 by the Honourable Minister of the State. These "Rath's" followed a route map; starting everyday at two p.m from one panchayat and reaching the other panchayat at four p.m. Through audio visual aids messages on various health aspects were disseminated. Prabhat Pheri, health quizzes and health related slogan writing by children were also a part of the rallies. Every day from 10.00 a.m. to 1.00 p.m. medical camps were organized at Primary Health Centres or Sub Centres or Aganwadi Centres covering as large a population as possible. **Results:** i) 9205 camps organized during the Health Awareness Rallies. ii) A total of 3105610 patients attended the camps, of which 1902598 patients were given allopathic treatment and 1203013 were given homeopathic treatment. iii) 285282 patients underwent pathological tests. iv) 13561 patients were referred. v) 150197 children attended the health check up camps. vi) 55205 BCG; 127213 DPT, OPV I, II & III vaccinations given to children in the age group of 0-1 years. vii) 3871 measles vaccinations and 96692 children (0-5years) were given Vitamin A drops. viii) 202074 women and pregnant women underwent check ups. 75714 pregnant ladies were registered, 5799189 women received iron folic tablets and 66600 pregnant women got tetanus injections. ix) Under the Janini Suraksha Yojana 75873 women were registered and 63052 women received the benefits of the scheme. x) 1058357 Birth and Death Registration Certificates were issued.
Cost	INR 8 crores.
Place	All the districts (except Dungarpur) of Rajasthan.
Time Frame	2 months.
Advantages	Wide coverage: The programme reached out to a large number of people throughout the State within a short span of time (one month). Accessibility to health service: Outreach of health services to people living in far flung areas. Inter-sectoral coordination: It demonstrated excellent inter-sectoral

	coordination between various departments. Intensive use of IEC: The publicity of Health Awareness Rallies was done through television, doordarshan, cable operators, FM radio, hoardings and handouts. Even during the rallies all kinds of IEC was used. Excellent Monitoring and Evaluation System: The three tier monitoring and evaluation system contributed to the success of the programme.
Challanges	Coordination: Coordination with various departments for such a massive campaign was a challenge. Availability of specialists: There were difficulties in arranging for specialist doctors at all the health camps. Availability of Drugs: Ensuring availability of drugs at health camps before the start of medical camps was quite challenging.
Prerequisites	Micro plans. Wide publicity. Good coordination between various departments. Committed Staff.
Who needs to be consulted	* Officials from various concerned departments at the State level. * District Collectors at the district level.
Risks	
Sustainability	There are funds available under NRHM for IEC activities which can be utilised for such kind of rallies/campaigns.
Chances of Replication	The initiative can easily be replicated in other states.
Comments	None.
Contact	
Submitted By	Dr. Kumkum Srivastava, ECTA State Facilitator, Rajasthan and Prabha Sati, Research Consultant, European Commission Technical Assistance, New Delhi, March 2007.
Status	Active
Reference Files	
Reference Links	

127. Mobile Voluntary Confidential Counselling and Testing Centre, Manipur

Subject Area="Access to service and coverage."	Objective="HIV/AIDS awareness testing and counselling."
Details for Reform Option "Mobile Voluntary Confidential Counselling and Testing Centre, Manipur"	
Summary	**Background:** AIDS is becoming the number one killer of young people in Manipur today. The J.N. Hospital, Manipur has provided treatment to more than 250 AIDS patients in the last few years and the Regional Institute of Medical Sciences, Imphal has also come across many patients with AIDS (more than 200 cases) during the last three years. Though there are various programs on HIV/AIDS in Manipur but many people living in the far flung areas are still deprived of the benefits of these programs. They cannot go to the hospital or Voluntary Confidential Counselling and Testing Centre (VCCTC) due to lack of transportation facilities, lack of time, monetary as well as other problems. Moreover, in remote rural and hilly areas people have strong stigma and discrimination against those affected and infected by HIV/AIDS. To tackle these problems, the mobile Voluntary Confidential Counselling and Testing Centre (VCCTC), the first of its kind in North East, started functioning from June 2005 with the financial help from ICCO, Netherlands. Mobile VCCTC is being run in Manipur by Manipur Voluntary Health Association (MNHVA) within the guidelines of National Aids Control Organisation (NACO), Government of India and Manipur State Aids Control Society (MSACS). **Action:** The mobile VCCTC team including one lady doctor, two lab technicians, two lady nurses and two counsellors move around the state reaching the interior parts of the state where high risk groups are mobilized to turn up through the institutional members of the MNHVA. HIV counselling and testing are initiated on clients' free will. Counselling in Mobile VCCTC consists of pre- test and post-test counselling. The blood samples are collected after proper pre-counselling and tested in the laboratory. The screening reports are submitted along with the blood samples to state referral centre at J.N. Hospital for further technical confirmation. Along with individual referral and voluntary approach, the collection of blood sample is also done during awareness programme and health check- up. **Result:** The functioning of the mobile VCCTC has helped in reducing the fear psychosis of high risk groups to a great extent through self awareness. Since the functioning of mobile VCCTC

	people have come out of their solitary confinement and out of the fear of stigma and discrimination. Even people from remote corners are coming forward for voluntary testing along with their family members to the testing spots. It is a sign of people's defiance of social stigma and discrimination and a good indicator of success of this programme. The result in numbers are: Number of blood samples screened -1707 Number of positive cases - 104 Number of females tested positive - 30 Number of males tested positive - 74
Cost	Approximately INR 5 lakhs per year. First year budget was INR 11 lakhs (it included the cost of the vehicle). Testing kits are provided free by MSACS.
Place	Remote risk pocket areas of the 9 districts of Manipur. The programme has been running since June 2005.
Time Frame	1 year.
Advantages	Coverage in remote areas: The programme is targeting the remote risk pocket areas which are otherwise deprived of VCCTC. Cost effective: Potential clients, who are otherwise constrained due to cost of travel and service, consider Mobile VCCTC to be cost effective and convenient. Gender considerations: Makes it convenient for women, some of who would otherwise be denied of services due to lack of financial control and freedom of movement. Great demand: Now, many organizations are approaching the MVHA for extending this programme at their operational areas as it has become a matter of compelling interest in public health sectors.
Challanges	Stigma: Reluctance still prevails amongst some people to take advantage of a service brought closest to them due to social stigma. Measures for continuity: Need for articulating measures for continuity, specially taking care of those who tested positive, information about treatment, referral systems for psychosocial, economic and legal support and adequacy of community education and sensitization of service.
Prerequisites	Agreement between the implementing agency and State Aids Control Society. Trained and committed doctors, counsellors other staff.
Who needs to be consulted	State Government Manipur State Aids Control Society. Manipur Voluntary Health Association.
Risks	
Sustainability	The programme is sustainable as long as there is money for the running cost of the programme. The testing kits are provided for free by Manipur State Aids Control Society.
Chances of Replication	Programme can be easily replicated. A similar program "Mobile AIDS Counselling" is being run by another organisation in Delhi.

Comments	None.
Contact	
Submitted By	Prabha Sati, Research Consultant, European Commission Technical Assistance, New Delhi, March 2007.
Status	Active
Reference Files	vp manipur4.jpg — Photo vp manipur3.jpg — vp manipur2.jpg — photo vp manipur2.jpg —
Reference Links	

128. Promoting Institutional Delivery through Monetary Incentive Scheme, Puducherry

maternal mortality and infant mortality rate."

stitutional Delivery through Monetary Incentive Scheme, Puducherry"

, the proportion of home deliveries of children in the Union Territory of Puducherry was high
lity at the time of delivery were a matter of concern. Under the National Rural Health Missio
s living below the poverty line in rural area and INR 500 to ladies living in urban areas for i
nt lady upto the hospital is paid INR 100 as remuneration incentive. In the Union Territor
s are easily accessible and there is no need for any outreach workers like ASHA, so the incen
ficiary mother.

es Mid-wife (ANMs) have been trained in ante natal care, foetal well being, birth weight and
tion services to the pregnant ladies and motivate them for consulting medical officers at
with the ANM and if there is any drop out in the follow up for ante natal check ups, then ho
rs examine and motivate pregnant ladies for hospital deliveries. The amount is released by the
NM.

usehold Survey- RCH Key Indicators for Puducherry/Karaikal (1998 and 2004) the institution
98 and there is a decrease of 5.1% (from 7.5% to 2.4%) in home deliveries. Thus, safe deliveri

Rural; for pregnant ladies living below poverty line.

erry

ANM: It has boosted the social status of ANM and made her more acceptable and friendly in th

.....

es: Timely diagnosis and treatment of any complication in the prenatal period helps in avoidin

and infant survival: Enhanced accessibility to qualified opinions and medical check ups to th
ce of the infants

rtality: It has also helped in reduction of maternal mortality with quality improvement in pre

ean section: Vested interest of profit among private practitioners has resulted in an increasing
d.

epidemiological data. Refresher training of ANMs in foetal well being. Antenatal check up
ts and obstetricians at primary and secondary care level health facilities Regular budget.

health professionals Directorate of Health and Family Welfare Services Mission Director, NRH

portive Information, Education and Communication activities and positive cooperation fro

lar settings.

onsultant, National Institute of Medical Statistics, New Delhi, January, 2007.

129. Window of Hope for differentially abled, Orissa

Subject Area="Access to service and coverage."	Objective="Access to quality services & other benefits under different schemes"
Details for Reform Option "Window of Hope for differentially abled, Orissa"	
Summary	**Background:** Mayurbhanj, the biggest district of Orissa is a land-locked district with a total geographical area of 10,418 sq.km and is situated in the Northern boundary of the state. This district is dominated by tribals with the main occupation being agriculture related. State commitments for the differentially able due to elaborate legal and policy pronouncements get postponed due to cumbersome procedure and inability of the intended beneficiaries to access promised benefits. The magnitude multiplies when the victims are from impoverished rural and tribal families for want of resources to compensate the loss. A differentially abled person has to collect an income certificate from the Tahsildar, based on that a disability certificate from the Chief Medical Officer of the district and further an Identity card from the District Social Welfare Officer. This expensive, lengthy and painful process is necessary to be eligible for earmarked benefits like employment under disability quota, credit, subsidy and training, allotments for home/shops pension, aids & appliances as well as travel concessions from different sources. **Activities:** To give a new ray of hope for the differentially abled, the District administration Mayurbhanj planned a 'Single Window Initiative'. As a first step, it issued authentic certificates from competent authority to each genuine beneficiary by facilitating a smooth and speedy completion of prescribed formalities. "Single Window System" that provided all these facilities under a single roof on a single date at block levels: Distribution of Disability Certificates Distribution of Income Certificates Distribution of Fare concession Certificates Distribution of Identity Cards Identification to beneficiaries for distribution of aids and appliances and corrective surgery where required. Earlier, ordinarily, children were identified through camps organized by DPEP / SSA to provide aids and appliances. Similarly, the CDMO would hold fortnightly camp in the District Headquarter Hospital to identify the differentially abled. The unique approach of converging the two departments enabled identification of children as well as elderly within a short period.The initiative targets universal access to quality services and all other benefits under different schemes.

	This has been made possible by decentralised service delivery strategies backed by convergence of concerned departments, philanthropic organisations, clients, Panchayats and civil society institutions. The strategies adopted for implementing the initiative/system was done in three steps (Document attached) **Results:** The obvious results are observed in terms of comparison between the earlier systems of issuing cards against the present system. The following table shows the comparison between the previous and the present system: Previous System Present System ·Costs for travel to distant offices· Reducing the hardship & inconvenience .Frequent visits to get the work done Reducing geographical distance in terms of service delivery ·Wage loss for the companion· Reducing cost and time involved to access the service .Payment of bribe Eliminating red-tapism & associated corruption. ·Harassment at various level Convergence of various agencies contributing to convenience and efficiency Better coverage of target groups under various schemes. As compared to the data of achievement regarding issue of handicapped certificates for the last 5 years, the results of the single window camp are given below: Year (January to December) No. Of Handicapped Certificate Issued 2000 109 2001 707 2002 835 2003 1473 2004 1815 2005 872 (upto Nov. 05) Total 5811 Single Window assessment Camp Dec. 05 6451 One of the major results achieved through this initiative is the '17 days' approach, i.e. issuing the cards within this time frame. An equal number of income certificates and Bus Concession certificates were also issued. Aids and appliances are being distributed to the identified beneficiaries. Apart from this measures have also been taken for Cataract Surgery, Cleft lip correction and Polio Corrective surgery.
Cost	Depends on the beneficiaries.
Place	Mayurbhanj District, Orissa
Time Frame	Three months
Advantages	1. Reducing hardship to procure the respective certificates 2. Reducing cost and time involved to access the services 3. Eliminating red-tapism and corruption 4. Better coverage of target groups under various schemes
Challanges	Complete and constant involvement of Collector and District Social Welfare Officer
Prerequisites	Budgetary allocation for the differentially abled persons in various schemes including Sarva Siksha Abhiyan/DPEP
Who needs to be consulted	District Administration, BDOs, Revenue Inspector, Tahsildar, CDMO, CDPO, RTO, Red Cross Society, Anganwadi Worker,

	Teachers and NGOs
Risks	
Sustainability	Depends on budgetary allocation
Chances of Replication	Can be replicated
Comments	None
Contact	
Submitted By	Mr S Sahoo, Deputy Director, CBHI Training Centre, Bhubaneswar, Orissa Manisha Ghose, Research Consultant, HS-PROD, CBHI
Status	Active
Reference Files	
Reference Links	

130. Mobile health clinic, Uttarakhand

Subject Area="Access to service and coverage."	**Objective="To deliver diagnostic and curative health services in inaccessible areas."**
Details for Reform Option "Mobile health clinic, Uttarakhand"	
Summary	**Background:** Over two-thirds of the Uttaranchal State has a difficult geographic terrain and is characterized by scattered and sparsely populated districts. The efficacy of the traditional 'fixed-location' healthcare facilities is severely limited by inaccessibility due to adverse topographical conditions. To make services available to the community mobile health clinics were started in the State. **Activities:** Mobile Health Clinic was initiated to supplement the existing public health facilities. It follows a 'fixed day, fixed time and fixed place' approach to provide health care service in remote, hard-to-reach and poorly served hilly areas in the State.Mobile van named 'Sehat ki Sawari' was started since 17thNovember 2004 in Chamoli District under Garwal division with the help of Standing Committee on Voluntary Action (SCOVA). It serves on twelve fixed points covering five to seven villages en route. Mobile clinic has fixes route plan and covers each point twice a month.Second mobile clinic called Technology for Information forecasting Assessment Counselling (TIFAC) was started in Kumaon division with the help of Birla institute, Bhimtal and run by State and Government of India (GoI). The clinic also provides diagnostic facilities along with curative health care and health awareness programmes in 6 districts (Champawat, Nainital, Almora, Bageshwar, Pithoragarh and Chamoli) covered under TIFAC project. Monthly visit is given at each served area. **Results:** Up to January 2005, under Sehat Ki Sawari:1177 OPD cases seen, 58 Family Planning cases and 63 counselling sessions held. Under TIFAC clinic: Patient attended were- 37,665 OPD patients, 8,305 ultrasounds, 4,729 X-rays, 1,476 ECG, 16,792 lab tests.
Cost	Information is not available.
Place	Chamoli and Kumaon division
Time Frame	Approximate one year.
Advantages	Coverage of difficult area: Mobile vans help to cover all those areas that are inaccessible topographically. Basic services availability: Minimum basic primary health care

	services are made accessible to the community living in difficult area.
Challanges	Inaccessible area: Due to geographical constraints even some area are very difficult to access. Therefore needs intensive IEC to reach on scheduled time. Logistic: drugs and other recurring logistics do pose problems in the smooth functioning. Staff constraints: Professional staff to replace the duty of the posted staff is difficult to get in case whenever it is needed.
Prerequisites	Government order
Who needs to be consulted	State government
Risks	
Sustainability	It is dependent on government commitment and funding
Chances of Replication	Good, especially in difficult hilly areas and limited human resources to deliver services.
Comments	With resource constraints, both financial and human, to deliver services in the uncovered areas mobile clinic is the alternative for optimum utilisation of the available resources
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, NIMS, February, 2006.
Status	Active
Reference Files	
Reference Links	

131. No-Scalpel Vasectomy Centres, Madhya Pradesh

Subject Area="Access to service and coverage."	Objective="Male participation in Family Planning."
Details for Reform Option "No-Scalpel Vasectomy Centres, Madhya Pradesh"	
Summary	**Background:** The acceptance of male contraception methods is abysmally low in India. According to the second National Family Health Survey (NFHS), 1998-99 condom usage is only 3% and male sterilisation 2%. Female sterilisation, by contrast, stands at 36%. In order to promote male participation in family planning, the Union Ministry of Health & Family Welfare, launched the "No-Scalpel Vasectomy Project" in 1998.Government of Madhya Pradesh (MP) followed soon after, by introducing NSV in the state in 1999-2000 under the Integrated Population and Development Project (IPD Project) supported by UNFPA. **Activities:** NSV was promoted systematically in the 5 districts. The first NSV camp was organised in Satna district in November 1999. The doctors trained in NSV played a major role in popularising the procedure. The encouraging results led to upscaling NSV services to other districts the same year. European Commission's Sector Investment Programme (SIP) supported the state government in upscaling NSV services; it was made part of by incorporating it in the State Action Plan. Government of MP decided to establish a NSV Resource Centre in Gwalior within the premises of State Institute of Health Management and Communication, Gwalior with the following mandate: 1. Impart training to Medical Officers (MOs) for expanding the Male Sterilisation Programme. 2. Undertake IEC for promotion of male participation in family welfare programme. 3. Organise NSV camps in all districts of the state. 4. Serve as a technical repository for NSV services. This state level NSV resource centre (NSVRC), the first of its kind in the country, was inaugurated on 12 April 2006. NSV camps are being organised by NSVRC in collaboration with the district administration. The camps are conducted on the first Thursday of every month. **Results:** The technique has become very popular with the medical fraternity. A total of 225 surgeons have so far undergone hands-on training in NSV. Those who have not acquired functional competence and are still willing to perfect their skill are being re-trained. Until now, 75 surgeons have been certified to perform NSV and 25 surgeons have been identified as Camp Surgeons. There has been a steady increase in acceptance of NSV by the community. In 1998-99, only 97 NSV operations were conducted and by 1999-2000, the number of operations went up to 26700). Ever since, there has been a consistent rise in NSV's acceptance (see Reference). The statewide impact has become perceptible only from

	2004-05 onwards.
Cost	UNFPA provided a support of INR. 9.15 crores for capacity building. INR 6, 18,000 was spent in IPD districts for training of MOs in NSV and organisation of NSV camps. INR 69,00,000 spent under SIP for establishment of State NSV resource centre at Gwalior.
Place	Initially, in 5 IPD district of UNFPA – Chhatarpur, Panna, Rewa, Satna and Sidhi. Later, the programme was upscaled to all 48 districts of the state.
Time Frame	NSV was being promoted since 1999. It took about one year to set up the State NSV Resource Centre.
Advantages	Capacity building: Facilitated in providing on-going training to MOs to perform NSV. The resource centre has created a critical mass of trained NSV surgeons and organised mega NSV camps in the state. Advocacy: The resource centre created a body of IEC material for promoting male sterilisation in the community. Coordination: The camps are organised well in advance with support from the district administration. The success of the programme is because of effective co-ordination between service delivery and IEC activities.
Challanges	Quality: Maintenance of quality of care in the camp approach poses difficulties. Integration: NSV is yet to become a part of routine family planning service in the health institutions. Future uncertain: There is no long-term plan to strengthen and sustain the state NSV resource centre. Counselling: There is a need to build on the resource centre's counselling capacity.
Prerequisites	1. Commitment of the State Government. 2. Institutional capacity for sustainability
Who needs to be consulted	1. Coordinator, State NSV Resource Centre/Regional NSV resource centres. 2. Director, Public Health & Family Welfare. 3. Joint Director, RCH.
Risks	
Sustainability	Adequate resource allocations have been made for NSV services in the state under RCH II.
Chances of Replication	Excellent, in view of its efficacy and operational feasibility. Under RCH II, the state planning implementation programme has decided to create three Regional NSV Resource Centres—at Satna, Indore and Bhopal.
Comments	NSV services were available only in three districts of Gwalior, Bhopal and Jabalpur in 1998-99; it increased to 7 districts in 1999-

	2000. The NSV programme in the state received focussed attention in IPD project districts from 2000-2001. Subsequently, NSV services were made available in more and more districts and from 2005-06, all districts, except Vidisha, have been providing the services on a regular basis. Although there is inter district variation in acceptance of NSV 10 districts of the state have recorded higher acceptance consistently. RCH -II has made provisions for strengthening state and regional NSV resource for counsellors have been made.
Contact	
Submitted By	Dr. Nandini Roy, National Institute of Medical Statistics, September, 2006.
Status	Active
Reference Files	
Reference Links	

132. Identity cards to below the poverty line population, Uttarakhand

Subject Area="Access to service and coverage."	**Objective="To facilitate availability of health services to the poor patients."**
Details for Reform Option "Identity cards to below the poverty line population, Uttarakhand"	
Summary	**Background:** The Below Poverty Line (BPL) population form 47.2 % of the total population as declared by GOI. Although, all hospitals are sensitive towards providing medical facilities to poor population but in absence of appropriate identity such patients do not receive adequate attention. Thus it was decided to issue BPL cards to poor patients so that medical facilities are made available to them at no cost. **Activities:** Health card scheme was launched by honourable chief minister on 10th of November 2006. Benefits related to health card are- 1. All the BPL family bearing this card will be entitled to avail free medical and health services in government facility. 2. Card holder get facilitation to obtain assistance under State Ailment Fund, constituted for tertiary care treatment of chronic diseases. 3. The BPL card also helps the BPL family for assistance under Janani Surksha Yojana. 4. The health card may be utilized by BPL family as authentic identity card for seeking help in any government development scheme. **Results:** State government has identified all the BPL families and has developed their cards but scheme may be evaluated later on for coverage of the targeted beneficiaries.
Cost	Cannot be furnished
Place	Uttarakhand State.
Time Frame	It took approximately one year for implementation and process of distribution is still under process.
Advantages	BPL identity cards: Health cards can be taken as identity card for various other government schemes. Privilege: Cards gives them opportunity to avail services on equitable basis.
Challanges	None
Prerequisites	Government order
Who needs to be consulted	State government

Risks	
Sustainability	Sustainable
Chances of Replication	Good, as State can plan their schemes based on database of population below the poverty line.
Comments	It provides opportunity to identify the population below the poverty line and provide them services on equitable basis
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, NIMS, February, 2006.
Status	Active
Reference Files	
Reference Links	

133. Health Accounts- financial data for decision makers

Subject Area="Health financing."	Objective="Information for policy makers."
Details for Reform Option "Health Accounts- financial data for decision makers"	
Summary	**Background:** Over the past 10 years, many countries have established a system of health accounts to provide policy makers with detailed, useful and appropriate financial data. **Action:** National health accounts (NHA) constitutes a comprehensive set of tables designed to quantify, classify and analyse the income and expenditures in the health sector (in both the public and private sector) of the country. At present, expenditures on health have been accounted only for the public sectors. The NHA will seek to integrate both these sectors so that the indicators for the health system of the country on the whole could be ascertained. NHA would, for example, give a clear picture regarding the split between health expenditures by the public and private sector. Similarly it would reveal allocations to the tertiary, secondary and primary levels of healthcare in the country. The Government of India has committed to develop NHA in the National Health Policy 2002. [see para (2.19.2.2) and para (4.19.2)] The Ministry of Health is still in the process of developing this. The issue has been discussed at at least two national workshops. Initial health accounts have been prepared in three states and a framework prepared for the preparation of NHA.
Cost	
Place	Studies conducted in the States of Punjab, Karnataka and Rajasthan. At the national level, the Ministry of Health is in the process of taking this agenda forward.
Time Frame	Could take five to 10 years to get a fully-fledged NHA in place.
Advantages	Comprehensive: Helps to form a comprehensive information base on which policy makers can assess performance and diagnose problems with the health systems in a country and thus take action. Comparable: Allows international comparison of health financing and expenditure patterns. Analytical: Once established, health accounts produced for multiple years allow trends to be analysed.
Challanges	Time consuming: It takes several years to fully establish a system of NHA.
Prerequisites	Data from: (i) Central, state and local government budget documents and statistical abstracts. (ii) Annual reports of state-owned

	enterprises and health insurance companies, in particular, Employee State Insurance Scheme and Central Government Health Scheme. (iii) National Survey Sample Organisation household surveys for private health expenditures. Setting up of a task force in order to decide on the following: (i)The methodology to be used. (ii)The appropriate institutional arrangements to produce the accounts at various levels. (iii) The funding arrangements to produce health accounts. (iv) Training of key personnel in health accounts methodology. (v) Decide on how data would be used e.g. how it would be incorporated into the existing budgeting process. Setting up of a task force in order to decide on the following: 1. The methodology to be used. 2. The appropriate institutional arrangements to produce the accounts at various levels. 3. The funding arrangements to produce health accounts. 4. Training of key personnel in Health Accounts methodology. 5. Decide on how data would be used e.g. how it would be incorporated into the existing budgeting process.
Who needs to be consulted	Government officials at Centre and State level, Research Organisations, Development partners.
Risks	
Sustainability	High, if the political will is there.
Chances of Replication	High.
Comments	It is difficult to put together information for such a vast country as India. Hence it is necessary that the government, as also research institutions and development partners come together to generate the necessary information.
Contact	
Submitted By	Dr Matthew Jowett, Former Programme Advisor, ECTA, New Delhi. September 2003.
Status	Active
Reference Files	
Reference Links	

134. Community-based Health Insurance

Subject Area="Health financing."	Objective="Mobilising community participation."
Details for Reform Option "Community-based Health Insurance"	
Summary	Community-based health insurance (CBHI) schemes facilitate the pooling of financial resources in order to cover the costs of future health problems. In such a scheme it is the community that decides on the level of contribution, the collecting mechanisms and the content of the benefit package, as opposed to national social insurance schemes where these are determined by the insurance company or the government. India has many such schemes that vary in terms of their design and sizes. There are three patterns of schemes that emerge: (i) Provider-owned schemes where the NGO running the scheme is also the healthcare provider. An example is the Voluntary Health Services scheme in Chennai. (ii) The NGO-owned setup where the NGO is the insurer but does not provide healthcare e.g. Raigarh and Ambikapur Health Association (RAHA) in Chhattisgarh. (iii) The NGO acts as an intermediary between the population and one of the General Insurance Corporation subsidiaries e.g. SEWA in Gujarat. While in many of these schemes the NGOs are women's self-help groups, SEWA being the best known example, there are also some milk cooperatives such as the Mallur Milk Co-operative.
Cost	
Place	Various schemes across the country but mainly concentrated in west and south India.
Time Frame	Between one and 5 years.
Advantages	Protection: From getting into debt due to ill health. Such a scheme would also ensure that people are more likely to seek care when needed. Empowerment: Strengthens the process of dialogue within the community and provides an opportunity to discuss health issues. For instance, people enrolled in such a scheme in Gudalur, south India, were unhappy that they were not receiving any injections. The scheme gave them the opportunity to discuss why injections were not necessary for treatment.
Challanges	Low coverage: The poorest of the poor are often not included in these schemes. Requires high participation: Schemes with low membership can be

	financially vulnerable. Lack of quality: The quality of healthcare services has not been taken into consideration. Unless this is taken care of, there will be few takers for CBHI. Requires good management: The reviewing of premiums, benefits etc. can be quite complex. Close monitoring necessary: To prevent the problem of moral hazard effects i.e some individuals using more care than required.
Prerequisites	An understanding of the benefits of risk sharing by the community is an essential prerequisite for the success of any such scheme. Good management capacity, in most cases this is being provided by NGOs.
Who needs to be consulted	Community heads and the general population to be served, the health providers, the insurance company. In some cases NGOs that play an intermediary role or help in providing technical support and training.
Risks	
Sustainability	It is a small scheme. It can be made viable, provided the scheme is integrated into and complements other community empowerment efforts.
Chances of Replication	Each community would have its own set of requirements so no scheme can be replicated entirely. It would have to be modified to suit the needs of the population to be served.
Comments	Even within a state, there are a variety of schemes with differences in terms of their designs and target population. Hence while designing any scheme, one should take into account people's preferences, needs, ability to pay, the disease burden of the community etc.
Contact	
Submitted By	Dr Mathew Jowett, Former ECTA Programme Advisor, New Delhi. September 2003.
Status	Active
Reference Files	
Reference Links	

135. Health Insurance Scheme for Women, Maharashtra

Subject Area="Health financing."	Objective="Mobilising community participation."
Details for Reform Option "Health Insurance Scheme for Women, Maharashtra"	
Summary	**Background:** The HALO Medical Foundation (HMF) trains and works with women to provide reproductive and child health (RCH) services to the rural population in Osmanabad district. Bharat Vaidyas (as these women are called) provide services for a nominal fee that she collects directly from the community. One of the activities undertaken by these women is to form self help groups and women's savings groups. Loans are given to members of the savings group from the funds collected. It was noticed that 25% of loans taken by the women was for medical treatment. Also there was a demand from the community that charges for medical treatments be taken once a year rather than every time they are treated. (For more on Bharat Vaidyas, see entry on 'Training of community health workers, Maharashtra'.) **Action:** HMF then came up with the idea of a life and health insurance scheme for its self-help group members. HMF jointly with Life Insurance Corporation and United India Insurance Company Limited came up with a scheme specially designed for the 'Bachat Sangh' members. The scheme covers members between 18-58 years for the following: (i) Hospitalisation expenses inclusive of maternity extension for first two pregnancies (excluding standard exclusions under Mediclaim) up to INR 5000 (ii) Natural Death INR 20000 (iii) Partial Permanent Disability INR 25000 (iv) Total Permanent Disability INR 50000 (v) Death due to accident INR 50000 Additional benefits under the scheme include: (i) Scholarship to children of insured women who are studying in classes IX to XII @ INR 1200 per year. (ii) Annual health checkup camp at the village by two doctors (one a GP and the other a gynaecologist), with free routine blood and urine tests. (iii) 50% concession on the investigation charges at Halo Medical Foundation Diagnostic Center, Anadur. (Ultrasound, X-Ray, all blood chemistry and urine tests) Bharat Vaidyas are the key motivators for the scheme. Seeing the good response to the scheme and with a demand from the community, a family health insurance scheme- "Rural women's self help group policy" (one of the existing schemes of the United India Insurance Company) was introduced in January 2005 to cover the member, her husband and two children under the age of 18. The premium for a year is INR 375 and a cover of INR 5000 is available as a floater policy for four persons- husband, wife and two dependent children. Thus far 400 women have opted for this policy. The first policy period expires in April 2005 and it is expected that the number will further increase.

	Results: Though the scheme only started in April 2004, the following indicators show a good response: (i) Total No. of women insured: 891 (ii) No. of pregnant women: 39 (iii) Total delivered till December 2004: 20 (iv) Institutional deliveries (at Govt. institutions 5): 18 (v) LSCS (caesarians): 6 (vi) Home deliveries: 2 (vii) Claims submitted: 36 (viii) Claims settled: 33 (91.6%) (ix) Delivery Claims: 13
Cost	Only one initial workshop for workers (the Bharat Vaidyas and their supervisors) was organised costing approximately INR 10,000.
Place	Anandur, Tuljapur Taluka, District Osmanabad, Maharashtra initiated in April 2004.
Time Frame	Six months.
Advantages	Increases affordability: The community can now get services from better health facilities. Increases health-seeking: Now they know they will get their money back, women stop neglecting their health. Incentive for institutional deliveries: Most insurance schemes do not include maternity benefit.
Challanges	Partial cover: Out Patient Department expenses not covered. Restrictive: Stringent conditions levied by insurance companies.
Prerequisites	Consultative workshop with district heads and local leaders; help from media in advertising scheme; identification of ethical medical practitioners and socially motivated insurance officers; an institution (such as HMF) to provide technical assistance (third party administrators).
Who needs to be consulted	Community, NGO staff, insurance companies, Government officials at State and district level.
Risks	
Sustainability	Good provided the following are in place: i) MOU between insurance companies, NGO (third part administrators), public service providers. ii) Ensuring premium - claim ratio is maintained for the scheme to be viable. iii) The set up of a scrutinising committee to avoid bogus claims. iv) Accreditation of private hospitals.
Chances of Replication	The District Panchayat (Zilla Parishad) Osmanabad has now allocated INR 5 lakh which will pay 50% of the premium of all pregnant women in district.
Comments	None.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, February 2005.
Status	Active
Reference Files	

Reference Links	

136. Community Health Insurance Programme, Karnataka

Subject Area="Health financing."	Objective="Mobilising community participation."
Details for Reform Option "Community Health Insurance Programme, Karnataka"	
Summary	**Background:** The main aim of the scheme was to develop and test a model of community health financing suited to a rural community. **Action:** The Government of Karnataka in partnership with UNDP, National Insurance Corporation, Karuna Trust and the Centre for Population Dynamics started a pilot project in two blocks of Karnataka in October 2002. The Karuna Trust is in charge of the overall management of the project. It directly implements the scheme in one block while the health department under the Chief Executive Officer (CEO) of the Zilla (District) Panchayat implements it in the other. The premium is INR 30 per person per year for those Above the Poverty Line (APL). This is fully subsidised for the Scheduled Castes and Scheduled tribes (SC/ST) Below the Poverty Line (BPL) and a subsidy of INR 10 is provided for non SC/ST BPL. The scheme provides a health insurance cover of INR 2,500 including all cases of hospitalisation including maternity care at public health facilities. In addition, INR 50 is given to compensate for wage loss and the hospital is given INR 50 for drugs. The scheme provides comprehensive healthcare without any exclusions. Local community organisations such as women's Self Help Groups (SHGs) and Village Health Committees (VHCs) are involved in motivating people and collecting premiums in their local area. This was taken even further at one block where the SHGs also provided micro-credit to members for outpatient care and set up a herbal garden and produced herbal medicines. **Results:** The first phase ran for one year. It has since been extended to include two more blocks. A good response in the first phase helped reduce premiums in the second phase to INR 20.52 . This time subsidy was only provided for the SC/ST BPL. A total of 85,092 persons (of which 82,546 were SC/ST BPL) were enrolled in the first phase of the scheme in the first block (T.Narsipur). The proportion of claims to total premium paid was only 23%. In the second block (Bailhongal), a total of 52,750 (32,428 BPL SC/ST)

	subscribed to the scheme. However here the proportion of claims to total premium paid was 78%. A possible reason for this high rate could be that here two Primary Health Centres (PHCs) were the designated health institutions while in T. Narsipura, the designated service delivery institutions were two Community Health Centres (CHCs). Also there was more emphasis on preventive services in T.Narsipura such as the herbal garden initiative. The second phase in T.Narsipura saw 65,770 members of which 61,780 were SC/ST BPL. The ratio of claims to premiums also increased to 58% possibly due to the reduced premiums and enhanced benefits. There was a dip in numbers the second year - probably due to the number of members who seemed to have left the area. In addition 33,716 tribal and rural people in Yelandur Taluk of Chamarajanagar District were also included in the scheme.
Cost	Approximately INR 50 lakhs to set up and run – excluding the premium subsidies.
Place	The pilot project was implemented from September 2002 in T. Narsipur block of Mysore district and from October 2002 in Bailhongal block of Belgaum district. (Phase II) From April 2003 in Yelandur, Charamarajanagar and Kollegal blocks of Charamarajanagar district (only for SC/ST BPL) and from mid-June 2003 in Belgaum block (only rural areas).
Time Frame	About 6 months to initiate the process.
Advantages	Increased access: To healthcare services to the poor and marginalised, especially women. Increased awareness: Among people of the benefits of risk sharing by the community.
Challanges	Possible opposition: Initial problems of getting Government Hospitals to cooperate.
Prerequisites	Requires good management (mostly from NGOs) and close monitoring. Any such scheme should provide reasonable benefits (if possible without any exclusions) at minimum premium and include an element of wage loss compensation. The scheme should be kept simple - avoiding a lengthy collection/claim procedure - to encourage people to subscribe.
Who needs to be consulted	Government Health & Family Welfare Department officials at State and District levels; CEO of the Zilla Panchayat; NGO representatives; Community organisation members (SHGs, VHCs etc.)
Risks	
Sustainability	Variable. Sustainability of the T.Narasipur and Yelandur project has been ensured because of participation and ownership of SHGs. The sustainability of the Bailhongal project depends upon the initiation of a State-wide World Bank health insurance programme which is currently at the planning stage (April 2005).
Chances of	The pilot demonstrates that the scheme can be expanded or

Replication	replicated elsewhere with necessary regional modifications. Sustainability and chances of replication were two main criteria that were taken into account during the design of the scheme.
Comments	The project illustrates that the larger the involvement of the community (such as panchayat bodies, village health committees, SHGs) in the implementation of the scheme, the more successful it is likely to be.
Contact	
Submitted By	Sara Joseph, Researcher, April 2005
Status	Active
Reference Files	
Reference Links	

137. Yeshasvini health insurance, Karnataka

Subject Area="Health financing."	Objective="Mobilising community participation."
Details for Reform Option "Yeshasvini health insurance, Karnataka"	
Summary	**Background:** Karnataka has many hospitals and medical colleges but bed occupancy rate was as low as 35% and a large number of people were dying without proper treatment because people could not afford hospitalisation. **Action:** The Yeshasvini health insurance scheme, launched in June 2003, was developed by the Narayana Hrudayala Foundation in association with the Department of Cooperation, Government of Karnataka, to cater for 17 lakh farmers. The scheme is self-funded and does not have insurance cover from any insurance company. The scheme offers free consultations, diagnostics at discounted rates and all types of operations on the stomach, brain, gall bladder, spine, bones, kidneys and heart for a monthly payment of INR 5 (€ 0.09) (INR 60 per person per year). The Government pays INR 2.50 (€0.045) (INR 30 a year) for every member, making it a yearly premium of INR 90 (€1.64). This year it has been increased to INR 120 (€ 2.19) for every adult member and INR 60 (€ 1.09) for children below 18 years to encourage family membership. The farmers' cooperatives collect the premiums - in most cases societies pay the annual premium for the members and deduct the amount from their transactions over the year. The amount from the societies is deposited to the Yeshasvini Trust account. The type of surgeries and their cost is mutually agreed upon between the hospital and the trust. The Family Health Plan Ltd. (IRDA recognised) has also been contacted by the Yeshasvini trust as the Third Party Administrator to carry out the scheme's day-to-day management. At present, the scheme recognises around 150 private hospitals throughout Karnataka. Members receive Yeshasvini identity cards which enable them to get treatment in the hospital of their choice. **Results:** In the first year the scheme had 1.7 million people and in the second year around 2.5 million people. At the end of 18 months more than 22,000 farmers had undergone operations.
Cost	Since it is a self-funded scheme, the entire cost has to be borne by the Trust. Initial cost of implementation was borne by Narayana Hrudayalaya. However they were unable to provide PROD with the costs.
Place	Karnataka since June 2003.

Time Frame	Approximately one year to setup.
Advantages	Financial protection: Prevents the poor getting into debt due to ill health. Increased awareness: Among people of the benefits of risk sharing by the community. Service improvement: Encourages the health care industry to upgrade services to enable optimum utilisation of their facilities.
Challanges	Requires high participation: A minimum of 10 lakh members are necessary to make the scheme viable. Limited cover: Covers only surgical interventions. Including essential inpatient treatment would encourage more people to take to the scheme.
Prerequisites	The existence of groups such as a farmer's co-operative society which overcomes the problem of the poor being unable to pay premiums as a lump sum and reduces administration costs in the collection of premiums. This could also help reduce adverse selection since this scheme covers pre-existing diseases. The premium should be collected for the whole year and deposited before the launch of the scheme. If the membership fees are only collected on a monthly basis, the logistics amount to more than the actual cost of the premium. A list of comprehensive packages for each operation needs to be agreed by the recognized hospitals. The total package must be paid for by the Health Scheme, including additional charges if he/she develops complications that require additional stay and treatment.
Who needs to be consulted	Government officials at State and district levels; Cooperatives; Health institutions; a charitable institution or a trust and an institution that can act as a Third Party Administrator.
Risks	
Sustainability	Good but requires a large membership base so as to ensure premium - claim ratio is maintained.
Chances of Replication	Based on this success, Narayana Hrudayalaya has initiated another scheme covering one block in Karnataka including inpatient treatment. (See PROD entry on Arogya Raksha scheme) A similar scheme is also being contemplated for teachers. Replication is only possible in states that have adequate hospital facilities and where co-operative organisations exist.
Comments	Future plans include giving members a smart card which they can charge with money at post offices, banks and other organisations.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, April 2005
Status	Active

Reference Files	
Reference Links	

138. *Arogya Raksha Yojana Health Insurance, Karnataka*

Subject Area="Health financing."	**Objective="Mobilising community participation."**
Details for Reform Option "Arogya Raksha Yojana Health Insurance, Karnataka"	
Summary	**Background:** The Yeshasvini health insurance scheme was developed by the Narayana Hrudayala Foundation in association with the State Cooperative Society to provide insurance to the farmers of the State to cover surgical interventions. After implementing the Yeshasvini for more than 18 months, it was decided that it was necessary to increase the insurance cover to include inpatient medical treatment. **Action:** Therefore on a pilot basis, a new health insurance scheme was drawn up for one block-Anekal in Karnataka. A trust was formed with Biocon Foundation and Narayana Hrudayalaya Foundation to create the 'Arogya Raksha Yojana'. The risk is covered by ICICI Lombard General Insurance Company. The Third Party Administrator (TPA) has been selected by ICICI. TTK limited has been contracted for a year to administer the scheme. The premium for individuals was INR 180, INR 150 for a family of two and INR 120 if four or more members of a family enrolled together. This was done to encourage family enrolments. ICICI organised enrolment camps where people could walk in with residence proof, pay the annual premium and get their photo-id cards. Under this scheme, free out patient consultations, discounted diagnostics, cashless surgical treatment for over 1,650 operations and in patient treatment for up to three days is offered at 17 accredited hospitals. 'BioCare' pharmacies have also been set up to provide generic medicines at discounted rates. These pharmacies are managed by an NGO- Karuna Trust and stock quality generic drugs from Biocon and other companies. Other initiatives include involving volunteers to educate the community on preventive health measures. Community education programs are being conducted at the village level where trained resource people do sessions on three broad issues- nutrition, hygiene and preventive care. **Results:** Sixty thousand members were enrolled in February 2005 when the scheme began. Because it is a new scheme, it has not

	been evaluated.
Cost	Arogya Raksha Trust was unable to provide PROD with the marketing costs. ICICI spent approximately INR 3 lakhs on photo-id cards (approx INR 5 each).
Place	Anekal block, Bangalore (rural) district, Karnataka since February 2005.
Time Frame	It's much easier to enrol an organised group (such as that done under the Yeshasvini scheme) than to sell to individuals but set up should take approximately six months if you are familiar with the area.
Advantages	Increases affordability: The community can now access and avail better health services.
Challanges	Requires high participation: Schemes with low membership can be financially vulnerable. Challenges faced: It involves concept selling and retailing (convincing, motivating and persuading people door-to-door) which is very time consuming and difficult.
Prerequisites	The existence of a reliable NGO/Trust in the area. Hospitals and institutions providing good healthcare facilities.
Who needs to be consulted	Health institutions providing care, a charitable institution or a trust, an insurance company and an institution that can act as a Third Party Administrator.
Risks	
Sustainability	In order for such schemes to be self sustaining, large numbers need to be enrolled. Quality of service is the most important issue in ensuring the numbers.
Chances of Replication	Variable. Each community has its own set of requirements so no scheme can be replicated entirely. It would have to be modified to suit the medical needs and financial capacity of the population to be served. This scheme is a pilot and if it is successful, the intention is to replicate it in other parts of the State.
Comments	This scheme is totally independent of the government set up.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, April 2005
Status	Active
Reference Files	
Reference Links	

139. Medical Aid Plan for voluntary health insurance, Tamil Nadu

Subject Area="Health financing."	Objective="Mobilising community participation."
Details for Reform Option "Medical Aid Plan for voluntary health insurance, Tamil Nadu"	
Summary	**Background:** Voluntary Health Services (VHS), a non-profit charitable organisation registered as a society. Dr.K.S.Sanjvi founded it in 1958 to meet the comprehensive medical needs of poor and middle-income sections of the community in Adyar, Chennai. The health services of the VHS can be broadly classified according to the level of care provided. Primary health care is delivered through Mini Health Centres (MHC) whereas specialised curative and diagnostic services are provided at a hospital and a Medical Centre, which also acts as a referral centre for the MHCs. The hospital is fully equipped and staffed and has grown into a 405-bed institution with a range of departments. **Action:** The Medical Aid Plan (MAP), a health insurance scheme offered by VHS, was conceived in 1958. It is based on voluntary subscription of the people on the basis of a sliding scale in relation to income. The head of the family is considered as a member on payment of an annual membership fee and his family members are considered as dependents. The monthly income of the prospective subscriber is usually assessed on an informal basis, although formal income assessment may be conducted either through income certificate or ration cards in cases of casual employment. Non-subscribers use the services after payment of the amount charged according to their capacity to pay. The collection is from two sources, the Medical Aid Plan (MAP) and user charges. User fees are levied for all direct personal services using a two-tier tariff schedule. The first charges are graded on the basis of membership to MAP and the second according to income. The sliding fee scale is employed for both subscribers and non-subscribers of the MAP. There is no waiting period following enrolment; the individual or family is immediately entitled to free Out Door Patient (OPD) services at MHCs and inpatient treatment at the tertiary referral hospital at concessionary rates. Categories of the subscribers based on monthly income and annual subscription fees are as follows: S.N. Category Monthly Income Annual membership INR INR Individual Family 1 Free Upto 750 35 80 2 Low Income Group 751-2500 70 120 3 Middle Income Group 2501- 5000 125 200 4 High Income Group 5001 and above 200 350 VHS in Adyar is the nodal referral center for 14 Mini Health Centres (MHCs) operating in adjoining Kancheepuram district. (For details of the MHCs see PROD entry No.126 Mini Health Centre Scheme, Tamil Nadu). **Results:** The total number of OPD attendance in 14 MHCs was 44,000

	during the year 2004. Of these, 26,000 were subscribers and 18,000 non-subscribers. Utilisation data of VHS: Facility/ Year 1999 2000 2001 2002 OPD utilisation 88910 69870 75501 57110 % of VHS OPD by free group 58% 63% 40% 44% VHS admission 8038 8226 7628 7404 % of VHS admission by free group 61% 45% 40% 42%
Cost	Information not available for establishment and running of the facility. But there are 5 major source of revenue generation- 1) Patient collection from MAP scheme and user charge 2) Government grant 3) Interest earnings 4) USAIDS 5) Private recurrent donations
Place	VHS hospital and Medical centre is located in Adyar, Chennai, and 14 MHCs under the VHS are in two blocks- St. Thomas Mount community development block and Thiruporur block of Kancheepuram district.
Time Frame	In the period of 1958- 1963, VHS has grown into fully equipped and staffed Medical centre.
Advantages	Risk pooling: Health insurance with charges set according to income makes services available to those with limited economic access to specialised care. Resource pooling: A nominal amount is encouraged from the weaker section of the society.
Challanges	Uneven subscription: The majority of the subscription is from the free category. Low motivation for renewal: Prime motive for subscription is to avail the tertiary care services. After availing the services renewal rate of the scheme is low. Of the subscribed population only 30-35% renewed their membership in the period of 1999-2003. Distance factor: Subscription depends on proximity of the referral hospital to community As the distance increases the rate of subscription decreases. Open to abuse: Absence of waiting period between enrolment and availing of services offers opportunities for abuse.
Prerequisites	Private health care facility runs by NGO or corporate sector.
Who needs to be consulted	Corporate sector, State government.
Risks	
Sustainability	The scheme is sustainable because of the fact that the single largest source of revenue generation is patient collection (both from user charge and premium collected), which accounts for 57% of the total income generated.
Chances of Replication	Replicable provided the initiative gets sustained support from the community and State government as well as from the Centre.
Comments	Pooling of resources according to ability to pay and cross subsidization

	is a growing concept in India due to resource constraints. Schemes can be made more viable by addressing issues such as the waiting period for utilizing the services after subscription and promoting the coverage through renewal of subscriptions.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, IRMS, July 2005
Status	Active
Reference Files	Schematic representation of MAP.doc — Schematic Representation and Plan categories health-Lok Satta.pdf — Ensuring a Healthy Future - Lok Satta VHS-Medical aid plan.jpg
Reference Links	

140. Integrated Insurance Scheme, Gujarat

Subject Area="Health financing."	Objective="Mobilising community participation."
Details for Reform Option "Integrated Insurance Scheme, Gujarat"	
Summary	**Background:** This Community Based Health Insurance Scheme is run by the Non Government Organisation (NGO) Self-Employed Women Association (SEWA), based in Ahmedabad, Gujarat. One of its primary activities is providing financial services for women and this was widened in 1992 to include health insurance as part of a wider insurance package including life, accident and asset insurance. **Action:** The scheme initially targeted just women in the informal sector but now includes men too. Members must be between 18 and 60 years old and a member of the SEWA union. They are asked to pay INR 85 per annum. In addition, women members can become lifetime members by paying a fixed deposit of INR 1,000 and the interest on this is used to pay the annual premium. The deposit is returned to her when she turns 60. The scheme covers: (i) Inpatient care (ii) Hospitalisation cover, plus one-time payment for denture and hearing aid. Members can use any kind of hospital, public, private or trust. (iii)Delivery benefits for fixed deposits members. There is a cap on reimbursement of INR 2,000 per year. At the time of discharge, the member must pay for the bill and apply for reimbursement from the scheme. Services excluded include pre-existing conditions, normal deliveries and conditions related to HIV/AIDS. The scheme is managed by SEWA which purchases medical insurance from a Government Insurance Company subsidiary National Insurance Company (NIC) and ICICI Lombard. **Results:** Membership has grown from approximately 5,000 in 1992-93 to 30,000 in 2000-01 to 100,000 individual members in 2005, covering approximately 17%, or one in six, of the population. However rates of utilisation have been low with approximately 18 claims per 1,000 members per year. In 13 years, 27,046 women have received INR 50 million in claims. Reimbursement takes place on average just over three months after discharge from hospital depending on when the claim is made. Since the scheme started, premiums paid by annual members plus interest from the fixed deposits of lifetime members has always exceeded medical claim payments. However if the costs of administration and social marketing are included, the amount collected through premium may fall short of covering the entire cost of the scheme.
Cost	SEWA obtained an INR 10 million original corpus grant fund from the German Government to help set up the project. Current running

	costs are INR 15 million per annum, supported by the premium, the Consultative Group to Assist the Poor (CGAP) and the Ford Foundation.
Place	Eleven districts of Gujarat since 1992. Has since been extended to Madhya Pradesh, Rajasthan, Uttar Pradesh, Bihar, Delhi, Kerala and Tamil Nadu.
Time Frame	One year for core infrastructure but it took 14 years to reach the present level of organisation, human resources and infrastructure.
Advantages	Increased demand: Insurance creates demand for government health services. Long-term cover: By linking insurance to other financial services provided by SEWA (savings and credit), the scheme provides longer-term cover. Economic support: Provides essential financial support during crises. Promotes planning: Encourages women to plan their future through insurance and promotes organisation and cooperation within the community for better financial security. Generates jobs: Insurance promotion can be a source of employment. Health promotion: The scheme is linked with health programmes to help promote health care and prevent spread of disease.
Challanges	Prepayment concept: Members have to accept that to be part of an insurance scheme, they must pay for a service that they might not use. See comments box. Low awareness: Members need to be reminded that they insured for their health. Many remember they have life insurance but forget they have health insurance. Promotion costs: Promotion and marketing costs are high when insuring the poor as are the processing of claims. Inflation: Premiums can only be increased very gradually.
Prerequisites	Social infrastructure: A network, built on trust, of poor women. Capable team with a variety of skills (financial, marketing, health management). Funds. Technical support of an actuary.
Who needs to be consulted	Central Government (who provided the original social fund, NIC). Community members. Trade unions. Development partners (in this case the Government of Germany, CGAP, Ford Foundation, International Labour Organisation (ILO)).
Risks	
Sustainability	The life and accident components of the scheme are sustainable but the asset and health components are not yet sustainable. The administrative costs still require grants.

Chances of Replication	The scheme began just in Gujarat but has since been extended to other states – Madhya Pradesh, Rajasthan, Uttar Pradesh, Bihar, Delhi, Kerala and Tamil Nadu.
Comments	SEWA carries out an annual, intensive campaign to promote its insurance package at grass-roots level. Administrators estimate that it takes three face-to-face visits before members can grasp the concept of insurance.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi, November 2005.
Status	Active
Reference Files	EPW (Akash).pdf — Akash Acharya, M Kent Ranson: Health care Financing for the Poor: Community-based Health Insurance Schemes in Gujarat. Economic and Political Weekly, September 17 2005.
Reference Links	

141. Health Insurance Scheme, Gujarat

Subject Area="Health financing."	Objective="Mobilising community participation."
Details for Reform Option "Health Insurance Scheme, Gujarat"	
Summary	**Background:** This community-based health insurance scheme was run by Navsarjan, an NGO established in 1988 for the dalit (untouchable) community. The health insurance idea was initiated by Navsarjan. **Action:** The organisation bought the 'mediclaim' policy from New India Assurance and paid the premium. They ran the scheme for a one year pilot period: coverage period was from March 17 1999 to March 16 2000. Premium charged was INR 175 per member paid by Navsarjan to GIC. New India Assurance gave a 5 per cent group discount. Covered only inpatient care. Free hospitalisation up to INR 15,000 was also included at just one hospital in Patan. Five doctors (two orthopaedic surgeons, one gynaecologist, one physician and one general surgeon) were approached in Patan town and agreed to treat members who produced a valid membership card. The doctors gave treatment on credit and were paid every three months. **Results:** Had only 574 members (all the Navsarjan members in Sami and Harij Talukas of Patan district), less than one per cent of the population. During the year, 57 claims were made costing INR 81,130 . Of these claims, 21 were rejected and Navsarjan bore the cost of two of them. The other 19 members had to pay for their own treatment which caused much discontentment. But by the end of the scheme most members said they were happy with it and were willing to pay the premium themselves if the scheme were restarted.
Cost	Total premium paid INR 91,216.
Place	Sami and Harij taluka of Patan district, North Gujarat, 1999-2000.
Time Frame	Approximately three months.
Advantages	Improved access: The community had previously (particularly women with gynaecogical problems) avoided doctors because of the cost.
Challanges	Fraud: Doctors inflated bills, overprescribed medicines and advised unnecessary hospitalisation when they knew the patient had health insurance. Managerially demanding: The scheme was time consuming and expensive to run.
Prerequisites	Good communication and relationship between the doctors and members. Clear understanding of the health insurance policy by all

	parties.
Who needs to be consulted	The Community. Staff at the NGO (in this case Navsarjan). Medical community.
Risks	
Sustainability	No. The scheme was partly subsidised by Navsarjan's Social Security membership fund (a larger comprehensive scheme which included accidental death, maternity benefits etc and had a membership fee of INR 400 per annum and partly by HIVOS (a funding agency)). Navsarjan did not continue the scheme beyond the pilot stage because it realised that it needed a huge commitment in terms of time, money and manpower to run and they wanted to focus on their primary activity, working with dalits. However the doctors were interested in continuing the scheme and offered to subsidise the premium on behalf of the members if Navsarjan was willing to coordinate the process. But Navsarjan declined for the following reasons: (i) Although the scheme was viable, it would primarily benefit the doctors who owned the clinic, pathological lab and also drug store. (ii)The drugs prescribed were more expensive (next generation) which contravened Navsarjan's ethical code and community health worker policy.
Chances of Replication	Navsarjan judge that this scheme is replicable but that the NGO would need to use doctors committed to their policies. Navsarjan suggests any NGO trying to run such a scheme should establish its own 20-bed hospital with its own committed doctors dedicated to their philosophy of community health.
Comments	None.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi, November 2005.
Status	Active
Reference Files	EPW (Akash).pdf — Akash Acharya, M Kent Ranson: Health care Financing for the Poor: Community-based Health Insurance Schemes in Gujarat. Economic and Political Weekly, September 17 2005.
Reference Links	

142. Sardar Patel Aarogya Mandal, Gujarat

Subject Area="Health financing."	Objective="Mobilising community participation."
Details for Reform Option "Sardar Patel Aarogya Mandal, Gujarat"	
Summary	**Background:** This community-based health insurance scheme is run by a charitable trust the Sardar Patel Arogya Mandal on behalf of the AMUL dairy company. It is not a formal insurance scheme but a way of ensuring that members of the dairy cooperative have the means to pay their health bills. **Action:** The scheme is open to all members of AMUL's dairy cooperative. It charges a premium of 1.5 paisa deducted from each litre of milk deposited plus one rupee per family per year. Members must deposit a minimum of 300 litres of milk per year and are not allowed to sell to AMUL's competitors. It covers inpatient and outpatient care and free hospitalisation at selected referral hospitals. Members must go for treatment at the Tribhuvandas Foundation (TF) (a trust also set up by Amul's founder chairman to provide health services to its members) or any of its sub-centres for referral to hospital. It has signed a Memorandum of Understanding (MoU) with 9 hospitals (all trust hospitals) and patients are admitted by showing a membership card containing the names of all family members. Bills are then sent directly to the Sardar Patel Arogya Mandal office on a monthly basis so the patients are not out-of-pocket at any stage. There is a cap of INR 7 to 10,000 on average on reimbursement but at the discretion of the management, reimbursements of up to INR 1 lakh can be made. Services excluded include angiography, angioplasty, bypass surgery, all cancers, major orthopaedic operations (joint replacement) kidney transplant, AIDS and TB. **Results:** The scheme has 83,000 family members.
Cost	In 2004, the scheme collected INR 27 lakhs through premiums but the total cost of hospitalisation exceeded INR 1.25 crore. The cost was borne by AMUL.
Place	Kheda and Anand districts, Gujarat. Since 2001.
Time Frame	Two years.
Advantages	Improved use of medical facilities: Insured members are more likely to seek care when they are ill. Direct billing: Hospital bills go directly to the Sardar Patel Arogya Mandal office so the patient is not out-of-pocket.
Challanges	Excludes the poorest: The scheme excludes those who cannot deposit

	a minimum 300 litres of milk per year. Prepayment concept: Members have to accept that to be part of a health insurance scheme, they must pay for a service that they might not use.
Prerequisites	Funding. Staff for collecting funds and processing claims.
Who needs to be consulted	The Community. The organisation backing the scheme (in this case AMUL).
Risks	
Sustainability	This scheme is not currently self-sustaining. It is heavily subsidised by AMUL (see costs box).
Chances of Replication	This scheme has not been replicated elsewhere. It is specific to rural, cattle-rearing areas.
Comments	None.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi, November 2005.
Status	Active
Reference Files	EPW (Akash).pdf — Akash Acharya, M Kent Ranson: Health care Financing for the Poor: Community-based Health Insurance Schemes in Gujarat. Economic and Political Weekly, September 17 2005.
Reference Links	

143. Graded user charges for hospital service improvement, Madhya Pradesh

Subject Area="Health financing."	Objective="User fees."
Details for Reform Option "Graded user charges for hospital service improvement, Madhya Pradesh"	
Summary	**Background:** Unhygienic, dilapidated hospitals and health centres due to lack of funds. **Solution:** Rogi Kalyan Samitis (RKS) or Patient Welfare Committees – management groups made up of members of the state and of the community – were authorised by the state government to levy user charges for services provided and also to receive donations. They were given the ability to mobilise finances (if necessary from banks) for (i) new construction, (ii) providing modern testing facilities (eg CT scans etc.) on the hospital premises using the private sector, (iii) Development of vacant land for commercial purposes. They can also recruit part-time cleaning/security staff, paramedical staff and accountants on a contract basis. They can seek exemption (for donations received and income earned) from income tax. They can incur expenditure on recurring items that are not available through the regular budget and items that are available through the regular budget but are in short supply. Their sources of finance now included revenues from income generating activities (eg cycle/ scooter stand, chemist, canteen, rents from leased out properties); loans from banks and financial institutions; loans/grants from state government and/or other agencies other than the user fees and donations they had earlier. **Results:** There are no figures available but the project leaders report the following: An increase in the sense of involvement of the community. An increase in the number of patients coming to government hospitals. An improvement in the efficiency of doctors and a strengthening of public institutions including a decrease in their deterioration and enhancement of their credibility.
Cost	Information not available.
Place	Madhya Pradesh at all levels of hospital services since 1999.
Time Frame	Six to 12 months to set up the committees.
Advantages	Financial sustainability: Increased.
Challanges	Equality of care: Care must be taken to ensure that those who are unable to pay should still be entitled to free services.
Prerequisites	Success of the model requires capacity building of the management bodies of RKS, a transparent system, responsiveness and communication with community.
Who needs to	State government, RKS management bodies and staff of hospitals.

be consulted	
Risks	
Sustainability	Sustainable but requires close monitoring.
Chances of Replication	The model is but the process would vary from one RKS to another, thus design must address issues in process management. RKS have been formed in 43 district hospitals, 53 civil hospitals, 228 community health centres and 717 primary health centres in the state.
Comments	During the year 2003-04, the RKS collected Rs 1183.52 lakhs and spent Rs 553.69 lakhs. There have been almost no protests in the state over the introduction of user charges. Each RKS is free to use the funds as it sees fit, within certain broad guidelines.
Contact	
Submitted By	Dr. S. K. Shrivastava, Member Secretary, SRB, Madhya Pradesh email skshrivastava@mp.nic.in. July 2002.
Status	Active
Reference Files	GO No F-8-1-99-17-Med2(PROD No 24).doc Reform Ideas at Work.doc
Reference Links	

144. Retention of user fees at health facilities, Punjab

Subject Area="Health financing."	Objective="User fees."
Details for Reform Option "Retention of user fees at health facilities, Punjab"	
Summary	**Background:** The existing health facilities in Punjab were either ill maintained or ill equipped, resulting in the non-availability of services to patients. **Action:** Under Punjab Government notification, Punjab Health System Corporation (PHSC) has rigorously adopted user charges for various services at its health facilities. However, under the rules, the following categories of patients were exempted from paying: (i) People living below the poverty line (Yellow Card Holders) (ii) Punjab Government Employees and Pensioners (iii) Handicapped (iv) Unknown patients (v) Critically ill patients(vi) Road side accidents (vii) Under trial prisoner and convicts (vii) Freedom fighter and their family members. Under a separate notification, State Government has also allowed the PHSC to retain user charges at the point of collection and use them for non-salary and non-recurring purposes. Detailed guidelines were formulated for Civil Surgeons and Deputy Medical Commissioners on how to use the user charges collected and they were allowed to use it in high priorities under the following proportions: Drugs- 45% Improving patient facilities- 25% Maintenance of buildings- 15% Maintenance of equipment- 15% **Results:** Actual collection and utilisation of the user charge was as follows- Year Collection (INR in lakh) Utilisation (INR in lakh) 1996-97 INR 40.8 INR10.11 1997-98 INR 120.31 INR 72.89 1998-99 INR 201.47 INR 154.03 2002-03 INR 1070.01 INR 907.89 2003-04 INR1294.59 INR 1199.40 2004-05 INR 1482.32 INR 1268.94
Cost	Only government order is required for the implementation of the user charge for various services and retention of the same at the health facilities.
Place	One hundred and fifty four hospitals in Punjab, including Community Health Centres, Sub divisional hospitals and District hospitals.
Time Frame	Approximate time from planning to implementing the reform is one year.
Advantages	Financial sustainability: Generation of funds and their retention at the point of utilisation of services helps the health facilities to manage their resources better. Improved infrastructure and equipment: Retention of user fees

	allows the health facilities to repair and maintain its infrastructure and equipment. Improved drugs availability: Retention of user fees allows health facility to purchase drugs when necessary.
Challanges	None perceived.
Prerequisites	Government Orders.
Who needs to be consulted	State government.
Risks	
Sustainability	Reform is sustainable but requires close monitoring and transparent system.
Chances of Replication	The process has been adopted by many states successfully.
Comments	Though levying user fees for the services rendered by the hospitals has grown into accepted concept among the policy makers and clients of the health facilities, but formulation of the guidelines to utilise the retained money is also equally important for patient's welfare.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, IRMS, September, 2005.
Status	Active
Reference Files	1614496-1HB-44291(dated 12-2-1997).doc — GO:20/7/89-4HBV/12402, dated 14.5.1991 20789-4HBV12402, dated(14-5-1991).doc — GO:16/144/96-1HB-4/4291, dated 12.2.1997
Reference Links	

145. Medicare Relief Societies at Community Health Centres, Rajasthan

Subject Area="Health financing."	Objective="Alternative means of financing public health services."

Details for Reform Option "Medicare Relief Societies at Community Health Centres, Rajasthan"

Summary

Background: In order to make public health care services sustainable, various options such as pay clinics and auto finance schemes have been explored by State governments since the 1980s. However, these schemes became dysfunctional due to a lack of interest among doctors and institutions and a lack of incentive to generate revenue, since all revenue from these schemes went to the State treasury. But dwindling resources in the public sector coupled with a lack of maintenance of infrastructure and equipment necessitated the Rajasthan Health and Family Welfare department to set up autonomous societies in medical colleges and other health facilities from 1995. The initiative aimed to encourage alternative sources of health financing through user-fee schemes and in-hospital pharmacies.

This strategy was first started in a tertiary level hospital, SMS hospital, Jaipur and its success led to its replication in other medical colleges, district hospital and sub-divisional hospitals. The success of this initiative has led the Rajasthan State government to support the setting up of such societies Rajasthan Medical Relief Societies (RMRS) at all hospitals having 30 beds or more, including Community Health Centres (CHC) and recently it has also been introduced in all model Primary Health Care Centres (PHCs).

Action: Following the drafting of a constitution and rules of the society, seed money of INR. 12 lacs was given to the medical college hospitals; INR 2 laks to district hospitals. Guidelines and orders were issued to ensure effective functioning of these societies. RMRS was allowed to collect the revenue of user fees from patients' hospitalised and out-patient department and laboratory, as well as from donations, and contracting out of space. Purchase of hospital equipment was permitted and the government contributed half the cost if the other half was obtained through public contributions.

In 1998 guidelines were issued for utilization of revenue generated by the societies; 50% could be used for purchase of equipment, while the other half had to be spent on provision of facilities to patients, cleanliness, and purchase of instruments. Detailed guidelines for purchase, maintenance and repair works were also issued. In 1996, the RMRS was scaled up to cover all hospitals with 100 beds. All equipment used under the auto finance scheme was transferred to a society which would be responsible for its maintenance. Amendments were also made to the Rajasthan civil service (Medical Attendance)

Rules, 1970, so as to allow re-imbursement of the charges paid by government employees to the RMRS for diagnostic tests and investigations. A regular audit of accounts was also ordered, along with the exemption of donations received from income tax. The management structure of the societies is autonomous and consists of 9 to 11 officials and non-officials at State, Regional and district levels. The Society functions outside the purview of the State, the General Financial Rules (GFR) do not apply and it can purchase equipment according to its own requirements.

Mainly, the funds in RMRS are used for maintenance and renovation of buildings, maintenance and repair of equipment, purchase of new equipment, improving sanitation and cleanliness, improving other facilities for patients and attendants, computerization of various systems and provision of free medicines for below poverty line (BPL) families. The source of funds for the Society includes seed money from the State Government and transfer of operational control of diagnostic machines. Free services are provided to certain sections of the population as stipulated in the Government Order.

These include, families living below the poverty line, widows, freedom fighters, destitute people, citizens over 70 years and retired government servants. Charges are as follows

i) Average OPD charge INR 2.

ii) Inpatient charges INR 5.

iii) In-patient referral by private practitioner INR 10.

iv) Bed charges for private rooms, cubicles or cottage wards from INR 50 to 600 depending upon the type of facility. Management training has been organised for RMRS senior managers on guidelines, stock keeping and accounting. The training programme was coordinated by State Institute of Health Family Welfare. Studies have also been carried out to assess the functioning of RMRS by IIHMR, Jaipur and SIHFW, Rajasthan. Accounting software for medical colleges and big hospitals and an operational manual which includes the audit process have been completed. The National Informatics Centre, Rajasthan, is developing the software for CHCs.

Results: In 2003 CHC Sadri, Pali constituted an RMRS with seed money from the European commission. The money generated through user charges was used for repairing the building, construction of cottage wards, buying furniture, petromax (used during load-shedding) construction of stores, paying honorariums to staff for extra work, providing medicines for BPL families. During the quarterly meeting, besides RMRS members there were also representatives from major political parties in the area and the CHC takes approval for the use of funds (for further details see minutes of the meeting available in the documents and illustration section). Before the presentation of any new proposal is presented, needs assessment is done. Availability

of funds and discretion to use them for improving the quality of care is a source of confidence for the CHC staff as they can plan what is required for the functioning of the facility. The funds from the RMRS helped the CHC to make a life line store operational. The training given by SIHFW was found useful by the CHC in-charge and that helped them to handle the issues concerning running the RMRS. The setting up of an RMRS in CHCs and PHCs is a recent phenomenon and therefore little documentation on the impact of this initiative on increasing the access to services is yet available.

However, a study done by SIHFW on RMRS does mention the achievements or improvements by RMRS (see documents and illustration section). In order to strengthen RMRS a monitoring cell was set up at the state level in 2004. Imbursement of the charges paid by government employees to the RMRS for diagnostic tests and investigations. A regular audit of accounts was also ordered, along with the exemption of donations received from income tax. The management structure of the societies is autonomous and consists of 9 to 11 officials and non-officials at State, Regional and district levels. The Society functions outside the purview of the State, the General Financial Rules (GFR) do not apply and it can purchase equipment according to its own requirements.

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ii) Inpatient charges INR 5.

iii) In-patient referral by private practitioner INR 10.

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	Sadri, Pali constituted an RMRS with seed money from the European commission. The money generated through user charges was used for repairing the building, construction of cottage wards, buying furniture, petromax (used during load-shedding) construction of stores, paying honorariums to staff for extra work, providing medicines for BPL families. During the quarterly meeting, besides RMRS members there were also representatives from major political parties in the area and the CHC takes approval for the use of funds (for further details see minutes of the meeting available in the documents and illustration section). Before the presentation of any new proposal is presented, needs assessment is done. Availability of funds and discretion to use them for improving the quality of care is a source of confidence for the CHC staff as they can plan what is required for the functioning of the facility. The funds from the RMRS helped the CHC to make a life line store operational. The training given by SIHFW was found useful by the CHC in-charge and that helped them to handle the issues concerning running the RMRS. The setting up of an RMRS in CHCs and PHCs is a recent phenomenon and therefore little documentation on the impact of this initiative on increasing the access to services is yet available. However, a study done by SIHFW on RMRS does mention the achievements or improvements by RMRS (see documents and illustration section). In order to strengthen RMRS a monitoring cell was set up at the state level in 2004.
Cost	In the tribal and semi-desert districts (Jaisalmer, Barmer, Jalore, Nagaur, Bikaner, Jodhpur, Sirohi, Banswara, Dungarpur and Pali), the CHCs have received seed funding from European commission supported Sector Investment Programme of INR 1 lakh each. For the study and for training of EC-SIP CHC in-charge and senior officers INR 2.5 lakhs was transferred to SIHFW, Jaipur.
Place	All public health facilities above Sub-centre level in Rajasthan.
Time Frame	One year.
Advantages	Revenue generation: Increased availability of financial resources to hospitals from renting of parking areas, auditoriums, contracting out the administration of canteens. Financial Autonomy: Each society is authorised to purchase items ranging from INR 1000 to10,000 though the State's guidelines suggest that institutional heads have authority to make decisions regarding expenses less than INR 5000. Improved efficiency in the system: The society can follow the State's established government financial and accounting rules or their own purchasing procedures. Cost recovery: Multiple sources of supplementary financing are available and user charges are levied for a full range of services. Exemptions are judicious.

Challanges	Management skills: Continuous enhancement of the management capabilities of hospital administrators, systems and procedures of procurement, maintenance of equipment and hospital buildings as well as contracting and outsourcing is necessary for smooth functioning of RMRS. Maintenance: A lack of clear policy regarding with whom rests the decision-making authority for repair and maintenance. A study found 53% societies report difficulty in repairing and maintaining equipment. User charges: Procedures for exemption of user charges to vulnerable groups are usually informal and discretionary. Increase in proportion of patients visiting the health facility will make it difficult for RMRS to spend money on upgrading services. Utilization of RMRS funds: Hospital managers fail to spend the generated revenue efficiently, as most of spending is on equipment in absence of trained personnel to operate the machines. So there is under-utilization of machines. Subsidy: The government subsidies to hospitals have not declined because of the transfer of matching grants to participating hospitals. So, it has not relieved the state's burden. Monitoring: Regular systemic monitoring of the RMRS has to be undertaken at all levels.
Prerequisites	Training of society officials regarding objectives of the society, guidelines governing the societies, budgeting, accounting, management information systems, pricing and needs assessment. Managerial guidelines should be in place. Facilitation of purchase of equipment, rationalising pricing schemes. Expert committee to resolve issues and problems. Continuous monitoring of the functioning of RMRS.
Who needs to be consulted	Dr. N.K. Mathur, Retired Medical Superintendent SMS Hospital. Dr. Ajit Bapna, Retired HOD E& NT, SMS Hospital. Dr. S.C. Mathur, Director SIHFW, Rajasthan. Dr. O.P. Gupta, Director Public Health. Dr. S.D. Gupta, Indian Institute for Health Management and Research, Jaipur.
Risks	
Sustainability	The programme is sustainable. Under NRHM, each year now INR 1 lakhs will be transferred to these societies as untied funds.
Chances of Replication	The innovative scheme was started in Rajasthan in one government hospital and later replicated in other facilities up to CHC level. (By March 2003, the number of RMRS in Rajasthan has reached to 301 which includes 16 RMRS in the Medical College Hospitals, 58 in the District Hospitals and 217 at the level of CHCs).Now government is going to start such societies in Model PHC across Rajasthan.
Comments	The success of Rogi Kalyan Samiti (RKS) in Madhya Pradesh was a

	basis to initiate RMRS in Rajasthan. As per a study undertaken in 1999-2000 by the Indian Institute for Health Management Research (IIHMR), 36% of the societies use only their own purchasing procedures; 44% follow the States' procedure and about 20% use both. The majority of the societies find purchase procedures comfortable. Cost recovery is 10 to15% of the hospital budget although it varies between 4 and 25%. 26% report selling pharmaceuticals. Private organisations and individuals have adopted wards in 36% of the societies. The proportion of clients receiving free care was lower before the introduction of user charges. Later in 2003 a study was undertaken by SIHFW, on the basis of which guidelines were developed for effective management of RMRS. A training module was developed. A series of trainings have been organised by SIHFW, Jaipur as per the demands of RMRS managers and the training cost per participant is kept at INR 500 per participant, financed by RMRS itself. There has been very high attendance at these training programmes and participants consider them useful.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, National Institute of Medical Statistics, October, 2005. Last Updated: Prabha Sati, Research Consultant, ECTA, December 2006.
Status	Active
Reference Files	scan.pdf GO1977.pdf GO1996.pdf User Charges and Expenditure Statement.doc RMRS.doc
Reference Links	

146. Providing low cost and quality drugs at Health Facilities, Rajasthan

Subject Area="Health financing."	Objective="Availability of low cost, quality drugs at Community Health Centres (CHC)."
Details for Reform Option "Providing low cost and quality drugs at Health Facilities, Rajasthan"	
Summary	**Background:** The state budget for drugs is inadequate and hence poor and not so poor patients in India have to buy medicines and surgical items from chemist shops at exorbitant rates. A lot of patients, especially Below Poverty Level (BPL) families, find it difficult to pay for these medicines. This leads to inadequate treatment and dropouts or incurring debts by families. In addition, it is well know that pharmaceutical companies spend a lot of money on advertisements, giving incentives to medical professionals and also some percentage goes to stockiest and distributors to buy their drugs. Also, at times when the prescribed drug is not available in chemist shops, poor quality drugs are often sold to people. In order to provide good quality medicines and surgical items from renowned pharmaceutical companies at cheap rates, the idea of opening Lifeline fluid Stores was conceived, initially in 1996 in SMS Hospital, Jaipur, Rajasthan. The success of this initiative encouraged the government of Rajasthan to start such stores within the premises of district hospitals; community health centers (CHC) and even at primary health centers (PHC). **Action**: An unused room near the CHC entrance was identified as a suitable area to house the Life Line Drug Store. The room had been constructed by a local donor for the use of attendants and relatives of patients but was redundant because there was an inn next to the CHC which provided accommodation. As per the government of Rajasthan, patients below the poverty line do not have to pay. The CHC then used the same process adopted by district hospitals in opening such drug stores. Firstly, a market survey was done to find the differential in pricing of drugs available in the chemist shops around Sadri. A technical committee was then formed to list out the essential drugs required and to list out the manufacturers who supplied drugs within the district and other parts of the State. They also got list of companies tat supplied drugs to various hospitals. For IV fluids it was decided to buy from companies that have high quality manufacturing. An open tender was then sent to pharmaceutical companies directly inviting them to supply medicines to the CHC. They negotiated with the company to reduce the cost of drugs and supply them directly to the CHC. It was decided that the modus operandi for procuring drugs from

	pharmaceutical companies or stockiest at CHC level needed to be different to that followed by bigger hospitals (where products were kept on consignment basis, stocks regularly replenished and payment made after 15 days) because the medicine turnover was low and stocks only need to be replenished once a month. In order to ensure a timely supply of drugs and surgical items and also to have reserve funds the pharmaceutical companies or stockiest were asked to submit INR. 5000 as a caution deposit which would be returned to the company once contract with them got dissolved. A retired grade I male nurse from the CHC who was trained pharmacist was selected to manage the drugstore. A list of drugs available at the store was prepared with the price list. **Results**: The Life Line Drug Store in Sadri CHC became operational from July 2005. Patients are now able to buy medicines at about 30-54% below the market rates. In the near future, the cost of each drug available at the store will be displayed on a board outside the building. The price of drugs was fixed after adding 10-15% over the purchase cost to generate an income for the CHC. The purchase and availability of drugs is monitored by storing the information on the CHC computer. The opening of the drug store has made good quality drugs affordable to patients who have often travelled long distances to attend the CHC.
Cost	The room for running the lifeline store was made available by donor. The other costs include purchase of 300-litre refrigerator, closed and open cupboard, table, chair, price list display board. Recurring costs include payments to the pharmacist, electricity bills and stationary which is met through the revenue collection from selling of the drugs and RMRS.
Place	At all the CHCs in Rajasthan. Government is promoting starting such stores in primary health care units.
Time Frame	Three months in this case.
Advantages	Cost: Availability of drugs at low cost reduces the burden on poor patients. Location: Patients do not have to go out of the health facility to get drugs - especially during night time or urgency. Necessary drugs are available round the clock within hospital premises. Resource generation for the health facility: The drug store generates an additional 10-15% on top of the cost of the medicines.
Challanges	Competition: Opposition from local chemists over the cost of drugs. Availability of drugs: Timely supply of drugs in smaller and more remote places is a problem. Regular flow of drugs and payment: Due to small size of the facility

	the requirement of medicines is not regular. Purchase of Drugs: Patients have the ability to purchase low cost drugs. In case there are more people below the poverty line then it becomes difficult for the store to run smoothly.
Prerequisites	Space to house the pharmacy. Availability of full time pharmacist. Continuous supply of low cost quality drugs. System to monitor the functioning of the store.
Who needs to be consulted	Officer in charge of CHC and District hospital. Pharmaceutical companies and stockiest.
Risks	
Sustainability	Yes, because they generate an income of 10 to 15 per cent above the price of the drugs i.e., they are self-sustaining and do not require additional funds to keep them functioning. However, as it is mandatory to provide free drugs to people below the poverty line, the issue of sustainability becomes difficult without government support.
Chances of Replication	Yes.
Comments	
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, National Institute of Medical Statistics, October 2005.
Status	Active
Reference Files	F1040021.JPG Binder3.pdf GO_26Aug_1996.pdf scan.pdf LLDS_SIHFW Excerpts.doc
Reference Links	

147. Scheme for Assistance to Families in Exigency (SAFE), Karnataka.

Subject Area="Health financing."	Objective="Provide health insurance for employees of a Government department."
Details for Reform Option "Scheme for Assistance to Families in Exigency (SAFE), Karnataka."	
Summary	**Background:** The social security schemes being offered by Department of Space (DoS) did not satisfy the varied financial needs of all its employees. Besides, the existing insurance providers could not meet their specific needs and some found the cost of the schemes to be very high. Therefore, a need for a comprehensive social security scheme was felt by the DoS employees, which supplements and complements social security is cost-effective and efficient in disbursing the financial assistance at the time of their need. **Action:** Two committees were constituted by DoS to carry out the preliminary work of forming the trust. Based on the recommendation of the two committees, Vikram Sarabhai Trust (VSAT), an autonomous and financially independent trust was established by DoS, Government of India (GOI) in 1997, which could meet the specific social security gaps of DoS employees and also fulfilled the requirement of section 10 (23A AA) of Indian Income Tax Act. Data was collected on mortality, serious illness and hospitalization etc. of DoS employees. Based on the data, a welfare scheme called Scheme for Assistance to Families in Exigency (SAFE) was formulated within the parameters of section 10 (23A AA) of Income Tax Act. The scheme enjoys tax exemption under the Income Tax Act; the corpus and surplus are invested in instruments approved by Department of Income Tax. The governing rules of SAFE including trust deeds and bye-laws were drafted out. In December 1997, an innovative social security scheme for DoS/ISRO serving employees and their families was floated. The procedures were chalked out so that they were well defined and easily understood for disbursal of benefits to avoid discretion and arbitrariness. SAFE governing rules have been widely circulated amongst DoS employees for their information. In addition, procedures for disbursal of Financial Assistance for Exigency (FAE) and residual bonus have been made available to all contributors. The annual report of the VAST provides audited accounts, which is sent regularly to contributors. The institutional structure consists of the Patron, Board of Trustees (BOT), Ombudsman and Link Committees (LC). The BOT is a policy making body. The number of trustees can range from 5 to 17. Approximately one-third of the trustees retire each year. For transparency, BOT appoints an Ombudsman for redressal of

	complaints/grievances. The procedure for grievance redressal is widely publicized through the annual report of VAST. Link committee members are identified at various locations of DoS to act as a bridge between the trust and the employees and to receive and process requests for benefits. The LC is supposed to give remarks for each of the application made by contributors in the prescribed format and send it to the Payment Facilitation Committee (PFC) formed by VAST. Normally, a trustee is a chairman of a LC. The PFC goes through all requests for benefits and remarks of the concerned link committees and gives recommendation on a prescribed format. The VAST thereby releases the financial assistance in one or more installment to the contributor or to the nominee. The scheme, prior to finalization was discussed in depth with a number of DoS employees. It was designed carefully and conservatively to ensure that it is cost-effective and financially viable. SAFE provides two types of benefits- FAE and residual bonus at the time of withdrawal from SAFE due to any reason. The scheme provides three types of cover to the DoS/ISRO employees. They can choose the kind of cover they require, and then fix their own contribution, which can be no less than 0.5 per cent of their basic pay plus Dearness Allowance (DA) and not more than 2.5 per cent of their Basic+DA. Within this band, the benefit amounts vary according to the type of cover chosen. Types of insurance coverage are: * Type 1 covers the death or permanent disability for contributor alone. * Type 2 covers the loss of eyes or limbs, prolonged sickness and loss of pay on account of illness for contributor alone. * Type 3 covers similar benefits under Type 2 for the contributors' spouse and children below the age of 25. The scheme has a nominee facility, for which the contributor may identify three nominees in order of preference in the joining form. It is a voluntary scheme; therefore, an employee of the department may request to join SAFE by submitting the prescribed form along with the necessary documents. **Results:** SAFE has been widely accepted by DoS employees as this versatile scheme offers more than just life insurance to ISRO employees. At present, there are about 10,000 contributors. During the year 2004-05, 351 employees joined SAFE as the first/regular contributors, including the membership campaign in February 2005. The trust during 2004-05 has extended financial assistance in exigency to 72 contributors amounting to INR 69, 62,375.
Cost	Not given.
Place	ISRO/DSO employees and their families.
Time Frame	One year.
Advantages	Cost: The premium cost for SAFE was much lower than other

	insurance coverage. It is low-cost risk coverage with incidental saving being the by-product. Incentive: The contribution and benefits automatically keeps up with inflation without any action by the contributor. Residual bonus: Paid at the time of withdrawal from the scheme to the contributor and to the nominee in case of death of the contributor. Flexibility: Contribution level can be chosen anywhere from 0.5% to 4.0% of (Basic pay + DA). Contributor has the choice to choose from the three types of coverage. Contributor has the opportunity to change the contribution level and type of coverage once in a year to meet the changing needs during the employment career. Comprehensive insurance scheme: Voluntary, contributory and multipurpose welfare scheme which provides substantial financial assistance in case of death, disability, loss of eyes/limbs, loss of pay due to sickness and serious/prolonged sickness of contributors and family. Non-medical expenses: The scheme has a provision for non-medical expenses, especially for serious/prolonged sickness. Voluntary and optional: It is a social security scheme which is voluntary in nature. Provides wide choice of coverage options and contribution levels.
Challanges	Effective communication to management and employees.
Prerequisites	Form a trust within the ambit of section 10 (23AAA) of the Income Tax Act. Support from the concerned employer- organization.
Who needs to be consulted	Vikram A. Sarabhai Trust. Contributors to SAFE.
Risks	
Sustainability	SAFE is financially independent and is designed to be financially self-sustaining and is not supported by DoS financially. DoS has extended critical support by establishing VAST, providing some office space, making it possible to deduct the contribution.
Chances of Replication	There is a latent demand for low-cost tailor-made insurance products in India.
Comments	The following social security gaps led to evolving of SAFE: – (a) The Group Insurance Scheme does not keep pace with inflation and higher income of DoS employees. The ratio of insurance amount to the basic pay has come down. Consequently, many employees were constrained to take additional life insurance at very high premium. (b) There was no risk coverage if an employee loses job because of disability except in case of accident, loss of pay due to prolonged

	sickness. (c) Non-medical expenses in case of prolonged sickness. (d) Contributory Health Service Scheme (CHSS) does not cover all medical expenses.
Contact	
Submitted By	Dr. Nandini Roy, Research Consultant- HS-PROD, NIMS. May 2006.
Status	Active
Reference Files	scan.jpg Hindu_Dec99.jpg BusinessIndia_2000.jpg Binder1.pdf SummarySheet.jpg
Reference Links	

148. Mukhya Mantri Jibon Jyoti Bima Achoni, Assam

Subject Area="Health financing."	**Objective="Providing health and personal accident insurance to the people of Assam."**
Details for Reform Option "Mukhya Mantri Jibon Jyoti Bima Achoni, Assam"	
Summary	**Background:** In July 2005 the Government of Assam decided to implement the Mukhyomantri Jibon Jyoti Bima Achoni. This is a combined health insurance and personal accident insurance scheme for all citizens of the State of Assam whose names appear on the electoral list as in force when the claim is being made along with their dependents. The employees of the Central and State Government, Public sector and Private companies, all those who have an annual gross income before tax exceeding INR 200,000 are not entitled to the benefit for health and accident coverage. However, the employees of tea companies, who are engaged in cultivation and processing of tea in the State, are entitled to the benefit of the scheme both for health and personal accident coverage. **Action:** The Government of Assam (GOA) and ICICI Lombard General Insurance Company Ltd (ILGICL) having its registered office at ICICI bank towers at Mumbai and its branch office at Guwahati entered into an agreement for implementation of the Mukhyomantri Jibon Jyoti Bima Achoni. The scheme is implemented by ILGICL through its branch office in Guwahati. It aims to provide health and accident risk insurance coverage to the entire population of 3 crore at a premium of INR 25 crore. The sum assured for each person is INR 50,000 in case of accidental death and INR 25,000 for any health-related eventuality. There would be no third party administration and the district administration alone with Revenue Circle Officer (RCO) as the facilitator, would help out the villagers. The settlement would be made within 60 days. The Planning and Development Department of the Assam Government, which worked out the deal, had earlier invited bids from a host of insurance companies. Seven insurance companies, including four from the public sector, had expressed interest in it. The contract went to ICICI Lombard because it had the lowest bid of INR 27 crore, inclusive of service tax. The government then squeezed it further, bringing the amount down to INR 25 crore, and this included sales tax and educational cess. **Results:** From August 2005 till July 2006 there have been approximately 4205 beneficiaries and Rs.9 crore has been spent on compensation since the scheme was enforced.
Cost	INR 25 crore.
Place	State of Assam.
Time Frame	Approximately 1 year.

Advantages	Monetary benefit: Medical expenses up to a maximum of INR.25,000 under the health insurance scheme for the treatment of certain specified diseases and compensation up to a maximum of INR 50,000 in case of death. Early settlement of claims: The settlement would be made within 60 days. No third party administration: The district administration through RCO would help out villagers. Wide coverage: The coverage includes snake bite, animal bite, drowning in river, tank, pond, flood, falling and drowning in a well, earthquake, landslide, rockslide, lightening, cloud burst, fire related accident, collapse of roof, falling from a tree or high- rise building, vehicle accident, accidental explosions or firing, riot or scuffle, excluding international involvement in the said peril or someone putting oneself in needless perils other than whilst saving human life.
Challanges	Limited benefit: The person shall not be entitled to any other benefit after the claim is admitted under this policy. Restricted coverage: The employees of the Central and State Government, Public sector and Private Companies, all those persons who have an annual gross income before tax exceeding INR 2 lakhs are not entitled to benefit from this health and accident coverage insurance.
Prerequisites	Commitment of the Government and ICICI Lombard.
Who needs to be consulted	Planning and Development Department of Assam Government.
Risks	
Sustainability	It is quite sustainable; the government in future may have other insurance schemes also. This initiative can be transferred to health department from the planning and development department and can be regularised by the health department in future.
Chances of Replication	Health insurance schemes are running in other states of India too.
Comments	Revenue Circle Officers (RCOs) have been made Claim Facilitating Officers (CFOs) while Deputy Commissioners (DCs) have been made final arbiter in doubtful claims.
Contact	
Submitted By	Dhrub Kumar Singh, Research Consultant, Central Bureau of Health Intelligence, New Delhi, October 2006.
Status	Active
Reference Files	Mukhyamantri Jibon Jyoti Bima Achoni.doc — Guidelines for Mukhyamantrir Jibon Jyoti Bima Achoni 2205-2006

Reference Links	

149. Mandatory government service by medical graduates, Maharashtra

Subject Area="Human Resources."	Objective="Reduced vacancies."
Details for Reform Option "Mandatory government service by medical graduates, Maharashtra"	
Summary	**Action:** State regulation that all graduates of government medical colleges in the state must work for one year for the government. Alternatively, the state offers medical students a scholarship in return for a money bond to work in rural areas for a certain period after qualifying.
Cost	Information not available.
Place	Maharashtra. (It is also common in other countries for medical students to do two years medical ' national service')
Time Frame	Twelve months.
Advantages	Increases coverage: Almost all medical vacancies can be quickly filled and future shortages prevented. Education: Graduates benefit from development of public health skills.
Challanges	Motivation: Medical officers are less motivated if they feel they are just working out their time.
Prerequisites	A state government order.
Who needs to be consulted	State government, government medical colleges.
Risks	
Sustainability	Good.
Chances of Replication	Good.
Comments	None.
Contact	
Submitted By	ECTA PROD team, New Delhi. July 2002.
Status	Active
Reference Files	
Reference Links	

150. Post graduate training as an incentive for medical officers to work in remote areas, Rajasthan

Subject Area="Human Resources."	**Objective="Reduced vacancies."**
Details for Reform Option "Post graduate training as an incentive for medical officers to work in remote areas, Rajasthan"	
Summary	**Action:** In order to persuade more doctors to work in rural or difficult areas, postgraduate colleges have been asked to give a 50% bias towards doctors who have worked for three years in difficult areas and five years in rural areas.
Cost	Information not available.
Place	Rajasthan.
Time Frame	Few months.
Advantages	Incentive-based: The incentive has encouraged more doctors to work in difficult areas.
Challanges	None identified.
Prerequisites	Cooperation of post graduate colleges.
Who needs to be consulted	State government, post graduate colleges.
Risks	
Sustainability	Good.
Chances of Replication	Good.
Comments	None.
Contact	
Submitted By	Dr. Kumkum Srivastava, State Facilitator, ECTA, Rajasthan.
Status	Active
Reference Files	
Reference Links	

151. Mandatory rural service prior to post-graduate training, Orissa

Subject Area="Human Resources."	Objective="Reduced vacancies."
Details for Reform Option "Mandatory rural service prior to post-graduate training, Orissa"	
Summary	**Action:** Government of Orissa has introduced a mandatory scheme for Medical Officers (MOs) to serve one year in a rural area before they can embark on post-graduate courses. The scheme is designed to help fill vacancies in remote and unpopular areas and at the same time to sensitise young doctors to the problems in rural areas and community medicine. The programme comprises 11 backward, tribal or otherwise unpopular districts in the state. The entrance examination for PG courses is conducted one year ahead of the date for admission; those who qualify are assigned to one of the institutions in these 11 districts. The Chief District Medical Officer supervises the candidates and certifies attendance. **Results:** The initiative has turned out to be successful as it uses the doctors' desire for further qualification as an incentive and is limited in time.
Cost	
Place	Eleven tribal, remote and backward districts in Orissa, since 1998.
Time Frame	Few months.
Advantages	On-the-job training: MOs are exposed to community medicine and problems in rural areas. Vacancies filled: Staff MO vacancies are filled in remote rural areas. Time-limited: Posting limited in time, so candidates are more willing to go and do not spend their time lobbying for promotion or transfer.
Challanges	Inflexible: MOs who desire highly specialised postgraduate qualification may see posting in rural areas as waste of time and just 'serve their term' with little commitment. Cost: Possible increase in administration costs through frequent rotation and selection procedures.
Prerequisites	Willingness of the state government Identification of posts to be covered under the scheme Sufficient number of medical graduates to fill vacancies. Amendment to the medical service rules.
Who needs to be consulted	Department of health and family welfare, state government. Medical colleges.
Risks	

Sustainability	Good.
Chances of Replication	Good.
Comments	About 50% of the posts of MOs were filled in 1999 & 2000.
Contact	
Submitted By	Dr. Matthew Jowett, Former Programme Adviser, European CommissionTechnical Assistance Office, New Delhi. July 2002.
Status	Active
Reference Files	GO No RCH-1098-106-R (PROD No 10).doc
Reference Links	

152. Hands-on training of medical interns in community health, Orissa

Subject Area="Human Resources."	Objective="Training."
Details for Reform Option "Hands-on training of medical interns in community health, Orissa"	
Summary	**Background:** The three-month training of medical interns in community health had been conducted in large groups (25 people) in fixed institutions, with no proper exposure to community health problems and was of poor quality. Medical college teachers, with little hands-on experience in the field, supervised the interns. **Action:** Groups of two or three interns are now sent to Community Health Centres (CHCs), where they spend three months in the field exposed to real life situations and are supervised by peripheral Medical Officers (MOs) and medical college teachers who are experienced in community medicine. The training programme consists of: (i) 50-day campus assignment at CHC – includes clinical skills, laboratory work, managerial & administrative work, data collection & analysis, staff meetings (ii) 25-day field programme– includes visits to villages, anganwadis, family welfare camps, schools, sub-centres and programme offices.
Cost	
Place	State of Orissa, since 2000.
Time Frame	Few months.
Advantages	Hands-on training: Improves doctors' experience in rural health and gives them administrative as well as professional experience in actual working conditions. Familiarisation: Increased likelihood of attendance if doctors are eventually posted to rural areas. Communication: Exchange of knowledge between doctors improved. Effective: Smaller groups are easier to manage.
Challanges	Poor facilities: Accommodation and transport in the field may not be adequate.
Prerequisites	Well-equipped CHCs with sufficient attendance of patients. Training & supervision structures to establish links between medical colleges and district health authorities.
Who needs to be	MOs in facilities, medical colleges, district health authorities.

consulted	
Risks	
Sustainability	Good.
Chances of Replication	Good.
Comments	None.
Contact	
Submitted By	Dr. Matthew Jowett, Former Programme Advisor, European CommissionTechnical Assistance Office, New Delhi. July 2002.
Status	Active
Reference Files	Resolution MII-IX-62-2000-42233H (PROD No 13).doc
Reference Links	

153. Updating the training syllabus of female health workers, Kerala

Subject Area="Human Resources."	Objective="Training."
Details for Reform Option "Updating the training syllabus of female health workers, Kerala"	
Summary	**Background:** The curriculum for training Junior Public Health Nurses (JPHNs) to become Female Health Supervisors in Kerala had not been updated for 20 years. **Action:** In July 2004 the Kerala State Government, with funding from the European Commission-supported Sector Investment Programme, asked the Principal of the Public Health Training School in Trivandrum to look again at the job descriptions of its female health workers to redefine their roles and responsibilities and then redesign the training curriculum to ensure they had the correct skills necessary to fulfil these job descriptions. The task involved: (i) Job analysis. (ii) Defining the objectives of the curriculum in view of the job description and expectations. (iii) Listing subjects which must be taught and then ranking by priority. (iv) Decide method of instruction (ie theory or practical) and time needed to teach each subject. (v) Devise a method of evaluation of trainers and trainees. In order to make these decisions, workshops were held with the additional secretary Health and Family Welfare (H&FW), the Director of Health Services (DHS), Additional DHS (Sector Reform Cell), Additional DHS (Planning) and experts from the Public Health Training School, representatives from concerned associations and unions and representatives of JPHNs. The module is for 6 months training and ends with an examination. Those who pass are promoted to the supervisory posts. This training is mandatory for promotion.
Cost	Cost for preparing the training module is INR 1,65,000. Training cost not included.
Place	Kerala.
Time Frame	One year.
Advantages	Up-to-date training: Female health workers are now given tailor-made training to fit their job requirements.
Challanges	None perceived.

Prerequisites	Definition of job responsibilities.
Who needs to be consulted	H&FW directors at State level. Training experts. Female health workers.
Risks	
Sustainability	The development of the curriculum is a one-off cost which has already been met with assistance from the European Commission. The Health Services Department will now conduct training through the State Budget.
Chances of Replication	The revised curriculum (available in the References section) may be useful for all States.
Comments	None.
Contact	
Submitted By	Dr K Sandeep, Technical Secretary, Sector Reform Cell, Directorate of Health Services, Kerala. March 2006.
Status	Active
Reference Files	Syllabus of Female Health Supervisory Training Programme.doc — Curriculum for the Female Health Supervisory in Service Training, Directorate of Health Services, Trivandrum.
Reference Links	

154. Ensuring traditional birth attendant training includes practical instruction, Karnataka

Subject Area="Human Resources."	Objective="Training."
Details for Reform Option "Ensuring traditional birth attendant training includes practical instruction, Karnataka"	
Summary	**Background:** It had been identified that there was an increased maternal mortality rate because Traditional Birth Attendants (TBAs) had not been taught in an institution which carries out deliveries itself and were therefore inexperienced and carrying out unsafe practices during childbirth. **Action:** TBA training to be carried out only at government institutions which conduct deliveries. On completion of training, the TBAs to be given good quality instrument kits.
Cost	
Place	Karnataka.
Time Frame	Information not available.
Advantages	Quality: Improves the quality of TBA training and brings them into contact with the hospitals, encouraging referral for complicated cases. Life-saving: Increases the number of safe deliveries.
Challanges	Short-term solution: At best a short term option as there is already a community preference for qualified health professionals to carry out deliveries in Karnataka – where there are already more than 50% institutional deliveries. In such a situation it may be better to concentrate investment on training professionals in delivery practices.
Prerequisites	Availability of training material and sufficient number of institutions doing deliveries.
Who needs to be consulted	The community needs to be asked who they want as their TBA.
Risks	
Sustainability	Sustainable – where there is funding and sufficient government institutions.
Chances of Replication	Replicable – but only where government institutions are doing a sufficient number of deliveries to accommodate the training.
Comments	None.
Contact	

Submitted By	ECTA PROD team, New Delhi. July 2002.
Status	Active
Reference Files	
Reference Links	

155. Developing a comprehensive training policy for public health personnel, Rajasthan.

Subject Area="Human Resources."	Objective="Training."
Details for Reform Option "Developing a comprehensive training policy for public health personnel, Rajasthan."	
Summary	**Background:** Providing health care services to the thinly distributed population of Rajasthan is a daunting task, especially because of difficult terrain. The state provides health care services through a chain of health care facilities including 9,600 sub-centres, 1,616 Primary Health Centres (PHCs), 238 Community Health Centres (CHCs), approximately 300 dispensaries, 35 districts and satellite hospitals and a number of associated hospitals under the control of six Government-run Medical Colleges. These facilities are manned by more than thirty-thousand staff. The human resource engaged in delivering the requisite services consistently need upgrading their knowledge and skills as once recruited their total service span is about 35 years. In last fifty years of independence, State has created variety of in-service training centres - 27 District Training Centres (common parlance: Auxiliary Nurse Midwife Training Centre), 3 regional level HFWTC and at state level State Institute for Health and Family Welfare (SIHFW). The trainings under different projects are fragmented and have narrow focus to a larger goal of improving the quality of health care delivery and achievement of comprehensive health indices. It was realized that developing a comprehensive training policy for the state health and family welfare department will be a useful pathways to strengthen the in-service training component. This was also mooted by programme implementers, policy makers and development partners. There is large number of people working in the healthcare services in the state of Rajasthan. They need regular refresher training to keep their skills up-to-date and relevant throughout an average 35-year career in Government service. To date there is no cohesive or well-planned training policy which will ensure an efficient workforce and programme implementers, policy makers and development partners are keen for one to be developed. **Action:** The European Commission-funded Health and Family Welfare Sector Investment Programme and the UNFPA-supported CP-6 Project asked the State to develop a training policy in health sector. The State Government requested the State Institute for Health and Family Welfare (SIHFW) to facilitate the development of a Training Policy in the Health Sector. A Committee, chaired by internationally-acclaimed training expert Professor Udai Pareek, was

	constituted by the Secretary, Medical and Health, Government of Rajasthan. The committee in turn thoroughly reviewed and revised the draft document developed in 1997-98 but it decided that developing a comprehensive human resource development policy would take too long. They therefore restricted the work to developing a training policy alone. The specific objectives of training policy were listed out and modus operandi for the same was worked out. A series of workshops were organized to deliberate on the scope and content of the document on training policy. **Results:** The resulting policy document outlines the challenges before the existing training institutions as a result of the shift of the focus of health programmes from family welfare to quality of care and reproductive and child health. It suggests developing a linkage between various training institutions and service institutions within the state. Further, SIHFW would be strengthened and all training institutions would bring under its administrative, financial and technical control. Director SIHFW would be designated as Director Training of the State. The document also lists out in detail the structure of training system and its implementation, training capacity and approaches, staffing pattern and development of training modules. It gives a brief job description and responsibilities of district level health care officials and functionaries. The document stresses the need for three types of training: (i) induction training (ii) executive training programme for senior officers and deputy Chief Medical Hospital Officers (CMHOs) (iii) Management development programme for district level officers. The draft was then presented to a group of all the State level officers under the chair of the Principal Health Secretary in the second week of May 2004. The suggestions evolved in the discussion were incorporated before formally submitting the Policy Draft to State Government for endorsement. Governments' response on the document is awaited. Following to drafting of training policy for health care staff, the state government asked SIHFW to draft job chart for all level of staff – reproductive child health care officer, Dy. CM&HO Sub-division, district Tuberculosis officer, Principal Medical Officer (PMO), Deputy Superintendent/ Deputy Controller, District Hospital, Specialists, Nursing Superintendent, Ward- In-charge, Nurse, MOI/C CHC, Medical Officers, PHC, Block Health Supervisor, Health Assistant, Health Worker, Radiographer, Ophthalmic Assistant, Laboratory Technician and Computer operator.
Cost	NA.
Place	Rajasthan.

Time Frame	3 years before SIHFW was asked to undertake the assignment.
Advantages	Focused Approach: It is expected to give direction to the existing in-service training programme. Human Resource Development: It aims to augment the skills of technical resource personnel within the public health care sector. Management: Develops a cohesive approach to the capacity building programmes for technical human resources available with public health care system.
Challanges	Implementation: It has already taken more than 18 months for the new training policy to be endorsed by the government. Fund availability: Earmarking funds for scheduling in-service training to technical human resource personnel. Training material: Appropriately- researched training materials need to be developed. Authority: The other training institutions within the state health department must accept SIHFW's leadership.
Prerequisites	Policy makers and programme implementers must have a consensus on the goals of training policy.
Who needs to be consulted	Director SIHFW, Jaipur. Director Public Health. District Training Centres.
Risks	
Sustainability	Sustainable only if the efforts of drafting the policy documents are realized. Government earmarks funds regularly for in-service training and directs funds available through various projects into one pool.
Chances of Replication	Replicable if the programme planers and policy makers recognize the importance of this initiative.
Comments	
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Consultant, NIMS, March, 2006.
Status	Active
Reference Files	scan.pdf
Reference Links	

156. Revision of Auxiliary Nurse Midwife Curriculum, Rajasthan

Subject Area="Human Resources."	Objective="Training."

Details for Reform Option "Revision of Auxiliary Nurse Midwife Curriculum, Rajasthan."

Summary

Background: The Auxiliary Nurse Midwife (ANM) is one of the main agents for increasing the utilization of health and family welfare services in India. However despite the changing face of medicine and healthcare needs, the ANM training curriculum prepared by the Indian Nursing Council in 1977 has never been reviewed. As a result, in 1996, State Institute for Health and Family Welfare (SIHFW), Jaipur, decided to give the basic training of health workers a facelift.

Action: In early 2003, under the European Commission-funded Health and Family Welfare Sector Investment Programme, the Government of Rajasthan asked SIHFW to review and revise the existing basic training curriculum in tune with the changes in epidemiology of disease and needs of the population.

Workshops were organized to deliberate on the existing curriculum and the changes required in the context of the changing epidemiological landscape. The workshop was attended by in-charges of the District Training Centre (DTC)/ Auxiliary Nurse Midwives Training Centres (ANMTCs), the president of the Rajasthan Nursing Council, a representative of State Government and the faculty of SIHFW and experts in community health. Monitoring visits were also made to DTC/ANMTCs by SIHFW faculty. SIHFW thoroughly reviewed the syllabus of the ANM course and found it to be quite comprehensive. But because of the changing circumstances, it felt there was an immediate need for micro-planning of the curriculum.

The revised curriculum has re-distributed the duration for theory, hospital-based and field-based training without changing the total duration of the 18-month course. The basic purpose of the revision of the curriculum was to update the information, knowledge and approach according to the present needs (change in epidemiological situation, disease pattern, approach to the client, programs, policies and rules etc.).

The curriculum addresses these issues largely rather than changing the teaching approach. Therefore the teaching schedule /slots have not been changed. Another workshop was then organized by SIHFW, Jaipur, to put forward its recommendations before State and National level experts including the Nursing Council of India Secretary before sending it to Government.

Results: SIHFW has presented the revised ANM curriculum to the

	Government of Rajasthan (GoR) for endorsement. Unfortunately, Nursing Council of Rajasthan and Nursing Council of India did not agree to recognize the revised curriculum as they said that the revision in the curriculum is the prerogative of Nursing Council of India not the Department of Medical, Health & Family Welfare, GoR or any other institute i.e. SIHFW. Hence, it could not replace the existing one. However, GoR has accepted the revised job description of ANMs and also already endorsed the curriculum and asked the ANMTCs to use the revised ANM curriculum Alternatively, DoMH&FW, GoR decided to teach their ANMs as per the existing curriculum. But the revised one will also be taught to them as an additional input for further development of their knowledge. However, the examination paper will not cover the revised syllabus. The GoR has now asked SIHFW to review and update the job responsibilities of all the existing technical human resource of health sector including ANMs. SIHFW organized workshops by involving various levels of officers to chalk out the responsibilities of ANMs.
Cost	Rs 8.475 lakhs given to SHIFW for the revised ANM curriculum, for the Training policy development and for the Revised job responsibilities.
Place	Rajasthan.
Time Frame	Review the ANM curriculum- 10 months. Getting it endorsed by government - 6 months.
Advantages	Quality of training: Improved and up-to-date training given to students. Service delivery: Better trained staff should result in improved health care delivery.
Challanges	Transport difficulties: Lack of vehicles makes it difficult for the students to go to field and clinical sites. Environment: Medical and nursing staff at hospitals are often uncooperative in providing practical “hands on" training to students. Upgrading Training Centres: The training centers are also not updated and equipped with the modern teaching aides. Refresher training of faculties is not being conducted regularly and properly. There is a need to have regular staff for the Training institutes and proper infrastructure. The staff also need regular capacity building to improve their knowledge and skills. Recognition: Nursing council needs to endorse the ANM curriculum to give it status.
Prerequisites	State Government and Nursing Council of Rajasthan must endorse the revised ANM curriculum to pave the way for a long term reform in Rajasthan. Qualified teaching staff at the training institutions. Sufficient teaching aids and stationery. Transport to ensure field and hospital visits by students. Hostels with mess facilities at each

	training institution. Hospital administration and staff willing to facilitate student training. Government orders endorsing the ANM curriculum.
Who needs to be consulted	Director SIHFW, Jaipur. Director Public Health, Rajasthan. Nursing council of Rajasthan and India.
Risks	
Sustainability	Sustainable if the curriculum gets endorsement by the nursing council can be considered as teething problems.
Chances of Replication	Replicable if the programme planers and policy makers understand the necessity for introducing revised ANM curriculum which is based upon the latest changes in epidemiological situation, disease pattern, approach to the client, programs, policies and rules etc.
Comments	The job responsibilities of ANM drafted out by SIHFW does not provide any insights into what minimum facilities will be available to them to carry out their work effectively.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Consultant, NIMS, January 2006.
Status	Active
Reference Files	
Reference Links	

157. District cadres for paramedical workers, Orissa

Subject Area="Human Resources."	Objective="Stable posting of workforce."
Details for Reform Option "District cadres for paramedical workers, Orissa"	
Summary	**Background:** The existing state cadres for paramedics stated that workers could be transferred anywhere in the state. These transfers often created difficulties for the workers and resulted in a reluctance to move, absenteeism and vacancies. **Action:** To overcome these problems the existing state cadres have been separated into district cadres. Preference is given to candidates who belong to the districts and the district authorities themselves select recruits. The posts declared as district cadres are pharmacist, staff nurse, paramedical worker, multi-purpose worker (male, female), laboratory technician and refrigerator mechanic. **Results:** This move has increased the availability of paramedics in difficult areas and reduced the inconvenience to workers.
Cost	
Place	State of Orissa, since 1998.
Time Frame	Few months.
Advantages	Workforce improved: Availability and attendance record of paramedics has increased. Staff friendly: Personal hardships for health workers (especially with families etc.) caused by frequent relocation have been reduced. Logistical: Districts have a better idea of specific requirements and special features of the area and are therefore better placed to organise the workforce.
Challanges	None perceived.
Prerequisites	State govt to devolve responsibility to the districts.
Who needs to be consulted	District health & family welfare agencies; departments of H&FW and general administration of the state.
Risks	
Sustainability	Good.
Chances of Replication	Replicable if state government devolves authority to districts. Orissa has now implemented the scheme across the whole of the state.
Comments	None.
Contact	

Submitted By	Dr. Matthew Jowett, Former Programme Adviser, European CommissionTechnical Assistance Office, New Delhi. July 2002.
Status	Active
Reference Files	GO No MSGN-VIIA-3-97-33953-H dated 23-09-98 (PROD No 8).doc
Reference Links	

158. Decentralisation of supervision structures, Assam

Subject Area="Human Resources."	Objective="Effective decentralised management of services."
Details for Reform Option "Decentralisation of supervision structures, Assam"	
Summary	**Background:** Due to a lack of supervision and authority at all levels, efficient management of the workforce in the district has been problematic. **Action:** Administrative and financial control of workers in the district has been transferred from state government to the district agency - which has in turn delegated the responsibility to the block level Primary Health Centre (PHC) Medical Officers (MOs) in Nagaon district, Assam. These powers include disciplinary action and reallocation of health workers and MOs between facilities as necessary. There are plans for delegating the annual confidential report (ACR) of the workers, including the MOs, to the block Sub Divisional Medical Health Officer (SDMHO). The SDMHO will then be able to decide on issues such as annual leave without consulting the district agency. Salary certificates have to be countersigned by the local block SDMHO. **Results:** These measures have substantially changed attendance records of workers in the facilities.
Cost	No cost involved.
Place	Nagaon District, Assam, since August 2000.
Time Frame	Can be effected immediately, if authorisation is delegated by the state government.
Advantages	Better Regulation: Due to more efficient control of workers at the local level, the attendance and regularity of service provision has improved.
Challanges	Shortage of manpower: Due to shortage of staff, problems are sometimes encountered in implementing the measure.
Prerequisites	Motivated district officials who are interested to improve workforce supervision in outlying areas.
Who needs to be consulted	The health and family welfare department of the state government. The district agency. MOs in outlying areas.
Risks	
Sustainability	The programme is running well since 2000.
Chances of Replication	The program has been replicated in some other districts of the State.
Comments	None.

Contact	
Submitted By	ECTA PROD team, New Delhi. July 2002. Last updated: Juy 2006
Status	Active
Reference Files	Assam PPT.ppt — Reform initiatives in the health sector- A power point presentation.
Reference Links	

159. Training of young village girls as ophthalmic paramedics, Tamil Nadu

Subject Area="Human Resources."	**Objective="Improved workforce efficiency."**
Details for Reform Option "Training of young village girls as ophthalmic paramedics, Tamil Nadu"	
Summary	**Background:** There are estimated to be 12 million blind people in India. Ophthalmologists in India are few in comparison to the large eye morbidity. At the same time nurses are not trained in ophthalmology and require an extra year's training to assist an ophthamologist. **Action:** Aravind Eye Hospital, Madurai, has developed a new cadre of staff – Mid Level Ophthalmic Personnel (MLOP) – by training local village girls (from poor households, aged 17 to 18 years old and educated to 12th standard High School Certificate but with no work experience) to assist doctors. After training, they can undertake tasks such as patient evaluation, conducting diagnostic tests, surgical assistance, counselling etc. The training, done in-house, takes two years, the girls are paid a salary of INR 2,500 and provided with free accommodation in a nearby hostel and subsidised food. The course starts with 4 months basic training after which an assessment is conducted to determine their area of specialisation. The speciality training lasts 8 months. During the second year, they are allowed to practice under supervision and after their final assessment, 99% are absorbed by the hospital. This training programme is now recognised by the Joint Review Council and the Joint Commission for Allied Health Personnel in Ophthalmology (JCAHPO), USA. **Results:** The hospital estimates that the availability of MLOPs makes the ophthalmologists two to three times more effective. It employs four MLOPs for every one ophthalmologist. They allow the doctors to perform a much higher number of surgeries and free them from carrying out time-consuming tasks such as taking a patient's history, explaining the consequences of surgery and showing them how to use eyedrops. It is also a cost-effective measure as trained ophthalmic nurses are significantly more expensive to employ.
Cost	Approximately INR 600 per trainee per month.
Place	Aravind Eye Hospital, Madurai, Tamil Nadu, since 1979.
Time Frame	It took 10 years to define and redefine the curriculum to the model used today. Two years to train each new intake.
Advantages	Time saving: It reduces the time that the doctor needs to spend on routine activities.

	Skill specific: The MLOPs are trained to specialise in just one activity - counselling, refraction (basic vision testing), surgical assistance etc – according to their individual skills. Efficiency: It increases the efficiency of doctors. Cost-effective: Employing MLOPs is significantly cheaper than employing trained nurses. Empowering: Provides village girls with secure, financially-viable and culturally-acceptable employment.
Challanges	Possible opposition: Initially there was some opposition from ophthalmologists Short-term: The hospital has found that after five years many of the girls leave to get married. But it still judges the scheme to be cost-effective.
Prerequisites	An institution that can provide training staff and facilities. Secure accommodation so that the girls' parents will feel comfortable with them working away from home.
Who needs to be consulted	Ophthalmologists. Parents, who need to be assured about the security of their daughters.
Risks	
Sustainability	The new cadre has been operating successfully at Aravind hospitals for the past 25 years and the curriculum has been internationally recognised.
Chances of Replication	Replicable if at an institution with training staff and facilities as in this case.
Comments	A similar course was tried for men but it was found that women were more loyal, more disciplined and were likely to stay in post for longer (despite the marriage drop-out rate). Although it has been internationally recognised, the hospital is currently seeking official recognition for its course from the Government of India. The hospital also conducts 1,500 outreach eye camps a year in Tamil Nadu and trained a separate cadre of MLOPs, who are capable of doing all tasks, to facilitate these camps.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	PROD82.jpg – Ophthalmic Paramedics undergoing training at Aravind Eye Hospital, Madurai PROD82-1.jpg – Trained Ophthalmic Paramedic checking a patient's eye pressure at Aravind Eye Hospital, Madurai PROD82-2.jpg – Trained Ophthalmic Paramedic counsels a patient before operation at Aravind Eye Hospital, Madurai

	mlop1-updated for web.ppt	Role of Mid Level Ophthalmic Personnel (MLOP)
Reference Links		

160. Afternoon Pay Clinics, West Bengal

Subject Area="Human Resources."	Objective="Improved hospital services."
Details for Reform Option "Afternoon Pay Clinics, West Bengal"	
Summary	**Background:** Medical Officers (MOs) of different specialisations are supposed to work between 8am and 4pm. However many were not staying at their posts for the full day - either leaving to practice privately or to go home. Many MOs would also not stay at their place of posting for the entire stipulated duration. **Action:** To give the MOs an incentive to stay at their post until 4pm, it was decided to set up pay clinics in the afternoon. The money charged to the patient would be split between the Government, doctors and the institution. Typically, out of an INR 50 charge, INR 10 would go to the Government, INR 2 would go to the institution and the rest would go to the MO. This service is aimed at patients who can afford it, though services are still free to those below the poverty line (BPL). Charges for the clinics are set by the Government. **Results:** There has been no evaluation of this scheme. However an initial rapid assessment suggested that only 5% of hospitals were actually holding afternoon pay clinics. An evaluation for further refinement of the scheme is planned in the near future.
Cost	Minimal establishment costs like electricity, water, etc.
Place	West Bengal medical college hospitals, district hospitals, sub-divisional hospitals and state general hospitals from November 2001.
Time Frame	Approximately 3 months to issue a Government Order.
Advantages	Funds generation: Not only does the scheme produce income for the MOs, it also generates funds to improve/maintain facilities at the institution.
Challanges	Generating awareness: Many institutions have had difficulties in getting the message out to patients that the facility is available. Incentivising MOs: Many MOs have been reluctant to take part.
Prerequisites	Willingness from MOs to take part in the scheme. Awareness generation of the scheme. Issue of Government Order.
Who needs to be consulted	Officials of the Department of Health & Family Welfare; MOs.
Risks	
Sustainability	Sustainable.
Chances of	The scheme has been slow in taking off in West Bengal. This was due

Replication	to a lack of proper dissemination of information to both beneficiaries and MOs and the fact that timings were not suitable for the beneficiaries.
Comments	Timely payment to service providers and Government order for participation of MOs are required for successful implementation of the scheme.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. November 2004.
Status	Active
Reference Files	
Reference Links	

161. Benchmarking to improve the performance of specialist doctors, Punjab

Subject Area="Human Resources."	Objective="Improved hospital services."
Details for Reform Option "Benchmarking to improve the performance of specialist doctors, Punjab"	
Summary	**Background:** The Punjab Health System Corporation (PHSC) identified that there was low utilisation of government health facilities by patients. One of the main reasons was that health professionals were not motivated to deliver services. **Action:** In order to improve the work output from hospitals revamped by the PHSC, it was decided to set performance benchmarks for specialist doctors. Benchmarks of the activities were decided on the basis of average work output and bed strength of the hospital. Benchmarking of the activiites.htm The officer in charge of the medical institution assesses the performance of the specialist doctor where they are working. At district level Civil surgeon and Deputy Commissioner conduct the assessment and by Director M.D. PHSC and Secretary Health and Family Welfare at the state level. Explanation was called against those specialist doctors who have not achieved the benchmarks and are conveyed displeasure. Appreciation letter are awarded to those doctors to fulfil the set benchmarks as an incentive. Fact is also reviewed while recording their Annual Confidential Report (ACR). **Results:** (a) The increase in work output at health facilities was judged by the increase in utilisation: between 2000-2001, Out Door Patients visits increased from 5.13 million to 6.88 million. In Door patients visits increased from 2,68,916 to 2, 76,746. Major surgeries increased by 21% X ray increased by 56%. Laboratory tests increased by 19%. Diagnostic tests increased by 24%. (b) Improvement in number of doctors who had achieved benchmarks. In 2004-1198 doctors had not achieved the benchmarks whereas in 2005 it was only 327 doctors.
Cost	Involvement of the cost element is nil because it needs only issue of the Government order.
Place	One hundred and fifty four hospitals in Punjab, including Community Health Centres, Sub divisional hospitals and District hospitals.
Time Frame	Approximate time from planning to implement the reform is one year.
Advantages	Accountability of specialists: Doctors are encouraged to perform according to set norms. Increased utilisation of the health facilities: Utilisation of the diagnostic

	and curative services available in the health facilities increases. Availability of the services to the patients: Availability of the services increases due to decrease in absenteeism of health professionals.
Challanges	None perceived.
Prerequisites	Government Order.
Who needs to be consulted	State government.
Risks	
Sustainability	Sustainable, as implementation of the scheme involves only the issue of a Government Order.
Chances of Replication	Good.
Comments	Giving health facilities a facelift by restoring the infrastructure and necessary equipment is not sufficient to improve service delivery if the health professionals are absent. Setting benchmarks and encouraging them to attain them is one of the ways to motivate health professionals to deliver services.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, NIMS, September, 2005.
Status	Active
Reference Files	PHSCHS20002112-2147.doc — GO: PHSC/HS/2000/2112-2147. Benchmarks for specialist doctors.doc — Benchmarks for the specialist doctors.
Reference Links	

162. Empowerment of Village Health Nurses: Improving Mobility, Tamil Nadu

Subject Area="Human Resources."	Objective="Improved outreach services."
Details for Reform Option "Empowerment of Village Health Nurses: Improving Mobility, Tamil Nadu"	
Summary	**Background:** One of the main problems of outreach services in the sub-centre area is an inability of the Village Health Nurses (VHNs - known in other states as Auxiliary Nurse Midwives or ANMs) to get around. Depending on public transport often makes it difficult for her to reach the villages. Private transportation is only available on main roads and does not reach out to the remote areas. **Action:** This started as a DANIDA-Tamil Nadu State Government project training 500 VHNs to ride a two-wheeler – either a moped or a bicycle - which had already been purchased with DANIDA loans but which were often being used exclusively by their men folk. It has now been extended to VHNs in three further districts in the State. The women are expected to purchase a moped using a private loan. The main features of the training are that it is given at a residential camp allowing freedom from domestic chores, with group learning in an all-woman set-up. Learners' driving licences are provided and help given to enable them to obtain their permanent licence. **Results:** The resulting increased mobility has freed VHNs from relying on male family members for mobility and allows them to plan their activities on a more systematic basis. It has brought about a saving of nearly 50 to 60% of time spent on walking, waiting for buses etc. and allows VHNs to increase the quantity and to improve the quality of their service. Specifically they can now visit villages more frequently, cover a larger number of families, spend more time with each patient and be immediately available in case of emergency. Some of the VHNs feel that their mobility has also increased their status. An evaluation study was carried out by A. F. Ferguson & Co. in three districts, which had benefited by DANIDA mobility loans: in Dharmapuri and Krishnagiri districts (which received training) and in a control district Cuddalore (which did not). See report in Documents and Illustrations box.
Cost	The cost of the state government loans for the two-wheelers was INR 15,000 per VHN. The state government no longer provides the loans and expects the VHN to get them privately.
Place	Eight districts of Tamil Nadu between 1996 – 2003 under the DANIDA project. It has been extended to sub project districts of Madurai & Theni districts since 2001 and is now part of the regular training programme of VHNs. A modified 5-day programme is under

	progress in Vellore district with the funding support of UNICEF.
Time Frame	Approximately seven months, which includes: Approval of the proposal by the funding agency: three months. Approval of the proposal by the state govt/allotment of budget: two months. To be done simultaneously: Discussion with the district officials for the selection of suitable training site: one month. Purchase of 12 two-wheelers and cycles: two months. Selection of resource persons for communication skills, driving trainers, mechanic for minor vehicle repairs: one month. Obtaining licences: one month. Three to 4 batches of 20 to 30 people can be trained per month.
Advantages	Time effective: Having fully mobile VHNs means that they use their time far more effectively and are able to reach remote areas more frequently. Training opportunities: The residential camp gives an opportunity for additional training. In this case, the VHNs were also taught additional computer, communication and gender awareness skills.
Challanges	Cost: The VHNs must be confident enough to take out a private loan to buy a moped. In addition one major limitation on the VHNs' mobility still exists, and needs to be tackled, namely paying for fuel. Logistics: VHNs are still hindered by having to carry kit, negotiate difficult terrain or dangerous roads, deal with mechanical problems and ride wearing a Sari. Possible opposition: From male health colleagues who do not like to see the women empowered; older VHNs and the VHNs' families who may view the initiative as unsuitable for a lone woman.
Prerequisites	Funding support & approval of state government. Site for training with suitable facilities including open ground for driving, class rooms and residential accommodation. Willingness of VHNs to participate in the training and purchase of two-wheelers after the training. Coordination with two-wheeler distributors and banks to facilitate the purchase of two-wheelers by VHNs. Negotiation with the transport authorities in the district to get the learners licence for the trainees and facilitating the trainees in getting the final driving licence. Resource persons, driving trainers, mechanics for the training period. Required number of two-wheelers and cycles (minimum of 12 two-wheelers and cycles) for training period.
Who needs to be consulted	Programme officers and policy makers. VHNs. VHN association office bearers. District officers. Resource persons.
Risks	
Sustainability	If the training can be integrated within routine VHN/ Auxiliary Nurse Midwife (ANM) training and the funding is available, it becomes sustainable.
Chances of Replication	Good. Mobility training (on mopeds and bicycles) has now been included in the revised curriculum for "multi-purpose health

	workers" (ANMs) in Tamil Nadu and will benefit all the VHNs and their female supervisors in the entire state. The empowerment of VHNs programme has also been included in the second phase of the RCH programme which is scheduled to start April 2005.
Comments	The programme managers suggest that: Additional training in maintenance/ repair of vehicles and in driving on main roads should be included as a routine. A budget should be made available for fuel (between INR 280 – 420 per month) and for spare parts. The regulations relating to the wearing of a uniform Sari should be modified to allow the possibility of a Salwar Kurta. Having women trainers seemed to be a critical aspect in building confidence and the residential training was beneficial.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	PROD66.jpg — VHNs with their mopeds PROD66-1.jpg — VHNs with their mopeds
Reference Links	

163. Short Course training of Medical Officers, Assam

Subject Area="Human Resources."	Objective="Create more specialists to give a better service to the rural community."
Details for Reform Option "Short Course training of Medical Officers, Assam"	
Summary	**Background:** During 1992, under the Child Survival and Safe Motherhood (CSSM) Programme, Community Health Centres (CHCs) were upgraded as First Referral Units (FRUs) to provide basic and comprehensive obstetric care. However, provision of equipment and improvement of infrastructure did not result in improvement of referral care throughout the country because specialists are limited in the State Health Services (SHS) and posting of available specialist manpower in FRUs was not possible because the state had no specialist cadre. For example, under CSSM/ RCH programme, 76 FRU kits were supplied in 1996-97 but these were unused till 2002. **Action**: During 2001, under the Sector Investment Programme (SIP), supported by the European Commission (EC), Government of Assam started to operationalise FRUs in Nagaon District. In April 2002, it was decided to have a Short course training for Medical Officers (MOs) to increase the number of specialists in the State ands allow the FRUs to function properly. Considering the need for expertise, State Govt. decided to train non-postgraduate (non-PG) MOs in Medical Colleges of the State and then post them to FRUs. Accordingly the Directorate of Medical Education (DME) was requested to direct the Medical colleges to conduct a six-month training for SHS doctors in the State using the SIP funds for the training courses. Initially, paediatrics and anaesthesia were selected. Later orthopaedics and then radiology were also added to the list. The basic objective of the training is: (i)Up gradation of theoretical knowledge and practical skills. (ii)Expertise to deal with surgical, anaesthesia and other emergencies. (iii)Ability to provide regular services in FRUs of rural areas. The training is residential and MOs below 40 years of age were selected for the courses. Trainees have to attend theoretical classes by the faculty with the PG students as well as hands on practical training supervised by faculty/ senior staff. They are evaluated regularly and a certificate of expertise is issued only after satisfactory performance under supervision. **Results:** Already 77 medical officers have been trained in

	anaesthesia (28), paediatrics (35), orthopaedics (7) and radiology (7). Number of batches and numbers of MOs trained and posted to FRUs: (i)Gauhati Medical College & Hospital, Guwahati: 4 batches. Anaesthesia: 18; Paediatrics: 21; Orthopaedics: 6: Radiology: 4. (ii)Assam Medical College & Hospital, Dibrugarh: 3 batches. Anaesthesia: 8; Paediatrics: 12; Orthopaedics: 1: Radiology: 3. (iii)Silchar Medical College & Hospital, Silchar: 1 batch. Anaesthesia: 2; Paediatrics: 2. Trained anaesthetists and paediatricians are also running District Hospitals.
Cost	Total expenditure so far: INR 18,48,000 Travelling Allowance and Dearness Allowance @ INR 24,000 per trainee per batch.
Place	Three Medical Colleges in Assam (i) Assam Medical College & Hospital, Dibrugarh (ii) Gauhati Medical College & Hospital, Guwahati (iii) Silchar Medical College & Hospital, Silchar
Time Frame	Three months (April 2002- July 2002)
Advantages	Expanded referral care: FRUs can be operationalised through this trained manpower. Increase of Specialists: Supplies more trained MOs.
Challanges	Professional bodies are against this training. Hesitation to perform: In a few instances, the trainees are hesitant to perform. Community acceptance: The community is less likely to accept an MO who has taken a short course rather than a full post-graduate course.
Prerequisites	Several rounds of meetings between the heads of departments and DME for finalisation of the course.
Who needs to be consulted	Director of Medical Education.
Risks	
Sustainability	Sustainable.This training has been operational for three years and is expected to continue in future.
Chances of Replication	Replicable. It would enable other states to address the issues of shortage of specialists.
Comments	None.
Contact	
Submitted By	Dr Arti Bahl, Research Consultant, CBHI,New Delhi October 2005. Last Updated: October 2006

Status	Active
Reference Files	
Reference Links	

164. *Management of Directly Observed Treatment Short Course Programme, Rajasthan*

Subject Area="Human Resources."	**Objective="Using patients instead of health workers to facilitate drug delivery at a Community Health Centre (CHC)."**
Details for Reform Option "Management of Directly Observed Treatment Short Course Programme, Rajasthan"	
Summary	**Background:** Under the National Tuberculosis Programme, Directly Observed Treatment Short course (DOTS) has been adopted in 1995 across all states of India. The key components of this strategy are – case detection by sputum microscopy, standardized treatment for 6-8 months, regular supply of essential drugs and standardized reporting system. For ensuring actual injection of medicine to patients suffering from tuberculosis (TB) so that drug resistance is reduced, Auxiliary Nurse Mid-wife (ANM) needs to visit patient's home on alternative days or once a week to ensure that they take the doses continuously on alternate days or once a week. It is very labour intensive. In addition, because the patient often feels better after one or two months, treatment is frequently interrupted. To tackle the large amounts of manpower necessary to successfully carry out this course of treatment, the Medical Officer (MO) in charge of one CHC, located in Pali district, Rajasthan, adopted an innovative strategy which requires the patients to come to the facility and take the medicine themselves. **Action:** (i) Identifying the Tuberculosis patients and categorizing them according to sputum positive or negative and whether they are first timers or repeaters. (ii) The medicine for each patient is put in separate boxes and the patients are asked to mark a suitable symbol to identify their box. (iii) The names of the patients along with their details are written in the box using different colour markers – red for category I (sputum positive); blue for category II (repeaters); green for category III (sputum negative). The symbols of the patients are also made using the same colour scheme. (iv) The different category boxes are stacked in separate

	compartments of an almirah (chest of drawers). (v) Patients are trained to identify their medicine and take out the required dose. (vi) The patients sit on a bench outside the doctor's chamber in direct view of the doctor. They come early morning to collect their medicines 8.30 am to 10.30 am. (vii) While seeing other patients the MO- DOTS keeps watch as to who is taking the tablets. After end of every week MO checks the boxes to verify whether all the patients have come and taken all the doses. If any patient has missed the dose or has not come for sometime to the CHC, ANMs (Auxiliary Nurse Midwife)/MPWs (Male multipurpose workers) are then sent to follow-up. (viii) Contact number or contacts of people living nearby or contact of teachers or some known person in the village is always taken and if the patient misses one dose he/she is contacted immediately. Hence, workers who would have been giving medicines to each of the patients now just chase up the dropouts. (ix) Regular maintenance of information on TB patients in the computerized Management Information System. **Results:** Patients are regularly taking medicines from the CHC. In addition, CHC reported that the system has generated an interest among patients to come to the CHC and take the requisite dose. The quality of supervision has remarkably improved the status quo of the patients, as there has been reduction in defaulters over a five year period. The data with the CHC shows that three-fourth of the patients have been cured. For more detailed results
Cost	Reduces the cost of staff regularly visiting villages.
Place	Villages adjacent to Sadri CHC and also the town. Similar strategy is used in the Sub Centres which are under the Sadri CHC.
Time Frame	Three months.
Advantages	Inclusive: Patients involved in making the treatment plan. Encourages a good doctor-patient relation. Timesaving: Reduces the field workers' workload. Effective: Reduces the number of defaulters.
Challanges	Needs careful monitoring: Chances of dropout unless continuous monitoring. Needs education: Patients do not always realize the importance of regular medication. Needs communication: Efficient contact must be made between doctor, institution, patient and prominent people in the villages.

Prerequisites	Dedicated and motivated MO. Cooperative CHC In-charge. Regular supply of medicine. Good quality diagnosis. List of identified TB patients and regular monitoring.
Who needs to be consulted	CHC In charge, Sadri CHC. MO – DOTS, Sadri CHC.
Risks	
Sustainability	Sustainable only when there is regular monitoring by MO.
Chances of Replication	Good, in rural and semi-urban areas. In urban areas the patient are very mobile and it is sometimes difficult to track them down. It is replicable mostly wherever there is a motivated MO and cooperative CHC In charge.
Comments	The TB control programme started in Rajasthan in 1966. However, lack of adequate funds, political wills erratic supply of drug, inappropriate IEC and supervision and monitoring were some of the reasons for the programme's inability to achieve its goals. In 1995, the TB programme was reviewed and DOTS strategy was drafted and was expanded in phased manner with decentralization of service delivery system. As of now the State has a TB cell, TB demonstration and training centre, 32 district TB centres, 143 TB units, 650 Microscopy centres, 1843 treatment centres and DOTS services provided at 11296 sites across the state. Quarterly newsletter was started since 1993. Few innovative approaches adopted – IPC slip, IEC homes and fixed tour programme.
Contact	
Submitted By	Dr Nandini Roy, HS-PROD Research Consultant, NIMS, September 2005. Last Updated: Prabha Sati, Research Consultant, ECTA, December 2006.
Status	Active
Reference Files	scan1.pdf
Reference Links	

165. Corporate policy on HIV/AIDS

Subject Area="Human Resources."	Objective="Awareness of HIV and workplace sensitivity"
Details for Reform Option "Corporate policy on HIV/AIDS"	
Summary	**Background:** According to a US National Intelligence Council report, there will be 20 to 25 million HIV positive people in India by 2010, and statistics suggest most will be in the most economically productive age group, 18 to 40. A Confederation of Indian Industry (CII) estimate puts the cost to business of one HIV-infected employee at about INR 1,00,000 annually. Businesses are now realising that it is cheaper to provide preventative measures than meet the costs incurred by dealing with workforce problems arising out of HIV/AIDS. As a result, a number have initiated programmes aimed at raising HIV/AIDS awareness among their workforce. The following is one drawn up by Larson and Toubro (L&T), one of the biggest private companies in India. A long established engineering firm with plants across India, L&T employs a total of around 23,000 employees. **Action:** In 1985, L&T launched an awareness programme at its Powai works, by collaborating with an NGO, the Dilip Kumar Tyagi Trust. Through lectures, counselling and discussions by the company's Employee Welfare Department, employees and their families were given a comprehensive overview of the infection, modes of transmission, prevention and treatment. Young people, including graduate trainees, employees' children and local students were a particular focus of the programme. In 1995, a 10 month baseline study was also conducted in a targeted intervention programme to give more structure. These initiatives were then taken up in the other plants and incorporated into their training calendars. Orientation on HIV/AIDS awareness is now part of the L&T induction programme. In addition the company undertakes the following: i) Awareness Generation Through posters and information booklets; street plays; lectures and discussions, and in partnership with NGOs (for a list of NGO partners please see References below). ii) Training: Peer educators are seen as one of the most important links in the prevention chain. 'Training of trainers' sessions are conducted quarterly among employees. Community-based training programmes are offered for employees' wives.

	A 2003 programme covered all the contract workmen and another covered about 70 bus drivers of L&T, Powai. iii) Condom Distribution and Sexually Transmitted Disease (STD) Treatment: Free condoms are provided at all medical centres on the plant sites and through vending machines at public places. Free medicines are provided for treatment of STDs as well as information and counselling on 'risky behavioural practices', HIV and its impact. Compliance to treatment and recurrence of STDs are also monitored. iv) Counselling: Professionally trained counsellors offer information on prevention of HIV, pre-testing counselling and referrals to Voluntary Testing Centres. Counselling is also given to HIV-positive employees and their families. Workers and staff trained on HIV issues act as peer counsellors to their co-workers. v) Care and support to HIV positive employees: L&T counsellors and doctors liaise closely with doctors at external hospitals to ensure access to services without discrimination. The company runs a scheme for reimbursement and hospitalisation benefits, and appropriate work adjustment is carried out if a worker is not fit for a certain period. Group counselling is arranged to ensure support from colleagues and avoid discrimination. **Results:** Since 1997, 140 peer educators have been trained. At Powai between 1995 and 1998 more than 10,000 employees, 4500 family members and 1600 local children have received HIV awareness education. No figures are available regarding the number of employees going for voluntary testing since this information is confidential. However the company reports that: i) No employees have quit their jobs or been terminated since the policy came into force. ii) There has been a reduction in the number of HIV cases reported amongst employees. iii) Since December 2003, the voluntary testing and counselling services have been utilised 573 times. The following are some of the lessons learnt from L&T's experience: i) A multi-layered response is necessary in large companies with several plants. ii) Education and prevention have to be built into the training strategy of the company. iii) Peer educators play a key role in both prevention and care.
Cost	To come

Place	Policy was first implemented in the Powai (Mumbai) plant but is now in place at all L&T plants.
Time Frame	Ten years until actual policy drawn up but workplace program had been in place since 1985. The policy was a natural progression of documenting all the practises the company was already following.
Advantages	Healthy workplace: The simplest way to help employees protect themselves is to provide accurate and up to date information. Cost reduction: High recruitment and training expenses are avoided by retaining experienced workers on the job, even if HIV positive. Production levels maintained: Reduced possibility of slow production or walkouts by colleagues opposed to working with an AIDS infected employee. Employee respect: Gained through a standard company-wide approach. Crisis avoided: By anticipating an increase in infected employees and being prepared to deal with it.
Challanges	Involvement of trade unions: Failure to include unions in the planning and implementation of programmes could lead to friction and delays. Ensuring multicultural material: Education materials should be multicultural and multilingual, and appropriately directed at specific target groups. Failure to do so could exclude certain groups Approachability: The company's programme implementation department should be positioned as a professional, neutral and non-threatening body. Any member percieved as judgemental could lead to intimidation amongst employees
Prerequisites	Recognition and acceptance that HIV/AIDS will affect the workforce. Steps taken now can help to deal with the epidemic in the coming years. Management support in policy formulation and involvement of trade unions.
Who needs to be consulted	NGOs working in this area for implementation of awareness generation programmes. Other corporates who have devised a written policy. Unions.
Risks	
Sustainability	This policy sustains itself through: Ongoing support programmes in step with policy guidelines such as awareness generation, across the cadre. Devising proactive and innovative ways to spread information and policy guidelines. Including a session on company policy in employee induction and orientation program. Developing an effective network and referral system outside company.

Chances of Replication	L&T's example is being replicated by numerous other corporates in various ways. It helped form The Industry Response to AIDS, a grouping of senior management from 13 companies based in Mumbai. The company has also contributed to the writing of policy guidelines for industry in India and attempts to share its programmes and expertise with other companies.
Comments	Many other companies, either on their own or with NGO or government participation, have opened counselling centres, provided medical cover for workers, and are working to eradicate the social stigma attached to HIV carriers from the workplace. See References for other examples.
Contact	
Submitted By	Tessa Laughton, Research Consultant ECTA, New Delhi. Nov 2005
Status	Active
Reference Files	L&T policy.doc Corporates which have taken action to fight HIV.doc CII.doc — CII plan of action by Indian Industry NGO partners.doc Guidelines issued on HIV.doc
Reference Links	

166. Rural Health Practitioner training, Assam

Subject Area="Human Resources."	Objective="To create a pool of qualified manpower to serve in underserved areas and among remote rural communities."
Details for Reform Option "Rural Health Practitioner training, Assam "	
Summary	**Background:** In order to cater to the health needs of the rural areas, the Government of Assam brought in the Assam Rural Health Regulatory Act in 2004. It is an act to provide for the establishment of a regulatory authority in the State of Assam whose brief is to regulate and register the Diploma Holders in Medicine and Rural Health Care (DMRHC) and their practise of medicine in rural areas (areas not included in a Municipal Corporation, a Municipal Board or a Town Committee or any other area notified as urban area) and also to regulate opening and running of Medical Institutes for imparting education and training for the course of DMRHC. **Action:** The act received the assent of the Governor on 4 December 2004 and it came out in the Assam Gazette Extraordinary on 18 September 2004. The prime objective of this act is as follows : i) Opening of Medical Institutes for imparting education and training for the course of DMRHC. ii) To regulate and register the diploma holders in DMRHC. In light of the above Act Jorhat Rural Medical Institute started this DMRHC course. The first batch was started in September 2005. The practical training for this course takes place at the Jorhat Civil hospital, Jorhat. **Results:** i) 98 students have been selected on merit basis, and are undergoing DMRHC training. This batch will pass out in September 2008. ii) Till date the construction of 1 library, a laboratory and 2 lecture rooms have been completed. iii) Though the training at present is taking place in Jorhat Civil Hospital, but approximately within three years a full fledged institute with all facilities will start functioning.
Cost	1 crore (including both capital and recurring cost).
Place	Jorhat Medical Institute at Civil Hospital, Jorhat, Assam.
Time Frame	Approximately 6 months. This course is running since September 2005 when the first batch of students was admitted.
Advantages	Trained man power for rural areas: It will lead to increase in trained manpower for rural areas and in the health sector. A pool of trained physicians, during time of crisis to increase the manpower pool in the health sector. Vacant posts to fill up: Vacant posts in rural areas will get filled up. Regularisation of trained manpower: It will regularise and streamline trained manpower in rural areas and simultaneously increase access

	to rural people in Primary Health Care. Certification Authorisation: Streamlining the certification procedure for death and birth as the Rural Health Practitioners will be authorised to issue these certificates
Challanges	Limited Employment Opportunities: The trained practitioners are limited to practice in rural areas only. They are not eligible for employment in hospitals, nursing homes and health establishments in urban areas. Limited Treatment: Only the diseases, procedures and drugs, outlined in the rules shall be treated, carried out and prescribed. Surgical Interventions: Surgical interventions cannot be carried out by these practitioners.
Prerequisites	Good number of students; interested and well oriented faculty members; strict regulations to ensure norm adherence and professionalism.
Who needs to be consulted	Ministry of Health & Family Welfare, Govt. of Assam.
Risks	
Sustainability	It depends upon commitment of concerned Government and the rigour of the training imparted.
Chances of Replication	Only after getting feedback from community regarding the services rendered by these practitioners and considering their acceptability that the replicability of this programme can be commented upon.
Comments	None.
Contact	
Submitted By	Dhrub Kumar Singh, Research Consultant, Central Bureau of Health Intelligence, New Delhi, October 2006.
Status	Active
Reference Files	Rural Medical Institute Jorhat.doc — The Assam Gazette, Extraordinary, No. 187, Dispur, Saturday, September 18, 2004, Assam Act no XIX of 2004 pg 1170-1191
Reference Links	

167. Training of the Health Service Providers on Gender Mainstreaming, Madhya Pradesh

Subject Area="Human Resources."	Objective="To enhance capacity of health service providers at all levels; to deliver gender sensitive and quality services."
Details for Reform Option "Training of the Health Service Providers on Gender Mainstreaming, Madhya Pradesh"	
Summary	**Background:** Improving quality of health services as per the clients and community needs is one of the concurrent health service delivery strategies. But simply ensuring quality of health services may not help in addressing gender issues. It needs to be understood that the lack of it can affect women and men differently (for example; even partial absence of privacy and confidentiality may affects the treatment seeking behaviour of men and women differently) and is more likely to reduce women's perceived access to services. Capacity building of health care providers on providing gender sensitive services has been identified as an activity under output five as well as six in the Integrated Population Development (IPD) projects operation plan. Therefore, comprehensive training was conducted for the medical officers and the paramedical staff in the five IPD districts in Madhya Pradesh by the Directorate of Health Services, Government of Madhya Pradesh in support with the United Nations Fund for Population Activities (UNFPA). Gender sensitive aspect has been integrated in all the ongoing skill development training (eleven days training programme under the RCH I) in which gender was made as a cross cutting component. Main Components: (i) Gender Dynamics (ii) Power Inequalities (iii) Gender Issues in Health Service Provisions (iv) Recognising Gender as a Health Issue (v) Gender Based Violence as a Public Health Issue (vi) Role, Responsibilities and Actions of a Gender Sensitive Service Provider **Results:** The actual training of the medical and paramedical staff was carried out in the districts and a total number of 1765 health service providers were trained out; of which 1211 were trained in the year 2004 and the balance 626 were trained in the year 2005. The total planned number of health service providers to be trained was 2350.

Cost	Information not available
Place	Five IPD districts: Rewa, Satna and Sidhi of Rewa division, Panna and Chhatarpur districts of Sagar division.
Time Frame	One year.
Advantages	Quality Improvement: orientation of the health professionals to gender issues and developing appropriate attitudes and skills among them will improve the health services delivery.
Challanges	Prejudices: the prevalent prejudices against women already rooted in the society are resisting factors to come over
Prerequisites	Baseline data need assessment, supportive environment, development of training curriculum and its pre-testing, trained staff, infrastructure to be used as a place where transferring knowledge, skills and attitudes can occur. Budget allocation as per project area.
Who needs to be consulted	Health professionals and workers, female patients, key informants in the community, development officials, state health department
Risks	
Sustainability	Good, capacity building and good training curriculum and methods adopted will support sustainability.
Chances of Replication	Chances of replication are good.
Comments	It will facilitate orientation and delivery of health services in a sensible, sensitive and client friendly manner.A step towards quality improvement and human resource development.
Contact	
Submitted By	Dr. Anil Bhola, Research Consultant, National Institute of Medical Statistics, New Delhi November, 2006
Status	Active
Reference Files	Organising Steps.doc
Reference Links	

168. Incentive to Tackle Absenteeism among Doctors in Tribal Areas, Orissa

Subject Area="Human Resources."	Objective="Increase presence of specialist doctors in tribal and backward districts."

Details for Reform Option "Incentive to Tackle Absenteeism among Doctors in Tribal Areas, Orissa"

Summary

Background: One of the challenges faced by the public health system in India is the acute shortage of doctors, especially in rural and tribal areas. Most doctors, posted in rural areas, do not take up residence at their place of work and therefore they are not available for duty at the health institutions. In Orissa, absenteeism was found to be chronic in 11 tribal districts: Koraput, Malkanagiri, Nawarangpur, Rayagada, Bolangir, Sonepur, Kalahandi, Nuapara, Boudh, Kandhamal and Gajapati.

Action: In February 2006, a resolution was passed by Government of Orissa (GoO) to curb absenteeism among doctors by giving them additional financial incentive. The resolution was passed only after the state finance department gave its clearance on January 17, 2006. The scheme is being piloted for a period of two years to see how effective it is in curbing absenteeism among doctors placed in tribal districts. In December 2007, the scheme will be reviewed for extension. The initiative gives additional financial incentive of INR.2000 per month to those Assistant Surgeons and specialists (class-II) at district level hospitals who attend to their duties.

Those working in peripheral hospitals or dispensaries get a financial incentive of INR 5000 (€ 85.48) per month. If a doctor goes on leave for more than three days or is in transit on account of transfer, he or she does not qualify for incentive. In order to get the incentive the Medical officers (MOs) in charge of Community Health Centres (CHCs), Primary Health Centres (PHCs) and Area Hospitals have to furnish a certificate every month to Chief District Medical Officers (CDMOs) certifying whether the concerned doctors in their administrative area have stayed and provided services in the respective institutions throughout the month. Surprise visits are made by CDMOs to verify whether the MOs have been physically present in the health institutions.

In case a doctor is found to have made incorrect statement regarding his or her attendance, the incentive amount is to be recovered from the countersigning officer. The district collector, who is responsible for administration of the district, is supposed to regularly monitor the attendance of doctors. The CDMOs, in their fortnightly confidential report to the collector, incorporates information regarding absenteeism.

Result: The initiative has been in operation only for a few months.

	The initial response is good. In Malkangiri, which is a tribal district, the rate of absenteeism has gone down considerably. However, a more definitive impact can be gauged after evaluation at the end of 2007.
Cost	The district makes the outlay from other allowances. The cost depends on the number of posts filled up.
Place	Tribal districts of Orissa: Koraput, Malkanagiri, Nawarangpur, Rayagada, Bolangir, Sonepur, Kalahandi, Nuapara, Boudh, Kandhamal and Gajapati.
Time Frame	Immediate.
Advantages	Access: The underserved population has greater access to services because MOs and specialists are present at their respective institutions in remote areas.
Challanges	Monitoring: Need to oversee that the scheme is not misused. Resentment: Ensure that there is no resentment among non-medical staff such as pharmacists, auxiliary nurse midwives, lady health visitors. Vacant Post: In remote tribal districts, many posts of doctors are lying vacant. Unless these posts are filled-up, this initiative will not have much impact. Opposition: The doctors are refusing to go for capacity building programmes for more than three days as they will loose their incentive.
Prerequisites	Government Order. Vacant posts of MOs are filled up. Para-medical staff has to be in place.
Who needs to be consulted	District collector Chief District Health Officers. In-charge of respective public health institutions. Medical officers.Community.
Risks	
Sustainability	The government of Orissa has adopted the scheme for a period of two years. The success of this first phase will determine whether it will be extended or not.
Chances of Replication	Not too high, because most of the posts are vacant. This initiative, which at present is only for allopathic doctors, may show greater results if the government extends the same incentive to Ayurvedic doctors as well.
Comments	It is a challenge to have a suitable monitoring mechanism to ensure availability of doctors in remote areas. The mode of monitoring still remains random field visits by district officials. Involvement of Panchayati Raj Institutions may be a good strategy to monitor attendance of staff, but doctors have to be willing.
Contact	
Submitted By	Dr. Nandini Roy, Research Consultant, National Institute of Medical

	Statistics, May, 2006.
Status	Active
Reference Files	
Reference Links	

169. Women Group Leader Programme: Sanjeevanis, Haryana

Subject Area="Community participation."	Objective="Community health workers."
Details for Reform Option "Women Group Leader Programme: Sanjeevanis, Haryana"	
Summary	**Background:** It is estimated that only 17% of women in Haryana have institutional deliveries, resulting in a high level of maternal and infant deaths. The sex ratio of Haryana has also seen a declining trend and is at present 861females to 1,000 males (* see "References" box below), one of the worst in the country. This, coupled with a strong patriarchal structure and low education level, leads to the poor status of women in the State. **Action:** Based on the lessons learned from the Integrated Women Empowerment and Development Programme (IWEDP) Project (undertaken by the Department of Women & Child Development 1994), the Health Department under the EC-supported Sector Investment Programme (SIP) adapted the programme in three pilot districts of Ambala, Yamuna Nagar and Karnal. While the IWEDP took social development/welfare as the entry point, the SIP initiated a component on women leadership, taking health as the entry point. Women were trained to give health education lessons to women in their communities. The Sanjeevani (named after an ancient herb that restores life) plays the role of an agent of change. She contributes towards the development of women with a focus on health, nutrition, sanitation, delayed marriages, small families and method of child spacing, along with generating awareness on available existing health schemes and facilities. She works voluntarily, mobilises women of the village into groups and functions as a friend and guide to women and adolescent girls. The focal point for discussion of various problems is a group of 20 women from the village known as the Jagriti Mandali (literally "awakening group") which is held at a specific time every week. They are paid INR 100 per meeting to cover the cost of travel and other incidentals. A contingency fund of INR 2,000 is also given immediately after training which is used for expenses on registers, pens, durries (mattresses) and other essentials. The block health educator also attends these meetings and updates the participants with the latest information on new schemes etc. The Sanjeevani makes reports of these meetings which she shares with the Swasthaya Kalyan Samiti of the area and

	maintains the accounts. Selection criteria for Sanjeevanis: (i) Need to have basic education - matric (middle school) pass - as well as a strong sense of motivation, leadership qualities and communication skills. (ii) Should not be the wife of a government servant, not have more than three children and should be an active member of the Mahila Mandal (Women's Cell) or the Mahila Swasthya Sangh (Women's Health Group). (iii) Selected by a committee consisting of the district training officer, the medical officer in charge of the concerned Community Health Centre (CHC) and the medical officer in charge of the concerned Primary Health Centre (PHC). On selection they are given 10 days residential training (including legal literacy; health issues such as ante-natal, natal and post-natal care, immunisation, family planning methods, other common ailments, nutrition, sexually-transmitted diseases including HIV / AIDS; and accounts and record keeping) in batches of about 30 each at the CHC Mullana in Ambala district. The curriculum identified for the training (annexed in the "References" box below) has been developed into a printed module which acts as reference material for discussion on the topics in the Jagriti Mandali. **Results:** 155 women were trained (10 days residential training) in Yamuna Nagar district between November 2001 and February 2003. A total of INR 9,26,900 has been paid to them through the District Health and Family Welfare Society. 112 women have been trained in Karnal and 171 in Ambala, giving a total of 438 trained. Confidence levels of women have gone up. They assist the ANM in recording births and deaths and maintain immunisation records of infants in their villages. Due to financing problems, the Sanjeevani programme was officially halted in June 2003, but meetings are still being held informally by Sanjeevanis who have already been trained. (See sustainability and replicability box for further details). The lessons learnt from the programme will now be put into the State's Accredited State Health Activist (ASHA) scheme under the Government of India's National Rural Health Mission.
Cost	Expenditure incurred for one year activities – INR 14,89,650 for the year 2001-02 including the honorarium and contingency expenses to Sanjeevanis, printing of the training module and salary of a training consultant INR. 20,000 per month. Funding stopped in June 2003.
Place	Districts of Ambala, Yamuna Nagar and Karnal from November 2001 - June 2003.

Time Frame	Approximately one year to get the programme going.
Advantages	Awareness generation: Spreads health messages to grass root level. Direct link: The Sanjeevanis connect the community with their nearest public health service. Personalised: Involves women in the health issues of their families as well as their own health concerns.
Challanges	Client reliant: The endeavour is not an end in itself. Unless the women can take decisions based on what they have learnt, the expected outcome of reducing maternal and child mortality cannot be achieved. Gender biased: Exclusively a women's programme, lacks partnership with men. Possible opposition: Mostly from within the system from those who do not understand the broader issues involved. The scheme can only work with supportive supervision from other health personnel. Committed trainers: Without committed Non Government Organisation (NGO) trainers, the scheme will not succeed. There is a need for motivation. Evaluation: To measure the impact of the programme, midterm qualitative and quantitive evaluation is necessary. Goal incentive: Sanjeevanis should be given some measurable goals to work towards to incentivise them. Long term process: Change will only be seen in the long-term.
Prerequisites	A good conceptual understanding of gender and women's issues, particular to the region is needed before any programme is started. Consultation workshops with those having long-standing experience of documentation of processes, lessons learnt and best practices. NGOs willing to take on training duties.
Who needs to be consulted	State Governments and any NGOs who have undertaken similar initiatives. The community.
Risks	
Sustainability	Initial funding is needed for capacity building and awareness generation. This was given by the European Commission's Sector Investment Programme (SIP). After that it was expected to take its own course through Panchayati Raj Institutions (PRIs) and other Community Based Organisations (CBOs) although this has not always happened. The Sanjeevani programme was

	halted in June 2003, mainly due to the inability to recruit a suitable training consultant when the post became vacant. Lack of good NGOs in the State (who could take up this activity) and strong PRIs was also a barrier to its sustainability. Also the need was felt for the programme to be modified to include a clear conceptual and operational framework.
Chances of Replication	Haryana State Government plans to modify this programme under the National Rural Health Scheme/ Reproductive Child Healthcare II programme and implement it as a link worker scheme.
Comments	None.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, October 2004.
Status	Active
Reference Files	Sanjeevanis.jpg Women Group Leaders.ppt — Powerpoint presentation on Sanjeevani Scheme, State Government of Haryana, January 2006.
Reference Links	

170. Mitanin Programme, Chhattisgarh

Subject Area="Community participation."	Objective="Community health workers."
Details for Reform Option "Mitanin Programme, Chhattisgarh"	
Summary	**Background:** Poor health education and the prevailing cultural practices of those living in rural areas of Chhattisgarh led to high levels of disease and a low use of health services. The community needed to be encouraged to address its own health needs by requesting and taking part in health programmes as well as using the health services already on offer. **Action:** The first step was to organise and empower women in the community as well as the Panchayati Raj institutions. This was done by establishing a state-wide Community Health Volunteer (CHV) programme. The CHV is a woman called a Mitanin (a special kind of friend in local tradition) who was a married woman from the same community, not necessarily formally educated, but with a background in social work, selected by the community and endorsed by the panchayat. The Mitanin is trained (20 days of camp-based training and 30 days on-the-job training) and supported by a block training team and the Auxiliary Nurse Midwife (ANM) and Anganwadi Worker (AWW). Her main role is to provide: (i) Elementary health education. (ii) First aid help and over-the-counter drugs. (iii) Treatment for minor ailments. (iv) Prompt referral advice if necessary. (v) A central role in community level health by setting up women's committees and helping the panchayats in health initiatives. Mitanins are working on a purely volunteer basis - no remunerations have been paid to them. Future plans envisage compensation for Mitanins who miss work time to attend training and some performance-based incentives. It is envisaged this will come to about two days a month. The programme is run by a state-civil society partnership at the state, district and block levels. At the state level this takes two forms:

(i) A state advisory committee.

(ii) An innovative institution called the State Health Resource Centre (SHRC) - formed as an additional technical capacity of the directorate to design and guide the Mitanin programme, as well as the entire reform programme of the state. This has been set up under a memorandum of understanding between the government and ActionAid India. The most important aspect of the Mitanin programme is that it is integrated with the entire range of health sector reforms that aim to strengthen the "supply side" rather than work on "demand generation" and community health aspects in isolation. For more details on the Mitanin training programme and activities, see References.

Results: The initial programme was launched in May 2002 and subsequently the selection and deployment of Mitanins was initiated in two phases: 81 development blocks are covered including 16 pilot blocks under Phase-1 of the programme (launched between September and December 2002). The programme was expanded to the remaining 65 blocks of the state during Phase-2 (launched in December 2003).

The initial estimate was to have 54,000 Mitanins in the state. Gradually, the total number of Mitanins selected has reached 60,092 (around 32,000 in phase-1 and about 28,000 in phase-2). Of these, 55,830 have now had various levels of training and training for the rest is to be initiated soon. Of the 55,830, more than 29,101 have completed 15 days of training (5 rounds) and another 24,275 have nearly completed 8 days of training (3 rounds). About 20,000 Mitanins from Phase-1 have started to provide first contact care using Mitanin Dawapeti (drug kit) and the remaining Mitanins will be provided with this after achieving the appropriate training level. Other results include:

(i) About 70 per cent of Mitanins are visiting every single newborn family on the first day of childbirth and delivering a package of health messages/practices to the new parents.

(ii) About 60 per cent of Mitanins meet every pregnant woman's family in the last month of pregnancy to ensure the birth is planned for and Antenatal Care is completed. However institutional delivery is being contrained by supply side problems.

(iii) Children with diarrhoea and fever are being visited and many being referred.

(iv) More than 75 per cent of Mitanins are taking part in Immunisation Days, bringing new children and women to

	be vaccinated. (v) More than 60 per cent of practicing Mitanins are delivering appropriate counselling to mothers with malnourished children and carrying out home visits. (vi) Some Mitanins are delivering Directly Observed Treatment Short courses (DOTS) for TB patients (about 15 per cent). (vii) About 48 per cent of Mitanins are holding hamlet level health meetings. A mid-term evaluation of the programme was conducted by community-based NGOs and is available in the References section. This indicates enhanced health awareness within the community and improvement in some of the health related practices. An external evaluation of the programme by the Society for Community Health Awareness, Research and Action (SOCHARA) was published in December 2005. This makes a number of recommendations for strengthening the programme and points out many weaknesses but acknowledges it as a huge human resource which should be built upon and not lost. The full report can be found in the References section.
Cost	For the first phase of the programme (from May 2002-March 2005) total budget was INR 24 crores (INR16.6 lakhs per block for 146 blocks) The second phase, from April 2005 (for five years) has a yearly budget of INR 22.5 crores for the programme and INR 15 crore for the (first contact care) drugs. The annual programme cost per Mitanin is estimated at INR 3750 (€67) and the annual drug cost per Mitanin is estimated at INR 2500 (€43.5).
Place	Chhattisgarh State (in all 16 districts and 146 blocks) since May 2002.
Time Frame	Pilot phase of 18 months (for the selection and first round training of 30,000 Mitanins). It is planned as a 60-month programme – 18 months to select, train and deploy the Mitanin, followed by 44 months of support in the community.
Advantages	Popular: Enjoys political support at the highest level, since this is a state-sponsored scheme. Extends healthcare: Effectively increases outreach of all existing programmes by overcoming demand constraints. Community based: Because the Mitanins come from the communities they serve they are more committed to their jobs. The proof is a less than 5 per cent drop out rate. Good quality training materials: These have been developed in

	Hindi and are well illustrated and widely distributed. State Health Resource Centre: The development of this innovative institution which is autonomous and outside the government to guide and support this programme has been essential. Training: Continued training and support ensures sustainability of the programme. Partnership: State-civil society partnership at all levels ensures ownership and cooperation.
Challanges	Slow to establish: Requires sustained political support for at least 5 years if substantial changes are to be achieved. Support must also be at all levels - State and district - if it is to succeed. Supply constraints: Reforms which require an increase on the supply side often fail to keep pace with demand, which can lead to unfulfilled expectations. In particular, Mitanins need regular drugs refills. Evaluation: Needs external evaluation if meaningful results are to be quanitified. Confidence: Need to persuade the community that the Mitanin is here to stay and is therefore worth supporting. Selection: Different types of selection of the Mitanin have shown varying degrees of success. For instance Mitanins who have been selected solely by the ANM/AWW without community input have been less successful because they are not accepted. The community must be informed in the selection process. Volunteerism: In some cases, poor village women have been given unreal promises of getting government jobs and payment after becoming Mitanins to persuade them to join the programme. This deception undermines the programme.
Prerequisites	State - civil society partnerships with adequate tradition of rights based work in the area of health and community health action.
Who needs to be consulted	Community-based NGOs and state, district and village level government officials/ functionaries.
Risks	
Sustainability	Requires support for at least 5 years - subsequent sustainability depends on the success of the last three years and the establishment of long-term support for the

	voluntary workforce. Requires funds. This programme has had funding from the Reproductive and Child Health (RCH) programme, European Commission, Danida and the State Government.
Chances of Replication	Good. The scheme is now being expanded to cover the entire state and is being used as one of the working models for the Government of India's National Rural Health Mission's Accredited State Health Activist (ASHA) scheme.
Comments	The state is also working towards linking all districts with leading health care institutions by a dedicated telephonic link.
Contact	
Submitted By	J.P. Mishra, Programme Advisor, ECTA, New Delhi. November 2003. Last updated March 2006.
Status	Active
Reference Files	

Medicine bag provided to Mitanins.jpg	
Mitanin training camp.jpg	
Presentation by Dr Alok Shukla Former Secretary Health - Chhattisgarh.ppt	
Mitanin Internal Evaluation Report_Final.doc	Internal evaluation report "Outcome evaluation of the Mitanin Programme"
Mitanins of Ghidali village, Chhattisgharh.jpg	
Mitanin Programme SIP presentation.ppt	Powerpoint presentation on Mitanin Programme, State Government of Chhattisgarh, January 2006.

Reference Links	

171. Local initiative programme for Reproductive & Child Health, Uttaranchal

Subject Area="Community participation."	Objective="Community health workers."
Details for Reform Option "Local initiative programme for Reproductive & Child Health, Uttaranchal"	
Summary	**Action:** The Rural Development Institute (the rural outreach arm of the Himalayan Hospital Trust) set up a Local Initiative Program (LIP) as a pilot Reproductive & Child Health (RCH) project. The aim was to provide outreach services by enhancing community ownership. It did this by: (i) Recruiting Lady Medical Officers (LMOs), stationed at its headquarters, to hold satellite/mobile camps in the outreach areas to supplement the health care infrastructure. Initially, the satellite clinics were organised at rented premises, away from the sub-centres/ Primary Health Centres (PHC). However, over a period of time many of these clinics were held at sub-centres. These clinics were held as per pre-determined schedules drawn up on a monthly basis. (ii) Training more than 400 community health volunteers (CHVs) in Eligible Couple (ECLO) mapping and basic RCH services. CHVs are women from the community who have been nominated by the villagers themselves. Each CHV monitors a population of 400 around her village. (iii) Forming Swasthya Prachar Samitis (SPS) or “village health committees” in 400 villages, covering a population of more than 200,000. The SPS is an independent body which includes village elders, the local CHVs, field supervisors (each monitoring 12 CHVs) and the Gram Panchayat president. This committee meets twice a month to discuss health issues/problems and suggest possible solutions. (iv) Identifying and training more than a 100 “peer educators”, through the SPS, who share information on reproductive health issues and family life education with approximately 10,000 adolescents in his/her area. (v) Training more than 100 Traditional Birth Attendents (TBAs) in clean and safe delivery practices. (vi) Introducing a Behavioural Change Communication (BCC) strategy where information on RCH has been used by the CHVs as part of their motivational campaign using posters, pamphlets and puppet shows. Wall writings in prominent places have also

	been found to be an effective medium and "swasthya melas" or health fairs are organised periodically where family check ups are offered free of cost. Specialist services are also available.
Cost	Estimated Cost: The costs during the project funding was a total of INR 1,42,75,000 of which INR 27,90,000 was that incurred on start up activities and a sustenance cost of INR 1,14,85,000 (for a period of 15 months).
Place	Uttaranchal across the districts of Tehri, Pauri, Uttarkashi and Dehradun since 1998.
Time Frame	Six to 8 months.
Advantages	Empowerment: Women are given decision-making information regarding their reproductive health behaviour. Availability: Of doctor services (especially lady doctors) enables villagers to ensure their health and well being. Education: Creates awareness and help to people in rural and hilly areas by utilising people from within their own community. Gender-friendly: Women find it easier to share their problems and interact with the CHVs because they are mostly women well known to them.
Challanges	Requires vision: Possible inability of existing bodies to see new ways of doing things. Expense: Terrain makes services/referral facilities difficult and not cost effective.
Prerequisites	Motivation. Government acceptance of volunteers. Willingness of people to volunteer.
Who needs to be consulted	Local government bodies, government health organisation, body imparting technical assistance (in this case Himalayan Institute Hospital Trust).
Risks	
Sustainability	Currently LIP depends on external funding and so is not yet self sustaining. The initiative is being sustained by the HIHT and the village community.
Chances of Replication	This was a programme that was adapted from the Bangladesh model and was simultaneously tried in Calcutta and Chandigarh (other than Uttaranchal) in partnership with Management Sciences for Health (MSH) and Technical Assistance, Inc. (TAI) and funding from the Bill & Melinda Gates Foundation. (http://www.india-lip.org/)
Comments	None
Contact	
Submitted By	J. P. Mishra, Programme Advisor, European Commission

	Technical Assistance, New Delhi. March 2003.
Status	Active
Reference Files	Puppet Show IEC Mela Taal -Yamkeshwar (Pauri).jpg Satellite Clinic Nakot, Chamba (Tehri).jpg SPS orientation Kumalda, Thatyud (Tehri).jpg Newspaper report in Deccan Herald on 22-06-02.doc Swasthyamela Kunjapuri, Narender Nagar (Tehri).jpg ELCO_map.doc
Reference Links	

172. Sahiyya Movement, Jharkhand

Subject Area="Community participation."	Objective="Community health workers."
Details for Reform Option "Sahiyya Movement, Jharkhand"	
Summary	**Background:** Jharkhand is a predominantly rural state with a large tribal population living in highly inaccessible areas. There has been no tradition of Panchayat Raj Institutions (PRIs) in the villages resulting in little or no community organisation. In order to provide quality healthcare services to the 'last person in the last household of the last village' the Government of Jharkhand (GOJ) initiated the Sahiyya Movement after a pilot in 2004 to encourage community participation in delivering quality health care to the needy and empowerment of women. **Action:** Non-Government Organisations (NGOs) work in partnership with the State Government to organise Village Health Committees (VHCs) in every village. Each VHC is encouraged to start a Village Health Fund from community resources to help fund its activities which include identifying and addressing health issues in the village. It is also empowered to develop a Village Health Plan (VHP) with active involvement of the community. The programme aims to focus on women and children in marginalized sections of the community, particularly those in remote, unreachable areas. The key activity is the establishment of community health workers called Sahiyyas, democratically selected by the community and approved by the VHC. The eventual goal is to have one Sahiyya per hamlet. Criteria and job description of Sahiyya: (i) A woman of reproductive age who is resident in the village, is (preferably) married, is functionally literate and has good inter-personal communication skills and social acceptability. (ii) Selected by the community and VHC, paid by the community in cash or kind (no honorarium provided by GOJ). (iii) Acts as a link between the community and service providers and works alongside the Anganwadi Worker (AWW) and Auxiliary Nurse Midwife (ANM). (iv) Works to promote health education. Helps to prepare the VHP. (v) Facilitates integrated mother and child health care, encouraging Antenatal Care (ANC), institutional delivery and

	routine immunization. (vi) Provides family planning advice and first aid. (vii) Agent for institutional referral and follow up treatment. (viii) Village depot holder for all family planning techniques. Each Sahiyya is given 21 days training consisting of 7 modules and including preventive and promotive primary health care. The training is organised at block level. Every six months there is a Sammelan (gathering) for the Sahiyyas to share their experiences with other stakeholders including NGOs, faith-based organisations and departmental officials from health and other convergence departments. Future activities planned: (i) Strengthening of a Sahiyya Working Group which include officials from health department, NGOs and faith-based organisations. (ii) Involvement of other departments for example social welfare and education, to promote better convergence. (iii) Development of guidelines for Sahiyya as well as communication aids (IEC) for her use in the villages and training materials. (iv) Identification of more NGOs for implementation. (v) Orientation of district and block health service providers. **Results:** Approximately 1,000 VHCs have been formed and 1,000 Sahiyyas chosen (as of end January 2006). Seven NGOs have joined the scheme and are working in 34 blocks supporting VHCs and Sahiyyas, There is already better convergence between the health, social welfare, public health education and rural development departments.
Cost	INR 10 lakh per block for 18 months. Funds are provided by Government of India (GOI), GOJ and also by European Union.
Place	Jharkhand since 2004.
Time Frame	One year.
Advantages	Empowering: Encourages the community to focus on their own health needs. Acceptance: Healthcare and advice provided by a woman the villagers know and trust. Cost effective: Ensures a wider reach of health services without great cost to the health department. Wide reach: This programme reaches all the villages in the State

	irrespective of its location and culture.
Challanges	Needs flexibility: The State has a very varied topography and cultures. Motivation: Perseverance is required to engage communities with rigid beliefs and practices. Education: Training of minimally educated Sahiyyas in local dialect. Self sustaining funds: Sustaining VHCs with community contribution.
Prerequisites	Capable NGOs working in the community. Motivated facilitators, cooperative community.
Who needs to be consulted	Government officials, NGOs and faith-based organisations.
Risks	
Sustainability	Good as this is essentially a volunteer scheme. However sustainability will depend on the Sahiyyas' motivation and on a continued commitment from the GOJ to pay for training, drug kits and materials. Training is now funded by the GOI and GOJ. Once the programme has taken off, VHC will contribute to the recurring expenditure from community contributions.
Chances of Replication	Should be replicable in any State which has capable NGOs and effective community leadership.
Comments	Jharkhand will continue to use this scheme rather than adopting the Accredited Social Health Activist (ASHA) scheme recommended in the GOI's National Rural Health Mission.
Contact	
Submitted By	R Gopa Kumar, ECTA State Facilitator, Jharkhand. February 2006.
Status	Active
Reference Files	Sahiya Movement Jharkhand Presentation.ppt — Powerpoint presentation: Sahiyya Movement: Government of Jharkhand. January 2006.
Reference Links	

173. Communitisation of Grassroot Health Services, Nagaland

Subject Area="Community participation."	Objective="Community management of health services."
Details for Reform Option "Communitisation of Grassroot Health Services, Nagaland"	
Summary	**Background:** Nagaland is a hill state in the extreme northeast of India. An important issue identified in 'Imagine Nagaland', an innovative programme in which civilians and government servants collaborated to design plans and identify challenges in the state, was the need to revitalise the massive welfare infrastructure and vast network of delivery services set up by the government which had become ineffective and dysfunctional. The community no longer trusted them and was increasingly turning to private institutions for these services. The quest for improvements led to the evolution of a unique communitisation approach. This sought to pool the extensive resources of the government with the potential skills base within the Naga society. The Government of Nagaland enacted the Nagaland Communitisation of Public Institutions and Services Act, 2002, in March 2002 thereby creating the legal and institutional context for the communitisation process to take off. Communitisation consists of a unique partnership between the government and the community with the aim of improving the delivery of public utility systems. It involves transfer of ownership of public resources and assets, control over service delivery, empowerment, decentralisation, delegation and capacity building. The scheme envisages changed roles and responsibilities on part of both government servants and the community. This focuses on a triple 'T' approach: (i)Trust the user community (ii)Train them to discharge their newfound responsibilities, and (iii)Transfer governmental powers and resources in respect of management. Action: Communitisation of health was built on five initiatives; (i) Boards or committees with representatives of the user community (village or town ward) were constituted. (ii)Powers and management functions of government were transferred to the committees or boards, including disbursal of

	salary to staff running the utilities and also the power to exercise a 'no work, no pay' principle. (iii)Assets of the government were transferred to the committee. (iv)A fund was created, where salaries along with other Government grants and community contributions were credited for running and developing the utilities. (v)Powers and responsibilities were conferred to these authorities, including critical supervisory and supportive assistance. In the first phase, all health sub-centres were communitised, which meant that the salary of the staff was to be paid through the Village Health Committee (VHC). Training in two batches, then retraining was provided to the health functionaries and the VHC members. VHC's were given funds to purchase medicines from any shop they chose on the prescription of the medical officer. Efforts were made to promote indigenous medicine systems and preventive health care. The impact assessment study of Grassroot Health Services, undertaken by external evaluators in June-July 2004 and supported by UNICEF, was conducted in 50 villages from seven districts, on a purposive sampling basis, ensuring 10% coverage of the programmes. **Results:** Efforts by VHCs have created a positive change on health services. A sense of ownership of the health centres is visible amongst both VHC members and beneficiaries. VHCs are effective in galvanising voluntary contributions of material and labour. The following results have been seen: (i) Attendance of the health functionaries increased to over 90% in all 28 villages studied reaching 100% in 7 of them. Unauthorised absences decreased to between 3 and 5%. (ii)Improvement in staff visits to sick persons in the village. Noticeable improvements were seen in the attitudes of health centre staff to work and towards patients. This led to improved quality of health care. (iii)Increased numbers of patients attending health centres, and patients moving from private practitioners and indigenous healers. (iv)More women and girl children attending health centres. Plus there has been a significant increase of more than 50% in children accessing the health centres across all villages. (v)At least 83 sub centres, which had no staff earlier, were given one ANM through redeployment.

	(vi)Improved availability of medicines in the centres and quality of medicines purchased by the VHCs. Better medicine availability is indicated as having very high impact on health care quality in Mokokchung, Phek and Zunheboto districts. (vii)Villagers have been provided quarters where none were available. (viii) Village Development Boards (VDBs) have made financial contributions to repair, refurbish, and extend infrastructure.
Cost	No extra cost involved. The allocation under different sectors under the budget head of the government has been transferred to VHCs. Total estimated cost: Rs. 657,105,000 Cost break-up: Reconstruction/ Major repairs of 52 PHC/CHC buildings@ Rs 10,00,000 each : Rs 520,00,000. Construction of 23 PHC buildings @ Rs 30,00,000 each : Rs 690,00,000 Staff quarters for 108 PHCs/ CHCs @ Rs 30,00,000 each : Rs 3240,00,000 Staff quarters for 394 sub centres @ Rs 3,00,000 each : Rs 1182,00,000 Construction of 144 SC buildings @ Rs 5,00,000 each : Rs 720,00,000 Medicines for 21 CHCs @ Rs 1,50,000 each: Rs 31,50,000 Medicines for 87 CHCs @ Rs 1,25,000 each : Rs 108,75,000 Medicines for 394 SCs @ Rs 20,000 each : Rs 1,88,000 Additional funds were also required for continuing training and capacity building and close supervision and monitoring of the VHCs on regular basis.
Place	350 of the 394 sub-centres, 7 of the 87 Primary Health Centres and one of the 21 Community Health Centres in all the eight districts of the state. The remaining 144 health centres would be communitised within two to three years.
Time Frame	Approximately three years. A concept paper on Communitisation was brought out in mid-2001. Implementation strategies were finalised in late 2001. An Ordinance was promulgated in January 2002. The Act was passed in March 2002. Communitisation of rural health sub centres began in September 2002 and was operational by 2004.
Advantages	Gender Sensitive: Increasing numbers of women are approaching the health centre in the village itself. Increased sense of security: Better attendance of health functionaries across all districts and increased patient access. Health of the children: Children have access to the health centre. Improved Quality of Medicine: The VHC itself purchases the medicine and availability has improved in communitised centres. Regular salary: Timely disbursement of staff salaries. Regular reporting: More regular submission of monthly reports.

	Community contribution: This is forthcoming in cash, in kind, through voluntary and free service on fixed days and from private practitioners. Indigenous system of medicine: This is being promoted in many areas. Publicising healthcare: Quarterly newsletter by one VHC on health issues has been reported.
Challanges	Lack of support from officials: The supervisory staff is not willing to surrender their authority to the VHC, resulting in friction. Hierarchy issues: The dual structure of authority and command creates an anomalous situation for health functionaries who are accountable to their line supervisors and the VHCs. Dual lines of command: One goes up to the highest echelons of government and the other stops in the village. Transfers of staff desired by the VHCs but decided on by district officials. Resistance from health functionaries and superiors: At the PHC level, this is a perceived obstacle in many of the districts. VHC fatigue: VHC members across districts say that the burden of responsibilities consumes their limited time (all work, no pay) and drains their personal resources.
Prerequisites	Close collaboration between government officials including the Medical Officer and the VHCs. Community Participation: The communities are extending widespread public assistance and contributing in both labour and cash.
Who needs to be consulted	Community Village Health Committee (VHC) Village Development Boards (VDBs)
Risks	
Sustainability	Assured according to the VHC, as both the VHC and the government officials want to see it work.
Chances of Replication	Encouraged by the response, the government decided to expand this programme, covering even urban health sub-centres and one Primary Health Centre (PHC) in each district, in the following year. Based on the experience of the Naga Hospital Authority, other hospitals will be communitised.
Comments	Communitisation creates convergence (i) Between the state's responsibility to provide health for all and citizen aspirations for a health safety net. (ii) In effective management of state institutions through people's institutions grounded in the social capital of the village. Suggestions from VHCs/ beneficiaries to strengthen

	communitisation of health services: (i) More funds to buy emergency drugs, paediatrics drugs and equipment. (ii) Upgrade, repair, rebuild or refurbish Sub- centre. (iii) Increase attendance of medical officers at Sub-centre. (iv) Implement VHC decisions and recommendations. (v) Mass awareness for enhanced community involvement. (vi) Training for VHC members and government functionaries. (vii) Adjustment for VHC members for days of work. (viii)Guidelines for cooperation with officials.
Contact	
Submitted By	Dr Arti Bahl, Research Consultant, CBHI,New Delhi September 2005
Status	Active
Reference Files	
Reference Links	

174. Village Health Committees, Karnataka

Subject Area="Community participation."	Objective="Community management of health services."
Details for Reform Option "Village Health Committees, Karnataka"	
Summary	**Background:** Despite a ruling by the Government of Karnataka that health workers form a 8-10 member Sub-centre Health Advisory Committee to support its health activities (under the India Population Project-IX), none had been formed because of a lack of training. **Action:** The Foundation for Research in Health Systems (FRHS) undertook a research project exploring ways of involving the community in Reproductive and Child Health (RCH) with decentralised planning. It tried out a new concept of health committee in terms of structure, formation process and role. Its project implementation process began with a baseline survey, followed by committee formation. Health committee members were selected by three methods: the Gram Sabha (an open village meeting for adults), the health workers, the Panchayat Raj: one member from clusters of 50-60 households in the village, with about equal representation of men and women. These members selected their committee president and secretary from among themselves. The committees' role was to: (i) Participate in identifying people's health needs and develop activity plans (ii) to foster trust and understanding between community and health staff (iii) to create health awareness and demand for new health services. The project provided five inputs to facilitate committees' functioning: (i) Community facilitators (CF) who helped to form committees and motivated them to undertake village level activities (7 in all, one CF for two PHCs). (ii) Start-up grant of INR 2000 per committee. Money spent had to be accounted for. (iii) Identity cards to legitimise the committee members' role and boost their status in the community. (iv) Presidents meetings were organised at block level to give them an opportunity to share experiences among themselves and

	with district and state level health officers. (v) A monthly newsletter, Arogya Midita (Health Pulse) to help motivate committees to organise more and better programmes. **Results:** The project was evaluated by doing a baseline survey at the beginning and an endline survey at the end of two years. Health committees were formed in all the 64 rural sub-centres in the block. At the end of the two-year project (June 2002), nearly 90% of the committees were active. They had conducted various health awareness and service camps and other health-related activities, some involving other Community-based Organisations (CBOs) and NGOs and others using local funds.
Cost	Cost of committee activities: The total investment was INR 92,500. The committees were able to spend INR 21,118. They could mobilise INR 48,433 in cash and kind and create a savings of INR 71,382 for future expenditure. Three additional cost items were: newsletter: INR 2,000 (€36)/per month, facilitators' salary (INR 5000(€89)/month/PHC) and Taluk (block) level committee presidents' meeting (INR 15,000(€322)/per year/Taluk). For upscaling, it was proposed that the block extension educators could play the facilitators' role, therefore there would be no additional cost to the government. District could also use existing health newsletter without additional cost and presidents' meetings could be integrated with Taluk level officers' meeting. The cost of the research project was approximately 25 lakh (€44,725) for two years (including researchers' salaries, base and end line surveys, dissemination workshops and the cost of all items mentioned above.)
Place	The project started in July 2000 and ran for two years in Hunsur Block of Mysore District, Karnataka.
Time Frame	Three months to set up 28 comittees. The project took about 8 months to start up the first half of the committees (set up under three different methods of committee formation). This also included the time taken for the baseline survey. The second half (which built on the experiences of the first phase) took another 3 months.
Advantages	Complementary: Committees have demonstrated their potential to play a complementary role to that of the government in providing preventive and promotive health services to the community, particularly to vulnerable groups like the very poor, elderly and adolescents. Community led: Community selects members. Demand creation: For RCH services. Convergence: Their ability to network with other CBOs indicates that they can bring about convergence of various development activities at grassroots level.

Challanges	Integration essential: If committees are seen as an independent initiative of civil society and cannot be integrated into the government system, then this might pose a threat to their sustainability. Possible opposition: From government health staff who might view committees as yet another layer of "supervisors". The gram panchayat may also see committees as usurping their role as "watch dogs".
Prerequisites	The five project inputs (see summary above). Initial facilitation by an NGO is also required.
Who needs to be consulted	Government health staff at district and state level, Gram Panchayat, NGO
Risks	
Sustainability	Sustainable if the government recognises the committees as independent and doesn't curb their initiative.
Chances of Replication	Replicable because community participation is a government policy and forming health committees is not expensive.
Comments	The project was funded by the Frontiers Group of the Population Council, New York.
Contact	
Submitted By	Dr. Nirmala Murthy, Foundation for Research in Health Systems. August 2004.
Status	Active
Reference Files	Villagers at Nellurpara, Hunsur Block, Mysore District, Karnataka, attend clinic organised by Village Health Committee.JPG Weighing baby at clinic organised by village health committee, Nellupura Village.jpg Singing group of villagers singing a song about reproductive health.jpg Doctor and facilitators discuss growth rates of children with parents.jpg Village health committee members Nellurpara, Mysore.jpg Villagers at Nellurpara, Mysore District Karnataka, attend clinic organised by Village Health Committee.JPG
Reference Links	

175. Training of Parivar Kalyan Salahkar Samitis, Himachal Pradesh.

Subject Area="Community participation."	Objective="Community management of health services."
Details for Reform Option "Training of Parivar Kalyan Salahkar Samitis, Himachal Pradesh."	
Summary	**Background:** Panchayat Raj Insitutions (PRIs) are the symbols of democracy at village level and are seen as instruments of development. But community leaders often do not give priority to the health needs of their community. **Action:** In order to involve PRIs in the provision of basic health care and undertake monitoring and supervisory activities, Parivar Kalyan Salahkar Samities (PARIKAS) or Family Welfare Advisory Societies were formed in 2001 by the Government notification at the three levels of PRI i.e. village, block and Zila. The Pradhan of the Gram Panchayat is the President of the Panchayat PARIKAS and the female health worker is the Secretary. The block PARIKAS has Chairperson of the Panchayat Samiti as the President and the Block Medical Officer as the Secretary; and the Zila PARIKAS has the Chairperson of the Zila as the President and the Chief Medical Officer as the Secretary.However it was seen that these PARIKAS were not proving very useful in their contribution so it was decided to train select members. Training was piloted in the Kangra district at the lowest level i.e. village PARIKAS in 2003 under the European Commission-supported Sector Investment Programme in the State. Six to 7 members were selected from each PARIKAS for training at block level. In addition, quarterly meetings were held and attended by the Block Medical Officer who provides input to improve their functions. **Results:** Since this training, the PARIKAS members' involvement in healthcare decisions has increased.
Cost	Approximate initial cost is INR18 Lakhs.
Place	Training was piloted first in the Kangra district in 2003. On its successful completion training workshops were extended to the whole State.
Time Frame	Approximately six months.
Advantages	Inclusive: Village level health planning with inputs from the PRIs provides a more realistic shape and gives them ownership

	and a commitment to fulfil the plans. Responsive: Training and empowering the PRI to understand the needs of the community is a good way to get them involved in the health concerns of their people.
Challanges	No challenges perceived.
Prerequisites	State Government Order.
Who needs to be consulted	Panchayat leaders.
Risks	
Sustainability	Training only needs to be done once. Visible changes in village action plans are seen as a result.
Chances of Replication	Based on the results of the pilot experiments in the Kangra district, training had been scaled up in all the districts of Himachal Pradesh. The State plans to train approximately 15,000 PARIKAS members by June 2006.
Comments	Training panchayat members and enabling them to get involved in village micro planning according to the needs of the community is a welcome step in the process of decentralisation. The scheme also fits well with the Government of India's National Rural Health Mission which aims to involve the PRIs in monitoring and supervising national health programmes.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, February 2006.
Status	Active
Reference Files	Parikas GO-10.12.2001.pdf Parikas GO-23.10.2002.pdf
Reference Links	

176. Community Health Activism, Kerala

Subject Area="Community participation."	Objective="Community advocacy."
Details for Reform Option "Community Health Activism, Kerala"	
Summary	**Background:** The Trivandrum Social Service Society, a community organisation under the Catholic Church, has identified three major issues related to health among coastal fisher folk: (i) lack of toilet facilities creating environmental and social problems (ii) lack of Maternal and Child Health (MCH) education (iii) lack of financial independence among women, many of whom have husbands with a serious alcohol problem. **Action:** (i) construction of sustainable and hygienic community toilet complexes at several locations along the sea shore. (ii) training young, reasonably-educated coastal women to work as activists (one per 20 families) to help identify and solve MCH and family planning problems and to establish links with nearby government and private health institutions as well as health workers (iii) training women to start a variety of cottage businesses to generate income for them and their families.
Cost	Information not available.
Place	The coastal areas of Trivandrum district, Kerala.
Time Frame	On average one year.
Advantages	Empowering: Builds community self sufficiency (particularly for the women) and involves community ownership and local decision making. Simplicity: Low cost, simple methods. Speed: Comparatively short time to set up.
Challanges	Community-dependent: Growth and development can be very slow depending on the will of the community and therefore only suitable for communities who are highly unified and motivated. Opposition: Possible opposition from men in the community

	who resent the growing independence of the women.
Prerequisites	A coordinating body in the community – in this case the Catholic church.
Who needs to be consulted	Local leaders, women activists, school teachers and parish priest.
Risks	
Sustainability	Self-sustaining as there is a cost-sharing element in the project, which is voluntary but binding on all who are involved.
Chances of Replication	Questionable. Requires community will and coordination.
Comments	There are several such projects on the seashores initiated and managed by the people in the area, with the Catholic church as the prime mover and motivating force. Other churches are learning from it and are trying to use these ideas.
Contact	
Submitted By	Dr. Oommen Philip, Former ECTA State Facilitator for Kerala. July 2002.
Status	Active
Reference Files	
Reference Links	

177. Aapni Yojana Sanitation Project, Rajasthan

Subject Area="Community participation."	Objective="Awareness of sanitation among rural populations."
Details for Reform Option "Aapni Yojana Sanitation Project, Rajasthan"	
Summary	**Background:** In Rajasthan, poor hygiene and sanitation practices in rural areas are a cause of much concern as they have immense consequence on health. A single large pit, without a roof or door was found to be used by most villagers. Few households (9 % in three districts of the State) had some kind of defecation system but they too did not follow basic hygiene practices. The Aapni Yojana project planned to address the issue of scarcity of water, sanitation and hygiene through community participation. The programme was designed to cover 2.6 million people across 20,000 square kilometres living in 1000 villages and 11 towns in three districts of Rajasthan. The project was divided into two phases. Funding for the first phase came from the government of Germany through Kreditanstalt fuer Wiederaufbau (KfW), the German Development Cooperation Agency (75%) and the Government of Rajasthan (25%). The technical work of the project was overseen by the Project Management Cell (PMC), Public Health Engineering Department (PHED). While, community participation measures were implemented by the Community Participation Unit (CPU). The CPU - a consortium of 5 leading NGOs of Rajasthan, with the Indian Institute of Health Management Research (IIHMR) in Jaipur acted as the nodal agency. **Action:** Institutional mechanisms were set up for the implementation of the project, including the formation of a PMC, CPU and appointing Indian and German consultants. At the village level, Water and Health Committees (WHCs) were formed and a legal contract was signed between WHC and PMC on rights and responsibilities. Before starting the sanitation campaign, a survey of existing latrines was carried out in order to prepare a village based plan of action. Changing the outlook of people was a necessary prerequisite. Therefore, local people interested in sanitation activities were identified and involved in propagating sanitation issues. To create demand for sanitation facilities, village sanitation drives and health education sessions were organised. The sanitation drives included identifying stagnant water points, garbage points and cleaning through voluntary labour. The health education sessions involved discussing sanitation issues in small groups using various advocacy materials. To ensure women's participation, it was made essential that the application for and

	the location of the sanitary unit in each household is to be made by the women. Villagers were shown a demonstration unit before actual construction started. Local masons were identified from the village and trained on technical and health aspects. The WHC invited applications for construction of toilets, giving priority to poor families, handicapped people, the elderly and households headed by women. A sum of INR 30 was collected from each of the households and used to provide a toilet brush. Training was organised, giving brief technical details of the sanitation package, its use and maintenance. The project procured the materials needed for construction, delivered them to beneficiaries and made payments to the masons. The beneficiaries contributed bricks and unskilled labour. WHC members' supervised construction of the toilets. This included procurement and distribution of sanitary materials to beneficiaries; supervising the quality and physical verification of the sanitation unit for preparation of reports. **Results:** The first phase of the project ended in March 2006. The sanitation programme was successful in garnering the support of the villagers. About 38% of the households in the project area had applied for the sanitary units, of which the application of about 90% of the families was sanctioned. 22,334 sanitary units were constructed until March 2006.The end term evaluation of Community Participation Unit (sample size was 210 sanitary units) shows the following results: * 98% latrines and bathrooms were functional * 98% of the latrines had soak pits of which 99% are functional. * 99% of the families reported that the bathrooms are used by the whole family. * 94% of the families reported that the latrines are used by the whole family. * Civil work of all the units is in good condition. The utilisation of toilets increased when villagers understood that the material collected in the soak pits could be used as manure. The use of latrines and bathrooms is 90% and 96% respectively. Initially, the sanitation package was meant for households only, but later demand also came from schools. By the end of April 2005, 358 schools have sanitation units, with separate models for boys and girls.
Cost	INR 85,653,074. The project's contribution was 62% and the rest was contributed by the beneficiaries in the form of bricks and labour.
Place	Villages and towns located in Churu, Hanumangarh and

	Jhunjhunu districts of northern Rajasthan.
Time Frame	Preparatory phase: 3 years. Programme implementation phase: 8 years The project was approved in 1994. The initial phase was preparatory and was spent on developing mechanisms for making the project operational. The project work started in 1997 mainly to garner support for the programme and the actual construction of sanitation units started in January 1998. The first phase of the project was completed by March 2006.
Advantages	Hygiene: Improves health and encourages good hygiene practices among villagers. Community involvement: Beneficiaries' involvement in construction and maintenance of toilets increases their utilisation of the units. Local resources utilised: Use of local masons for construction results in increased training and employment. Women-friendly facilities; toilets and bathrooms provide privacy for women.
Challanges	Cultural ethos: Discourages people to adopt new sanitary practice. Non-involvement of women: Where ever the site selected for latrines is near the entrance of the house women found it difficult to go freely during daytime. Cost: People were scared that they have to pay extra for construction and maintenance of latrines.
Prerequisites	Involvement of NGOs in creating community participation. Inter-sectoral and inter-department coordination. Material provision in place of cash grant. Community understanding of the importance of sanitation facilities. Consideration to sentiments of the community. Participation of women. Capacity building of WHCs and good rapport of project staff with community.
Who needs to be consulted	Community Participation Unit, AAPNI YOJNA, District: Churu. Chief Engineer, PMC AAPNI YOJNA, Churu. KfW, New Delhi Director, IIHMR Jaipur Vice chancellor, Gandhim Vidya Mandir, Sardarshahr, Distt. Churu. Project Director, Bhoruka Charitable trust, District Churu Executive Director, IIRM, Jaipur. Secretary URMUL Setu Society, Bikaner
Risks	
Sustainability	Sustainable, as long as the following are in place: *Demand for sanitation units and understanding of the advantages associated with them; *Involvement of beneficiaries in construction of sanitation units; *Use of local resources in construction; *Sufficient time to assess sustainability of institutional mechanisms set-up at local level.
Chances of	Replicable, where the community understands the advantages.

Replication	
Comments	The first phase of the project ended in March 2006. End term evaluation of Community Participation Unit under Aapni Yojana has been done. The findings of the study are very encouraging and show that the project has been very successful.
Contact	
Submitted By	Dr. Nandini Roy, Research Consultant, National Institute of Medical Statistics, June 2005. Last Updated: July 2006.
Status	Active
Reference Files	
Reference Links	

scan.pdf	
Photo 1.jpg	photo
Photo 2.jpg	photo2
Photo 3.jpg	Photo 3
ayp_Drashok.ppt	" End term evaluation of community participation unit" . A power point presentation by Development and Research Studies Pvt. Ltd.
CPU_BCC_anoop.ppt	Behavioural Change Communication in Aapni Yojana - a power point presentation by Mr. Anoop Khanna

178. Empowerment of rural women in Aapni Yojana Project (our scheme), Rajasthan

Subject Area="Community participation."	Objective="Women's participation and students' involvement in promotion of health."
Details for Reform Option "Empowerment of rural women in Aapni Yojana Project (our scheme), Rajasthan"	
Summary	**Background:** An Integrated water supply, sanitation and health education programme was initiated in Churu and Hanumangarh districts of Rajasthan to improve the overall health situation of the people. The project was designed to cover 2.6 million people living in 1000 villages and 11 towns spread across 20000 sq. kms. The project was divided into two phases. The funding for the first phase was provided by the government of Germany through Kreditanstalt fuer Wiederaufbau (KfW), the German Development Cooperation Agency (75%) and the Government of Rajasthan (25%). The complementary measures included enlisting women's participation in all community level decisions including health, water and sanitation, which was carried out by a consortium of 5 leading non-governmental organisations (NGOs) of Rajasthan and of which Indian Institute of Health Management Research (IIHMR) Jaipur was the nodal agency. **Action:** The foremost task was to set-up institutional mechanisms necessary for the implementation of the project. At the village level, Water and Health Committees (WHCs) were formed consisting of at least one woman. The project recruited female field staff to garner women's involvement by identifying women's problems and leaders who could encourage other women to come forward. Initially, small group meetings of women were organised by the NGOs to discuss about the project and later large group meetings were organised to select women's representatives to WHC. Water user groups were formed by listing a female member from each household for decision on the location of toilets and bathrooms to be constructed. Similarly, their opinion was sought on sites, for construction of public taps. Self help groups (SHGs) were formed and revolving funds was created to increase women's earning capabilities. Health education programmes were organised with support from district health system. Health camps were also organised by involving medical officers from local government health facilities. Members of WHCs and SHGs helped in making arrangements for the health camps. Video shows were

	also organised on health issues. Adolescent girls were given education on personal hygiene, reproductive health, common female health problems and use of sanitary napkins. Mamta Kits (delivery kits) were distributed to dais (traditional birth attendant) and expectant mothers in 90 villages. A health survey was conducted to collate information for formulating the health education plan. Health rallies, cleaning campaigns and school competitions on health issues were organised. Health check-ups of students were organised and school sanitation committees formed to promote good personal hygiene practices. Every Monday, the committee reviewed students' concerns of students health **Results:** The programme has been successful in garnering support of the women. Initially(1999), the participation of women in various activities of project was limited to 27-52 villages and by the end of 2004, women's participation increased in all spheres of project implementation (in 321 villages women were involved in map making and in 333 villages for site selection). By the end of March 2006, 316 WHCs and 220 SHGs were formed; the cummulative figure of SHGs money transaction has crossed INR 20 lakh; in 324 villages' women voluntary labour were used for digging trenches in villages for water and construction of sanitation units; in 338 villages women participated in selecting the beneficiaries of sanitation units and sites for construction of the same. Women's empowerment initiatives have benefited not only women but also the social fabric in rural areas of these districts - people have started accepting that women can attend meetings and many women have started going out on their own. Women are taking collective initiative to maintain the places where Aapni yojana hand pump points are located within a cluster (a village consists of clusters). Similarly, the SHGs have been able to enhance the status of rural women as men have started respecting them. Noticeable changes were also observed with regard to objects used during delivery as women have started giving up the habit of using sand bed, unclean clothes and old cutting objects.
Cost	The project was unable to provide a clear account of the costs involved in women's empowerment programme and in income generation activities. However, the cost of the CPU was INR 18.46 lakh. The medicines were provided by district health department. Funds were provided by local donors for organising advocacy programme including school competition.
Place	Villages and towns located in Churu and Hanumangarh districts.
Time Frame	3 years to initiate. The project was approved in 1994 but implementation of the activities started in the middle of 1997.

Advantages	Confidence: Women feel empowered. Knowledge: New hygienic practices are being followed by women. Organising various competitions facilitated knowledge enhancement of students concerning their health. Equity: The males empathize with women's concern
Challanges	Sustainable: The strategies used for empowering women needs to be continued by either involving an NGO or local government ensuring further improvement in life of rural women. Funding: Unavailability of funds to undertake advocacy programmes at local levels.
Prerequisites	Involvement of NGOs in creating community participation.
Who needs to be consulted	State government. Panchayat Raj Members. Non-government organisations. Schools. Community. Programme Director, CPU, AAPNI YOJNA, Churu. Director KfW, New Delhi. Director, IIHMR, Jaipur.
Risks	
Sustainability	The measures can be sustainable when local bodies continue with similar initiatives that empower village women.
Chances of Replication	The strategies used to involve in community level decision making will address equity issues in villages.
Comments	The first phase of the project ended in March 2006. The end term evaluation report reveals that the project has been quite successful.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, NIMS. September 2005. Last updated: July 2006
Status	Active
Reference Files	

Women 3.gif	
women 4.gif	
ayp_Drashok.ppt	"Critical success factors in Aapni Yojana with special reference to community participation". A power point presentation.
Final_Presentation_drs.ppt	End term evaluation of community participation unit. A power point presentation by Development and Research Services Pvt. Ltd.
women 2.gif	Photo
Copy of scan.jpg	Photo
scan2.jpg	Photo 4

Reference Links	

179. Cheyutha, A Helping Hand For People Living With HIV/AIDS, Andhra Pradesh.

Subject Area="Community participation."	Objective="Improve the quality of the life of People Living With HIV/AIDS (PLHA) and protect their right to health."
Details for Reform Option "Cheyutha, A Helping Hand For People Living With HIV/AIDS, Andhra Pradesh."	
Summary	**Background:** Responding to the needs of a growing number of people living with Human Immuno-deficiency Virus (HIV) in Andhra Pradesh and address the issue of stigma, Leprosy Relief Association (LEPRA) Society, an international non-governmental organization (NGO), launched a programme called 'Cheyutha' in the twin cities of Hyderabad and Secunderabad. Cheyutha means 'helping hand'; the project aims to address: quality treatment for opportunistic infections, create an enabling environment for and strengthen the network of PLHA, protect and promote the rights of the infected, promote community and family-based care and support to PLHA, establish linkage with available health services in the two cities and promote development activities for HIV infected and affected children. **Action:** LEPRA Society joined hands with Network of People Positive (NPP+) Andhra Pradesh, a community based organisation established by like-minded PLHA to strengthen the network as well as to disseminate information about the support centre, Cheyutha. Group meetings: Such meetings were regularly organised at the beginning of the project to create bonding. Most of these meetings were used as a platform to discuss various aspects of positive living with emphasis on what precautions to take to lead a normal life. Support Centre: A PLHA support centre (PLHASC) was set up and then had to be shifted to a bigger place owing to growing number of PLHA visiting the centre. Counselling is given to PLHA and their families. Marriages between eligible PLHA have been promoted by Cheyutha. The support centre has a recreation area, where PLHA can play caroms, chess, read books, news papers and magazines. Besides, PLHASC identified skills of PLHA and organised occupation training programme, which helped 20 PLHA to obtain jobs. In addition, PLHASC also organised 2 learning summer camps for children infected and affected by HIV. Staff: The project staff consists of a PLHA counsellor, principal organiser, facilitator and 5 outreach workers who are HIV positive. The medical and programmatic support is provided by the staff of LEPRA Society.

Clinic: Weekly clinics are organised for poor patients every Saturday except the first Saturday of the month. The LEPRA Society contributes to the drugs distributed free by the government hospitals to below poverty line HIV patients in the state. Outreach work: The outreach staff regularly visits various institutions including prevention of parent-to-child transmission of HIV Centres (PPTCTCs), voluntary counselling and confidential testing centres (VCCTCs), government and private hospitals, registered medical practitioners (RMP) and other service providers to inform about Cheyutha and gain support for HIV infected persons. Besides, various mass media channels are used to disseminate information on HIV.

Health Camps: Medical camps are organised the first Saturday of every month to provide treatment against opportunistic infections. The health camps are a platform for PLHA networking and increasing Cheyutha membership so as to improve the outreach services. This includes, giving information to new members on opportunistic infections, treatment facilities and contact details of the referral hospitals. Trained PLHA positive speakers are called upon to motivate infected persons towards positive living; there are 16 of them and they have been trained in positive speaking by LEPRA Society and Andhra Pradesh State AIDS Control Society.

Linkages: For referral of PLHA, LEPRA Society established linkages with government and charitable hospitals, such as Tuberculosis Hospital, Freedom Foundation Hospital and Andhra Pradesh Chest Hospital. One of the 5 outreach workers is posted at the government hospital to help poor patients, particularly those referred by the weekly clinics, procure the free anti-retroviral (ARV) treatment. Often these patients find it difficult to complete the formalities in a government institution. Other

Activities: LEPRA Society with the support from the Volunteers of Latter-Day Saint Charities, USA distributed Baby Care Kits to positive mothers and undertook a study to learn the effectiveness of a nutritional supplementation powder called Atmit among PLHA.

Results: Currently, the network has about 700 PLHA as its members. In 2005 alone Cheyuthas' outreach activities led to contact with 451 new PLHA. In one year, Cheyutha was able to facilitate hospitalisation of 28 PLHA, it got the CD4 blood test for immunity done for 120 PLHA and ensured that 116 patients could get the expensive ARV treatment. Cheyutha also referred 14 PLHA for TB treatment.

The outreach workers so far have sensitised 14 Rural Medical Practictioners (RMPs) and 28 NGOs working in and around the twin cities. Eleven health camps were organised in the past year

	alone. Impressed by their work Osmania Medical College, Hyderabad offered to sponsor free ARV treatment for 15 of Cheyutha's members. IBM, Hyderabad has agreed to hire HIV positive candidates as data entry operators. Cheyutha has thus assisted 20 PLHA to find gainful employment. A total number of 109 children of PLHA have been identified for educational support. A sum of INR 5,000 per family was provided towards meeting the schooling needs of the children.
Cost	INR 12 lakhs (1.2 million) was given by LEPRA society for support centre, clinical staff and medicines. Tides foundation, UK based provided INR 1.3 lakhs (130,000). Satyam Foundation donated INR 50,000 for other support activities. Central Bank staff provided cereals, rice, cupboards. Volunteers of Latter-Day Saint Charities, USA sponsored nutritional supplementation powder and baby care kits.
Place	Hyderabad and Secunderabad.
Time Frame	Four weeks as the network of PLHA existed prior to launch of Cheyutha and LEPRA Society had been providing medical support for this network for more than two years before the launch. The programme was flagged off in February 2005.
Advantages	Conducive environment: Organised general awareness programme in community setting. Comprehensive package: The programme tried to address the mental, economic and social needs of PLHA. It was an opportunity for PLHA to ventilate grievances on stigma and discrimination; they also gained strength by sharing experiences. Services: Weekly clinics provided free treatment to poor patients. Various mechanisms were established to provide necessary and quality referral services. Stronger networking: The programme was able to expand and build cohesiveness into the PLHA network to generate positive spirit towards life.
Challanges	Premises: Stigma associated with the HIV makes it difficult to find a suitable place to house the PLHASC. Group dynamics: Within PLHA there exist group dynamics and communication gaps. Treatment: Motivating the PLHA to adopt precautions and treatment for opportunistic infections. Hopelessness: The general pessimism among PLHA is a challenge. Livelihood: To find appropriate alternative employment.
Prerequisites	Government and local support. Provision of legal support system to PLHA. Referral linkages for hospitalisation and care.

	Availability of requisite funds. Effective information education and communication channels. Trained counsellors.
Who needs to be consulted	Community based organisations. Andhra Pradesh State AIDS Control Society. Network of Positive People. Referral hospitals. Panchayati Raj Institutions for building same network in rural areas. Women and Child Development Department. Youth welfare programmes.
Risks	
Sustainability	Possible only if funds are available. Currently, LEPRA (UK) is funding this programme.
Chances of Replication	The LEPRA society is going to start similar activities in Bhubaneswar, Orissa and other districts of Andhra Pradesh (Jaggaiahpeta in Krishna district) in 2006.
Comments	LEPRA society is also working with AP AIDS Control Society. They provide technical guidance, monitoring and capacity building to VCCTCs and PPTCTCs spread across 23 districts of Andhra Pradesh. Other ongoing projects include a clinic-based intervention programme for truck drivers and prevention programmes for vulnerable sections at 14 sites in Telengana and Rayalseema regions of AP.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, NIMS, May 2006.
Status	Active
Reference Files	Cheyutha-FINAL[1].ppt
Reference Links	

180. Village Health Committees, Jharkhand

Subject Area="Community participation."	Objective="Community ownership of government healthcare."
Details for Reform Option "Village Health Committees, Jharkhand"	
Summary	**Background:** Jharkhand is predominantly a rural state with 40% of the population belonging to Scheduled Castes (SCs) and Scheduled Tribes (STs). There are 32,628 villages and nearly 20,000-odd hamlets (Tolas) spread across a variety of topography in the state. Most of these villages are inaccessible due to reasons that are both natural and man-made. With limited infrastructure and scarce human resources, the government health system is unable to reach services to all these villages. Effective monitoring of the existing healthcare delivery system is also very difficult due to inaccessibility. It was felt, therefore, if the community could be involved in the system and it if it could be made to own the system, that would go a long way towards improving service delivery in the state. Formation of Village Health Committees (VHCs) in each village or tola was one of the initiatives on this front. Partner NGOs (initially 10 in number), working in the area, facilitated the formation of VHCs and helped to identify a female village health link worker. This link worker in Jharkhand is called Sahiyya, which in the local dialect means friend. Sahiyya is also Jharkhand's equivalent of the village level Accredited Social Health Activist (ASHA), recommended by the National Rural Health Mission (NRHM). **Actions:** VHC is a people's body. It comprises adult members selected by the Gram Sabha at a public meeting of the villagers. In order to facilitate the process of VHC formation, a facilitator is chosen from the partner NGO or village by a team under the leadership of Block Medical Officer. The facilitator can be a member of a Non Government Organisation (NGO) working in the area or an active youth. A facilitator is given orientation training in community mobilisation and VHC formation. He then organises a Gram Sabha meeting; all households are reminded a second time about the meeting, three days prior to the meeting, so as to ensure maximum participation by villagers. Thus the Gram Sabha members choose VHC members through a democratic process. The main role of the facilitator is to act as a link person between the government health system and the VHC.

	The VHC acts as an apex community-based health and sanitation body in the village. Training is also given to the VHC members to prepare Village Health Plans (VHP). Village Health Plans are made in consultation with the village community. Normal tenure of VHC members is two years. VHCs meet every month to evaluate their own and Sahiyya's performance. Disciplinary actions can be taken against VHC members who are absent at 5 consecutive meetings or if majority of the members feel that he/ she is a non-serious member. VHCs are encouraged to raise resources in the form of voluntary contributions in cash or kind from every household to the Village Health Kosh (VHK). The purpose of this village health fund is to meet the recurring expenses and to undertake collective community initiatives like cleaning of common wells, repairing village hand pumps, organising health camps and paying honorarium to Sahiyya. To manage the VHK, members select one of its members as treasurer. The statement of income and expenses are displayed before the Gram Sabha every year. The prime role of the VHC is to identify the health needs of the community and to generate awareness on health issues. It formulates local implementation plans for the public health programmes in consultation of the Auxiliary Nurse Midwife (ANM) and Anganwadi Workers (AWWs). VHC also supervises and supports the activities of the Sahiyya (For details, please see entry on Sahiyya, PROD ref no 153). **Results:** As on 1 July 2006, there are nearly 3000 Sahiyyas and 2000 VHCs in place. Plans are that on average 800 VHCs will be formed every month. It has been observed, villages which have a VHC and Sahiyya the community is more aware of its entitlements under various health programmes; the demand for quality of services has also increased in such villages.
Cost	Approximate cost involved for the formation of VHCs, identification of Sahiyyas, 21-day training for Sahiyyas (8 modules), Training for VHC members, etc is INR 4 lakh (400,000) per block
Place	Started in 34 blocks of 6 districts—Ranchi, Hazaribagh, Gumla, Jamtara, East Singhbhum, Seraikela Kharsawan.
Time Frame	Approximate time frame from planning to implementation is one year, following a pilot project in Ranchi district.
Advantages	Community ownership: Community involvement in managing its own healthcare needs enhances ownership. Increased demand: Raised awareness for the services increases the demand for them. Community monitoring: Effective monitoring mechanism at village level.

Challanges	Voluntary involvement: Mobilising the community for voluntary involvement in government programmes is difficult task. Training: VHC members and Sahiyyas need training to identify their own health needs and to prioritise them to make an action plan.
Prerequisites	Committed government officials. Clear policies and guidelines.
Who needs to be consulted	NGOs and Faith-Based Organisations. Concerned government officials. Community leaders and facilitators.
Risks	
Sustainability	Highly sustainable since it functions on community contributions and voluntary participation.
Chances of Replication	Replicable especially in low-performing states.
Comments	When resources are limited and services need to be delivered to the people, involving community to manage their own healthcare needs is the way to enhance their ownership in the system.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, May, 2006.
Status	Active
Reference Files	
Reference Links	

181. Home Based Newborn Care, SEARCH, Gadchiroli, Maharashtra

Subject Area="Community participation."	Objective="Home based newborn care to reduce newborn mortality and morbidity."
Details for Reform Option "Home Based Newborn Care, SEARCH, Gadchiroli, Maharashtra"	
Summary	**Background:** Gadchiroli district in Maharashtra state, tribal in nature, is very poor both educationally and economically. Female literacy rate in 1991 in the Gadchiroli was 28.9% as compared to 52.3% in Maharashtra. Although Government health services exists in the district following the pattern for tribal region, they suffer from various problems such as staff absenteeism, poor motivation of the staff and poor supervision of the workers. In a study based on prospectively observed 763 mothers and neonates in 39 villages of Gadchiroli during 1995-96, it was observed that health service delivery in the region was so poor that in the area where around 54% of the neonates needed medical attention, only 2.6% were able to receive medical attention and 0.4% were managed to get hospitalised. **Actions:** Society for Education, Action and Research in Community Health (SEARCH) was founded in 1986 as a non-governmental organisation. Based on baseline observational data, tools for Home Based Neonatal Care (HBNC) were developed. The services are provided through the Community Health worker (CHW) who is a local resident woman of the community, has strong willingness to work in the area and is able to read and write. Women with 5 to ten years of schooling are preferred. The tools for HBNC include: 1) Community sensitisations: Through health education of mothers and grand mothers, sensitisation about care of the newborn was generated by the Community Health Worker (CHW) called Arogyadoot and Trained Birth Attendant (TBA). Health education was conducted in following manner:· Group Health education through audio visual and group games· To individual mothers, by home visits- twice during pregnancy and once on the second day after delivery. To mothers of high-risk neonates. 2) Listing of the pregnant women: CHW regularly makes home visits and maintains updated list of the eligible women (women who can become pregnant) in the community for future follow up. Through bimonthly visits she identifies the pregnant women and registers them.

	3) Immediate charge of the newborn baby: Newborn babies are taken under care by the CHW in collaboration with TBA. (Please see the reference section for detail: Intervention in the home based management of the new borne). CHWs are well trained in identifying birth asphyxia and high-risk babies (premature and low birth weight and babies with breast feeding problems) and their management at home. Through various experimental studies a simple and validated method of screening of neonates at high risk was devised by SEARCH for these field level workers. CHW and TBA are also trained in various health education messages like promotion of the exclusive breast feeding, maintenance of hygiene and care of the neonate to prevent death due to sepsis. (Please see the reference section for detail: Intervention for the home based management of the neonatal sepsis and diagnosis and management of asphyxia by Village Health Worker). For immunisation services CHWs refer the women to nearby PHC. Otherwise there is no formal links with government health facilities and patients are referred there as per need. 4) Field supervision: Twice in a month by a doctor or a nurse. The supervisor visits each CHW twice a month and ensures that he visits the neonate at least once during the neonatal period. Results: Aceivements are reflected in various indicators: (1)Low Birth Weight : 4.9 percent in 1996-03 as compared to 11.3percent in 1995-96. (2)Pre term Babies: decreased to 10.1 percent in 1996-03 from 33.3percent in 1995-96 (3)Sepsis: Reduced to 6.9percent in 1996-03 from 18.5 percent in 1995-96. (4) Asphyxia : reduced to 20.2percent in 1996-03 from 38.5 percent in 1995-96 (5)Neonatal mortality rate: 70 percent reduction in 2001-2003 as compared to control area. (6)Infant Mortality rate: 57 percent reduction in 2001-03 as compared to control area
Cost	The training costs per CHW is INR 5368 Equipment and CHW kit cost is INR 3936 Recurring cost per village INR 7040 as in 2001-2003.
Place	Gadchiroli district, Maharashtra.
Time Frame	One year (1995-96).
Advantages	Community mobilization: Awareness among community is raised and are mobilized to take care of pregnant women and new born baby.

	Propoor: Home based care with the help of community health workers is pro poor strategy where cost and trained man power is a constraint. Culturally sensitive: Home based care promotes those practices, which are culturally acceptable and traditionally sound. Home based care: Raising the capacity of the mothers to look after her new born baby and provision of immediate care to the babies who have no access to medical care through doctors or institutional facilities. Timely care: Early identification of the highrisk new born babies and timely care.
Challanges	Selection and training of the CHWs: Identifying a women worker who can minimally read and write and can learn basic skill to handle the new born immediately after delivery is a difficult process where female illiteracy is very high. Provision of supportive supervision: With limited staff field level supportive supervision to the CHWs is a tricky task. Process intensive intervention: Basic interventions need to learn right from diagnosing the sick babies to applying various basic care. Sustaining motivation of workers: To maintain the continuation of work by community health worker it is important to keep up the motivation level of CHW.
Prerequisites	Familiarity with the community.
Who needs to be consulted	Local communities.Local TBAs.
Risks	
Sustainability	Scheme is self sustainable technically because of the fact that services are delivered by the identified local resident and she is given training to identify the high risk neonates and manage them at home. However supervision and financial support are needed.
Chances of Replication	The strategy has been devised through various field-based trials. It has already been proved replicable through NGOs (ANKUR project for replication of HBNC over a population of 88,000 in 7 sites(Rural, Tribal and Urban slum) through 7 different NGOs. It has been accepted as one of the components of duties of ASHA under the National rural Health Mission of India.
Comments	In States where resources are scares and new born babies are dying due to ignorance, illiteracy of the mother and non availability of the basic care at the time of birth and medical care due to non accessibility of institutional facilities - Home based

	newbornl care through trained community worker is the alternative.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, New Delhi, Oct 2006.
Status	Active
Reference Files	Interventions in the home based management of new borne-AB-anu.doc Interventions for Home Based managt of neonatal sepsis-AB-anu.doc Diagnosis and management of Asphyxia by the VHW-AB-anu.doc HBNC-Asphyxia.jpg HBNC-sepsis.jpg HBNC-Health edu.jpg
Reference Links	

182. Khoj Project, Manipur

Subject Area="Community participation."	Objective="Maintaining good health of the people through preventive and curative health services."
Details for Reform Option "Khoj Project, Manipur"	
Summary	**Background:** In Manipur, about five major communities live as brothers and sisters from times immemorial. Unfortunately, at an early part of 1990's, a misunderstanding suddenly sprang up between two communities resulting into ethnic clashes. As soon as this came back to normal situation, another similar incident took place and this time the wave of violence spread in the hill districts of Manipur making life of the simple hill people miserable. At this critical juncture, the Manipur Khoj (Search) Project was conceived under the guidance of Executive Director of Voluntary Health Association of India (VHAI), New Delhi as a mission to bring back normalcy and peace in Manipur. Five Khoj field units were taken to include all sections of the warring communities in 5 neglected pockets of the most backward areas of the 5 districts of Manipur through activities on health and social development. Khoj is an effort to generate a series of integrated and comprehensive health centered projects in areas, which have abysmally low health status for a variety of reasons. The project is expected to lead not only an increase in awareness about health improvement but also increase in the general well being of community in the targeted areas. The approach aims to encourage community action oriented not only towards raising the health status of the people through health care services but also improving the overall socio-economic, politicaL and environmental milieu which creates conditions non-conducive to health of an individual. KHOJ efforts are not to provide ready-made solutions for the people's problems. It is an effort to involve people in a programme aimed at their own well being so as to foster a sense of self-reliance amongst the people that they can initiate an implement. The objectives of the project were: i) To reduce mortality and morbidity through Mother Child Health (MCH) services. ii) To impart health education and awareness to the general population to reduce the incidence of diseases which are preventable. iii) Promotion of folk media for the purpose of sensitising health to the general population. iv) To set up health centres wherever necessary as referral centres of the Field Unit Out Patient Department (OPD) centres

	to provide MCH services. v) To implement innovative programmes of health promotion in schools. vi) To undertake social activities like water and sanitation, total literacy campaign, improvement of inter village roads and support to women society clubs, local schools and village library. vii) To impart skill training and to extend financial help to the rural people and tribal population to enable them undertake socio-economic activities and to viii) Promote traditional system of healing. **Action:** Main activities under the programme were: i) Maternal care services – antenatal, intra natal and postnatal care. ii) Under 5 child care-immunization, diarrhoea management, prevention from malnutrition and vitamin A deficiency. iii) Health education and awareness programmes included training of Community Health Workers (CHWs); Training of Traditional Birth Attendants (TBAs); health awareness including prevention of AIDS and small family norms. iv) Regular OPD services in all the 5 Khoj Field Units namely Sandangkhong, Sagang, Khelakhong-Irong Chesaba, Awangkhul and Keithelmanbi. v) Deliveries and simple treatment also carried out at the health centres. vi) For school health teachers and senior students were engaged to take up village health camps and exhibitions. vii)Construction of low-cost sanitary latrines and programmes on safe drinking water. Result: The community of five Khoj areas have now raised their voice to authorities to meet their health needs like supply of drinking water. Tangjeng village under Sandangkhon Khoj Unit has got drinking water facility under rural water supply scheme of the Government which was commission by Agriculture Minister. i) There has been reduction in common ailments in all Khoj areas. ii) 905 children (under 5 years of age) have been immunized. iii) Malaria has been totally eradicated in Keithelmanbi Khoj Field Unit which was earlier malaria prone area claiming 30 lives every year. iv) Two health centres were started as referral centres (i) one at

	Sandangkhong for both Sagang (Churachandpur District) and Sandandkhong (Bishnupur District) and the other at Awangkhul (Tamenglong District). v) Health education has covered 80% of the population. vi) 152 Traditional Birth Attendants (TBAs) have been trained under the Khoj programme. vii) 115 teachers have been given orientation in school health with follow up activities in all local schools. viii) Community Health Centre (CHC) building at Sandangkhong has been constructed by the community by raising funds from the public.
Cost	Not specified.
Place	Sandangkhong, Sagang, Khelakhong-Irong Chesaba, Awangkhul and Keithelmanbi (the 5 neglected pockets of the most backward areas of 5 districts of Manipur).
Time Frame	1 year.
Advantages	Community Participation: It is a community action oriented programme involving the community at large for the various programmes within the project. Holistic Approach: The programme is not only addressing the health needs of the community but it also has social and economic activities, literacy campaigns and women's empowerment programmes. Focuses on Local Needs: Focussing on local needs especially of the underprivileged sections is an integral component of the project.
Challanges	Disruption in program due to floods: Many areas of Manipur faced flood problems due to incessant rains and this disturbed the programme. Law and order situation: The law and order situation in Manipur also disturbed the program to some extent. Meeting the expectations: Meeting the expectations of the people in Khoj areas has also been a challenge due to certain limitations. For example it has not been possible to construct low cost latrines for all households or construct many inter village roads.
Prerequisites	Government Support. Trained staff. Community participation.
Who needs to be consulted	Manipur Voluntary Health Association.
Risks	

Sustainability	To ensure sustainability inputs are provided in the initial stages. The large role of community participation in the programme also ensures sustainability.
Chances of Replication	The programme has been replicated in U.P, M.P, Jammu & Kashmir, Orissa, Bihar, Tripura, Sikkim and West Bengal.
Comments	None.
Contact	
Submitted By	Prabha Sati, Research Consultant, European Commission Technical Assistance, New Delhi, March 2007.
Status	Active
Reference Files	
Reference Links	

183. Involvement of Self Help Group In Malaria Control Programme, Orissa

Subject Area="Community participation."	Objective="Raising awareness about various measures of malaria control"
Details for Reform Option "Involvement of Self Help Group In Malaria Control Programme, Orissa"	
Summary	**Background:** The National Programme for Control of Malaria is being implemented in Orissa since 1953. For effective control of malaria, Enhanced Malaria Control Project (EMCP) is being implemented in 158 tribal blocks of 21 districts since 1997-98. There has been a declining trend in the annual parasitic incidence from 2001-2003 but in the period 2004-05, 82 more blocks where annual parasitic incidence is in excess of 5 per 1000 population and slide positivity rate is in excess 5 per 1000 and parasite falciparum percentage is more than 30% have been included in the EMCP. In 2006, it was decided by the state government to involve the self-help groups in the EMCP for effective community involvement. **Activities:** Members of the self help group spread awareness about malaria control and motivate the members of the community to avail facilities provided by the state government, such as provisions of drugs, spray of D.D.T., rearing of gambusia fish and use of impregnated mosquito bed nets. **Results:** The initiative is in the process of implementation. Evaluation is yet to be done.
Cost	Evaluation of the programme has not been done
Place	All districts of the state Orissa.
Time Frame	One month
Advantages	Raised Awareness: Self Help Groups have more involvement within the rural population so the level of awareness about prevention of malaria will be raised.
Challanges	Sustained Motivation: keeping up motivation of the members of the SHGs is difficult.
Prerequisites	· SHG registered under Director, Mission Shakti (Women and Child Development, Govt. of Orissa) · Orientation of self-help groups about malaria control measures, · Motivated members in a self help group, . Uninterrupted supply of drugs, DDT and bed nets. · Budgetary allocation for IEC & Training

Who needs to be consulted	State government,Local government bodies,Chief Medical Officer,Community Development Project Officer,Self help groups.
Risks	
Sustainability	Depends on performance and involvement of SHG
Chances of Replication	It can be replicated in similar settings at other geographical location.
Comments	None
Contact	
Submitted By	Dr. Anil Bhola, Research Consultant, National Institute of Medical Statistics, New Delhi & Mr S Sahoo, Deputy Director, Bhubaneswar FSU. January, 2007
Status	Active
Reference Files	
Reference Links	

184. *Urban Health Improvement Programme, West Bengal*

Subject Area="Urban Health."	Objective="Access to facility-based RCH services."
Details for Reform Option "Urban Health Improvement Programme, West Bengal"	
Summary	**Background:** Areas in and around Kolkata have seen a tremendous increase in population, initially in the form of migrants from Bangladesh and later as increased industrial growth attracted people from neighbouring states looking for work. This led to the establishment of a large number of slums in these areas, bringing with it social problems such as poverty and illiteracy and health issues due to unhygienic conditions. Those most affected were women and children. (For more see "Documents & Illustrations" column.) **Action**: To address these issues, the Health Department of the Government of West Bengal requested the Kolkata Municipal Development Authority (KMDA) to take up urban health services along with its other developmental activities. Community based health programmes were initiated: Calcutta Urban Development Programme – III or CUDP-III (between 1984 and 1992), Calcutta Slum Improvement Programme or CSIP (1992-98), India Population Project - VIII or IPP-VIII * (1994-2002) and most recently the Urban Health Improvement Programme (UHIP) since July 2002 which helped set up the infrastructure to provide Reproductive and Child Health (RCH) services in the KMDA area. The main features of the system were: (i) Honorary Health Workers (HHWs) who work as link workers and are the first point of contact between the public and the health system. For more information on HHWs, see Documents and Illustrations. (ii) Sub centres form the next level and are established for every five blocks. Five HHWs report to the supervisor (usually an upgraded HHW) who is based at the sub centre. Two part-time medical officers and the first-tier supervisor based here provide basic primary health care services including antenatal and post natal care, immunisation of children and family planning services. They also organise periodic meetings for parents. (iii) The Health Administrative Unit (HAU) has 6 or 7 Sub centres under it. One sub centre is located at the HAU building. A HAU is manned by a health officer, assistant health officer, part-time medical officer and second-tier supervisor. The HAUs ensure procurement of drugs, storage and distribution. (iv) The next level is the Extended Specialised Outpatient Department

	(ESOPD) serving a population of 200,000 and offering specialist services and charging user fees. For more details see Documents and Illustrations below. In addition, a Regional Diagnostic Centre (RDC) has also been set up for a population of 400,000 providing services such as x-rays, ultra-sonography and other pathological tests. Here again user fees are levied at differential rates for those above and below the poverty line, but charges are slightly lower than the prevalent market rates as the RDC competes with other private diagnostic centers. Under the European Commission-assisted Urban Health Improvement Programme (UHIP), six municipalities were identified as pilot areas in order to integrate the existing health delivery system with other parallel departments and programmes. The programme includes: (i) Upgrading the existing structures. (ii) Provision of the following services: specialised service delivery for detection and management of Reproductive Tract Infection (RTI) and Sexually Transmitted Infection (STI) cases including preliminary laboratory investigations for screening of these cases at the HAU; safe Medical Termination of Pregnancy (MTP) services up to 10 weeks at HAU level (beyond 10 weeks at Maternity Home); female sterilisation/ IUD insertion at the HAU. (iii) A School Health Programme. (iv) A Management Information and Evaluation System (MIES). (v) Resource mobilisation has been started with the setting up of a Health Development Fund. See Documents and Illustrations for more details. **Results:** The endline evaluation survey for the IPP-VII (2002) shows an infant mortality rate (IMR) of 25.6 while the 6 municipalities under the UHIP had an IMR of 15.6 in the year 2003-04. Similarly the Couple Protection Rate (CPR) which was 75% in 2002 went up to 78.8% in the UHIP municipalities in 2003-04.
Cost	INR 703,000 for the first year. Total expenditure incurred under the UHIP upto 31 December 2004 was INR 37,281,000. Costs for earlier programmes: CUDP-III (1984-92) INR 767,57,000. IPP-VII (1994-2002) INR 9841,63,000. CSIP (1992-98) INR 558,90,000 (Euro 980,852)
Place	Six municipalities in West Bengal – Bhadreswar, New Barrackpore, North Barrackpore, Naihati, Madhyamgram and South Dum Dum since July 2002.
Time Frame	Construction and setting up of facilities completed within one year from commencement of project.
Advantages	Inclusive approach: Inter-sectoral convergence & integration with

	other similar development programmes. Self-sustaining: Resource generation by local bodies. Practical: Optimal use of existing infrastructure. Effective use of manpower: Capacity building for better management at all levels including training on clinical, administrative, financial and logistics. Needs specific: Provision of services based on the disease burden of the area. Authorities and service providers are accountable and accessible to the population, hence service quality is maintained. The operation being on a small scale, cooperation with and communication from other related departments is easy and can be readily accomplished, thereby making implementation smooth and successful.
Challanges	None perceived.
Prerequisites	Technical assistance on establishing the conceptual and operational framework and capacity building of the municipalities to provide health services is necessary.
Who needs to be consulted	Officials at the State Health & Family Welfare Government, KMDA and Municipalities.
Risks	
Sustainability	Initial funding is needed for upgradation of services, capacity building and awareness generation. After that it would be self reliant through the use of the community-based health development fund.
Chances of Replication	On achievement of successful reforms at the six municipalities, it will be replicated in the remaining municipalities under the KMDA area.
Comments	The programme largely owes its success to a strong political backing in West Bengal.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, December 2004.
Status	Active
Reference Files	School health clinic in New Barrackpore, West Bengal.jpg Maternity ward, Bhadreswar.jpg Pathology at Regional Diagnostic Centre, New Barrackpore 1.jpg Background.doc — Background note Further details on UHIP.doc — Further details on UHIP HONORARY HEALTH WORKERS.doc Current Status upto September 2004.doc

Reference Links	

185. *Urban Health Programme, Aurangabad, Maharashtra*

Subject Area="Urban Health."	**Objective="Access to facility-based RCH services."**
Details for Reform Option "Urban Health Programme, Aurangabad, Maharashtra"	
Summary	**Background:** Aurangabad is one of the fastest developing cities in Maharashtra, having a population of more than 10.7 lakhs (2001) and growing rapidly. However the socio-economic condition of the city is not very good. The city has a total literacy rate of 56.28% and a female literacy rate of just 39.64%. Aurangabad has a crude birth rate of 26.4 and an infant mortality rate (IMR) of 48.9%. Another cause of concern is the high number of home deliveries. In 1999, one zone in the municipality had 98.8% home deliveries. The Health Officer of the municipality, private practitioners, project consultants and various NGO's along with representatives of the State government met to discuss the issues. A baseline survey was also conducted. Based on the health problems found by the survey and discussions, a plan was prepared with the aim of improving the Reproductive Child Health (RCH) services in the city. Considering the available resources and health problems identified, the following objectives were prioritised to be achieved by end of a 4-year project period: (i) Improvement in awareness and knowledge with reference to reproductive and child health issues. (ii) Substantiation of delivery and Medical Termination of Pregnancy (MTP) services with stress on institutional deliveries. (iii) Extension of services for infants and under 5 population. (iv) Strengthening and sustaining RCH education among adolescent girls. (v) Strengthening existing health institutions under public sector. (vi) Establish and improve the referral system. **Action:** To achieve the above mentioned objectives, 11 components have been drawn up. Different activities have been specified under each component.

	(i) Intersectoral co-ordination for increase RCH awareness. (ii) Adolescent health education for girls. (iii) Essential obstetric care: services and referral. (iv) Improving child immunisation. (v) Reduction of incidence of malnutrition and vitamin A deficiency in children under 5. (vi) Reduction in infant and under-5 mortality by management of Acute Respiratory Infections (ARI) & diarrhoea. (vii) Access to family welfare and MTP services. (viii) Diagnosis and treatment of Sexually Transmitted Diseases (STD) and Reproductive Tract Infections (RTIs). (ix) Strengthening health management at the municipal corporation. (x) Staff support: strengthening health workers. (xi) Male participation. It was decided to upgrade 6 health centres of the municipal corporation and to provide 24-hour delivery services, MTP and family planning operations. At present, 4 centres have started functioning round the clock. The remaining two centres at present provide out-patient services. The staff, including the specialist doctors, Auxiliary Nurse Midwives (ANMs), staff nurses, lab technicians and group IV staff, are recruited on contract basis. Contingency funds are made available for purchase of instruments and medicines. For Information Education Communication (IEC), an NGO- Jan Shikshan Sansthan was identified as the coordinating agency. Under this component, 6 community organisers and 90 Mahila Mandal (Women's cell) representatives work (as community volunteers) in slum populations for awareness creation and demand generation. IEC activities include street plays, wall paintings, interschool essay competitions, healthy baby competitions etc. Adolescent health education component includes a training of teachers to conduct health education classes in schools. School health check ups are also held. The ANM, MPW and mahila mandal workers follow up on the non-school going and dropouts. **Results:** The project took almost 18 months to initiate mainly due to administrative problems such as frequent change of the chairperson and member secretary, leading to delays in appointment of staff, procurement and installation of equipment etc. However after the start of the programme, there has been an increase in quality of and demand for health services. ANC cases for example, have increased from 5,426 in the year 2000-01 to 7,929 in 2004-05 and deliveries

	have increased from 22,300 (2000-01) to 31,450 (2004-05).
Cost	Total budget for this project is INR 4 Crores 45 Lakhs . The action plan for the first year was for INR 106.83 lakhs. One crore has been sanctioned for the second year of which Rs 30 lakhs have been released thus far.
Place	Aurangabad city, Maharashtra since January 2002.
Time Frame	Approximately one year.
Advantages	Intersectoral coordination: Meetings, competitions held at schools. Improved access: To better quality services at low costs and free of cost for the poor. Awareness raising: Improves health education and knowledge of health services and facilities available.
Challanges	Difficulties faced: Administrative problems such as frequent change of officials. Though the project was meant to be managed by a separate team, initially the project manager was based at and had to carry out duties at a health centre.
Prerequisites	Good network of reliable NGOs to carry out the services. Community participation and willingness of community persons to volunteer.
Who needs to be consulted	Government officials at State and district levels, Municipal Corporation, NGOs, community.
Risks	
Sustainability	Initially needs heavy support both for funding and technical support. At present this is funded by the European Commission-supported Sector Investment Programme. However the municipality has agreed to take over the activities after the project period (December 2005).
Chances of Replication	Replicable if funding is available. However some things need to be kept in mind: The project should be managed by a set up separate from the Corporation. Provision should be made for necessary construction and repairs of buildings.
Comments	None.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, March 2005.
Status	Active
Reference Files	
Reference Links	

186. Women-centred health project, Mumbai, Maharashtra

Subject Area="Urban Health."	Objective="Improved outreach services."

Details for Reform Option "Women-centred health project, Mumbai, Maharashtra"

Summary

Background: The Municipal Corporation of Greater Mumbai (MCGM) (also known as Brihan Mumbai Municipal Corporation i.e. BMC) is the largest health care provider in the public sector in the Mumbai metropolis. Approximately three million women, particularly the poorest ones use the municipal health care services. The Women Centred Health Project (WCHP) was initiated in 1996 by BMC in collaboration with SAHAJ, an NGO and Liverpool School of Tropical Medicine, UK. The aim was to improve the quality of services provided by public health department of the MCGM.

A study on the prevalence of Pelvic Inflammatory Disease (PID) in slum women of Mumbai showed that women who attended the dispensaries for conditions like infertility, pelvic inflammation diseases and for sterilisation operation had special problems. Often, they did not have access to adequate information. Most municipal health care facilities lacked counselling services. Availability of limited gynaecological services at the primary level health care facilities meant that women had to avail speciality services at the secondary or tertiary hospitals which were costly in terms of time and money spent on accessing these services. Women also expressed a need for doctors to speak to their spouses as they had little decision making power.

Action: Initially, process and baseline studies were carried out to understand the health infrastructure and services provided. The baseline study brought out the following:

(i) Men's perception of their responsibility regarding RH is largely limited to financially supporting women in treating their reproductive problems.

(ii) Men had unmet information needs regarding reproductive and sexual health of both men and women and they preferred male health workers to conduct health information sessions.

(iii) Limited counselling, information and education, on diagnosis, advantages and disadvantages of treatment and other interventions, social aspects directly related to health problems.

(iv) The need to sensitise providers on their behaviour, and clients' perceptions.

(v)The need to implement clinical and administrative protocols at all

	levels of the health care delivery system. In light of the findings of the surveys, the following steps were taken: (i) Gynaecology Outpatient Clinics (GOCs) started at 8 health posts. (ii) A counselling centre was started at the GOC at a secondary hospital in January 2000. (iii) Development of gender sensitive interactive IEC material on Reproductive Tract Infections (RTIs), Medical Termination of Pregnancy (MTP) and Ante-Natal Care (ANC). (iv) Developing a Patients' Charter including the Rights of Patients. (v) Development of training manuals for sustaining the capacity building component beyond the project period. **Results:** The introduction of gynaecological OPDs at the health post and dispensary levels has helped services to improve and also brought women closer to quality health care services in a sensitive and private environment. This has helped them prioritise their health needs and seek treatment for problems which they would otherwise ignore. This was reflected in the fact that the number of women visiting the dispensaries for treatment increased three times in just a year. Health care providers feel that the project's efforts at strengthening and streamlining the referral system will reduce the load at tertiary and secondary hospitals and help patients with referrals to receive priority treatment. The referral system is viewed as a tremendous achievement within the MCGM.
Cost	The WCHP cost totalled to approximately INR. 8,000,000 spread over 7 years with a significant contribution from the MCGM.
Place	Seventeen health posts and 14 dispensaries, one peripheral hospital in two wards of the MCGM in Mumbai 1996 – 2003
Time Frame	Between five to 7 years since it is process intensive.
Advantages	Incentives: The Quality Assurance approach ensured ownership of the hospital by the staff and encouraged teamwork with a goal of client satisfaction. Gender inclusive: Men were involved in the process.
Challanges	Broadening the appeal increases the caseload: services need to be planned so that the quality of care can be sustained. Time constraints: such process oriented approaches take time which is not always available to government officers and health care providers. Work overload: National health programmes such as immunisation, polio, and TB can become a constraint, leaving health workers less

	time to concentrate on this project. Needs education: Importance of gender sensitisation in RH provision may not be acknowledged by all health care providers and administrators thus according low priority to the programme and affecting the pace of progress of interventions. Additional workload perception: Health care providers who have been 'ordered' to participate may resent it and oppose the pilot interventions as 'additional workload'. Peer pressures: Health care providers participating in the pilot phase may be influenced by negative peer pressure and may not express ownership of the interventions.
Prerequisites	-- Willingness of the public sector partner for exploring newer strategies for improvement of quality of care. -- Existing infrastructure, administrative pathways, and human resources. -- Training for change to all cadres of health care providers and administrators. -- Provision of physical resources that could not be mobilised from the PHD of MCGM. -- Coordination of monitoring and supervision of services provided through the gynaecology clinics and the counselling centre, including honoraria for the supervisors.
Who needs to be consulted	Highest authority for the public sector partner. For example, Municipal Commissioner for MCGM. Patients, their relatives, healthcare facilities, healthcare staff.
Risks	
Sustainability	Ownership of the interventions by the administrators concerned, and initiative by them for ensuring sustainability (through support in terms of resources and monitoring), are some of the crucial factors. Mass production of gender sensitive IEC material produced by WCHP is being taken over by the IEC Cell of BMC. The work on Referral Systems initiated by WCHP has been taken over by another partnership initiative, SNEHA and referral protocols are being developed and refined. The Counselling Centre within the gynaecology OPD in VN Desai Hospital continues to provide services and is in the process of being taken over by the hospital administration. However, inability of the MCGM to recruit personnel to fill the vacant staff positions is likely to result in the death of the interventions like the primary level Gynaecology Clinics. In the later phases, the project focussed its efforts on ensuring that the MCGM qualified for the second phase of the National Programme on RCH through which the interventions initiated by the project could be mainstreamed and sustained.
Chances of Replication	The intervention is replicable in an urban setting with adequate training and protocol formulation. MCGM has planned to expand it to other wards.

Comments	Training the staff in communication skills and sensitivity for women having gynaecological and other health problems can result in increase in the utilisation of the services. However, it requires the involvement of the staff, which may take some time to show results.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	Situation Analysis Women health Project.doc — Situation analysis of Women Health Project
Reference Links	

187. Women-centred health project, Mumbai, Maharashtra

Subject Area="Urban Health."	Objective="Improved outreach services."
Details for Reform Option "Women-centred health project, Mumbai, Maharashtra"	
Summary	**Background:** The Municipal Corporation of Greater Mumbai (MCGM) (also known as Brihan Mumbai Municipal Corporation i.e. BMC) is the largest health care provider in the public sector in the Mumbai metropolis. Approximately three million women, particularly the poorest ones use the municipal health care services. The Women Centred Health Project (WCHP) was initiated in 1996 by BMC in collaboration with SAHAJ, an NGO and Liverpool School of Tropical Medicine, UK. The aim was to improve the quality of services provided by public health department of the MCGM. A study on the prevalence of Pelvic Inflammatory Disease (PID) in slum women of Mumbai showed that women who attended the dispensaries for conditions like infertility, pelvic inflammation diseases and for sterilisation operation had special problems. Often, they did not have access to adequate information. Most municipal health care facilities lacked counselling services. Availability of limited gynaecological services at the primary level health care facilities meant that women had to avail speciality services at the secondary or tertiary hospitals which were costly in terms of time and money spent on accessing these services. Women also expressed a need for doctors to speak to their spouses as they had little decision making power. **Action:** Initially, process and baseline studies were carried out to understand the health infrastructure and services provided. The baseline study brought out the following: (i) Men's perception of their responsibility regarding RH is largely limited to financially supporting women in treating their reproductive problems. (ii) Men had unmet information needs regarding reproductive and sexual health of both men and women and they preferred male health workers to conduct health information sessions. (iii) Limited counselling, information and education, on diagnosis, advantages and disadvantages of treatment and other interventions, social aspects directly related to health problems. (iv) The need to sensitise providers on their behaviour, and clients' perceptions. (v)The need to implement clinical and administrative protocols at all

	levels of the health care delivery system. In light of the findings of the surveys, the following steps were taken: (i) Gynaecology Outpatient Clinics (GOCs) started at 8 health posts. (ii) A counselling centre was started at the GOC at a secondary hospital in January 2000. (iii) Development of gender sensitive interactive IEC material on Reproductive Tract Infections (RTIs), Medical Termination of Pregnancy (MTP) and Ante-Natal Care (ANC). (iv) Developing a Patients' Charter including the Rights of Patients. (v) Development of training manuals for sustaining the capacity building component beyond the project period. **Results:** The introduction of gynaecological OPDs at the health post and dispensary levels has helped services to improve and also brought women closer to quality health care services in a sensitive and private environment. This has helped them prioritise their health needs and seek treatment for problems which they would otherwise ignore. This was reflected in the fact that the number of women visiting the dispensaries for treatment increased three times in just a year. Health care providers feel that the project's efforts at strengthening and streamlining the referral system will reduce the load at tertiary and secondary hospitals and help patients with referrals to receive priority treatment. The referral system is viewed as a tremendous achievement within the MCGM.
Cost	The WCHP cost totalled to approximately INR. 8,000,000 spread over 7 years with a significant contribution from the MCGM.
Place	Seventeen health posts and 14 dispensaries, one peripheral hospital in two wards of the MCGM in Mumbai 1996 – 2003
Time Frame	Between five to 7 years since it is process intensive.
Advantages	Incentives: The Quality Assurance approach ensured ownership of the hospital by the staff and encouraged teamwork with a goal of client satisfaction. Gender inclusive: Men were involved in the process.
Challanges	Broadening the appeal increases the caseload: services need to be planned so that the quality of care can be sustained. Time constraints: such process oriented approaches take time which is not always available to government officers and health care providers. Work overload: National health programmes such as immunisation, polio, and TB can become a constraint, leaving health workers less time to concentrate on this project.

	Needs education: Importance of gender sensitisation in RH provision may not be acknowledged by all health care providers and administrators thus according low priority to the programme and affecting the pace of progress of interventions. Additional workload perception: Health care providers who have been 'ordered' to participate may resent it and oppose the pilot interventions as 'additional workload'. Peer pressures: Health care providers participating in the pilot phase may be influenced by negative peer pressure and may not express ownership of the interventions.
Prerequisites	-- Willingness of the public sector partner for exploring newer strategies for improvement of quality of care. -- Existing infrastructure, administrative pathways, and human resources. -- Training for change to all cadres of health care providers and administrators. -- Provision of physical resources that could not be mobilised from the PHD of MCGM. -- Coordination of monitoring and supervision of services provided through the gynaecology clinics and the counselling centre, including honoraria for the supervisors.
Who needs to be consulted	Highest authority for the public sector partner. For example, Municipal Commissioner for MCGM. Patients, their relatives, healthcare facilities, healthcare staff.
Risks	
Sustainability	Ownership of the interventions by the administrators concerned, and initiative by them for ensuring sustainability (through support in terms of resources and monitoring), are some of the crucial factors. Mass production of gender sensitive IEC material produced by WCHP is being taken over by the IEC Cell of BMC. The work on Referral Systems initiated by WCHP has been taken over by another partnership initiative, SNEHA and referral protocols are being developed and refined. The Counselling Centre within the gynaecology OPD in VN Desai Hospital continues to provide services and is in the process of being taken over by the hospital administration. However, inability of the MCGM to recruit personnel to fill the vacant staff positions is likely to result in the death of the interventions like the primary level Gynaecology Clinics. In the later phases, the project focussed its efforts on ensuring that the MCGM qualified for the second phase of the National Programme on RCH through which the interventions initiated by the project could be mainstreamed and sustained.
Chances of Replication	The intervention is replicable in an urban setting with adequate training and protocol formulation. MCGM has planned to expand it to other wards.
Comments	Training the staff in communication skills and sensitivity for women having gynaecological and other health problems can result in increase in the utilisation of the services. However, it requires the involvement of the staff, which may take some time to show results.
Contact	

Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004.	
Status	Active	
Reference Files	Situation Analysis Women health Project.doc	Situation analysis of Women Health Project
Reference Links		

188. Kolkata Family Welfare Urban Slums Project, West Bengal

Subject Area="Urban Health."	Objective="Mobilising community participation."
Details for Reform Option "Kolkata Family Welfare Urban Slums Project, West Bengal"	
Summary	**Background:** Kolkata, capital of the state of West Bengal, suffers from huge overcrowding and strained public utilities because of mass migration into the city post Partition (1947) and the creation of Bangladesh (1971). The migrations have resulted in a vast Below Poverty Level (BPL) slum population posing high volatility and social and political pressures. The challenges for provision of minimal and decent RCH care in such a mix are huge. **Action:** The India Population Project (8) Kolkata programme aimed to address the formidable challenge of delivering cost-effective, affordable and quality RCH interventions in the slums. The project was a critical part of the World Bank's strategy of supporting human development and poverty alleviation in India, providing the opportunity to extend rapid and targeted assistance to the most vulnerable slum populations who were not adequately covered by the existing primary health care infrastructure. The objectives were to: (i) Reduce fertility by improving access to demand for family planning services. (ii) Improve maternal and child health by decreasing mortality rates. The programme addressed this by: (i) Recruiting volunteers: local women were trained and designated as Honorary Health Workers (HHWs). They were paid a monthly honorarium (INR 500) and told to work closely with the community and the health workers operating in the facilities created under the project. (ii) Enhancing access to RCH services: through the construction of new service outlets and upgrading of existing facilities. Emphasis was placed on (a) pre-service and in-service training for medical and paramedical staff; (b) training of female volunteers to help outreach service delivery; (c) Increased involvement of Community-based Organisations (CBOs) and private medical practitioners in training as well as service delivery.

	(iii) Training cells were established to plan and implement systematic training to the above personnel. Essential supplies such as health worker kits, medicines, etc. were provided. A two-pronged strategy was adopted to generate the demand for Family Welfare (FW) and Maternal Child Health (MCH) services – first, establishment of client-friendly services; second, development of an Information, Education, Communication (IEC) strategy, which had a focus on priority health seeking behaviours giving attention to inter-personal communication. Messages disseminated through entertainment media such as folk songs, drama, magic show, etc., However, the most important media of behavioural change was interpersonal communication, especially through HHWs. To facilitate women's empowerment and income generation, the project involved innovative schemes focusing on young females and adolescent girls and included vocational training, entrepreneurship development training, reproductive health education, etc. The implementation was done in close collaboration with CBOs and local municipalities. **Results:** Evaluation report by the World Bank found: Infant mortality rate down from 55.6 to 25.6. Institutional delivery up from 53.9 to 89. Fully immunised children up from 57.1 (mid-term) to 89.1.
Cost	INR 94.76 crore). Funding included support from the International Development Association (IDA) of INR 3,28 crore and the Kolkata Metropolitan Development Authority (KMDA) which used a Credit of about INR 78 crore .
Place	Kolkata 1994 – 2002. Now ongoing under the supervision of Local Urban Bodies with technical oversight from Kolkata Metropolitan Development Authority and funding from the state budget of the Municipal Affairs Department.
Time Frame	Five to seven years.
Advantages	Quality: Provides a network of quality infrastructures. Better service: Provision and utilisation of service delivery. Empowerment: Community mobilisation and involvement and ownership of low cost interventions. Sustainable: Enhanced institutional and financial sustainability.
Challanges	Needs comprehensive approach: No single agency can effectively address the growing health needs of the urban poor. There is a need for strategic partnerships between public and private sectors working closely with the communities. Needs lengthy commitment: There needs to be a long-term social and political commitment to the programme for it to succeed. Increased provision of RCH services needed: To keep pace with the demand from newly empowered women. There is no point in

	educating them about contraception or institutional deliveries and then not being able to provide the facilities. Needs flexibility: There is no single solution to Urban RCH issues and strategies need to be flexible and based on local needs and capacities.
Prerequisites	Stakeholder consultation. Formation of steering or executive committees to oversee implementation of project. Training cell established. Recruit female volunteers from community targeted. Management training for project managers. Minimising delays by obtaining all clearances in advance is critical for project implementation. -- Bringing health on to the local political agenda through decentralisation is critical for sustained delivery of health care to the slum populations.
Who needs to be consulted	Ministry of Health and Family Welfare. State Government (State Urban Development Department; State Health Department; Municipal Affairs; State Finance Dept) The Municipal Corporation. Donor organisation (in this case World Bank). Community based organisations. Local private medical officers and facilities.
Risks	
Sustainability	The project has been proven to be sustainable and is still ongoing (September 2004). On the institutional side, the management has been decentralised to Local Urban Bodies and the chair persons/ mayors of the 40 local bodies are now managing the programme with technical oversight from KMDA. Very high level political commitment by the State of West Bengal contributed substantially to institutional sustainability of the project. On the financial sustainability side, a provision has been made for the recurring charges through provision in the state budget of the Municipal Affairs Department.
Chances of Replication	The project has already been extended to 20 more cities (outside the KMDA areas) in the State of West Bengal with support from the Department for International Development (DFID) and International Development Association. The IPP (8) project was also being implemented concurrently in 4 cities (Kolkata, Bangalore, Hyderabad and Delhi). All the 4 cities followed different operational models to implement the IPP (8) project according to the city specific situation. Replication may not be straightforward and would depend on the specific context. For example: (i) Kolkata slums were stationary (vis-à-vis Delhi where slums shifted after the construction of health posts, adversely affecting utilisation); (ii) using part-time doctors on modest compensation and volunteers on payment of nominal honoraria is unlikely to work automatically in other cities; (iii) in the absence of social and political mobilisation and pressure, the community-based low-cost and cost sharing arrangements may not work easily; and

	(iv) ethnic composition of the Kolkata slums was also more varied, allowing for a wide mix of interventions. However, replication with suitable modifications is possible. The positive lessons learnt from the Kolkata model would be useful in other settings: community drafted project; voluntary characteristic of grass root level workers; bottom-up approach; active involvement of CBOs acting as a solid platform; developing community partnership; active involvement of elected representatives; effective management and supervision cell and involvement with private medical practitioners for service delivery.
Comments	The project was innovative, accepted by the community and provided 'value for money'.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	
Reference Links	

189. Integrated sanitation promotion programme, Tamil Nadu

Subject Area="Urban Health."	Objective="Intersectoral coordination."
Details for Reform Option "Integrated sanitation promotion programme, Tamil Nadu"	
Summary	**Background:** It is estimated that in the slums and squatter settlements of urban India, only 15% of the households have toilets and 21% have access to community toilets. Attempts by municipalities to provide these facilities prove futile as the community is often not consulted and so do not cooperate. **Action:** The Tiruchirapalli Corporation and District Administration came up with a plan to construct community latrines in 41 slums. It approached WaterAid, an international NGO with an office in Tiruchirapalli, for financial support. WaterAid proposed collaboration with their partner NGOs in selected areas, leaving the Corporation to replicate the work in the remaining areas. The Corporation on its part forwarded the plan to the state government. On approval, WaterAid worked out detailed plans for 25 slums and a baseline survey was undertaken in each. Community latrines were established with adequate water supply, lighting and disposal systems. They were maintained on a pay and use system. Child-Friendly Toilets (CFTs) were also built. The women were organised into Self-Help Groups (SHGs) to maintain, manage and collect charges for these new facilities. A programme of hygiene education was also undertaken which led to changes in behaviour, particularly that of children and women. **Results:** The results show a reduction in disease burden in the slums two years after the start of the project. A significant reduction in diarrhoea from 73% to 10% (children) and 13% to 2% (adults). Hygiene behaviour changes like hand-washing were now practised by 94% of the people.
Cost	Estimated cost: There were 25 slums covered under the project directly by three NGOs - GRAMALAYA, SCOPE and SEVAI - at an approximate cost of INR 1.80 crore for three years which include software and hardware components. Apart from the 25 slums, another 75 slums were covered by the Tiruchi City Corporation under a self-help scheme. The hardware components such as constructing community latrines are directly undertaken by the City Corporation at a cost of INR 3 crore (€535,930) while WaterAid has extended financial support for IEC activities and software components.
Place	About 100 slums in the city of Tiruchirapalli, Tamil Nadu since 1999.

Time Frame	Approximately two years for initialisation and implementation of the project.
Advantages	Disease prevalence reduced: Especially diarrhoea. Empowerment: Of the slum-dwellers, especially women. Self-sustainable: Income generation and mobilisation of resources, leading to self sustainability of the SHGs.
Challanges	Possible opposition: From private water vendors, political groups who exploit the prevailing situation and use the slum communities as vote banks and 'power groups' within the slums opposed to the changes.
Prerequisites	Approval of state government. Consensus building with the community. Identification and selection of NGOs with appropriate skills and resources. Good rapport with the communities and existing groups, if any, in the locality. Understanding of the city sewerage and water supply system.
Who needs to be consulted	Local population. Municipal corporation, elected members. District and state governments. NGOs. Body imparting technical assistance (in this case WaterAid).
Risks	
Sustainability	Elements supporting sustainability: Total management of the facilities and the system by the community groups and their federations. The establishing of a solid fund base generated, held and managed by the community groups. Aptitude to scale up is demonstrated by the actual output. Healthy relationship with the local authorities. Community members' entry into the decision-making arena.
Chances of Replication	On successful implementation of the 25 slums taken up by WaterAid, the Corporation has decided to replicate in 75 other slums simultaneously. The Community-based Organisations (CBOs) in the slums help in initiating community management systems and structures.
Comments	One slum took the project a step further. With the help of WaterAid's partner NGO - Gramalaya, they excavated several tonnes of excrement and planted a herb garden. They opened up a shower block as well, charging the labourers working in the neighbourhood INR 3 to have a shower. Once the block was up and running, the women started other entrepreneurial schemes. The enormous quantities of biodegradable waste generated from the wholesale banana market nearby provided the opportunity for the slum dwellers to initiate a vermi-compost scheme (production of compost with use of worms). The SHG members attended training in Kerala, bought some worms and after a pilot study started full-scale production. The harvested compost was sold at the rate of INR 5 (€0.09) per kg and they make a profit of INR 2,500 (€45) for each

	cycle (one cycle takes 45 days) of vermi-composting
Contact	
Submitted By	Dr Richard Brough, Team Leader, European Commission Technical Assistance, New Delhi. October 2003.
Status	Active
Reference Files	Kalmandhai - hoarding.jpg Community toilet constructed by Gramalaya with WaterAid grants2.jpg Vermi Culture Unit.jpg Kalmandhai slum.jpg Children of Kalmandhai using Child Friendly Toilet.jpg Members of women SHGs.jpg Newspaper Report - Express.jpg TN Resolution (Tamil Version).doc TN Resolution (English Version).doc
Reference Links	

190. Women and Community Empowerment, Maharashtra

Subject Area="Urban Health."	Objective="Access to family planning."
Details for Reform Option "Women and Community Empowerment, Maharashtra"	
Summary	**Background:** Kalyan Dombivli Municipal Corporation covers 96 wards including 62 villages in Thane district on the outskirts of Mumbai, and has a population of 1,193,266. The sex ratio is 884. KDMC is surrounded by an industrial belt which attracts migrants, leading to unplanned growth of slums where even basic sanitation services are not available. The population density is as high as 11,585 per square foot. The infant mortality rate is high with less than half of pregnant women receiving full antenatal care. While almost all married women in KDMC are reportedly aware of family planning, only a little more than half are currently using any method. Only 24.3% of adolescent girls from slum areas have heard of Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs), whereas over 75% have heard of HIV/AIDS. **Action:** With financial and technical assistance from the UNFPA, the Integrated Population and Development project was first implemented in 2000 with the aim of improving women's and adolescent reproductive health. Now in its second phase, 2003 to 2007, the UNFPA-assisted IPD project places a strong emphasis on creating opportunities for women through community empowerment, to develop links with the health service system. It aims not only to improve women's reproductive and general health but to reduce gender-based violence and improve women's understanding of their reproductive rights. It supports activities to improve family planning as well as advocacy activities for gender equality. Various NGOs are involved in the implementation of the IPD project. Reach Education and Action Project (REAP) and Social Aspiration for Participatory Reform by Evolved Manpower (SAPREM) work specifically for Women and Community Empowerment (WCE). Their aim is to enable women and men to demand high quality reproductive health services, through a supportive environment in the community and health system. Their strategy involves mobilising women's groups in 10 slum areas of KDMC to familiarise them with reproductive health and gender issues. Each NGO has been allotted 5 slums to work in. The following activities have been undertaken: (i) 25 women's groups have been formed with 10 to 12 women in each group (ii) A 3-day orientation of women's group representatives was undertaken in 2003 (iii) Reorientation of group members is conducted every month (iv) A co-

	ordinating committee was formed, meetings held at three locations (v) A community mobilisation team was formed, meetings held at two locations The women's group members carry out events and conduct campaigns to tie in with flag days such as Safe Motherhood Day and World Population Day. Performance is found to be one of the most effective ways of disseminating information to slum populations. In the month of June 2004 alone, 107 street plays were performed in the KDMC area. 22 organised by REAP, 40 by SAPREM. The street plays are also concerned with encouraging safe motherhood interventions, raising awareness in the community regarding the referral of high risk mothers, and on breaking the taboo surrounding RTI and STIs and HIV/AIDS. This 'culture of silence' presents a major obstacle in the treatment of women for infection. **Results:** In 2004, 72 women's groups representatives participated in quarterly orientation. Of these: (i) 25 women attended a three-day orientation session (ii) 250 women attended seven one-day orientation sessions (iii) 25 groups attended a refresher training session In addition, awareness drives have been conducted covering the following issues: (i) HIV/AIDS (ii) Formation of self help groups (iii) Education about government schemes and health programmes (iv) High risk mothers (v) Good nutrition (vi) Breast feeding (vii) Sanitation and personal hygiene
Cost	INR 755, 072.
Place	Kalyan Dombivli Municipal Corporation, Maharashtra
Time Frame	Five years for the NGO to take the role of project partnership with the donor agency. The NGO initially leads the process then subsequently it withdraws and plays the role of facilitator, encouraging the initiatives from a less prominent position. Baseline survey in 2000. Three years for first phase of project, four years for second.
Advantages	Empowerment: As a tool for women's societal development. Women's position in the home and in the community is strengthened by knowledge and promotion of their reproductive rights Increase in demand generation for better services Education, health and social Multi-purpose: Project links social activism with the need for medical care Sustainable Once women's groups are formed, they require little funding to sustain them. Trained representatives can pass on information to large numbers of women. Community involvement: Through street plays and performances, all sections of community can participate or be entertained and informed
Challanges	Dependent on community participation: The project is owned and driven by the community. The implementing agency must ensure

	participation, the wrong approach may fail to gain people's confidence and result in a lack of response. Dependent on existence of groups: If the women's self-help groups are dismantled or become dormant the project could die. The NGO's role is to keep them active and alive. Requires constant networking between components: Missing any one of them will hamper the effectiveness of the project.
Prerequisites	Donor Agency, willing NGOs.
Who needs to be consulted	Local community, IPD Society, Local Government body
Risks	
Sustainability	Since the project is owned and driven by the women themselves it can be sustained after the withdrawal of the NGO and donor partner. The NGO can continue to ensure sustainabililty by quarterly visits and by providing support at community level for organising events.
Chances of Replication	SAPREM are planning to replicate the project in five other blocks of Thane district not presently covered by the UNFPA.
Comments	There have been success stories from this programme where women as individuals or in groups have come forward and set examples for others to follow. These include: (i) Collective action for provision of electricity (ii) Fight against contaminated water supply (iii) Construction of individual toilets (iv) Increased awareness of health and social issues
Contact	
Submitted By	Tessa Laughton, Research Consultant, ECTA, New Delhi. February 2005
Status	Active
Reference Files	Women - Community Empowerment project plans & budget.xls — Work Plan IPD-UMC Project on Women and Community Empowerment Women - Community Empowerment project proposal.doc — Project proposal on women and community empowerment Women gathered for presentation, Maharashtra.jpg — Women gathered for presentation, Maharashtra womens empowerment presentation, Maharashtra.jpg — womens empowerment presentation, Maharashtra
Reference Links	

191. Community Volunteer Initiative, Tamil Nadu

Subject Area="Behavioural Change Communication."	Objective="Community health workers."
Details for Reform Option "Community Volunteer Initiative, Tamil Nadu"	
Summary	**Background:** A lack of effective health education in rural/isolated communities leading to poor health and nutritional status of children and pregnant and feeding mothers. The problem was worsened by poor use of primary health centres and Anganwadi Centres (ICDS Centres). **Action:** The Tamil Nadu Science Forum (a local NGO, using funding from UNICEF) started the Arogya Iyakkam programme. They trained unpaid volunteers in each village to look after 125 families each with children under 5 years old. They followed them from pregnancy through to pre-school period in the hope of bringing about behavioural change. They discussed various issues and problems within the family and counselled them on a full range of subjects linked to health and nutrition of the children. They also weighed and measured the nutrition status of the children and encouraged the parents to make better use of existing health services. Each volunteer was supported by a motivated and trained full-time woman who looked after ten volunteers. A village health committee was formed with a number of women members along with elected Panchayat leaders to manage and monitor the project. **Results:** The programme was evaluated using data collected from the village health registers between May 1999 and February 2001. In the first 18 months of the programme, of 8,536 children (from 30,041 families in 197 villages) weighed, the percentage of children with a 'normal' weight increased from 36.25% to 46.69% - an overall increase of 10.5 %. It was identified that in some villages there was a strong intervention by the volunteers but in others there was no intervention and these villages were used as a control to monitor the programme. In 'control' (comparison) villages, the increase in percentage of children of 'normal weight' was 3.29%. In villages where there was effective intervention the percentage improvement was 15%. Number of village health activists trained: 238
Cost	INR 1.5 lakh per year for 60 villages or INR 2 per head of population covered.

Place	387 villages in 7 blocks from four districts in Tamil Nadu from May 1999 to February 2001. Funding (from UNICEF) was extended to February 2002 and has continued since with local support.
Time Frame	Seven months to establish contacts, funding and setting up self help groups in the villages. Took a further two years to implement in each village.
Advantages	Personalised approach: The programme ensured that each family was counselled individually based on their needs and their problems and supported with repeated visits. They were also linked to the VHN and the ICDS. Inclusive: The personalised approach meant that the whole family was involved. Behavioural change strategy: Good instrument for awareness raising throughout the community with more focus on education leading to behavioural change. Strengthens links: between health and Integrated Child Development Services (ICDS) workers. Health promotion: Appears to have positive effects on nutritional status and therefore, no doubt, on child survival prospects. Community ownership: Achieves significant community involvement in health/ nutritional issues and thus ownership. In this sense, reliance on non-paid volunteers is a strong-plus point.
Challanges	Funding: Possibly dependent on upfront donor funding to initiate action on a very large scale (though it seems that the social welfare department has adopted this approach without external funding). Volunteer reliant: The fact that the system depends on the goodwill of volunteers may have negative repercussions if local enthusiasm flags.
Prerequisites	Willingness of local community to participate.
Who needs to be consulted	NGO (in this case Tamil Nadu Science Forum), State Government, Panchayat members, ICDS, DH&FW.
Risks	
Sustainability	The scheme is based entirely on volunteer action so sustainability is reliant on their good will. They need good support and encouragement but are largely sustained by their increased status within the community.
Chances of Replication	This methodology has now been taken up by ICDS and by the Tamil Nadu H&FWD in a further series of districts. The model has also been replicated in Chattisgarh. Has since been extended

	and is being continued in 17 districts by the Tamil Nadu State Government.
Comments	The project was accepted by the community and it proved that using an individual family 'problem-centred' approach to IEC activities can be highly successful. UNICEF chose the programme as one of its 10 best programmes in the world and recommended it as a model to the State Government.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	
Reference Links	

192. Training adolescent girls to mobilise the community to use health services, Tamil Nadu

Subject Area="Behavioural Change Communication."	**Objective="Community health workers."**
Details for Reform Option "Training adolescent girls to mobilise the community to use health services, Tamil Nadu"	
Summary	**Background:** The success and sustainability of community health programmes primarily depend on the participation of the community. It was decided to make use of adolescent girls in the rural areas to create a greater demand for health services, particularly reproductive health services. **Action:** The programme selects non-school going adolescent girls (aged 15 to 18) from the villages and trains them at block headquarters for 5 days – three days at first, then a refresher day after 6 months and another refresher day after another three months. The training includes information on personal hygiene, menstrual hygiene and other problems for adolescents as well as about conception, antenatal (AN) care, danger signs during pregnancy and the importance of institutional deliveries and postnatal (PN) care. The girls are also taught about maternal and child health issues, empowering them to take care of/support pregnant women, following the advice of the Village Health Nurses (VHNs – Tamil Nadu equivalent of Auxiliary Nurse Midwives). They are also told who to contact if they fear a villager is contemplating killing a female child. Each girl is then expected to take care of 5 to 6 pregnant women and 5 postnatal women in their village, providing advice on diet, regular consumption of Iron and Folic Acid (IFA) tablets and the benefits of breastfeeding, as well as persuading them to use institutional services. **Results:** Has yet to be evaluated but will be monitored with a monthly review on the number of visits made by the adolescent girls to pregnant women; the number of women taking IFA; number of cases referred to VHNs/other hospitals; number of women having AN/PN care; number of newborns referred and number of infants fully immunised.
Cost	Workshop (5 days for 20 people) to finalise curriculum and methodology of training: INR 79,000. Cost of training 63 trainers for two days each: INR 55,020. Cost of training 10,500 girls (in batches of 50): INR 69,51,000. Background materials: INR 220,000 (€3,940) TOTAL: INR 73,05,020 (€130,836)

Place	Madurai and Theni districts, Tamil Nadu, from November 2002.
Time Frame	Two months to complete curriculum, methodology of training, select trainers and girls and get the approval of central and state government. Five days training workshop. Two days to train each trainer.
Advantages	Motivation: Younger girls are more open to new ideas and are keen to learn about their own bodies. Cost effective: For relatively little cost, healthcare provision is extended further out into the community. The girls can be involved in other health programmes at a later date. Empowering: The scheme makes the girls feel they are an important part of their community. It is hoped it may encourage some to go back to school.
Challanges	Written curriculum: Relies on a high level of literacy as the curriculum is written.
Prerequisites	Curriculum. District microplan (to help recruit the girls). Trainers.
Who needs to be consulted	State Government. Central Government (Ministry of Health and Family Welfare) Medical Officers at Primary Health Centres. Village Heath Nurses.
Risks	
Sustainability	Sustainable if the funding is in place.
Chances of Replication	Tamil Nadu Public Health department plan to extend the scheme to all districts under RCH2. The programme was approved by the GOI Ministry of Health and Family Welfare.
Comments	None
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	g.o_6 training adolescent girls.doc — Government Order: GO (2D) No 6 (21 January 2003) – Capacity building of adolescent girls to act as link persons between the community and the health service providers in Madurai and Theni Districts. CAPACITY BUILDING OF ADOLESCENT GIRLS -2.doc — Report: Capacity Building of Adolescent Girls to Empower them as Link Persons in the Community for Health Programmes (Tamil Nadu State Government).
Reference Links	

193. Female Infant Life-Saving Programme, Tamil Nadu

Subject Area="Behavioural Change Communication."	Objective="Improving sex ratio."

Details for Reform Option "Female Infant Life-Saving Programme, Tamil Nadu"

Summary

Background: Female infanticide was first acknowledged as an issue in Tamil Nadu, a State otherwise known for its high literacy rate and enlightened attitude to women, in the early 1990.Despite penal action and various government initiatives, the practice still continues in some districts although it is believed to be considerably reduced.

Action: Female Infant Life Saving Committees were formed at Health Sub Centre (HSC), block and district levels in order to educate, train and counsel the community. The HSC committee is made up of: Village Health Nurse; NGO representative; Mukya Sevika (female worker); teacher; Anganwadi worker; Panchayat (local council) presidents of local villages; self help group member; village administrative officer; police representative; adolescent link volunteers. The Block level committee is made up of: Panchayat union chairman; block PHC medical officer; block development officer; Child Development Project Officer (CDPO); NGO representative; Tahsildar (chief of block); police inspector/sub inspector.

The District level committee (which monitors the HSC and block committees) is made up of: district collector; police superintendent; joint director/ deputy director of medical services; health services deputy director; project officer; district social welfare officer; NGO representatives; programme officer Integrated Child Development Service (ICDS); any other member nominated by district collector. The HSC committee works at grass roots level to identify potential high risk families (defined as a family which already has one or more girl children or a family with a previous history of female infanticide). A list, updated monthly, is made of these families and the pregnant mother and her family is visited once a month from month 5 to 9 and every week from month 9 until the baby is two weeks old.

The Medical Officer will also visit the family once before and once after the delivery to certify health of the child. The committee will arrange priority care at the hospital and transport. The committee is trained by professional counsellors and given a handbook, listing all the various benefits available under government schemes, to supply to all high risk families. It also visits elderly women and the dais (untrained birth attendants) in the village and warns them of the possibility of

	prosecution if they bring pressure on the mother to kill a girl baby. The Block level committee meets once a month to discuss the progress of all activities and to monitor the HSC level committee. The District level committee also meets once a month to review the activities. It will identify villages where there were previously cases of female infanticide and after a year of no cases, will project them as a role model for others through the mass media. The training strategy includes a one day workshop for district level committee members; a one day course for trainers in each block; a one day training course for the block level team; the development of a curriculum and handbook for each committee and a one-day sensitisation training programme for district officers of health, social welfare, nutrition, women development corporation, police, rural development, education and Panchayat union chairmen etc to enlist their support and cooperation. **Results:** Has yet to be evaluated.
Cost	INR 65.5 lakh for two districts. Breakdown of costs: Trainers training INR 1,77,00 HSC committee training INR 21,50,00 Block committee training INR 2,00,70 District sensitisation training INR 60,00 (€106) HSC meeting expenses INR 7,86,00 (€1,392) Travel expenses INR 6,55,00 (€1,160)
Place	Madurai and Theni districts of Tamil Nadu since 2002.
Time Frame	Selection of committees. One day training for each committee. Development of curriculum and handbook by RCH directorate.
Advantages	Personal approach: Delivers the message at grass roots level and directly confronts families who may be considering killing a girl child. Community ownership: Involves the whole community so that no one individual is working to tackle the problem. In the past informants faced the wrath of the community.
Challanges	None identified.
Prerequisites	Formation of committees. Government Order.
Who needs to be consulted	State Government health and family welfare department. Community leaders. NGOs. Police.
Risks	
Sustainability	Sustainable if the funding is available.
Chances of Replication	Tamil Nadu State Government plans to extend this scheme to Dharmapuri, Salem and Namakkal districts (where female infanticide is still practised) under the RCH2 programme.
Comments	None

Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	GO.doc — Government Order G.O.Ms.NO.81 dated 26.12.2002 Social mobilization activity against the female infanticide and foeticide.doc — Proposal: Social mobilisation activity against the female infanticide and foeticide (Tamil Nadu State Government Public Health Department).
Reference Links	

194. Devi Rupak Yojana, Haryana

Subject Area="Behavioural Change Communication."	Objective="Improving sex ratio."
Details for Reform Option "Devi Rupak Yojana, Haryana"	
Summary	**Background:** The Population in Haryana has been steadily increasing from 1 crore (10,000,000) in 1971 to 1.6 crore (16,000,000) in 1991 and 2.1 crore (21,000,000) in 2001. At the same time, sex ratios are declining from 867 females (per 1000 males) in 1997, to 865 in 1991, and 861 in 2001, one of the lowest in the country. **Action:** In order to stabilise the population and tackle the skewed sex ratio in the state, an incentive scheme has been introduced wherein parents are encouraged to undergo sterilisation following the birth of one male or two female children. A monthly pension is paid from the date of undergoing a terminal method of contraception (vasectomy or tubectomy) and is promised for 20 years. The incentive amount is INR 500 if the couple have just one child and it is a girl. If they have one child and it is a boy then the amount is reduced to INR 200. This amount is also offered to couples who have just had their second child giving them two girls. This scheme is applicable only for people who are not income tax payees and the money is credited to the couple's joint-account in the post office. The husband and wife should also be aged less than 45 and 40 years respectively on the date of adoption of the scheme. The scheme, which was started in September 2002, was revised in November 2003 to make it simpler and more acceptable to the community. Initially, the couple had to undergo the vasectomy or tubectomy immediately following birth - now they are allowed to wait until the child is 5 years old. The original scheme was segregated into two categories: i) couples married before 25 September 2002 had to register their intent to take up the scheme before 26 January 2003 to be eligible; and ii) couples married on or after 25 September 2002 had to register and state that their first child would not be born before they had been married for two years or that their second child would not be born until two years after the birth of their first daughter. These requirements made the scheme too complicated and now all couples below the age of 45 (men) and 40 (women) are covered, irrespective of their date of marriage and are permitted to wait until their child is 5. Also under the initial scheme, if the beneficiary underwent

	recanalisation (a reverse of the tubectomy or vasectomy), they would have to refund the entire amount along with interest of 9% per annum. Under the revised scheme, if the child dies and the beneficiary undergoes recanalisation, the benefit will be stopped but past benefits will not be recovered. A number of Information Education Communication (IEC) activities were conducted to promote the scheme including wall paintings and messages on public buses, newspaper advertisements, puppet shows, street plays, posters and pamphlets. **Results:** A total of 181 cases were registered under the scheme in the year 2002-03 which increased to 426 after the scheme was amended (until October 2004). A district-wide survey on socio-economic status was conducted in both the years 2002-03 and 2003-04. Both found that the majority of those who adopted the scheme after the birth of the first male child worked in agriculture had an annual income between INR 10,000-30,000 and practised Hinduism. The age of men who accepted was between 25 and 34 in both years of the scheme, but the age of women fell from 25 to 34 years in the first year (2002-03) to between 15 and 24 years in 2003-04.
Cost	The budget provision for the year 2002-03 was INR 15 lakhs and for the year 2003-04 was increased to INR 26 lakhs.
Place	Haryana since September 2002, with revisions introduced in November 2003.
Time Frame	A maximum of six months. Haryana was able to do this in two months.
Advantages	Currently politically backed: State scheme announced by the chief minister.
Challanges	Relies on political will: Could be discontinued on change of government.
Prerequisites	Political will. IEC - needs to be publicised so that persons below the poverty line (BPL) who are often illiterate, know the scheme exists.
Who needs to be consulted	State and district level officials.
Risks	
Sustainability	Good if the political will exists in the form of budget allocation, especially on change of government.
Chances of Replication	Good. Any state could adapt the scheme once provision of funds is ensured. Punjab is planning to replicate this scheme (Further information available from Director, Health & Family Welfare, Government of Punjab, Parivar Kalyan Bhawan Sector-34-A Chandigarh Ph.No. 0172- 2600455).

Comments	Other states have implemented similar schemes: In Tamil Nadu, women who undergo tubectomies after two girl children are issued bonds of INR 15,000 for each child which can be claimed only after the girls have passed class X. There is some concern that now Haryana has had to extend its scheme to allow parents with one girl child to try for a second child, the object of population control is defeated. To control the population explosion in the state, statisticians say parents need to be limited to one child only.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, October 2004.
Status	Active
Reference Files	
Reference Links	

195. Promoting HIV/AIDS education through targeted mass media communications, Maharashtra

Subject Area="Behavioural Change Communication."	**Objective="HIV/AIDS awareness."**
Details for Reform Option "Promoting HIV/AIDS education through targeted mass media communications, Maharashtra"	
Summary	**Background:** A review of existing research revealed high-risk attitudes and behaviour prevail among men in the lower socio-economic groups in Mumbai, which has the largest brothel-based Commercial Sex Workers (CSWs) area ('red light district') in India. Most HIV/ AIDS preventions in the city had focused on educating and empowering the CSWs in the red light district with varying degrees of success. However, it was recognised that work needed to be done in motivating their clients to practice safe sex across the city in a sustained and effective manner. **Action:** Population Services International (PSI) carried out an aggressive communication campaign using the principle that people can learn by observing the behaviour of others. They (with the help of advertising agency Lowe) created an 'alter-ego' in the form of a fictional character named 'Balbir Pasha'. Through a mixture of strategically-placed outdoor communications (billboards, posters on trains and buses), hard-hitting television and radio messages and comprehensive newspaper exposure, this character was portrayed in various intriguing scenarios, serving as a behavioural model for consumers of Mumbai mass media to relate to, learn from and empathise with. By gradually unravelling each of the 'Balbir Pasha' scenarios in an approachable and familiar manner, the campaign succeeded in building intrigue, personalising HIV risk and bringing the topic of HIV/ AIDS 'out of the closet' in a unique, hard-hitting manner. The campaign included promoting an HIV/ AIDS helpline, voluntary counselling and HIV testing services as well as on-the-ground interpersonal communications. Key activities: The campaign devised a 'positive preventive message' rather than using scare tactics and concentrated on known attitudes and false beliefs eg that 'healthy' looking people could not be carriers of the HIV virus. It released each stage of the 'story' over a period of four months, thereby increasing the intrigue and 'gossip value', similar to a television soap opera. The campaign began with a 'teaser' and then used key insights about a particular target group in the

	hopes of prompting members to question their own behaviour. The final stage of the campaign asked them to contact an HIV/AIDS helpline for more advice. **Results:** An independent research agency TNS MODE evaluated the impact of the campaign by conducting studies at the beginning and the end. Though faced with some criticism for its frankness, impact studies and other data demonstrated that the campaign achieved phenomenal reach and that those exposed to its messages exhibited marked knowledge acquisition, attitude change, and understanding of risk and behaviour change with regard to HIV / AIDS.
Cost	Approximately INR 2.5 Crore (after securing a 40% discount because the campaign spread social awareness). Of this amount, about INR 1 Crore (€178,325) was spent on hoardings. The balance was spent on TV, radio and press campaigns. For the helpline, major start- up expenditures (including software, equipment, recruitment, training) came to an estimated INR 25 lakh . Monthly operational costs (call centre costs, staff pay etc) are approximately INR one lakh (€1,783) (not including supporting communications campaigns or monitory and evaluation studies). Programmes replicating the helpline would have substantially lower start-up costs as they would not include development and ownership costs of the software programme. The cost for starting up a new helpline in India is an estimated INR 13 to 15 lakh (€23,179-26,745).
Place	Mumbai, November 2002 – February 2003.
Time Frame	Two to three months.
Advantages	Personalised: By developing a character that the target consumer could relate to, the campaign was able to personalise HIV risk, which resulted in attitudinal shifts among those exposed to the messages. Familiarity: Much of the reason the campaign's main messages made such an impact is attributable to the intrigue that was built up by the preceding teaser campaign. Familiarity with the character of Balbir Pasha gave the target consumer the opportunity to form a relationship with this character before the main precautionary HIV/ AIDS campaign was introduced. Wide-reaching: The effective use of a variety of communication media, eg. train posters, billboards, television, etc. was especially relevant to achieving the high visibility of the campaign's messages.
Challanges	Open to criticism: Can attract criticism for its frank approach towards sexuality. The campaign was also considered to be 'anti-women' by some as it depicted that the male character

	could be at risk of getting AIDS by having unprotected sex with a woman, thereby implying that HIV is passed on from women to men. Some women by the name of Manjula (the female character) took personal offence and some women's groups argued that as the name Manjula is a Hindu name, the campaign targeted this specific religious group. PSI had to channel its efforts and resources towards defending its campaigns and in fact agreed to end its theme-based campaign 4 days earlier than planned.
Prerequisites	Detailed research into lifestyle, attitudes and beliefs of target audience. Campaign tailored to those attitudes and beliefs. Helpline.
Who needs to be consulted	State govt (particularly health and AIDS cells); NGOs working in HIV/AIDS
Risks	
Sustainability	Calls to the PSI helpline have been increasing post 'Balbir Pasha' in Mumbai and mass media communication campaigns have continued to promote it. As of March 2004, the helpline was still receiving on average 2000 calls per month.
Chances of Replication	Replicable although the campaign must be tailored to account for regional and cultural differences. It has been successfully replicated in the cities of Vizag, Chennai and Kolkata. Regional adaptation of Balbir Pasha was done in the south to become the 'Puli Raja' campaign.
Comments	The project was innovative, accepted by the community and provided 'value for money'. However, it may be noted that the campaign is being run in parallel to the existing health system interventions (government) and, given the criticisms faced during the Mumbai campaign, it is necessary that key stakeholders in a city be taken into confidence prior to introducing the campaign, in order to build up an 'ally base' that can help protect the full execution of the campaign messages.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	Balbir Case Study_FULL VERSION .pdf
Reference Links	

196. The HAMARA Project, Rajasthan

Subject Area="Behavioural Change Communication."	Objective="HIV/AIDS awareness."
Details for Reform Option "The HAMARA Project, Rajasthan"	
Summary	**Background:** It is now largely accepted that an important cause of the spread of Human Immunodeficiency Virus (HIV) is the migration of young men to large cities for employment, leaving behind families in the rural areas. In India, the National AIDS Control Organisation (NACO) considers the State of Rajasthan a low prevalence State. However, the economic realities and socio-demographic milieu makes it vulnerable to HIV because many men are being forced to leave their traditional roles as agricultural labourers due to drought and are moving to big cities to find work. The State's vulnerability to HIV is also increased by the presence of a number of mines attracting migrant workers. Heavy traffic passes along its national highways, bringing truck drivers who engage in casual sexual activity. In order to meet the challenge posed by HIV/AIDS, the Canadian International Development Agency (CIDA) provided assistance through the India Canada Collaborative HIV/AIDS Project (ICHAP). One major initiative under this assistance was to design, implement and demonstrate a replicable programme model for HIV prevention and care for migrant men and their sexual partners from two states - Rajasthan and Karnataka. The project is referred to as the HAMARA project. **Action:** The Rajasthan HAMARA project works in the Shekhawati region of Rajasthan (place of origin) and in Ahmedabad, Gujarat (place of transit) and Mumbai, Maharashtra (place of destination). The primary target groups are the spouses of migrants including the return migrants and potential migrants. The ICHAP collaborated with the State AIDS Control Society and partnered with four organisations for designing and implementing the programme - Bhoruka Charitable trust, M.R. Morarka GDC Rural Research Foundation, Saral and Jyoti Sangh. (i) Needs assessments: A situation needs assessment was done in all blocks of three districts of Rajasthan – Churu, Jhunjhunu and Sikar in October- December 2002. At the same time, a needs assessment was done in Mumbai (place of destination). (ii) Baseline study: A baseline study was done during January-March 2003 in those blocks that showed high out migration

and cases of HIV were identified.

(iii) NGOs identified: Identified the grass root level agencies to implement the programme at place of origin, transit and destination. The two agencies selected have been working in remote corners of the Shekhawati region and work in tangent with Rajasthan State AIDS Control Society.

(iv) Training: Capacity building exercises were done for the partnering implementing agencies and HAMARA designated staff to work in the area of Sexually Transmitted Infections (STI), HIV, AIDS and public health approaches. The training was on how to carry out community needs assessment, how to talk about sex and sexuality, how to work with high-risk groups and the general population and how to promote condom use and STI treatment.

(v) Cluster offices opened: In the areas of operation, the implementing partners opened cluster offices for every 18,000-20,000 population and for each cluster recruited one male and one female health worker. Other staff involved in implementation included one project coordinator, two assistant project coordinators and 5 administrative staff for the whole project.

(vi) Links formed: The project established linkages with the Government-run Primary Health Centres (PHC). This included training 50 PHC doctors on syndromic management of STI/Reproductive Tract Infections (RTI) and care to people living with HIV/AIDS and involving them in holding STI camps in villages. Medicines were procured and distributed to PHC doctors for management of STI cases. The partnering agencies mobilised community support by partnering with smaller partner non-government organisations in the area of operation. Village Health Committees (VHCs) were formed in every village and the platform was used for HAMARA programmes.

(vii) Condom depots: The project established condom depots at strategic locations within the villages. The needs assessment studies and baseline survey undertaken at the beginning of the project revealed that the reason for low condom use was difficulty in accessing free condoms. In Rajasthan, each village is divided into mohalla (locality) and in each mohalla a meeting was organised to identify condom depot holders. In keeping with the culture of the area, the meeting was arranged separately for men and women. The project now has 50 condom depot holders and half of them are women. The condoms were provided by the government sources.

(viii) Peer educators: Male and female Peer Educators (PE) were selected from the villages. The PE was the contact between the implementing agency and the community. They used to report

	to health workers of HAMARA project. About 1,200 volunteers were selected and trained to carry out household surveys, identify potential migrants and refer cases from the community to PHCs run by government and NGOs. (ix) Publicity: The project developed a lot of communication material on HIV in the Hindi language such as flip STD cards, stickers, pamphlets, snake and ladder games related to HIV, booklet etc. (x) Monitoring: The project prepared a household register consisting of household characteristics including migration status. The PE updated the register regularly for identify potential migrants and arrange one to one or one to group meetings. (xi) Destination: From mid-late 2004, Hamara has been working with Rajasthani migrants in Piplaj, Ahmedabad and in Kherwari, Mumbai. In Ahmedabad, local resource agency, SARAL, and an NGO, Jyothi Sangh. In Mumbai, ICHAP is undertaking direct implementation with Rajasthani staff recruited through one of the Hamara partner NGOs in Rajasthan, BCT. In Ahmedabad, through a partner NGO, an outreach team of six is reaching almost 3,500 Rajasthani migrants. This outreach team distributes free condoms, conducts VCT and STI referrals, and organizes popular IEC cultural events. A team of 15 trained Shekhawati peer educators is in place to support community outreach. In addition, 17 condom depots have been established. In Mumbai, 6-person outreach team distributes free condoms and provides VCT and STI referrals, and reaches 2,200 Shekhawati migrants. Seven peer educators have been trained and support program outreach. The Rajasthan States AIDS Control Society (RSACS) was involved from the very beginning of the HAMARA project i.e., in the design, training and monitoring of the project. At the destination level (in Ahmedabad and Mumbai) there is also a technical agency monitoring the project and providing all the technical support. Overall project management responsibility is with the Project Officer who reports to the State Coordinator. **Results:** The project covered 30,000 Migrants, 24,000 migrants' wives and 6,000 "potential" migrants. The key achievements of the project are as follows: (i) Condoms are promoted through condom depot holders, separately for men and women in all villages. (ii) An enhanced STI management system with quality referral service is operational in all sites. Over 70 government doctors

	have been trained in syndromic case management. (iii) The capacities of 2 Non-Governmental Organisations (NGO) – Borukha Charitable Trust and Morarka Foundation have been strengthened for effective programme implementation. The two agencies, in turn, are partnering with 8 grass root level NGOs. (iv) During the project period in 133 villages spread across Sikar, Jhunjhunu and Churu, the project was able to identify 4,609 STI cases and 3,735 cases were treated. (v) The condom use at the beginning of the project was almost negligible in the project area. The available statistics culled from monthly progress report of the project shows that by the end of February 2006, the cumulative condom distribution figure was 1,319,513 at district of origin in Rajasthan. (vi) Awareness on STI/HIV has increased. The number of one-to-one contacts and one-to-group contacts was 62,537 and 1, 19,249 respectively. After the completion of the project in March 2006, the activities undertaken in HAMARA will be up-scaled by Rajasthan State AIDS Control society. Till this happens, a trust namely, India Health Action Trust has been formed to oversee the project activities.
Cost	About INR 80 lakhs for the project period 2001-2006.
Place	In Rajasthan, the project spread across the Shekhawati Region (in 133 villages from eight blocks in the districts of Churu, Sikar and Jhunjhunu). Also covered 4,500 migrants in Ahmedabad and 3,000 migrants in Mumbai 2004.
Time Frame	Around 6-8 months.
Advantages	Ownership: Adoption of participatory processes at all stages improves the efficiency of the project implementation. Flexibility: There was an in-built flexibility in the programme design that could accommodate emerging needs. Linkages: Training the government doctors in STI management and linking the grass-root NGO functionary with government set-up improves utilisation of government facilities. Design: Proper understanding of the field area that is high and low prevalence pockets within the district ensured better implementation of the project goals. Model: An innovative cyclical model addressing HIV and migration in the informal sector.
Challanges	Low Prevalence: Rajasthan is listed as a low prevalence State, thus there is a little understanding and response at all levels

	towards HIV. Geography: Drought situation leads to out and return migration on a large scale. Also, rural nature of the epidemic means that target areas are geographically diverse and it is a challenge for the government health services to address the preventive and curative aspect of STI/HIV. Funds: Require funds to cover all the villages at risk. Project implementation: Success depends largely on how long the project has been operational at field level.
Prerequisites	Availability of funds. Flexible project design. Trained and devoted human resource. Involvement of government official and NGOs. Community involvement. Local experts.
Who needs to be consulted	Community leaders. Local administration. Senior bureaucrats in health ministry and implementing partners. Bhorukha Charitable Trust, Churu, Rajasthan Morarka GDC Rural Research Foundation, Rajasthan. Saral, Ahmedabad. Jyoti Sangh, Ahmedabad.
Risks	
Sustainability	The current funding to the project from CIDA is coming to an end in March 2006 so ICHAP is trying to receive funds from other interested agencies so that the project can be sustained.
Chances of Replication	The project has been greatly appreciated by the different agencies, senior government officials and experts who are advocating for its replication in the other districts and States. ICHAP has also documented its best practices to share its learnings with other agencies doing similar work.
Comments	The project may be considered a successful model addressing rural out migration by having a linked program at place of origin, transit and destination. However, for up-scaling of such programmes, it may become sometimes a challenge to work in tandem with so many organisation/institution and also developing appropriate monitoring tools. Community participation and capacity building of project staff, service providers and community volunteers is the key to success.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, NIMS, New Delhi, March 2006.
Status	Active
Reference Files	1.jpg 2.jpg 3.jpg 4.jpg
Reference Links	

197. Health education of adolescents, Maharashtra

Subject Area="Behavioural Change Communication."	Objective="Adolescent health."
Details for Reform Option "Health education of adolescents, Maharashtra"	
Summary	**Background:** Although the district of Satara in Maharashtra has relatively better health indicators, there is still a low age of girls at marriage, a high number of home deliveries by untrained persons, low awareness levels among adolescents on reproductive health issues and a lack of technical and communication skills amongst paramedics to address these issues. Giving adolescents health education would go a long way towards preventing possible health hazards and changing the community's behaviour which will have a long term impact on Reproductive Child Health (RCH) indicators. **Action:** The Health Department of the Zilla Parishad (district level government office) at Satara has initiated a component on adolescent health as part of the Sector Investment Programme in the district. This includes providing health education, medical examinations and treatment for all adolescents (11-17 years). Activities undertaken included (i) Sensitisation workshops and training of its staff including Medical Officers (MOs), Auxilary Nurse Midwives (ANMs), Anganwadi workers (AWWs) and headmasters and teachers at schools. (ii) Health check-up camps. (iii) Preparation and distribution of health check-up cards and booklets on adolescent health education. Booklets include information on growth patterns of male and female, diet and exercise. While teachers are trained to give health education to adolescents attending school, the AWWs are trained to educate those not in school. MOs conduct the health check-ups and follow up. It was decided that in one block, trainings would be undertaken by an NGO- Parivarthan. They have now completed trainings in two rural blocks (Koregaon and Jawali) and are in the process of training teachers in Satara block. Along with this component, various other activities are undertaken to increase the age of girls at marriage. These include meetings with parents at the village level by ANMs and MOs, meetings with Sarpanchs at block level and meetings with priests and printing press owners. The ANMs keep a check and maintain a register of all girls in the age group 15-18 years in

	their locality. Information Education and Communication (IEC) activities such as distribution of hand bills and slogan displays are undertaken. Newly weds who have waited for the legal ages at marriage are felicitated every year on World Population Day. **Results:** In 2000, the percentage of girls married before the age of 18 was 21.9%. This has decreased to 5.4% by March 2004. Approximately 40 marriages of girls below 18 have been avoided due to the spread of information. Now it is common practice to ask for age certificates before a marriage can take place. 586 secondary schools were covered under the adolescent health education programme.
Cost	Approx. INR 25 lakhs in the first plan of 18 months (September 2001-March 2003). The second plan (April 2003-Dec. 2004) had a budget of INR18 lakhs . Approx. INR 8.4 lakhs and INR18.1 lakhs budgeted for the first and second year respectively, for the component on raising age at marriage.
Place	Satara District, Maharashtra since September 2001.
Time Frame	Six months.
Advantages	Intersectoral coordination: Between health, ICDS staff and school teachers. Educational: Addresses the need for basic knowledge on health and sex issues which adolescents would otherwise never get. Behaviour change: All adolescents are possible future parents and so awareness would definitely reduce problems such as early age at marriage and home deliveries.
Challanges	Possible Opposition: Reluctance by teachers to talk to students about sex related issues. In Satara for instance, teachers were initially wary but were more comfortable after the first training. A number of re-orientations have since been conducted.
Prerequisites	Good communication between AWWs and school teachers. Public Private Partnership with NGOs to provide training.
Who needs to be consulted	Health and Family Welfare department officials at state, district and sub district levels, school principals and teachers, ICDS workers-AWWs, NGOs with ability to provide health education trainings.
Risks	
Sustainability	Needs initial support in terms of conducting training, preparation and printing of health cards and booklets.
Chances of Replication	Good provided proper situational analysis, planning, monitoring and evaluation is undertaken.
Comments	None
Contact	

Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, February 2005.
Status	Active
Reference Files	
Reference Links	

198. Life Skills Programme, Maharashtra

Subject Area="Behavioural Change Communication."	Objective="Adolescent health."

Details for Reform Option "Life Skills Programme, Maharashtra"

Summary

Background: A study by the Institute of Health Management (IHMP) in Pachod into the reproductive health of women living in the Paithan block of the Marathwada region of Maharashtra showed that:

(i) The median average age of girls at marriage was 14.5 years.

(ii) The average age at first conception was 16 years.

(iii) 90% of married adolescents conceive before the age of 19.

(iv) 60% of girls who abort develop severe complications.

(v) 60% of girls in the adolescent age group are anaemic.

Action: To improve the social status of these girls and reduce their mortality and morbidity levels, IHMP developed a one-year course on life skills. This course was developed after several meetings and workshops with the adolescents and their parents. The course consists of 225 one-hour sessions and 36 hours devoted to a community project. There are five sections:

(i) Social issues and institutions.

(ii) Local government bodies.

(iii) Life skills.

(iv) Child health and nutrition.

(v) Health. The community project deals with Non-Formal Education (NFE) and nutrition education for mothers. Each literate girl is expected to adopt a few illiterate girls and make them literate through NFE. This course is taught 5 times a week over 10-12 months. Three sessions a week focus on skills on how to improve social and health status. One day a week is devoted to art and craft and one day is kept for the community project. The classes are conducted by a woman from the community and at a convenient time and place. There is also a monthly visit and discussion with parents.

Results: The impact of the programme is evaluated once every three months. The results over the last three years have shown a

	significant increase in the median age of girls at marriage from 14 to 17 years. The self-confidence of the girls noticeably increased due to new communication and leadership skills.
Cost	Estimated Cost: Total cost of conducting the programme in a year would be INR 1,400,000 . For break-up and unit costs, check the word document link below.
Place	Seventy-two villages, 100 sites in Paithan Taluka, District Aurangabad, Maharashtra with Pachod as the base. Started with preparatory phase in 1997. The actual intervention started in 1999.
Time Frame	Two years - one for needs assessment and another for preparatory phase and pre-testing.
Advantages	Empowerment: Improvement in the social status of girls. Education: Decrease in the health problems of adolescent girls and married women.
Challanges	Possible opposition: From parents and the elderly, especially towards the module on sexuality, sexual health and reproductive health. In this case, this was dealt with by ensuring that this module was taught only to girls above the age of 14. Letters were sent to every parent for their consent.
Prerequisites	Participatory need assessment with adolescent girls. Workshops with parents for needs assessment and to develop curriculum. Workshops with experts to plan training objectives, content, methods and materials. Developing material and pretesting. Consensus building (with the parents and community). Identification and selection of community based workers and their training. Establishing village health committees to monitor and solve problems. Developing instruments for monitoring and evaluation.
Who needs to be consulted	Local population especially, adolescents and their parents; Body imparting technical assistance (in this case IHMP)
Risks	
Sustainability	Fair. Parents have now started paying a fee and the village contributes towards the teacher's costs.
Chances of Replication	The state government has decided to go ahead with a larger scale replication. The Government of Maharashtra has adapted the content of the manuals and is implementing this programme through Integrated Child Development Services (ICDS) workers. UNFPA has adapted the manuals for use by NGOs and corporation workers in the districts and municipal corporation areas where they are providing support.
Comments	None.
Contact	

Submitted By	Dr Christopher Potter, Former Team Leader, European Commission Technical Assistance, New Delhi. April 2003.
Status	Active
Reference Files	B2- Female Empowerment for RH - Life Skills_FINAL.ppt — Powerpoint presentation “Impact of Life Skills Education on Age at Marriage of Adolescent Girls” made at the 31st Annual Global Health Council Conference: June 1 - 4, 2004
Reference Links	

199. Street theatre as an Information, Education & Communication tool, Tamil Nadu

Subject Area="Behavioural Change Communication."	Objective="Community advocacy."
Details for Reform Option "Street theatre as an Information, Education & Communication tool, Tamil Nadu"	
Summary	**Action:** Itinerant street theatre (known in Tamil as Kalaipayanam) was incorporated in a campaign on health and gender issues in the Dharmapuri district of Tamil Nadu, funded by DANIDA. With the focus on creating awareness about female infanticide, women's empowerment and community participation in health, a number of skits and songs were developed at workshops under a professional street theatre playwright and director. A team of street theatre activists working full time with the district mass literacy campaign helped to shape the language and idioms to give them local colour and authenticity and they also served as master trainers. The active involvement of key officials was a significant feature of the effort. The themes touched upon were: (i) violence against women; (ii) early marriage and frequent childbirth; (iii) rights to reproductive choice, education and employment; (iv) dowry, the preference for sons and the wider context of patriarchy which provide the basis for the practice of female infanticide; (v) the importance of antenatal care and institutional delivery in minimising maternal deaths; (vi) the need for male participation in reproductive and sexual health; (vii) the exploitative character of commercialised private health care and (viii) the right of people to access public primary health care. Around 280 persons, a third of them women, were gathered together in 18 theatre troupes and trained for a fortnight. Over a period of 40 days, they presented 140-150 performances each lasting 60-90 minutes. The programme kicked off with a colourful rally involving the Minister of Health and the Minister of Information and Publicity. In every primary care centre, a

	team was formed to liaise with community leaders over the purpose and timing of the campaign and the facilities needed for the performance and the artistes. Between 26 April and 12 June (1998) – approximately 3,000 performances were conducted before a total audience of 8,00,000 people. **Results:** Baseline and end surveys were conducted to assess the impact of the street theatre programme on the behaviour of the community. The street theatre campaign seems to have provoked a large and statistically significant increase in the average number of outpatient attendance at Primary Health Centres (PHCs) in the district and a substantial increase in the number of deliveries at PHCs. However, it is important to note that the IEC effort at Dharmapuri was even more about community mobilisation than it was about communication and information. It was noted after the campaign that several local communities had formed sub-centre committees and given valuable land at the centre of the village for a new sub-centre, participating in planning and helping with construction.
Cost	A major portion of the costs are one time investments. The main recurring costs are the incentives given to the performers.
Place	Initially Dharmapuri district, Tamil Nadu, between April – June 1998. Kalaipayanam activity was started in Dharmapuri district and extended to Thiruvarur district in May 1999. Based on the success this programme was extended to one of the RCH sub-project districts Theni. The Kalaipayanam activity was slightly modified for another sub-project district Madurai. Based on the success at Madurai, the modified Kalaipayanam activity is under progress in Vellore district (September 2004). Under RCH II this activity will be extended to all districts of Tamil Nadu.
Time Frame	Policymaker's clearance: one month Funding support from the agency: one month Proposal to get Govt approval and allotment of funds: one month Selection of topics for IEC/BCC: one month Selection of script writers for drama, lyrics for songs etc. : one month Selection of place for practice/ rehearsal: one month Selection of artists from the health functionaries, social welfare functionaries, NGOs, women groups etc. : one month Procurement of musical equipments, audio and lighting equipments: one month Formation of block level troupes: one Script writing and approval of scripts from the programme managers: one month Selection of master trainers and training them and training of the block level team: two months Actual conduct of Kalaipayanam activities in the village: continuous activity Some activities can be combined and can be carried out simultaneously.
Advantages	Attention grabbing: The street theatre performances focused attention on health and gender issues and generated a great

	deal of discussion, providing a rallying point for health workers, activists and community leaders.
Challanges	Misses some sectors of society: It seems that theatre performances were not acceptable to some people belonging to the minority community. Possible opposition: From health functionaries who may consider this activity as an additional workload and from service providers who may fear that the community will now demand quality services due to increased awareness.
Prerequisites	-- Clear and simple messages. -- Trained performers. -- Good venues and times for the performances.
Who needs to be consulted	Policy makers and programme managers. District health managers. Health and health-related officials, NGOs, women's groups, Panchayat leaders. Communication experts.
Risks	
Sustainability	Depends upon funding however costs are minimised by selecting the performers, who must all have suitable skills, on a voluntary basis.
Chances of Replication	Good. The project has already replicated well across various districts in Tamil Nadu (see Location box).
Comments	None
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	PROD68-2.jpg — Performers at street theatre, Andipatti PROD68-1.jpg — Children enjoying performance PROD68.jpg — Health workers performing street theatre GO.doc — Government Order G.O. (2D) No. 5 dated 13.1.2003 regarding Kalaipayanam troupes based at Madurai and Theni districts.
Reference Links	

200. Women Counselling Centres, Mizoram

Subject Area="Behavioural Change Communication."	Objective="Reduction in vulnerability of young women to HIV/AIDS."
Details for Reform Option "Women Counselling Centres, Mizoram"	
Summary	**Background:** Bordering Myanmar and Bangladesh, the northeastern state of Mizoram has a high prevalence of Human Immunodeficiency Virus (HIV). Its population of 8.9 lakhs (Census, 2001) spreads across 8 districts and is majority Christian. Female literacy is high at 86% yet. HIV prevalence among high-risk group is over 1.5% with 429 HIV positive women (State AIDS Control Society, 30.04.05). This number is increasing daily. High literacy coupled with partial awareness of medication and use of unprescribed tablets for sexually transmitted diseases (STDs) indirectly increases the vulnerability of the population. According to the United Nations (UN), there is lack of support system to address the individual problems of women in spite of the strong network of existing community-based organisations (District Situational Analysis conducted for 3 months in 2002 prior to the programme). **Action:** In response to India's HIV/AIDS epidemic, a project known as Coordinated HIV/AIDS response through capacity building and awareness (CHARCA) was formulated by a joint UN system in 2001. Aiming to reduce the risk of HIV infection among the most vulnerable sections of the society, particularly adolescent girls aged between 13 and 25, it will cover six Indian states. The project encourages women to protect themselves against HIV and Sexually transmitted infections (STIs) and realise their rights. Vulnerability is reduced by providing information, improving their skills and access to quality services. Five districts of Mizoram were selected for the project. The aim is to mainstream the activities under the project into the ongoing National programmes. Following the development of District Action Plans and a Log frame, two baseline surveys were conducted: on impact parameters and communication planning and on awareness and understanding of myths and misconceptions associated with drugs and HIV/STIs in Mizoram (final results expected by July 2005). Training of 900 women counsellors for three days was undertaken. Of these, 300 will be selected as peer educators and appointed at centres where young girls can come together,

	interact and have group discussion and counselling on HIV/AIDS. So far 510 counsellors have been trained, of which 170 peer educators have been selected. 13 drop-in-centres have been set up in the 3 district headquarters. 289 villages where there is a Mizo Hmeichhe Insuihkhawm Pawl (MHIP) (the largest women's federation in the State) have been selected for the implementation of the project. Women's centres have been set up at the MHIP offices in these villages. They function on the same lines as the drop-in-centres but at the village level. CHARCA has built capacities of trainers (master trainers, key stakeholders, members of MHIP at both district and village levels) on gender and HIV issues and conducted Training of trainers (TOTs) for each district. Information, education and communication (IEC) plans were drawn up covering vulnerability of women, HIV/AIDS, drugs, general knowledge and sex & sexuality, using gender specific IEC material, radio jingles, talk shows and Young Mizo Association (YMA) newsletter. Guidelines were developed incorporating gender concerns in HIV. Materials were developed in the local language on women's vulnerabilities issues, resulting in greater outreach and awareness generation on the theme and identification of critical gaps (the existing IEC material from various departments on HIV/AIDS and other programmes was analysed (including hoardings, posters, banners, pamphlets) and was made gender specific by 2 IEC consultants). Key stakeholders from various ministries as well as health workers, the media, church leaders and community-based organisations have been sensitised on the gender dimension and the project strategy. Other tools employed include: (i) A CHARCA film for awareness generation on women's vulnerability. (ii) Music bands to sensitise young audiences. (iii) Dramas, with the women's vulnerability issue as its main theme. Monitoring and evaluation framework were developed, such as formats for peer educators and NGOs to report to CHARCA. In addition, the community representatives have collated a resource directory giving information on all existing schemes and resources. This will be distributed to all the NGOs and peer educators, to assist in the referral of the target group for vocational training and medical services. Institutional mechanisms (infrastructure and staff) at the districts are in place. **Results:** As it is a very new programme, the results have not been evaluated so far.
Cost	Training cost: For 40 to 45 women counsellors for three days,

	approximately INR 35000 to INR 45000 . (This includes travel allowance, a training kit and refreshments.) One time cost of INR 5000 per centre to MHIP for refurbishment. Monthly honorarium per Peer Educator: INR 2000. Approximately INR 30,000(€576) given to NGOs where peer educators have been placed for documentation and reporting.
Place	289 villages in three districts of Mizoram namely, Aizwal, Kolasib and Champai since August 2004.To start in the districts of Mamit and Serchip in 2006.
Time Frame	Three years.
Advantages	Issues addressed: Subject of women's vulnerability discussed with a range of stakeholders. Creates alliances: New partnerships forged between Governmental and non-governmental organisations. Intersectoral links: Church and NGOs working on issues of women's vulnerability with links to drugs, alcohol and HIV. Resource materials: New local language materials developed.
Challanges	Project interventions: Time and process intensive. Behaviour change: Required at public and personal level. Frequent Transfers: Concerned Government Officials change frequently.
Prerequisites	Situation analysis and planning. Intersectoral coordination Involvement of Church and other community based organisations such as Young Mizo Association (YMA), Mizo Hmeichhe Insuihkhawm Pawl (MHIP), NGOs working in drugs, HIV & women issues.
Who needs to be consulted	Government departments including Health, Social Welfare, Police, Excise, Information and Public relations (I&PR), Education. Church Community based Organisations
Risks	
Sustainability	Sustainable.The project aims at strengthening the ongoing programmes of both Government and NGOs whilst being streamlined into the national programmes.
Chances of Replication	So far, it has not been replicated in any part of the country, as it is a pilot project. It is also being implemented in five other States, Guntur (Andhra Pradesh), Bellary (Karnataka), Kishanganj (Bihar), Kanpur (Uttar Pradesh) and Jaipur (Rajasthan).
Comments	School and college students have also been covered. Support to the ongoing School AIDS Education programme in the five project districts. The state is giving free treatment to the girls

	referred by the peer educators, taking care of the nutrition of the target group under the Integrated Child Development Scheme (ICDS).
Contact	
Submitted By	Dr Arti Bahl, Research Consultant, CBHI, New Delhi July 2005.
Status	Active
Reference Files	
Reference Links	

201. Health education, Uttar Pradesh

Subject Area="Behavioural Change Communication."	Objective="Raising sensitivity and awareness of health related issues."
Details for Reform Option "Health education, Uttar Pradesh"	
Summary	**Background:** Any improvement in the health and well being of children and mothers cannot be sustained or advanced further without primary education, literacy and basic knowledge for better life skills training for girls and women. The Functional Literacy, Health Education and Care Programme was started by the Ramakrishna Mission Home of Service (RKMHOS) as a part of its centenary celebrations. It uses computer based multimedia health education products in hindi, delivered to the doorsteps of targeted beneficiary groups: students in schools and colleges, hospital patients and their attendants, villagers and slum-dwellers. **Action:** The health education team, equipped with multimedia projector, DVD Player, speakers and inverters with batteries visits the various locations and educates the students and other people using discussions and printed materials such as coloured summary sheets. Schedules for the school visits are finalised in consultation with the District Inspector of Schools and respective Principals so that regular studies are not hampered. The following Multimedia Health Education products (30-35 minute long films) have been developed in the multi media lab built in late 2000 at the Mission by using makeshift production facilities: * Tobacco Use Prevention (TUP) * Roll Back Malaria * Stop Tuberculosis * Food for Health * Hygiene and Sanitation * Exercise – The True Body Guard * Acute Respiratory Infection * Child Health Multimedia Presentation work has begun on two themes. In order to reinforce and sustain the message of the multimedia presentation, the RKMHOS has also designed and developed an information brochure on each topic summing up the contents of the product. The students take these brochures home so potentially widening their reach. In

	addition, RKMHOS has developed the following IEC materials designed to increase awareness of health related subjects among the target population: * Maternal and child health Calendar on the Rule of the Ten (more information in Documents and illustrations) * Information brochure on Antenatal care Results: (from Jan 2004 to May 2006) Product development * Eight multimedia health education products * Four summary sheets * Antenatal calendar, antenatal mother card, child development card, anaemia detection card and 16- page nutrition booklet. Dissemination * Approximately 19,990 across 67 schools participated in the Acute Respiratory Infection programme and completed assignments on the topic including discussing the issues with their families and neighbours. * Approximately 19,014 students participated in the Hygiene and Sanitation programme including discussing the issues with their families and neighbours. * Approximately, 20.5% of students completed the assignments on hygiene and sanitation. *Approximately 18,549 students participated in Exercise- the true bodyguard programme and 14% completed the assignment. * Approximately 18,090 students across 74 schools participated in the Food for Health programme. * Approximately 18,622 students across 33 schools participated in the Stop Tuberculosis programme and approximately 33% completed the assignments. * Approximately 27,000 students participated in the Tobacco Use Prevention programme and 4000 have completed assignments on the topic including discussions. * Approximately 8000 slum dwellers have watched the Tobacco Use Prevention through the direct outreach programme with the help of the network of affiliate health education centres.
Cost	Estimated cost for slum outreach and health education for five years is INR 20,000,000. The break-up of costs is approximately 46% for slum outreach and 54% for health

	education.
Place	Varanasi and Mirzapur districts of eastern Uttar Pradesh.
Time Frame	Activities began in late 2002 and the first health education product was designed and developed in three months
Advantages	Targets receptive audience: Brings about the desired behavioural changes by targeting school-going adolescent population, slum dwellers and hospital patients. Innovative: Meaningful health education delivered in an entertaining and engaging way. Cost Effective: Utilisation of relatively cheap local manpower and resources in product design and production.
Challanges	Skill dependent: Production and dissemination of products are dependent on availability of highly qualified IT experts, animation experts, and health educators.
Prerequisites	MOU between funding agency and implementing agency, cooperation from the schools' management, District and State health authorities.
Who needs to be consulted	State or District Health Authorities District Education Authorities School & college management Community leaders NGOs
Risks	
Sustainability	If funding is in place and experts are available it is sustainable.
Chances of Replication	Chances of replication are good.
Comments	The programme is supported by the European Commission funded Sector Investment Programme, Uttar Pradesh, World Health Organisation, Sir Dorabji Tata Trust, Tata Consultancy Services, British Medical Association and large number of philanthropists.
Contact	
Submitted By	Dr Arti Bahl, Research Consultant, CBHI, New Delhi, July 2005. Last Updated: November 2006.
Status	Active
Reference Files	
Reference Links	

202. Use of Gambosia fish for prevention of Malaria, Rajasthan

Subject Area="Behavioural Change Communication."	Objective="No cost prevention of malaria."
Details for Reform Option "Use of Gambosia fish for prevention of Malaria, Rajasthan"	
Summary	**Background:** With the recurrence of communicable diseases such as malaria across the country, the Central and State governments have tried to reinforce strategies for malaria control. During a medical education programme attended by doctors at Bikaner, Rajasthan in 2004, the use of gambosia fish was demonstrated as a no-cost method of preventing malaria. **Action:** The education programme motivated the Chief Medical Health Officer (CMHO) from Churu district in northern Rajasthan, to take a small quantity of gambosia fish from Bikaner to his office in Churu. The driver and Male Multipurpose Worker (MPW) were trained to collect the fish from the hatcheries, transport them and release them in the public underground water tanks, traditional water storage tanks (referred as bawdis), district hospital, Community Health Centres (CHCs) and Primary Health Centres (PHCs) across the districts. By end of one year all the tanks and ponds within Churu have become breeding sites for gambosia fish. All the public health facilities have become demonstration sites as well as hatcheries of gambosia fish. Auxiliary Nurse Mid-wives (ANMs) was trained to impart information to the community about the use of gambosia fish in the prevention of malaria including how to maintain the breeding sites of the fish. In all health camps, demonstrations of gambosia fish eating larvae are given to the community. **Result:** Although Churu is not a malaria endemic zone, the district does have a number of stagnant water sites. Since the introduction of gambosia fish, a large number of people in the district have adopted this technique. The district level comparative epidemiological report for 2004 and 2005 given in documents and illustration reveals reduction in positive cases. The government through various orders has notified the district to take precautions against malaria. In 2005 government of Rajasthan directed all the districts to launch operation malaria control from August in which CMHOs are directed to

	(a) Constitute mobile teams in the district. (b) The team should make visit to rural areas, visit house to house and check blood slides and also provide treatment. (c) Start anti-larval activities to breeding places (d) in high risk areas establish temporary microscopy centres for active surveillance and (e) Initiate information education communication (IEC) activities. The collectors have been given the responsibility to monitor the programmes.
Cost	No cost other than transporting larva.
Place	Community health centres (CHCs), primary healh care centres (PHCs), Sub-Centres, ponds in Churu district, Rajasthan.
Time Frame	Three to 6 months for developing a hatchery of gambosia fish.
Advantages	Cost: No cost involved as fishery department distributes fish freely. Technique: Simple and non-harmful technique. Easy to transport. Easy to develop hatcheries. Unskilled: Does not involve technically trained staff. Utilization: Can be used at community level.
Challanges	Maintenance: Need to see that the water does not overflow or run dry. Predatory fish and dead fish should be periodically removed.
Prerequisites	Presence of fresh/ brackish water bodies. Accord with the concerned authority at district level. Government order.
Who needs to be consulted	Chief Medical Health Officer of district concerned. Medical Officers from PHCs.
Risks	
Sustainability	Yes. The gambosia is freely available. Regular maintenance of the breeding sites is a necessary pre-requisite.
Chances of Replication	Replicable in malaria endemic regions as gambosia fish is freely available. Authorities as well as communities understand the usefulness of this preventive measure.
Comments	The Gambosia fish was brought from Italy in 1928 and mass production of the gambosia affinis was undertaken in many parts of the country. It breeds three times a year and can be used in various breeding sites like drains and underground tanks. Initially, this was introduced with pisci culture of Carp where it was found to have no adverse impact on edible fish and the mosquito nuisance decreased to such levels that other farmers were motivated. The fish consumes 200 to 300

	mosquito larvae in a day.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, NIMS. September 2005.
Status	Active
Reference Files	Binder2.pdf scan.pdf
Reference Links	

203. Mobile AIDS Counselling Services, Delhi

Subject Area="Behavioural Change Communication."	Objective="HIV/AIDS awareness, prevention and treatment"
Details for Reform Option "Mobile AIDS Counselling Services, Delhi"	
Summary	**Background:** In 1996 the Rajiv Gandhi Foundation (RGF), recognising the consequences of the HIV/AIDS pandemic in India, set up a mutually supportive network of General Practitioners (GPs) and Non-Governmental Organisations (NGOs). This involved a training programme linked with post-programme networking to ensure better longterm impact. Training workshops were organised for GPs in Delhi, Mumbai and the North-Eastern states. The project simultaneously trained field NGOs. So far (end 2005), the 'Rajiv Gandhi Workforce' consists of 1400 trained GPs and 450 NGOs who provide services such as diagnosis and treatment of Sexually Transmitted Infections (STIs), preventive and supportive counselling on HIV, referral and follow-up services for the HIV-positive in their respective regions. Reports suggest that there are currently about 45,000 HIV-positive people living in Delhi. That number is increasing, especially amongst the category considered 'high risk' which includes slum dwellers. **Action:** To supplement the efforts of the Workforce, the RGF created a new project, the Mobile AIDS Counselling Services (RGMACS), as an integrated, holistic model for the prevention, control and management of HIV/AIDS. Launched in Delhi in August 1996, it aims to raise awareness through mobile exhibitions and Information, Education and Communication (IEC) activities using folk media. A vehicle equipped with medical aids visits one slum or high risk area every day. One counsellor and an activist travel in the van, while specially trained troupes perform various educative programmes through activities such as street plays or puppet shows, as well as giving audio and video presentations. People suffering from Sexually Transmitted Diseases (STDs) are given medical help. Those wishing to be tested for HIV are offered on-the-spot testing. The project offers preventive and supportive counselling and works at reducing the stigma, discrimination and denial associated with AIDS. The intervention package also includes: ii) Networking with hospitals and nursing homes (for management of opportunistic infections)

	iii) Tuberculosis treatment iv) Management of people with HIV/AIDS v) Social marketing of condoms In Delhi, the RGF is working with FICCI Socio Economic Development Foundation and covering six areas: Jasola, Madanpur Khadar, Wazirpur JJ Colony, Hastsal, Gandhi Nagar and Geeta Colony. In these areas coverage is ensured by a network of 16 NGOs, Government hospitals, Delhi State AIDS Control Society (DSACS), Voluntary Counselling and Testing Centres (VCTC) and STD clinics. Results: Thirty slums in Delhi have been covered by the project so far. By the end of 2005: (i) The programme has reached 61,772 individuals through various IEC activities (ii) 31,033 pamphlets, 4,267 posters and 4,202 stickers have been disseminated (iii) 18,179 people have been counselled in the mobile van and 13,364 during home visits (iv) In 2005, 38 people were referred to VCTCs, of whom four tested positive vi) Another 1,111 people were referred to STD clinics (vii) In collaboration with DSACS, health camps were conducted through which 220 STD patients, 129 patients with skin related disorders, 31 TB patients and 642 patients with other ailments were given free medicines. (viii) 44 condom depots have been set up, and 18 community based groups have been trained on HIV/AIDS issues. The programme was successfully replicated in Mumbai, where it is being implemented by the People's Health Organisation (PHO) with the help of Johnson & Johnson Ltd. in an additional 10 slum areas. Since 2000, a total of 41 slums in the city have been covered. In 2005 in Mumbai: (i) More than 23,500 people were given counselling on HIV/AIDS related issues (ii) 834 people came forward for voluntary testing, of whom 15 tested positive.
Cost	INR 2.20 per beneficiary. Vans were donated and GPs provide services voluntarily. The total cost of running the project is approximately INR 570,000 per annum.
Place	Delhi since 1996, Mumbai since 2000. The programme is also running in several districts of Maharashtra: Nasik, Pune, Sitapur and Ahmednagar.

Time Frame	Twenty-30 days to plan and organise the training for GPs, identify intervention areas, NGOs and institutions necessary to provide links for service delivery.
Advantages	Holistic: Provides comprehensive services for the prevention, control and management of HIV Multi-targetted: Main beneficiaries are vulnerable groups but all sections of the community are targetted, spreading focus to remove stigma of HIV Cost effective: By disseminating messages through street theatre and folk media, costs are kept down and large numbers reached Intersectoral approach: Impact of the programme is heightened due to complementary roles played by GPs and NGOs in the community
Challanges	Stigma through visibility: Bold labelling of van led to initial reluctance to approach it. Non-availability of medicines: Due to heavy demand for curative services for STDs, treatments are sometimes in short supply. Male-heavy team: The Rajiv Gandhi Workforce currently has predominantly male doctors. Women are often reluctant to discuss reproductive health problems with them.
Prerequisites	Cooperation and participation of local NGOs and GPs Cooperation of local nursing homes and hospitals Trained and dedicated staff Scientifically accurate and culturally appropriate audio-visual IEC material.
Who needs to be consulted	Local community and GPs at planning stage. Various stakeholders, who undergo communication and training needs assessment before training strategy is evolved.
Risks	
Sustainability	To ensure the project is sustainable, community based groups, youth groups and other stakeholders are trained on HIV/AIDS issues. Strong links are established with NGOs and GPs in each project area. RGF, in partnership with the National AIDS Control Organisation (NACO), has also planned another initiative, the Red Ribbon Express, along the lines of the Mobile AIDS Counselling project. For more information click on the link in References below.
Chances of Replication	The Rajiv Gandhi Workforce is operational in the North-eastern states where the Mobile AIDS Counselling Services are due to start in 2006 – 2007. The project can be replicated successfully across the country, with necessary adjustments to the model to meet local needs.
Comments	The UNAIDS/Royal Tropical Institute Programme has included the RGMACS project (Mumbai model) as one of the best global practices in its toolkit of local responses to HIV/AIDS.

Contact	
Submitted By	Tessa Laughton, Research Consultant, ECTA, Delhi. March 2005
Status	Active
Reference Files	RED RIBBON EXPRESS.doc
Reference Links	

204. Traditional Healers Promote Healthcare in Tribal Pockets, Chhattisgarh.

Subject Area="Behavioural Change Communication."	Objective="Improve outreach services"

Details for Reform Option "Traditional Healers Promote Healthcare in Tribal Pockets, Chhattisgarh."

Summary

Background: Bastar is a predominantly tribal district located in the south of Chhattisgarh state. The rugged topography, dense forest cover, scattered settlement pattern, traditional beliefs and over-dependence on traditional healers makes it difficult for the public healthcare service to reach out to the tribal population. Following the formation of Chhattisgarh state in November 2000, the government is adopting many strategies; including roping in traditional healers as agents of behaviour change, as the tribal population largely relies on them for cure. Besides, traditional healers, known as Sirha-Gunia- Baiga, also create obstacles to delivery of as well as access to health services.

Action: The district Collector and Chief Medical Health Officer (CMHO), Bastar requested Medical Officers (MOs) to evolve a suitable strategy whereby Sirha-Gunia- Baigas could be made partners in promotion of modern health care services among the tribal population. Initially, a meeting was organised by block level MOs to befriend them and understand their reasons of obstructing delivery of health services to the tribal population. The strategy worked; some of the Sirha-Gunia-Baigas volunteered to be the government's partners in the promotion of health services. The district administration was thus able to win over Sirha-Gunia- Baigas by removing their fear that the public health system would jeopardise their livelihood and diminish their status in the village.

Subsequently, in April 2005, the district administration started a movement to educate the Sirha-Gunia- Baigas in modern medicine and take their assistance in provision of health services. The district administration also urged them to refer villagers to the nearest government health centre in case of complications they were not confident to handle. Fourteen block level workshops were organised to educate Sirha-Gunia-Baigas and to motivate them to participate in the delivery of public health care services.

Many of these workshops were inaugurated by the district Collector and state ministers. Sirha-Gunia- Baigas were

	welcomed in traditional ceremonial manner at these meetings; they were also given a badge. The workshops mainly tried to dispel the myths and misconceptions surrounding modern medicine and focused on ways to treat common ailments of villagers. Besides, they were also motivated to become depot holders of over-the-counter drugs for common ailments and contraception. The willing Sirha-Gunia- Baigas were identified and were made depot holders at the meeting; they were given medicine supplies, for which they could charge minimal amounts from the patients. The supplies included drugs such as anti-diarrhea, paracetomol, Oral Rehydration Salt (ORS) packets and contraceptives. Thereafter, a list of Sirha-Gunias was prepared at every Primary Health Centre (PHCs) and Community Health Centres (CHC) and records were maintained to see the number of patients referred by them to the PHC and CHC. On August 15, 2005, the Sirha-Gunias who had been sending a sizeable number of patients to PHCs/CHC were felicitated by the district administration as part of the Independence Day official ceremony. The next large-scale block level Sirha-Gunia workshop was organised on June 9-10, 2006. At the end of the workshop drug kits were distributed to Sirha-Gunia-Baiga, containing medicines on seasonal diseases. The district administration is also issuing identity cards to Sirha-Gunia-Baigas. **Results:** Currently, Bastar district has 1500 Sirha-Gunias-Baigas as depot holders. This initiative has helped service providers in their work. According to the CMHO of Dantewada, the initiative has led to fewer causalities and deaths in the district.
Cost	CARE, Madhya Pradesh gave one-time support to the district administration of INR. 50,000 for organising workshops and thereafter the district administration is using its own funds to do the same.
Place	All blocks of Bastar and Dantewada districts.
Time Frame	Few weeks.
Advantages	Mainstreaming: Sirha-Gunia-Baigas have starting motivating villagers to go to PHCs for treatment as the initiative nurtured their transition from traditional to modern medicine. Enabling environment: The health workers can work more effectively with support from Sirha-Gunia-Baigas in the villages.
Challanges	Funds: It is difficult for the district to manage funds as requirement of medicines has gone up as medicines are provided to various levels of functionaries.

	Management: Continuous effort has to be made by the district administration so that all Sirha-Gunia-Baigas refer patients to the nearest government health centre. Services: Unavailability of doctors and services at PHCs rolls back all that is achieved by the initiative as the community loses faith in the health delivery system.
Prerequisites	District administration's will to improve health care services. Funds to organise workshops for traditional healers. Availability of health centres to manage cases.
Who needs to be consulted	District Collector. Chief Medical Health Officers. Block level Medical Officers. Sirha-Gunia-Baigas. Tribal community.
Risks	
Sustainability	Sustainable, but it depends largely on how efficiently the system delivers health services.
Chances of Replication	Can be replicated in all tribal pockets.
Comments	In November 2000 there was an onslaught of malaria in the tribal belt causing a large number of deaths. The district CMHO believes the epidemic spread further mainly due impediments caused by Sirha-Gunias-Baiga. This initiative has improved the overall health situation in the district as there has been no untoward incident or epidemic in the last two years in Bastar district.
Contact	
Submitted By	Dr. Nandini Roy, HS-PROD Research Consultant, NIMS. May 2006.
Status	Active
Reference Files	scan1.jpg scan2.jpg scan3.jpg
Reference Links	

205. Promoting Change in Reproductive Behaviour of Youth, Bihar

Subject Area="Behavioural Change Communication."	Objective="Improving reproductive health status of youth."
Details for Reform Option "Promoting Change in Reproductive Behaviour of Youth, Bihar"	
Summary	**Background:** The health survival and well being of families, mothers and their infants are adversely affected by the social customs of early marriage, too frequent and early child bearing with inadequate space between children. By delaying the first child until the age of 21 and spacing subsequent children by three to five years, communities could benefit from a significant drop in maternal and infant mortality rates. Family planning interventions that delay the first child and space subsequent children by at least 36 months have a proven value in improving maternal health and child survival. Addressing youth fertility can deliver multiple benefits like: health, demographic, economic which in turn would benefit both family and country. Changing the reproductive behaviour of youth requires that both individual beliefs and wider social norms are addressed and changed. Targeting youth alone cannot change youth reproductive behaviour. PRACHAR Project of Pathfinder International has, since 2001, supported a group of 30 Non Governmental Organisations to promote change in reproductive behaviour of adolescents and youth in Bihar. This project was run in five districts of Bihar namely Nalanda, Nawada, Patna, Gaya and Shiekhpura covering a population of 6, 36,803 (22%) in 552 villages. **Action:** Each NGO partner worked in a cluster of 30 villages with a population of approximately 30,000. They conducted community based programs to reach the community at large with standard messages promoting the value of delaying and spacing births. The community was segmented into specific primary and secondary target groups of unmarried adolescents, young married couples, parents and influential adults. These groups were reached with life stage specific information and communication that promoted the messages of delaying and spacing children and adopting safe sexual and reproductive behaviour to remain free of unwanted pregnancy and infection. Standardized information and messages on these subjects were communicated through a combination of training programs, home visits, group meetings and infotainment events to all target groups, ensuring high coverage (between 60-80%) of each target

group:

* Adolescent girls between 12-14 years of age received training about puberty, menstruation, personal hygiene, and nutrition.

* Adolescent girls and boys between 15-19 years of age were trained and received age appropriate information about reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS prevention and the importance of delaying childbirth and spacing subsequent children.

* Through home visits and group meetings, newly wed couples, who had not yet had a child, received information about delaying and spacing children, as well as responsible planning for family life.

* Young couples with only one child, received information about spacing subsequent children.

* Families of young couples, especially the mothers-in-law, received messages about the health and economic benefits for young couples who delay first births and space subsequent children.

* Respected elders and community leaders with influence received messages similar to those directed at families of couples. All communication material, training curricula and agenda for meetings were developed by Pathfinder and these standard materials were used by all partners, who were trained in using this material to maximum effect. Highly structured and standardized monitoring and reporting systems were designed and partner staff trained to use them for reporting and reviewing progress of their own work. Monitoring data was received on a monthly basis and computerized, permitting sophisticated analysis of results.

Results: The program was widely accepted in the 552 villages where it was implemented. The rigorous monitoring system tracked the frequency and effectiveness of project activities and interventions, as well as key family events such as births, deaths, marriages and pregnancies. It also enabled measurement of changes in contraceptive use. Extensive project data reveals:

i) The project has reached more than 90,000 adolescents and young adults with information on key issues in Reproductive Health (RH) and Family Planning (FP).

ii) More than 100,000 parents and other community adults received similar messages aimed at building wide social acceptance for the ideas of delaying and spacing children.

iii) The percentage of the population (all respondents) who

	believe that contraception is both necessary and safe increased from 38.3% to 80.8 %. Among unmarried adolescents, this figure increased from 45.3 % to 90.5 %. iv) The percentage of newlyweds who use contraceptives to delay their first child more than tripled, from 5.3 % to 19.9 %. v) The percentage of newlywed adopters who began using contraception within the first three months of the consummation of marriage increased dramatically, from 0.1 % to 20.8 %. vi) The percentage of first time parents who used contraception to space their second child increased from 14 % to 33 %. vii) 30 local NGOs in Bihar were provided with extensive training, supervision, and resources to attain new levels of capacity and sustainability, particularly in maintaining and developing programs in RH/FP. viii) Basic RH/FP training of 1,398 traditional birth attendants (dais) and 447 rural medical practitioners.
Cost	The cost of intervention per 30,000 population for over four years was INR 8,289,474 (The cost per head is calculated by dividing the total cost of project by size of the population or that of primary group served. The cost is not calculated by any specific individual or combination of individuals). However, if the cost of reaching the primary target group is commuted (adolescents and young married men and women) it is INR 1,428 per head for over four years. This includes the cost of the grants for community mobilization and training, all communication support, all monitoring, evaluation, technical support and supervision. The total grant from the Packard Foundation to Pathfinder for the four year Project was $ 3.5 million.
Place	This project covered five districts in Bihar namely Nalanda, Nawada, Patna, Gaya and Sheikhpura.
Time Frame	Preparatory Phase: One year for Pathfinder (to recruit its staff, identify partners, conduct baseline studies, and work out strategies, help partners to develop proposals and to make awards to partners). Three months for NGO Partners (for staff recruitment and orientation, preparing beneficiary lists and for being trained in Pathfinder's monitoring systems before starting systematic intervention activities in the community).
Advantages	Large coverage: Prachar is one of the few innovative programs for youth that have attained scale. Prachar demonstrated that even in resource poor rural settings, scale can be attained with carefully constructed implementation structures, development of human capacity and close program monitoring. Effective Model: The model has also been tested and found

	effective by Pathfinder in other states of India (Rajasthan, Delhi and Tamil Nadu) in both rural and urban slum settings. Quick Impact: It is capable of bringing about significant levels of behaviour change in a relatively short period of two years.
Challanges	Government Involvement: The Prachar approach changes social norms and builds demand for RH/FP services. It has been a challenge to involve the government system in effectively providing essential RH/FP services in outreach mode through the primary health care setting, to local communities who need affordable services close to home.
Prerequisites	Partnership with local community based NGOs; the provision of strong central technical support; capacity building for implementing NGOs; and rigorous monitoring of NGO programs.
Who needs to be consulted	*Pathfinder International team in Patna and in New Delhi. *Partner NGOs of Prachar.
Risks	
Sustainability	Behavioural changes were brought about in the target population. The adoption of new behaviour continues to grow even after project inputs have ceased.
Chances of Replication	Project methodologies are so standardized that the project can easily be replicated. The methodology has been developed and tested in a variety of states and sites- urban as well as rural and has shown similar results, proving its effectiveness and replicability.
Comments	The “Prachar model” is open for various national, international government and non-government organisations, academicians, researchers, planners and policy makers to visit, examine, adopt, adapt the community based youth focused RH/FP program.
Contact	
Submitted By	Prabha Sati, Research Consultant, ECTA, New Delhi, September 2006.
Status	Active
Reference Files	IMG_0119.JPG Photo 2.JPG — Photo 2 Photo for page.JPG — Photo 3 Prachar Overview 15.06.06.ppt — Overview of Prachar- A power point presenatation.
Reference Links	

206. Tobacco Cessation Centre, Dr. B. Barooah Cancer Institute, Assam

Subject Area="Behavioural Change Communication."	**Objective="Create public awareness on the harmful effects of tobacco."**
Details for Reform Option "Tobacco Cessation Centre, Dr. B. Barooah Cancer Institute, Assam"	
Summary	**Background:** Tobacco problem in the North-East is more complex than probably any other state in India, with a large burden of tobacco related diseases and death. In the North Eastern States tobacco is smoked in cigarettes, bidis and pipes. Tobacco is also chewed in the form of paan or betel nut with tobacco and slaked lime. In Assam, a fermented form of areca nut known as tamol or bura tamol is chewed extensively. Bura tamol is often infected with fungus. Tobacco water (known as tuibur in Mizoram and hidakphu in Manipur) is also used by passing tobacco smoke through water. A very common feature in the North East is the use of gutkhas and pan masalas. Tobacco related cancer alone accounts for over 40% of the cancer and as much as 35-50% are due to food and the contaminating materials in the food. Tobacco related cancers account for half of all the cancers in males and 1/4th of all cancers in females. The National Family Health Survey (NFHS-2) survey conducted in 1998-99 among the individuals aged above 15 years revealed that the consumption of tobacco use in Mizoram is very high compared with other states of the North East. Meghalaya also has high consumption of tobacco. In the state of Assam according to the data available it was found that about 34.9% of the male population smoke tobacco while a high rate of 48.2% chew tobacco. But still, the figures are very high compared to the national figures. The NFHS2 (1998-99), revealed that the percentage of tobacco consumption was higher in case of illiterates than educated individuals. Similarly the percentage of tobacco users was twice as high in the case of population with low standard of living as those whose standard of living was high. A survey done between 2000-2004 (Global Youth Tobacco Survey) supported by World Health Organisation (WHO) in 26 major states of the country revealed that in North Eastern States tobacco users who first used tobacco before the age of 10 years were more than 65%. In Nagaland, exposure to tobacco is as high as 60% among children in the age group of 11-13 years. **Action**: To mitigate the problem, the Department of Preventive Oncology, in Dr. B. Barooah Cancer Institute, started a “Health Education Programme on Cancer and Tobacco”. The programme

	was started in 2003 in various schools and colleges where the students were educated and made aware of the harmful effects of tobacco on health as a whole. Similar activities were conducted in the state of Meghalaya, Nagaland and Arunachal Pradesh. In addition, cancer screening camps and public awareness on tobacco related cancer for community was organized from time to time. Regular awareness for female population on common cancer among females was conducted in rural and urban areas. A 'Tobacco Cessation Centre' (TCC) has also been started with support from WHO and Government of India where the people who want to quit the habit of tobacco consumption are counseled and motivated. The center is manned by a clinical psychologist who counsels the people on quitting and also provides them with Nicotine replacement therapy available in chemist shop in the form of chewing gums. The center has a social worker who generates awareness amongst the people on tobacco and its related problems. The center was inaugurated on 20 April 2005. Following are the aims and objectives of the center : i) Help people to quit tobacco ii) Forming anti tobacco network iii) Awareness in rural and urban areas iv) Setting up satellite clinics Results: * New patients in the center : 222 * Patients reviewed : 207 * No. of satellite clinics : 04 * No. of training programme : 04 (45 volunteers trained) * Number of Schools/Colleges/Institutes covered : 26 * Number of students & teachers made aware : 2200 & 80 * Number of awareness programmes in communities : 21 places (1600 people made aware) * Number of street plays : 05 (attended by over 500 people) * Exhibitions held : 2 (over 450 people participated) * Number of TV and ratio spots : 07
Cost	The budget for Tobacco Cessation Centre for the year 2005-06 was INR 21, 5000 and the budget for the year 2006-07 is INR 2,64000. This fund is for staff salary, awareness programme and IEC materials Setting up of a Satellite Tobacco Cessation Centre does not require any extra fund. All that is required is a

	committed person with counselling skills and some space for seating.
Place	Dr. B. Barooah Cancer Institute, Guwahati, Assam
Time Frame	Time to set up this facility is relatively less. What is needed is about a few weeks' training programme (for Counsellors), some space and basic infrastructure. The Health Education Programme on Cancer and Tobacco started in 2003. Phase I of the programme was from Jan. 2005 to April 2006. Phase II was from May 2006 to 2007.
Advantages	Strategic Location: Being in the Regional Cancer Institute, where the tobacco consumption is one of the major reasons for cancer helps the TCC to create awareness amongst people who come from different areas and communities. Cost Effective: By disseminating information through street plays, exhibitions, satellite centres and counselling centres, costs are kept low and greater numbers of people are reached.
Challanges	Improper network: Forming anti-tobacco networks remains a challenge. Lack of Commitment: Lack of commitment of NGOs to work on a sustainable basis in cooperation with the TCC.
Prerequisites	* Dedicated team of counsellors. * Space for holding counselling sessions. * IEC for awareness creation.
Who needs to be consulted	Office of the WHO Representative Tobacco Free Initiative 534 A Wing Nirman Bhawan Maulana Azad Road New Delhi-11 Tel: 011 23018955 01123792179
Risks	
Sustainability	TCC at Dr. Borooah Cancer Institute will continue till WHO continues funding and after that it will be taken up by the Institute. The Programme does not require huge funds so it is easily sustainable.
Chances of Replication	After the positive response from 12 TCCs, 5 more new centres at Guwahai, Mizoram, Hyderabad, Kolkata and Trivandrum have beenset up.
Comments	None.
Contact	
Submitted By	Prabha Sati, Research Consultant, ECTA and Dhrub Kumar Singh, Research Consultant, Central Bureau of Health Intelligence, New Delhi, October 2006.
Status	Active
Reference Files	Tobacco Cessation Clinic.doc — Newspaper Clippings PREVENTION & DETECTION OF — Prevention & Detection- a

	CA.ppt	power point presentation
	SMOKING FACTS - II.ppt	Smoking facts- a power point presentation
	TCC 2005-06 REPORT.doc	Report on Tobacco Cessation Centre
	AWARENESS PROG WITH SCHOOL CHILD, SHILLONG.JPG	Photo
	IMGP2075.JPG	Photo
	AWARENESS PROG AT SHILLONG.JPG	Photo
Reference Links		

207. Dancing Feat, Mumbai

Subject Area="Behavioural Change Communication."	Objective="To develop coping up abilities among children of age 6-18 years; with the emotions due to the presence of STIs."
Details for Reform Option "Dancing Feat, Mumbai"	
Summary	**Background:** Dancing Feat is a child- friendly strategy which involves the use of dance and interpersonal communication as tools for psychosocial support. The children infected or affected by HIV/AIDS usually have difficult circumstances in their background which further gets aggravated by social stigma as a 'double discrimination' against them. The Shiamak Davar's Institute for the Performing Arts (SDIPA) and Committed Communities Development Trust (CCDT) entered into partnership in November, 2001, for the project Dancing Feat to work towards 'no discrimination' for HIV/AIDS infected/affected children. The project is funded by the United States Agency for International Development (USAID) with technical support from Family Health International (FHI). **Action:** All participating children; irrespective of their HIV/AIDS status, perform their dances together at public forums; sending the message of 'no discrimination' to the audience. At annual public performances, the young participants get the opportunity to perform in front of an audience comprised of their families, friends and communities. Children are also involved in development of dances exploring themes related to their own lives such as gender disparities, money utilisation, coping up at a time of death of a loved one due to AIDS. Life Skills Education (LSE) sessions are designed to teach positive behaviours that enable children to deal effectively with the demands and challenges of everyday living. Peer groups are encouraged to express out their problems and discuss the probable solutions. It is supported by the group counselling sessions that explore reproductive and sexual health, growing up, relationship, gender, reduced vulnerabilities and HIV risk behaviours. Group counselling session facilitate the child's decision making process towards healthy growth, avoiding risk situations. There are also sessions on issues related to children development such as bed wetting, coping with examinations, relationship with opposite sex and on sexually transmitted diseases as part of prevention, care and support strategies. The project team also offers capacity building which involves training the staff of partner NGOs to enhance the quality of existing activities. The project staff reaches out to the children

	by going to the community based NGO centres where the children receive other services. The Dancing Feat has its partners all across Mumbai, from Andheri–Colaba. Clients: Children in the age range 6-18 years; children of women in prostitution or of infected persons, children in sex work or with a high probability of being abused or exploited, street children, slum children and those with a history of multiple sex partner and substance users/abusers. **Results:** An evaluation of the Dancing Feat initiative was done in June, 2006 which has shown encouraging results for a developing understanding among children for positive sexual and reproductive health, building self-esteem and raised awareness about prevention against STI.
Cost	It depends on the scale and extent of the programme events and activities. Exact information is not available.
Place	Mumbai.
Time Frame	To start a similar programme for strength of children over 1500, it takes approximately 4 months.
Advantages	Building up self-esteem: with improvement in life skills, the children learn to develop a self-recognizing and asserting personality. Promoting positive sexual and reproductive health: it helps in the reduction of stigma against STIs and HIV/AIDS afflicted persons.
Challanges	Socio-cultural barriers: the prevalent prejudices, norms and values in the society act as resisting factors to efforts of stigma reduction. Difficulty in designing and implementing counselling: it is because the children joining the programme have quite different background and circumstances. It is a tedious job to design a common counselling tool for all. Resources and capacity building: networking of NGOs is difficult owing to varying ideologies. Planning and linking of Dance, counselling, life skills education, STIs prevention, care and support services in relation to issues of children still a challenge owing to resources constraint. Sensitivity and confidentiality in case of HIV/AIDS positive children: it is well taken care of but persistent efforts are needed to maintain it.
Prerequisites	Baseline data, need assessment, supportive environment and advocacy campaign Open space for the children and a music system Life skills education training Child friendly material (art, craft, puppets) Expert counsellor, cultural and dance teacher, child psychologist, committed professionals Donors to support

	staff salary, cultural and counselling sessions
Who needs to be consulted	Sex workers, children, health professionals, key informants from the community, NGOs working on HIV/AIDS issues, donors. Director, Committed Communities Development Trust for any technical input.
Risks	
Sustainability	Fair: Persistent support from the donor agencies and continuous capacity building is required.
Chances of Replication	The states with high prevalence of STI and HIV/AIDS can think of this initiative after having assessed the local needs, incidence of HIV/AIDS among adolescents, demography and socio-cultural patterns. Chances of replicating it are good enough. The similar initiatives to reduce stigma against HIV/AIDS and to impart life skills education have been tried in Kerala, Madhya Pradesh and Maharashtra. The Dancing Feat programme has developed a resource manual for interested NGOs.
Comments	It is a good and appropriate attempt with fun, to impart life skills education, positive sexual and reproductive health understanding among children living in high risk environment.
Contact	
Submitted By	Dr. Anil Bhola, Research Consultant, National Institute of Medical Statistics, New Delhi November, 2006
Status	Active
Reference Files	Evaluation Report.doc DF_Review_presentation_August_2006.ppt
Reference Links	

208. Pictorial Tools for behaviour change communication for tribal population, Jharkhand.

Subject Area="Behavioural Change Communication."	**Objective="To disseminate health messages among illiterate women."**
Details for Reform Option "Pictorial Tools for behaviour change communication for tribal population, Jharkhand."	
Summary	**Background:** Health status of the Jharkhand showed that 80 percent of children suffer from anaemia, out of them 56 percent are moderately to severe anaemic. Disseminating the life cycle approach for the prevention of low birth weight and anaemia among the children and pregnant women is a complex phenomenon especially when female illiteracy is very high. Taking in to account the high female illiteracy rate, pictorial tools for behaviour modification were devised to adopt healthy eating habits. **Actions:** In order to integrate appropriate healthy habits during the critical stage of human life cycle in illiterate tribal population pictorial tools were devised by Kishi Gram Vikas Kendra (KGVK) under a project named Ranchi Low Birth Weight Project (RLBWP). Project was action research project in collaboration of three institutes –Kishi Gram Vikas Kendra (KGVK), Child In Need Institute (CINI) and Government of Jharkhand. Sahiyya, a voluntary female health worker, delivered health messages in the community. (For detail on Sahiyya Please see PROD entry no:153). Pictorial tools used by the Sahiyya were: Immunisation annual calendar: All the vaccine required for a child up to the age of one year are depicted in the calendar. Months given in the calendar are as per English as well as in local Hindi version. Common festive to celebrate in these months are also mentioned to get better reference point. Tri colour food chart: As per nutritive value, food items were categorised in to three colours i.e. orange, white and green. Green colour includes all the green leafy vegetables, white colour includes milk and milk products, eggs etc and orange colour includes all the pulses, coloured fruits etc. Registration booklet for pregnant women and child: It is meant for follow up a pregnant women in antenatal, natal and post natal period as well as her child upto one year age for exclusive breast feeding and complete immunisation. All the questions asked are depicted in the pictorial forms. Their answers are

	also colour coded- green for yes, red for no. **Results:** As in the absence of any evaluation data, it is difficult to mention the percentage of change in the desired behaviour but definitely it helps the worker as well as community members for the required message to understand.
Cost	Information not available.
Place	In two district of Ranchi.
Time Frame	Approximately one year.
Advantages	Client friendly: Advocacy material are designed in a way which depicts the message in more clear way as per local setting. Easy to understand: Message are conveyed in the form of a picture so that illiterate or semi-literate women can easily pick the right message.
Challanges	None perceived.
Prerequisites	Training of Sahiyya to explain them.
Who needs to be consulted	Local NGO.
Risks	
Sustainability	Good as it involves one time training of the resource person.
Chances of Replication	Good especially in States / population where female illiteracy is quite high.
Comments	To disseminate the right messages of health to the population and ultimately they are adopted in their behaviour as part of routine is a difficult process especially when female illiteracy is very high. Devising the pictorial tools to make them understand the right healthy habit is one of the ways to disseminate the appropriate message to the population.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, ICMR, Oct, 2006.
Status	Active
Reference Files	ANC monitoring-2.jpg ANC monitoring-1.jpg ANC monitoring.jpg Food chart.jpg Food chart-1.jpg Food chart-2.jpg Food chart-3.jpg food chart-4.jpg

	Immunisation calender.jpg
Reference Links	

209. Jigyasa: Adolescent Centre, Madhya Pradesh

Subject Area="Behavioural Change Communication."	Objective="Empower adolescents to make better life choices for overall development including sexual and reproductive health and rights."

Details for Reform Option "Jigyasa: Adolescent Centre, Madhya Pradesh"

Summary

Background: Small Family by Choice, a 10-year project implemented in 4 districts of Madhya Pradesh, gave Family Planning Association India (FPAI) many insights into the myths and misconceptions among youth regarding sexual and reproductive health, both in rural and urban areas. While working with them FPAI learnt that adolescents need a platform where they can discuss their reproductive health needs and also enhance their skills so as to find new avenues of employment.

Action: The idea to start a resource centre for adolescents was proposed by youth group in Bhopal district. It was after a wide range of consultations with representatives of youth groups, teachers, parents, project volunteers and non-governmental organisations (NGOs), the FPAI established an adolescent resource centre in Bhopal in 2002 .It was called Jigyasa Adolescent Centre (JAC) and was run by young people for young people. Currently, FPAI runs a JAC in Bhopal and three satellite centres in Mandideep Industrial area and Harrakheda Rural area, on the outskirts of Bhopal, and Vidisha. The JAC is managed by a programme coordinator, male and female adolescent advocacy officer-cum-counsellor.

A youth committee has been constituted to oversee functioning of the centre; this committee meets once a month to review the activities of the JAC and plan for the future. An advisory panel has been set up by FPAI. The resource centre caters to adolescents and youth from vulnerable sections of society; these include school-goers, college students, school drop-outs, children working in roadside eateries, rag pickers, platform children, juvenile delinquents, street children and adolescents from urban slums. Information about the JAC was disseminated by placing advertisements in the local newspaper and in film theatres. Different stakeholders, including school authorities and state policy makers also spoke about it at various forums. Parent orientation programmes and youth melas were organised to create awareness about the adolescents' reproductive and sexual health needs and rights.

The youth fairs included quiz, health camps, competition, puppet shows, entertainment and educational programmes. Street plays were shown to highlight issues concerning sexual and reproductive health and age at marriage. JAC provides

	information, entertainment facilities, counseling, clinical services, internet, library and referral services for adolescents, who need specialised treatment. There is a weekly clinic at JAC every Wednesday, where any adolescent can get consultation for INR 20). JAC also offers help and guidance on reproductive health, nutrition and growth, HIV prevention, teenage pregnancy and abortions, myths and misconceptions related to sexual health, sexual violence and other related subject areas. The JAC conducts short skill development courses in computer use, personality development, dance, cooking, tailoring, karate, making handmade jute products, spoken English, acting, henna application, and painting for a monthly fee of INR 50. JAC organised workshops to disseminate information on reproductive and sexual health among young girls ready to get married. Acting classes were organised so that interested youth could form a theatre group and enact street plays and also earn their livelihood. The JAC charges membership fees of INR. 10. The centre sustains itself through consultation fees, donations and by selling advocacy material. The resource centre has become a platform for students specialising in social work to have hands-on training on adolescent reproductive and sexual health programmes. An interactive website, www.jigyasa.org has also been launched, from where young people can access information. **Results:** The JAC has trained 125 young boys and girls from over 100 slums as peer educators. In addition, records show that it has trained 12,223 school teachers on issues of human sexuality; 5,495 adolescents on gender issues; 6147 rural and urban adolescents have been enabled with modern and traditional skills; improved information needs of 249792 on sexual and reproductive health. Besides, the adolescent clinic has been able to address reproductive and health problems of the youth. The initiative involving adolescents has also led to the empowerment of youth. In Vidisha district, young people from the villages, who participated in activities organised by FPAI's skills development centre, approached the panchayat for a spare room, which they could use as a library. They could also impress the collector, who provided funds to make basic purchases. The street theatre group, formed by JAC adolescents, puts up plays on social issues for FPAI and other NGOs. This helps them to earn a livelihood.
Cost	INR 4, 50, 000.
Place	Mandideep Industrial area, Bhopal, Harrakheda Rural area of Bhopal district and in Vidisha district.
Time Frame	6 to 12 months.
Advantages	Conducive environment: Peer educators, who are themselves young people, disseminated information on sexual and reproductive health (SRH). This drew young people to take part in

	JAC activities. Clinics: Adolescent clinics attached to JACs increased access to and utilisation of SRH services by young people. Overall development: Increased level of confidence among adolescents visiting Jigyasa. Self-reliant: The trainings and skill development courses have helped many to earn a living.
Challanges	Attendance: Ensuring adolescents come to the centre regularly. The JAC activities and services have to be relevant and be easy to access by the young people from vulnerable sections of society, who are often hesitant. In addition, more visibility is required and this requires JACs to work with various stakeholders including parents of the adolescents and youth. Retention: There is continuous drop-out of adolescents for various reasons.
Prerequisites	A felt need for such a resource centre. NGO interested in promoting them. Schools interested.Government, PRI and corporate support.
Who needs to be consulted	FPAI Schools. Adolescents.
Risks	
Sustainability	Depends on support from government community and other funding agencies. Resource mobilisation initiatives by the resource centre may also help sustain its activities.
Chances of Replication	Good. The government in the second phase of Reproductive and Child Health programme has replicated the initiative. Please refer to the National Youth Policy.
Comments	FPA India partnered with international agencies like UNICEF, UNFPA, CARE, DANIDA, Johnson & Johnson, SOS and local NGOs like Aarambh, Prerna, CASP Plan, Abhivyakti, Bachpan, Sudhar, MPVHA, professional agencies, schools, colleges and government departments like Central Jail, Social Welfare Department, Mahila Thana, Women & Child Development Department and Academy of Administration, etc.
Contact	
Submitted By	Dr. Nandini Roy, Research Consultant, National Institute of Medical Statistics, June 2006.
Status	Active
Reference Files	
Reference Links	

210. Preventive Oral Health Care in Children, Kerala

Subject Area="Behavioural Change Communication."	Objective="Promoting dental care."
Details for Reform Option "Preventive Oral Health Care in Children, Kerala"	
Summary	**Background:** The health indicators of Kerala are comparable to developed countries, but oral health indicators show high prevalence of oral diseases. Prevalence of oral diseases like periodontal disease and dental caries are similar to all India figures. Dental caries and periodontal disease are both preventable diseases and significant reduction in the disease pattern has been demonstrated world wide by oral health education and preventive strategies. Treatment of dental ailments is expensive and hence there is need for promoting primary prevention. As the disease starts in early childhood with the eruption of the milk tooth, preventive strategies are most effective if it is started at or before the time of eruption of milk tooth at the age of 6 months. Nursing caries, rampant caries are frequently found in infants due to erratic feeding habits and lack of proper oral hygiene. These diseases affect the growth and development of the child by affecting diet and nutrition, chronic oral facial infections, pain, suffering and tooth loss. Persistent pain and painful mouth prevents the child from eating properly. It affects the overall well being of the child. Educating mothers on infant dental care will promote life long good oral hygiene habits and bring down the prevalence of this oral disease considerably. **Action:** After conducting a baseline survey, resource materials for training on oral hygiene were developed. Trainings were conducted for Junior Public Health Nurse and Anganwadi functionaries in Thiruvanathapuram District. Community level oral health promotion classes were conducted through mothers meetings in the Anganwadi Centres. Junior Public Health Nurse and Anganwadi workers jointly conducted these meetings. A post training evaluation was also conducted. **Result:** By training Anganwadi workers and primary health care staff it is becoming possible to educate the community especially mothers of young children. More results are yet to come.
Cost	Budget for one District is INR 19.9 lakhs.
Place	Trivandrum, Trichi and Athiyannur block of Kerala.
Time Frame	Twelve months.
Advantages	Implementation using existing infrastructure: No extra

	infrastructure is needed for the programme and can be easily integrated with the on going health programmes. No additional manpower is required: It does not require additional manpower. Inter- sectoral cooperation: The programme establishes inter-sectoral linkages between various departments. Excellent response: The programme has received excellent response from the community, various departments and the Panchayati Raj Institute.
Challanges	None Perceived
Prerequisites	* Government Order * Inter-sectoral linkages between Panchayat, Social Welfare Department and Health Department
Who needs to be consulted	Director of Health Services. Child Development Centre. Dental Public Health Expert.
Risks	
Sustainability	Programme is sustainable if it is integrated into the existing health programmes.
Chances of Replication	The programme is being replicated in other districts of Kerala also.
Comments	There has been an excellent response from the staff of various departments and Local Self Government. Response from the community is also good and they have expressed that awareness regarding oral health was very low in the community and hence this programme is highly relevant.
Contact	
Submitted By	Dr K Sandeep, Technical Secretary, Directorate of Health Services, Thiruvananthapuram, Kerala and Prabha Sati, Research Consultant, European Commission Technical Assistance, New Delhi. December 200
Status	Active
Reference Files	BROCHUREFINAL.pdf — brochure Chart and Posters.pdf — charts & posters Oral health Care Training project.ppt — Power point presentation on dental health Oral Health Hand Book English .pdf — Handbook Oral Health Hand Book Malayalam.pdf — Handbook Oral Health Training Project-Malayalam.ppt — Training (power point presentation)

Reference Links	

211. Hiring of private anaesthetists at First Referral Units and Primary Health Centres, Tamil Nadu

Subject Area="First Referral Units."	**Objective="Availability of anaesthetists."**
Details for Reform Option "Hiring of private anaesthetists at First Referral Units and Primary Health Centres, Tamil Nadu"	
Summary	**Background:** An acute shortage of anaesthetists in the public health system meant that even if other facilities were available, operations could not be conducted. **Action:** Under the Reproductive and Child Health (RCH) programme, the Medical Officers (MOs) at the First Referral Units (FRUs) and Primary Health Centres (PHCs) in Tamil Nadu were empowered to contract in private anaesthetists (local practising anaesthetists or a retired anaesthetist). Initially, it was permitted at FRUs to provide emergency obstetric care including the conduct of Caesareans and hysterectomies. Later, anaesthetists could also be hired to conduct tubectomies and other elective gynaecological surgical cases at FRUs and tubectomies in PHCs where operation theatres are functional, on specific days. **Results:** On average, 12% of the total number of Caesareans (around 2,500 Caesarean surgeries per year) were performed in the secondary level hospitals (FRUs) by hiring the services of private anaesthetists. During the last 4 years around 48,000 additional tubectomies were performed by hiring private anaesthetists at FRUs and PHCs. 112 more PHC operation theatres were made functional.
Cost	INR 1100 which includes INR 100 for conveyance per case of caesarean or major gynaecological/obstetric surgery. Similarly for conducting tubectomies, INR 1100 per visit which includes INR 100 for conveyance per visit. No minimum number tubectomies are prescribed for each visit. It is generally between 5 and 10 cases. If the number of tubectomies performed exceeds 10, INR 100 (€1.76) is paid for every additional tubectomy.
Place	44 PHCs in the districts viz. Thanjavur, Thiruvarur, Nagappattinam, Dharmapuri, Krishnagiri, Madurai and Theni and selected 75 FRUs in 24 districts. The scheme is now extended to all the PHCs and government hospitals in the state except the medical college hospitals and urban municipal hospitals.
Time Frame	Six months.
Advantages	Local service: Enables emergency obstetric surgeries to be conducted in FRUs without patients having to waste time and money on travel. Reduces the unnecessary referral from one institution to another for

	want of anaesthetists. Life-saving: Reduces the maternal deaths due to timely availability of anaesthetists. Patient-friendly: Enables tubectomy surgery to be carried out at the PHC which most people prefer because of the 'family atmosphere'.
Challanges	Opposition: The government doctors association initially resisted the entry of private specialists. Due to frequent review of the FRU performance the situation changed.
Prerequisites	Availability of local anaesthetist within the reach of the FRU /PHC. Delays should be avoided in the release of funds to the anaesthetists.
Who needs to be consulted	State and District level officials. Medical Officers at FRUs and PHCs. Government doctors association.
Risks	
Sustainability	Sustainable if the funding is in place.
Chances of Replication	Tamil Nadu Public Health department plans to continue the scheme under RCH2 and to extend it to the urban municipal corporation hospitals.
Comments	None
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	GO.doc — Government Order No 475 dated 10-11-1999 regarding hiring of anaesthetists for abortion services at PHCs
Reference Links	

212. Providing round-the-clock Comprehensive Emergency Obstetric and Newborn Care centres, Tamil Nadu

Subject Area="First Referral Units."	**Objective="24 hour service."**
Details for Reform Option "Providing round-the-clock Comprehensive Emergency Obstetric and Newborn Care centres, Tamil Nadu"	
Summary	**Background:** A large number of maternal and infant deaths can be prevented if emergency services are made available within the reach of people's homes. Though there are 163 designated First Referral Units (FRUs) in Tamil Nadu, round the clock services for obstetric and newborn emergencies are not available in all the FRUs. **Action:** It was decided to select two to three hospitals in each district and fully equip them with necessary infrastructure and human resources, certify the hospitals and closely monitor them to ensure the availability of services. Sixty-two such hospitals known as Comprehensive Emergency Obstetric and Newborn Care (CEmONC) centres were set up all over Tamil Nadu. In the first phase, a minimum of two CEmONC centres have been established in every district – one at the district hospital and the other at either the teaching hospital or the taluk (block) level hospital. These have 4 obstetric and gynaecology specialists, 4 paediatric specialists, two general surgeons and two anaesthetists. The services of private anaesthetists and obstetricians have been hired in places where there has been a shortage of these specialists. In addition, general surgeons have been given training in obstetric and gynaecological surgical interventions and have been empowered to conduct Caesareans. CEmONC centres will focus on blood availability round the clock and a two-day training programme on blood bank services for doctors and staff nurses of these centres was organised by the Directorate of Reproductive and Child Health Project in collaboration with UNICEF. All the nurses, lab technicians and doctors perform grouping, cross matching of blood, transfuse the blood and manage the transfusion reactions without depending on the blood bank staff. **Results:** Maternal mortality has dropped by 36 per cent between 2001 and 2005.
Cost	Blood bank training for all the doctors, nurses and lab technicians in 270 hospitals cost INR 20 lakhs . The recruitment of additional specialists cost around INR 56 million per year. The cost of employing a specialist per annum would be approximately INR 2.4 lakhs per year. As the equipment was already available, no additional cost was involved but it is advisable to conduct a facility survey to asses the infrastructure, equipment and human resource

	requirements of the CEmONC hospitals before beginning the initiative.
Place	Tamil Nadu since August 2004.
Time Frame	Facility survey: Six months. Blood bank training: Three months. Procurement of equipments & recruitment of specialists: One year.
Advantages	Life-saving: Expected to bring about a decrease in the IMR, MMR and morbidity levels. Extends service: Ensure availability of emergency services for complicated deliveries, sick newborns and adequate blood round-the-clock. Quality: Improve the quality of maternal and newborn care.
Challanges	None perceived.
Prerequisites	Government Order. Funding support. Available staffing levels.
Who needs to be consulted	All programme officers at the district and state level. Director of Medical and Rural Health services to provide the training.
Risks	
Sustainability	Expected to be good, if the funding is available.
Chances of Replication	Already implemented in 62 centres in all the districts of the state. An additional 50 centres will be made functional under RCH 2 so that the mothers can reach a CEmONC centres within half an hour of travel, wherever they live in the district.
Comments	None.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, October 2004. Updated February 2006.
Status	Active
Reference Files	CEmONC_GO.doc — GO No. 2D. No 42 dated 2 August 2004 on Identification of Government Hospitals as CEmONC CEmONC clipping.htm — Newspaper clippings dated 20 May 2004
Reference Links	

213. Comprehensive plan to assess operational needs of First Referral Units, Madhya Pradesh

Subject Area="First Referral Units."	Objective="24 hour service."
Details for Reform Option "Comprehensive plan to assess operational needs of First Referral Units, Madhya Pradesh"	
Summary	**Background:** Huge operational difficulties including lack of staff, training, equipment, maintenance and poor availability of drugs were preventing First Referral Units (FRUs) in the State, including some district hospitals, from functioning. **Action:** The State Government, under the European Commission-assisted State Improvement Programme (SIP), drew up an action plan to carry out rapid and comprehensive assessments of the operationalisation needs of FRUs. It developed a operationalisation needs assessment form which took a comprehensive look at the physical condition and location of the FRU, its manpower, their training, the service it provided, other services in the area and the quality and quantity of its existing equipment and supplies. It drew on facility survey assessments previously carried out by UNICEF and UNFPA. The exercise was initiated in July 2004 with the intended goal of making at least one facility fully operational at each block headquarters. The needs assessment was carried out by the Medical Officers/ Post Graduate Medical Officers (MOs/PGMOs) posted in the FRUs, approved by the District Health Societies and further cross checked by officials of the Directorate of Health Services. The MOs/PGMOs were given training on how to fill in the form via the State's SATCOM system. Once the needs were assessed at headquarters (this took about 4.5 months), moves were made to operationalise the FRUs. This included: (i) Appointment of specialists on contract by the District Health Societies responsible for the facility. (ii) Procurement of equipment (both by district as well as state in line with the delegation of powers, approved specifications of the equipments and guidelines by the Government of India GoI). (iii) Training of MOs in speciality skills and refresher training for PGMOs. (iv) Contracting in of private specialists.

	(v) Provision of referral transport charges to women belonging to the Below Poverty Line and Scheduled Caste and Scheduled Tribe category needing institutional delivery/emergency obstetric care. (vi) Matching grant to Rogi Kalyan Samitis for effecting planned improvement in service delivery. **Results:** Implementation of the scheme was initially weak as MOs/PGMOs failed to understand the importance of giving a comprehensive needs assessment and the FRUs had to be visited twice by officials from the Directorate of Health Services before this was finally achieved. However, at the time of writing (May 2005), advertisements had been placed for 137 specialist vacancies in 173 FRUs. In addition INR 2.58 Crores of equipment had been ordered and training had begun of existing MOs/PGMOs in anaesthesia, paediatrics and gynaecology.
Cost	INR 24 Crores under EC-supported SIP to carry out the needs assessment and operationalise the FRUs. Site visits of 24 senior health officers to FRUs to carry out needs assessment cost approximately INR 12 lakh.
Place	Madhya Pradesh at all district hospitals, civil hospitals, community health centres, Primary Health Centres with the criteria that there will be at least one Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) facility for a population of five lakhs and 50% PHCs to provide Basic Emergency Obstetric and Neonatal Care (BEmONC). Scheme started July 2004.
Time Frame	Two to three weeks to draw up the operational needs assessment form. One day orientation of senior health officers in how to use the form. Three hours for them to train MOs/PGMOs (via SATCOM system).
Advantages	Systematic: Provides a routine and comprehensive way to assess the needs of each FRU. Efficient: When done properly, the needs assessment can be done in just four days. Improved coverage: Will supply an unmet need for CEmONC and BEmONC.
Challanges	Officer dependent: The MO/PGMO must take the exercise seriously. In this case, many did not and passed the form to the computer operator to fill in – giving poor results. Possibility for misinterpretation: Many of the MOs/PGMOs limited themselves to talking about equipment and did not include building/site condition or manpower. Requires comprehensive training: Senior health officials and the MOs/PGMOs need good training to understand that the form is more than just a questionnaire and requires thought and time.
Prerequisites	Needs assessment form. Training of MOs in how to fill it in. Team to

	assess the forms. Funds to carry out the improvements once the assessment has been done.
Who needs to be consulted	Directorate of Health Services.
Risks	
Sustainability	Moderate: depends on funding. This scheme has been funded by the EC until December 2005 and then will be included under Reproductive Child Healthcare 2 (RCH2).
Chances of Replication	Judged to be promising.
Comments	Practical but needs careful handling. In this case, many MOs/PGMOs did not take the exercise seriously and took more than one month to return the form. The forms were often returned incomplete and the State then had to send a team of senior health officials out to the FRUs to complete them. It then took them two attempts to complete the forms properly. Only one FRU filled in the form correctly on the first attempt.
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. May 2005.
Status	Active
Reference Files	NeedsAssessment Format for FRUs.doc — Needs Assessment Form for FRUs ToRs for the Assessment Team.doc — Terms of Reference for the Assessment Team
Reference Links	

214. Certification of Comprehensive Emergency Obstetric and Newborn Care Centres, Madhya Pradesh

Subject Area="First Referral Units."	Objective="24 hour service."
Details for Reform Option "Certification of Comprehensive Emergency Obstetric and Newborn Care Centres, Madhya Pradesh"	
Summary	**Background:** Madhya Pradesh has a high Maternal and Infant Mortality Rate (MMR and IMR). Data indicates that 75 % of all maternal deaths take place during the natal and postnatal periods with one fifth of all deaths taking place during transfer to an appropriate and affordable health facility following the onset of an obstetric emergency. Given this background, it was decided that MMR and IMR depends crucially on the availability of 24-hour Emergency Obstetric services, thus all First Referral Units (FRUs) are now expected to provide these round-the-clock services and are referred to as Basic or Comprehensive Emergency Obstetric and New Born Care service (BEmONC or CEmONC) centres. (BEmONC centres provide 24 hour delivery and neonatal services while CEmONC centres offer additional services including Caesarean section or blood transfusions). To maintain standards, it was decided to introduce a process of certification for CEmONC centres to ensure they were properly staffed and equipped and functioning efficiently. **Action:** The State Government passed a Government Order identifying what services and facilities a CEmONC Centre must provide. (See References for full details). These include: (i) Easy access, 24-hour service and accountable staff providing quality service. (ii) List of services. (iii) Obstetric and paediatric casualty facilities (including anaesthetist) available round-the-clock. (iv) Staff nurses trained in labour room procedures, new born resuscitation, blood bank operations and operation theatre work. (v) Hiring of private anaesthetist and obstetrician where applicable. (vi) Functional blood bank and storage with fully trained staff available 24 hours. (vii) Functioning equipment and 24-hour availability of essential drugs. (viii) Sanitary conditions with responsibility assigned to officer in

charge of the institution.

(x) Monthly coordination/review meetings for FRU staff and Medical Officers/ Lady Health Volunteers/Auxiliary Nurse Midwives from local Primary Health Centres/Sub Centres to improve referral and service delivery.

(xi) Minimum staff structure and infrastructure requirements. The same Government Order also details the process for certification of each centre:

(i) A committee of gynaecological, paediatric, surgery, anaesthetist and technical experts from district hospitals, state headquarters and development partners was formed and empowered to certify centres.

(ii) The committee visits each CEmONC centre only after the Chief Medical and Health Officer (CMHO) has declared that the centre meets the necessary criteria of CEmONC to the Directorate of Public Health and Family Welfare (DPHFW).

(iii) Each centre is visited by this 'certification agency' and must prove it meets the necessary criteria based on the requirements listed above. (See References for Criteria form).

(iv) Reports are also examined by an accreditation committee at State level chaired by the DPHFW.

(v) Once the centre has been accredited it may display a board publicizing that it has been certified by the State Government as a 24-hour provider of CEmONC services. Motivation is provided with the promise of assured placement of manpower, training and prioritised and additional budgets for repair of buildings and equipment. Standards are ensured by monthly reporting (see Results section).

Results: The first round of accreditation was being carried out at the time of writing (February 2006). The committee has been told it must complete inspection and accreditation where applicable of 38 district hospitals by March 31 2006. There are a further 132 institutions (including Civil Hospitals and Community Health Centres) which then need to be inspected. However at the time of writing, the process of certification was not yet complete due to slow progress having the facilities operationalised. The local Development Partners Technical Assistance Team is also designing a new reporting mechanism for these facilities (170 CEmONC and 500 BEmONC) which will include the following five UN indicators:

(i) Quantum of EmOC services available.

(ii) Geographical distribution of EmOC facilities.

	(iii) Proportion of all births in BEmONC and CEmONC facilities. (iv) Met need for EmOC. (v) Caesarean sections as a percentage of all births. (vi) Case Fatality Rate.
Cost	INR 437,000 for the first round of inspections (38 institutions).
Place	Madhya Pradesh since January 2006.
Time Frame	Three months.
Advantages	Evaluation: Ensures all CEmONC centres achieve minimum standards in healthcare provision, staffing levels and infrastructure. Accountability: The inspections make medical and paramedical staff feel more responsible for the services they are delivering. Coordination: Improves communication and therefore referrals between the districts or rural areas and the FRU.
Challanges	Sustainability: Must ensure repeat inspections to maintain standards. Special inspections are to be commissioned if significant deficiencies are noticed in the monthly performance report.
Prerequisites	Government Order. Criteria for accreditation. Inspection committee.
Who needs to be consulted	Secretary Medical Education. Commissioner Health. Directors of Medical Services and Medical Education. Deans of Medical Colleges. Directorate of Health Services directors. District Collectors. Chief Medical and Health Officers. Civil Surgeons.
Risks	
Sustainability	As the reform is new, this is difficult to judge. It will require a sustained effort by policy and decision makers in the Department of Health and Family Welfare.
Chances of Replication	Judged to be very good.
Comments	None.
Contact	
Submitted By	GS Sachdev, ECTA State Facilitator, Bhopal. March 2006.
Status	Active
Reference Files	Order - Provision of CEmOC.doc: Government Order: Provision of CEmONC, Madhya Pradesh
Reference Links	

215. Outreach blood donation camps, Tamil Nadu

Subject Area="First Referral Units."	Objective="Improved blood supply."
Details for Reform Option "Outreach blood donation camps, Tamil Nadu"	
Summary	**Background:** Although there is a general willingness by people to give blood, there was no system for allowing them to donate easily without travelling long distances to blood storage centres. **Action:** To hold blood donation camps in the community on pre-set dates at a set venue, eg schools, colleges and community centres. The donors will then know which day of the month the blood bank team will be there. A register of donors is created which includes their blood type so that those with rare blood types can be contacted in times of emergency. Each donor is screened before donation and given a certificate after donation. The campaign also aims to clear up myths and misconceptions about blood donation which allows donors to come forward. People are encouraged to come and watch the process before deciding whether they wish to give blood or not. The collected blood (after mandatory testing) is given to patients in Government hospitals and sold to private hospitals in cases of genuine emergency. **Results:** In the period 30 April 2003 and 11 June 2004, 19 outreach camps were held and 1,539 units of blood collected.
Cost	Each camp costs INR 1,000 to hold.
Place	Theni District, Tamil Nadu, since April 2003.
Time Frame	One month to develop a district micro plan.
Advantages	Education: Dispels myths and misconceptions by allowing people to see how blood donation is carried out. Systematic: The camps are held at the same place and on the same day of the month so they are easy for people to remember. Saves lives: By ensuring a constant supply of blood to the blood banks.
Challanges	None perceived.
Prerequisites	Availability of suitable facilities to hold the camps. A trained blood donation team – including lab technicians.
Who needs to be consulted	State Government health services departments. Blood Bank medical officers.
Risks	

Sustainability	Sustainable provided the funding is there.
Chances of Replication	It is planned to scale up the campaign in all districts in the state under the RCH II programme on fixed dates in every month as well as on the birthdays of leaders.
Comments	None
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. September 2004.
Status	Active
Reference Files	PROD76.jpg — Blood donation camp at Andipatti Blood donation campaign Theni District.doc — Report: Blood donation campaign: An innovative life-saving project implemented in Theni district for timely availability of blood for emergency obstetric and other cases and scaling up for all districts. (Tamil Nadu State Government).
Reference Links	

216. Birth Companionship Programme, Tamil Nadu

Subject Area="First Referral Units."	Objective="Scope and quality of First Referral Units."
Details for Reform Option "Birth Companionship Programme, Tamil Nadu"	
Summary	**Background:** Relatives were banned from maternity wards in Government institutions across the State, leaving women to deliver without any support from someone they knew. Studies have shown that allowing a woman to be comforted, reassured and praised during childbirth has many benefits including the following: (i) Shorter labour (ii) Less pain medication (iii) Fewer medical procedures (iv) Decreased rates of Caesarean section (v) Increased satisfaction with birthing experience and less postpartum depression. (vi) Early initiation and continuation of breast feeding. **Action:** After a pilot scheme in two Emergency Obstetric Care Centres in Corporation of Chennai, a Government Order was passed in July 2004 allowing one female companion to be admitted to the labour ward in all Government hospitals in the states with the expectant mother. The birth companion must have: (i) undergone labour herself (ii) agreed to wear clean clothes, an identification tag and to attend the whole labour (iii) agreed not to interfere in the work of the hospital staff and the treatment procedures or with any other woman undergoing labour in the same ward (iv) be free of communicable diseases. The order applies to all teaching hospitals, district and sub district hospitals in the State. The practice was already being informally carried out in Primary Health Centres and Health Sub Centres and this is to be continued. A one-day training/sensitisation programme was carried out at each hospital for the labour ward staff nurse and doctors in an effort to overcome opposition to the scheme. The pilot scheme found that most opposition was overcome once the doctors and nurses saw the

	benefits for themselves. **Results:** First documentation of the results of the programme was just beginning in February 2006. These will be posted once they are finished. Nodal officers have been appointed at each institution to monitor the scheme, looking at the number of Caesarean sections and the number of new mothers breastfeeding. They have also conduct exit polls of mothers to gauge satisfaction with the service.
Cost	State level workshop to draw up action plan: INR 60,000 Training film: INR 20,000 District level training: INR 9,000
Place	All Government hospitals in Tamil Nadu from August 2004.
Time Frame	Two month pilot scheme. One month to provide training/orientation at each institution.
Advantages	Low-cost: International studies have shown that a birth companion can reduce the number of Caesarean sections and pain control needed (see documents below). Increased patient satisfaction: improves the birthing experience for the mother. Health benefits: leads to less postpartum depression and increased breast feeding.
Challanges	Possible opposition: from doctors and nurses who fear relatives will interfere with the birthing process.
Prerequisites	Government Order. Action plan. Training/orientation material.
Who needs to be consulted	State government: specifically the director of Medical and Rural Health Services, the director of Medical Education, the director of Family Welfare, the director of Public Health. Obstetricians, gynaecologists and staff nurses at Government hospitals.
Risks	
Sustainability	The programme is extremely low cost. It has already been implemented successfully for four years at the CMC Hospital, Vellore.
Chances of Replication	If there is enough political will to bring about a Government Order there is no obvious reason why this scheme cannot be easily replicated.
Comments	None
Contact	
Submitted By	Clare Kitchen, Research Consultant, ECTA, New Delhi. September 2004. Updated Februray 2006.
Status	Active
Reference Files	Note on Birth Companionship Programme.doc — Summary note on Birth companionship programme.

Reference Links	

217. Strengthening community health centres to avoid maternal deaths, Rajasthan

Subject Area="First Referral Units."	**Objective="Scope and quality of First Referral Units."**
Details for Reform Option "Strengthening community health centres to avoid maternal deaths, Rajasthan"	
Summary	**Background:** The Averting Maternal Deaths and Disability (AMDD) project covers a population of 13 million in Rajasthan. According to a need assessment survey conducted in 2000, met need for Emergency Obstetric Care (EmOC) was as low as 8% and institutional births were 11%. The main cause was that most of the Primary Health Centres (PHCs)/ Community Health Centres (CHCs) were not prepared for EmOC because of an absence of specialists in obstetrics, gynaecology and anaesthesia. **Action:** (i) Because the availability of obstetric and gynaecology specialists and anaesthetists at CHCs was low, a training module was finalised to train the available graduates. (ii) The doctors were trained to manage emergency before, during and after labour including heavy bleeding, fever after childbirth, high blood pressure, obstructed labour, resuscitation of a newborn baby, etc. (iii) A list of 145 items was prepared including storage facilities, furniture, medical equipments, etc. and was procured through the District RCH Society. (iv) A mobile maintenance team was set up to service the old instruments. (v) Essential drugs were also procured. (vi) The infrastructure of several CHC/ Block PHC structures was renovated to become client-friendly and reduced the risk of infection. (vii) The state government set up blood storage units at sub district hospitals.

	(viii) Staff at 27 institutions were trained for prevention of infection during delivery. For this purpose, 12 teams of master trainers were trained. (ix) The project also initiated improvement of quality of care. The staff of district hospital – Alwar - were trained in EmOC. A hospital-based action plan was prepared and implemented at the hospital. Efforts were made to assess the status of quality of EmOC services being provided, using a Quality Improvement Module developed by Engender Health. (x) Community awareness building through orientation workshops for local representatives at state, district, block and Panchayat levels and media campaigns. The main purpose was to orient local representatives about the danger signs during pregnancy and about early referral. Another important message was about donating blood when the situation requires. **Results:** The project was completed in December 2003 but the evaluation process hasn't yet started (March 2004). But the following results have been recorded: An increase in institutional births by 16.5% from the baseline figure. Delivery complications treated increased from 5,607 in 2000 to 9,128 in 2003. This indicates that more cases of complicated deliveries were referred to the project institutions. The met needs for emergency obstetric care increased from 8.8% in 2000 to 14% in 2003.
Cost	On an average, cost of renovation of operation theatre in each hospital was INR 329,000.
Place	Seven districts in Rajasthan- Alwar, Bharatpur, Karol, Sawai Madhopur, Bhilwara, Chittorgarh and Udaipur. From January 2001 – December 2003.
Time Frame	Information not available.
Advantages	Bottom-up approach: It tackles the problem from the bottom up, ie from the first referral unit level. Comprehensive: It includes technical, managerial and community empowerment inputs. Availability and awareness: It aims to ensure availability of the service and at the same time increase community's awareness about the facilities available and when to refer.
Challanges	No significant disadvantages recorded.
Prerequisites	A needs assessment followed by a comprehensive plan to cover training, renovation and other activities.
Who needs to be consulted	All the stakeholders including the PHC, CHC, medical officers, district hospitals.
Risks	

Sustainability	Sustainable provided the trained doctors remain at the facilities. It would also require refresher courses for the doctors and nurses. For financial sustainability, continuous support is required.
Chances of Replication	The programme has already been replicated successfully in 7 districts in Rajasthan.
Comments	The AMDD project was implemented as a component project in the UNFPA-supported Integrated Population Development Project with financial support from the Bill and Melinda Gates Foundation.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi, September 2004.
Status	Active
Reference Files	
Reference Links	

218. Improving blood availability in peripheral health institutions, Rajasthan

Subject Area="First Referral Units."	Objective="Scope and quality of First Referral Units."
Details for Reform Option "Improving blood availability in peripheral health institutions, Rajasthan"	
Summary	**Background:** High maternal mortality is one of the major causes for concern in the health sector in India. One of the factors behind this high rate is a lack of blood for good blood transfusion services, good blood storage facilities and education so that family members and the community are willing to give blood. The Government of Rajasthan, in collaboration with UNICEF, identified the absence of blood storage facilities at Community Health Centres (CHCs) as a major difficulty in averting maternal deaths as rough terrain and lack of adequate transport facilities delayed getting blood from blood banks at district headquarters especially during emergencies. Initially, it was mandatory for the CHC to organize blood storage camps for district hospitals and in return the CHC could procure requisite blood from district hospitals on payment. But in 2003, the maternal and health division, government of India published the guidelines for setting up blood storage centres and first referral units to prevent the delay in transporting blood from the district hospital and the need for payment. This facilitated the states to take up this initiative for the benefit of the population. **Action:** At the start of this UNICEF/UNFPA/Government of Rajasthan project, only one blood bank was functioning in each of the three districts targeted. Infrastructure and laboratory facilities were poor, basic equipment and medicines were often unavailable and record keeping was weak. (i) Blood storage centres with blood transfusion facilities were set up in six first referral units (FRUs) and a training programme was drawn up and implemented for medical and laboratory staff. It was decided that “no woman will be referred to a higher centre or die for want of blood in this hospital”. (ii) A checklist for operationalising and guidelines for functioning of blood storage units were drafted. Guidelines were also translated into the local language. (iii) As per the guidelines, the CHC Medical Officer (MO) is responsible for blood storage units and returning unused blood units at least 10 days before expiry to district hospitals. (iv) CHC MO is responsible for providing the Principal Medical Officer (PMO) with a monthly requirement of blood units. The blood is

	supplied on a monthly basis. (v) Four-day training was organized for MOs and lab technicians in handling blood units. (vi) A room was earmarked within CHC for housing the blood storage equipments. It was seen that CHC has regular supply of electricity for the blood unit to be functional. (vii) Recruitment and maintenance of a panel of voluntary blood donors. This was intended to complement blood donated by family members (who are frequently resistant to the idea) for women relatives in urgent need. (viii) Voluntary blood donation camps on occasions such as International Women's Day and Independence Day etc., with the support of local NGOs and influential members of the community. (ix) Activities were undertaken aimed at motivating people to participate in blood donation by dispelling myths and misconceptions and certificates of appreciation were distributed to voluntary donors on Independence and Republic Days. (x) A list of donors with rare groups was drawn up and maintained in the blood bank. **Results:** Under this programme, six FRUs now have fully functional blood storage units. Under further programmes which had the support of the European Commission Sector Investment Programme, nine more were made functional. All experienced delays in setting up functional units because of a delay in equipment procurement which was done at state level. Voluntary donations have almost doubled. Total collection of blood in the hospital has increased. Use of blood in the maternity departments has increased (by 70% and 150%) in two of the three hospitals (the other needs further work). Deaths due to haemorrhage have decreased by 70%.
Cost	Cost information is not available – but after improving storage facilities, the cost of running the project is negligible
Place	Rajasthan. 2000 – 2003. Initially in Jhalawar, Dholpur and Barra districts. Now being replicated in all districts.
Time Frame	Three years.
Advantages	SService delivery: Availability of blood storage facilities within the CHC premises improved the quality of services. Such as conducting C-section delivery, accident cases etc. Access: The availability of blood at lower administrative unit increase people's access to emergency care.
Challanges	Maintenance: Constant power supply is necessary to maintain

	optimum temperature for storing blood. Skills: Blood storage unit officer-in-charge and lab technician need regular training. Monitoring: Blood storage unit should be regularly monitored. Equipment procurement: Many FRUs have been held up waiting for equipment and supplies to be provided.
Prerequisites	Availability of equipments. Regular supply of electricity to maintain the blood storage unit. Trained medical doctor to handle blood transfusions.
Who needs to be consulted	State government. MO in charge of FRUs District hospitals Local NGOs.
Risks	
Sustainability	Once the initial expenditure to improve storage facilities has been undertaken, the cost of this action is negligible and local demand will ensure sustainability.
Chances of Replication	On condition that money can be found for the capital expenditure necessary to improve storage facilities, the action should be replicable. Following evaluation, the State Government of Rajasthan has now decided to implement the project throughout the state with funding from several development partners.
Comments	Even in very unpromising settings, such as in Empowered Action Group (EAG) states, significant progress can be made through low-cost interventions aimed at strengthening infrastructure.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, New Delhi. September 2004. Updated Dr Nandini Roy, HS-PROD Research Consultant, NIMS, October 2005.
Status	Active
Reference Files	scan.pdf Binder1.pdf BSU_certificate.pdf 00970008.jpg
Reference Links	

219. Organisation of the referral system, Kharar Hospital, Punjab

Subject Area="First Referral Units."	Objective="Scope and quality of First Referral Units."

Details for Reform Option "Organisation of the referral system, Kharar Hospital, Punjab"

Summary

Background: The patient referral system in Punjab is disorganised and haphazard. A patient has to go through certain administrative procedures and queue up for his or her turn when he or she goes for treatment to, say, a Primary Health Centre (PHC). When he is referred to another facility, for example, a district level hospital, the patient has to follow the same procedure all over again. And again, after treatment at the big hospital, when he goes back to the PHC for follow-up checks, he has to stand in queue and go over the whole process yet another time. This causes great inconvenience to patients. Lack of organisation in the patient referral system also creates excessive patient load on Community Health Centres and District Hospitals. The Punjab Health Systems Corporation (PHSC) was set up as part of a World Bank project in 1995 to revamp the delivery of the secondary level government healthcare system. (See PROD entry No 145: Punjab Health Systems Corporation, Punjab). Systematising the practice of referring patients to a higher facility and back was one of the crucial reforms brought about by PHSC. A case study of Kharar Hospital highlights the difference this reform has made.

Action: Kharar Hospital was functioning as a 30-bed hospital with a trauma unit. After being taken over by PHSC, in October 1996, it was upgraded to a 50-bed hospital. Until then patient referral was being done on the normal Out Patient Department (OPD) slip. PHSC took the following steps to rationalise the referral system: Zoning: Units referring cases to district Civil Hospitals were grouped into zones on the basis of rural roads leading to the district town. Thus the Civil Hospital has patients referred from 22 subsidiary dispensaries, one Primary Health Centre (PHC) and one Community Health Centre (CHC). Though patients coming from other zones are not refused primary treatment, they are referred back to their particular administrative zone for follow-up. Grouping into zones helps referring units as it leaves no room for confusion regarding where to send patients for treatment.

Referral cards: Referral is a two-way process—one, when a patient is referred to a higher facility and two, when he or she is referred back, after treatment, to the original facility for follow-up. Colour-coded referral cards, according to the type of health facility, were introduced, where CHCs and PHCs refer on blue cards to sub-divisional hospitals, which in turn refer on a green card to the district hospital. Referral of patients from the district hospital is on a

	white card. The card serves as an OPD ticket. No fee is charged from a patient with a referral card; it gives the patient direct access to the concerned speciality, bypassing the OPD queue. The patient is also provided feedback cards so that the referring doctor gets information with regard to improvements made by the patient. Mismatching in the posting of specialists minimised: The government system of posting is often irrational whereby specialists, like a surgeon or an ophthalmologist, is sent to a PHC while a general physician is posted in a CHC or a district hospital where there is demand for the specialist's skills. PHSC corrected this anomaly with internal re-arrangements (deputation) within a district so as to make the specialist available at the referral unit. Besides creating a new system, other changes were introduced to the hospital to strengthen the referral system: Infrastructure: Only one Operation Theatre (OT) was functiong till PHSC took over Kharar Hospital in 1996. In the process of strengthening infrastructure, this was converted into a labour room and three new OTs were constructed, one each for Gynae, Surgery and Ophthalmology. Four new wards were also added—two emergency and two male wards. Equipment: were made available according to norm and in working condition. Maintenance of the equipment was done through annual maintenance contract; 15% of the user charge was earmarked for repair and maintenance. Ambulance service: Two ambulances were made available round-the-clock; recurring cost of running the ambulances was met by levying a nominal user charge at the rate of INR 3.50 per kilometre. Laboratory test facility: Laboratory has been provided with semiautomatic analyser and range of tests to be conducted increased according to norms for the facility. Blood Bank: Blood bank services were revived after a gap of 4 years, in 2000, as per guidelines with a capacity of 50 units of whole blood per month. Workforce: Vacant posts in the non-clinical services were filled by contractual appointments. At present, there is no vacant post in the hospital. **Results:** Though no proper study has been conducted to evaluate the refurbished referral system, the patient certainly stands to gain. Healthcare providers are also able to utilise a particular health facility according to its strength.
Cost	Capital cost was needed basically to strengthen infrastructure and to revive the blood bank. Recurring cost of laboratory tests, ambulance, etc are taken care of by revenue collected from user charges.
Place	Kharar Hospital, Punjab.
Time Frame	Approximately one year
Advantages	Early diagnosis and referral: Improved laboratory facilities help determine the kind of treatment required and the new organised

	system makes quick referral possible. F Faster: Referred patients are given due care and privilege of bypassing the formalities for consultation. Follow-up: System of back referral gives the opportunity to treating physician to follow up on their patients. Rational utilisation: A proper referral system prevents both over and under utilisation of the health facilities.
Challanges	Unwillingness of doctors to comply with internal deputation.
Prerequisites	Government order.
Who needs to be consulted	State Government, Tertiary care hospital.
Risks	
Sustainability	Only in the initial phase clinical and para-clinical staff needs orientation training to follow the defined referral norms in favour of patients.
Chances of Replication	Replicable. Internal deputation of specialists, colour coded referral cards and strengthening of the services at the first referral unit makes the referral system efficient.
Comments	A strong and efficient referral system depends, to a large extent, on simultaneous upgradation of facilities. Along with making referrals more systematic it is important to strengthen services at the health centres.
Contact	
Submitted By	Dr. Anuradha Davey, Research Consultant, National Institute of Medical Statistics, May, 2006.
Status	Active
Reference Files	Referral card-Punjab.jpg
Reference Links	

220. Contracting specialists for community health centres, Gujarat

Subject Area="First Referral Units."	Objective="Medical specialists."
Details for Reform Option "Contracting specialists for community health centres, Gujarat"	
Summary	**Action:** State government agrees to allow unused funds from vacant specialist posts in Community Health Centres (CHCs) to be used to contract private practitioners or government doctors at CHCs twice each week at a rate of INR 500 (later increased to INR 1000 per visit.
Cost	Information not available.
Place	Narmada District, Gujarat, from September 2002. Later extended to Rajkot District.
Time Frame	Three months.
Advantages	Improves quality of service: Ensures access to specialist services at CHC on regular basis.
Challanges	Limited cover: Specialist services only available at CHC at specific times. Corruption: Private practitioners may subsequently lure patients to their private clinics and charge exorbitant prices.
Prerequisites	Specialists available in the area or willing to come to the area.
Who needs to be consulted	State government, specialists, CHC superintendent, district agency.
Risks	
Sustainability	Good; funded from an unused regular budget.
Chances of Replication	Good.
Comments	Complements provision of services in a similar manner at Primary Health Centres (PHCs) funded by World Bank Reproductive and Child Health Programme.
Contact	
Submitted By	Dr Uma Vyas, Programme Advisor, ECTA, Gujarat. July 2002.
Status	Active
Reference Files	
Reference Links	

221. Operationalisation of a First Referral Unit, Maharashtra

Subject Area="First Referral Units."	Objective="Access to RCH services."
Details for Reform Option "Operationalisation of a First Referral Unit, Maharashtra"	
Summary	**Background:** The population of Osmanabad district is 1,472,256, of whom the vast majority (1,239,009), live in rural areas. This population was served by three Primary Health Centres (PHCs), one of them situated at Washi, which referred patients to the District Hospital at Osmanabad, 65km from Washi. The rates of maternal mortality (MM) and infant mortality (IM) were high in the district and institutional deliveries were low. In 1999 a Women's Right to Life and Health (WRLH) project was implemented in Maharashtra under UNICEF's border district cluster strategy (BDCS). Its aims were to reduce MM and IM by providing 24-hour comprehensive emergency obstetric care (C-EMOC) through identified First Referral Units (FRUs). Under a pilot scheme, four FRUs from Osmanabad district were selected as EMOC centres. Washi rural hospital was one of them. Washi operated as an FRU from 1999 but was not fully operationalised until 2002 since the specialists at the clinic during that time were not able to perform emergency operations. **Action:** In 2002 Washi rural hospital was upgraded and provided with a dedicated EMOC team consisting of three specialists: a gynaecologist, an anaesthetist and a paediatrician. The unit also employed an additional Medical Officer and seven staff nurses as well as a laboratory technician, x-ray technician, ophthalmic assistant and various support staff. Facilities at FRU Washi, including an operating theatre equipped with instruments supplied by UNICEF, and 24-hour water and electricity supply, enable it to offer the following: (i) Out patient and in patient services (ii) C-EMOC services including blood transfusion (iii) Laboratory services (iv) Major and minor operations in theatre (v) X-ray facility (vi) Ambulance services (v) Medico-legal work including post-mortems. The unit also follows

	six National Health Programmes: (i) Family planning (ii) Maternal and child health (iii) Revised national tuberculosis control (iv) Leprosy control (v) Malaria control (vi) Control of blindness **Results:** Between 2000 and 2005, FRU Washi has seen steady improvement in the number of obstetric admissions, live births and successfully treated complications. (i) Obstetric admissions have risen from 562 in 2000 to 971 in 2004. (ii) Deliveries have more than doubled from 328 to 700. (iii) Live births have risen from 325 to 685. (iv) Obstetric complications treated have gone from nil to 164. (v) There have been no maternal deaths at the hospital since July 2002. Additional training has also resulted in: (i) Sensitisation of staff. (ii) Improvements to the ante-natal clinic including screening of high risk patients. (iii) Monitoring of progress of labour using partograph. (iv) Effective infection prevention practises and disposal of waste. (v) Use of anaesthesia during obstetric surgery. (vi) Efficient record keeping.
Cost	Information not available.
Place	Rural hospital Washi, Nr Kunthalgiri, Osmanabad, Maharashtra.
Time Frame	Two and a half years from implementation of WRLH project to operationalisation of FRU, Washi. Following upgrade and posting of specialists in 2002, comprehensive emergency obstetric care services took immediate effect.
Advantages	Access to obstetric care: Provides emergency and non-emergency specialist care to patients who would have had to travel long distances to district hospital.

	Increased institutional deliveries: Proximity of services encourages patients to choose institutional over home delivery.
Challanges	Dependent on specific skills mix: Should one specialist be transferred there is no guarantee of another of the same specialisation being posted there. Without the current skill mix the FRU would not be able to provide the same services.
Prerequisites	Availability of specialists. Funding from UNICEF or other donor for initial upgrade and maintenance of equipment.
Who needs to be consulted	Health officials at State and district levels; donor agency.
Risks	
Sustainability	Depends on skills mix within FRU.
Chances of Replication	Depends on funding from donor and availability of specialists.
Comments	None
Contact	
Submitted By	Tessa Laughton, Research Consultant, ECTA, New Delhi. February 2005.
Status	Active
Reference Files	FRU Washi, Maharashtra.jpg — FRU Washi, Maharashtra Maternity ward, FRU Washi, Maharashtra.jpg — Maternity ward, FRU Washi, Maharshtra OT equipment, FRU Washi, Maharashtra.jpg — OT equipment, FRU Washi, Maharashtra
Reference Links	

222. Protocols on Emergency Obstetric and Newborn Care, Tamil Nadu

Subject Area="First Referral Units."	Objective="Providing emergency obstetric training."
Details for Reform Option "Protocols on Emergency Obstetric and Newborn Care, Tamil Nadu"	
Summary	**Background:** Most cases of maternal mortality occur due to complications during pregnancy and childbirth. Similarly two-thirds of neonatal deaths occur during the first week. These deaths can be prevented by early detection and treatment. It is therefore imperative to train and capacitate the birth attendants/health workers to recognise these symptoms and initiate treatment at the earliest possible opportunity. **Action:** The Government of Tamil Nadu has developed and implemented standards of care for the management of common obstetric emergencies at the first referral level. Called “Protocols on Emergency Obstetric Care and Newborn Care”, six protocols have been developed for the immediate management of six most common emergencies seen at First Referral Unit (FRU) level in Tamil Nadu. These protocols are adapted from guidelines for emergency obstetric and newborn care published in the WHO /UNFPA /UNICEF /World Bank manual: “Managing Complications in Pregnancy and Childbirth: a guide for midwives and doctors” and after consultations with senior obstetricians, paediatricians and UNICEF to review and adapt these to the local conditions. The protocols have been brought out in the form of an easy-to-read chart booklet and supplied to all the district and sub district hospitals in the state. The individual protocols (wall charts) are to be displayed in the labour ward and in all other areas in the hospital where such emergencies are seen. The technical basis for each protocol is discussed in the booklet and provides the evidence for management of the emergencies. It is intended that the medical officer in charge of the FRU should initially discuss these protocols with his/her medical and nursing colleagues and provide the necessary training and make available necessary equipments/drugs needed to implement this. These protocols will thus be used in all FRUs whenever a doctor, nurse or health worker is confronted with an obstetric or newborn care emergency. As a first in the implementation of the use of treatment protocols, a training programme was organised for two doctors - one obstetrician and one paediatrician from each district at Christian Medical College, Vellore. These trained doctors in turn trained all the other obstetricians, paediatricians and other doctors providing delivery care and new born care in the district and sub district hospitals. The use of these protocols will be reviewed during

	monthly regional meetings of the chief medical officers. These protocols could also be used as a standard for assessing the quality of care in the obstetric emergencies and it is intended that the quality of care in obstetric emergencies at the FRU should be audited by the team using these protocols. **Results:** No evaluation has been undertaken since this is a very new initiative.
Cost	Estimated cost: Cost of developing protocols: State level workshop INR 1,00,000 Cost of working group INR1,00,000 Cost of printing INR 200 per chart booklet Training of trainers INR 1,00,000 Training of doctors in the FRUs-Cost per FRU INR 10,000 (€ 169) Note : As the treatment manuals are readily available in Tamilnadu,It can be reproduced without any additional cost for development.
Place	All FRUs in Tamil Nadu since January 2004.
Time Frame	The time for development of manuals - 1 month Trainers training - 3 months Training of FRU doctors - 2 months (done simultaneously)
Advantages	Life-saving: Expected to bring about a decrease in the IMR, MMR and morbidity levels. Quality: Improve the quality of maternal and newborn care. Efficiency: It increases the efficiency of doctors, nurses and health workers.
Challanges	None perceived.
Prerequisites	Initiative to be taken by the Department of Health & Family Welfare, involving all stakeholders.
Who needs to be consulted	Reproductive and Child Health (RCH) directorate of the state government, senior obstetricians, gynaecologists and paediatricians and donor agencies working in the field of RCH.
Risks	
Sustainability	Sustainable as this is a one time intervention.
Chances of Replication	Assumed replicable. No perceived problems with replication.
Comments	On a similar initiative, the Government of Chhattisgarh has made available the “Managing Complications in Pregnancy and Childbirth: a guide for midwives and doctors” in a bound form as a training manual for doctors.
Contact	
Submitted By	ECTA, November 2004.
Status	Active
Reference Files	
Reference Links	

223. Integrated Planning and Management of Health Services, Madhya Pradesh

Subject Area="Convergence among Development Partners."	Objective="Coordinated technical assistance to the state government on planning, implementation and monitoring."
Details for Reform Option "Integrated Planning and Management of Health Services, Madhya Pradesh"	
Summary	**Background:** Convergence of Development Partners (DPs) has been a matter of active interest, both among partners as well as state governments. In 2001, DPs in Madhya Pradesh came together to make joint communication to the state government with a view to avoid duplication of efforts and to discuss policy matters with the State Government. This resulted in the State Government seeking to develop a Medium-Term Health Strategy. The strategy document was produced through Technical Assistance (TA) from UK's Department for International Development (DFID) and others. However, the purpose of seeking mandates of DPs on the State-led strategy did not effectively materialise. Subsequently, at the time of developing Reproductive and Child Health (RCH II) Programme Implementation Plan, in 2003-2004, DPs came together to render coordinated TA to the State Government. This coordinated TA was well reflected in the State Programme Implementation Plan (PIP) for RCH-II. It has also led to a need for more refined convergence and concerted action among DPs following the launch of the National Rural Health Mission (NRHM) in 2005. **Action:** DPs, that included DFID, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and European Commission (EC), initiated a series of planned consultations amongst themselves; lately, Japan International Cooperation Agency (JICA) has also joined in. Together, they have produced a set of terms of reference (ToRs) for joint planning and support to the State Government and have requested it to issue an Order whereby the roles of DPs are defined in terms of competence, interest and mandate, as well as geographical area. They have initiated joint visits to districts and now act as independent monitors of various programmes, schemes and projects. **Results:** There is improved coordination and DPs now have a common platform for policy dialogue with the State. DPs meet once a month and a meeting with government representatives is held once in three months. The Bhopal UNFPA office is secretariat of DP convergence. DPs have worked together in

	finalising PIP of RCH-II and NRHM. Following field visits, they share experiences, information and technical viewpoint with the state government.
Cost	Minimal.
Place	Bhopal, since August 2005.
Time Frame	2 months.
Advantages	Effective Planning: Well-defined and previously agreed thematic areas reduce duplication of effort by DPs in the state. Decision-making: The quality of decisions at state level has improved due to integrated approach. Coordination: State government has formalised the role of DPs in policy and implementation consultations; this has led to better acceptance of programmes at the State and district levels.
Challanges	Coordination: Cohesive implementation is still a challenge because DPs have their own programme mandates. Individual mandates and identities dominate, sometimes at the cost of convergence in planning. Personnel: Some of the DPs do not have state technical assistance in the area of health.
Prerequisites	§Continued dialogue among partners and sharing of information in a transparent manner. §Focus on issues of policy, structures and systems. §Focus on improved monitoring mechanism.
Who needs to be consulted	State Programme Coordinator, UNFPA State Government UNICEF JICA. DFID.
Risks	
Sustainability	Highly sustainable, as it only requires coordination in communication and joint consultations with the state government.
Chances of Replication	Excellent.
Comments	A high degree of will on the part of each partner is crucial to the success of convergence among DPs.
Contact	
Submitted By	Sara Joseph, Researcher, ECTA, Bangalore & Dr. Nandini Roy, Research Consultant, National Institute of Medical Statistics. May 2006.
Status	Active
Reference Files	
Reference Links	

224. Establishment of Leprosy Referral Centre LRC in National Leprosy Eradication Programme. Maharashtra

Subject Area="First Referral Units."	**Objective="Early assessment and provision of timely service to leprosy patients."**
Details for Reform Option "Establishment of Leprosy Referral Centre LRC in National Leprosy Eradication Programme. Maharashtra"	
Summary	During October 2006 to March 2008, 48 LRCs were established with the support from ALERT-INDIA and are functioning mainly at Rural Hospitals and in sub-district Hospitals. ALERT-INDIA played the role of facilitator, equipped the LRCs and provided hands on training to selected team. LRCs are manned by Medical Officer of RH (trained in leprosy), Physiotherapy technician (trained in leprosy), GHC workers (Leprosy / health workers – specially the staff nurse at some places). Following services are provided at these LRCs – • Assessment of high-risk patients identified and referred by PHC. • Treatment for neuritis and reaction patients. • Services like self-care, physiotherapy, ulcer dressing, muscle stimulation. • Providing protective aids like splints, Micro Cellular Rubber (MCR) footwear / goggles and ulcer kit to needy leprosy patients. • Back referral of cases to Primary Health Centre (PHC) for follow-up through out-reach programme. • Referral of cases from LRCs to specialised centres for Reconstructive Surgery (RCS), management of non-responding reaction, rehabilitation etc. • Counselling for confidence building and self-care. Following are the results achieved from October 2006 to March 2008 (LRCs were established at varied points of time) • 137 NLEP workers and staff nurse given hands-on training in providing quality services at LRCs activities. • 2954 GHC staff were sensitised on the services available at LRCs (Leprosy/health workers – specially the staff nurses); • 558 (21%) new cases were diagnosed among 2612 suspects

	referred to LRCs; • 326 cases with complications (Reactions/Neurities) managed successfully; • 160 cases provided ulcer care; and • 1340 cases provided with protective aids – MCR sandals and hand splints.
Cost	Cost of establishment of LRC is as below: 1. Physiotherapy equipments: Rs.20,000/-; 2. Dressing instruments/Medicines/consumables: Rs.5,000/- 3. Stationary:Rs.5,000/- 4.Furniture & fixtures:Rs.20,000/- Total cost per center:Rs.50,000/-
Place	Rural Hospital (CHCs) & Sub-District Hospital in Disrricts of Raigad, Mumbai, Thane, Nashik, Nandurbar, Gondia, Gadchiroli of Maharashtra
Time Frame	Alert India has indicated technical & logistic support of these LRCs for initial five years; as capacity building continues LRC activities are being gradually taken over by General Health Care staff of the State Govt. This transfer is slow but has definite long term potential and benefit. The retention of technical staff alongwith GHC staff at these LRCs during this period is crucial to achieve the objective of enabling the GHC staff to provide appropriate services to leprosy affected persons.
Advantages	1. Early assessment and provision of timely services to all high-risk patients' nerve damage will minimize the morbidity due to leprosy. 2. Improvement in disability status of cured leprosy patients. 3. Capacity building of GHC staff will enable them to gradually take over assuming the responsibility/ownership for managing LRCs. 4. Awareness creation in community at PHC level will promote appropriate referrals. 5. Counselling of patients & family members will improve compliance for self care measures. 6. No additional staff appointed – existing GHC personnel were trained and involved to provide quality care at LRCs.
Challanges	Full involvement of local Health authority (District Health Officers, Civil Surgeons etc.). Mobilization and motivation of leprosy patients to avail the specialized services at these LRCs.
Prerequisites	Good network of Govt. health institutes. Commitment of General Health Care staff, referrals from PHCs of needy leprosy patients. Information in the community about LRCs.
Who needs to	District level Health officials, Mid-level Programme Managers, NGOs

be consulted	engaged in leprosy control work and the community.
Risks	-
Sustainability	Today, LRCs supported by ALERT INDIA, in terms of helping the State to establish LRCs in health infrastructure of the Govt. is playing the role of facilitator. The support will be provided till five years. Thereafter the LRC activities will be totally taken over by General Health care System.
Chances of Replication	Experiences of LRC functioning has created enthusiasm among other District Leprosy Officers of the State and shown interest to start LRC in their Districts. The State has proposed this initiative in Annual National Leprosy Eradication Programme (NLEP) as a part of the plan to be supported by GOI as a routine activity. Some of these LRCs will be supported by ALERT-INDIA
Comments	Following are the results achieved from October 2006 to March 2008 (LRCs were established at varied points of time) • 137 NLEP workers and staff nurse given hands-on training in providing quality services at LRCs activities. • 2954 GHC staff were sensitised on the services available at LRCs (Leprosy/health workers – specially the staff nurses); • 558 (21%) new cases were diagnosed among 2612 suspects referred to LRCs; • 326 cases with complications (Reactions/Neurities) managed successfully; • 160 cases provided ulcer care; and • 1340 cases provided with protective aids – MCR sandals and hand splints.
Contact	Joint Director of Health Services (Leprosy & TB), Behind Pune Rly Station, Raja Bahadur Motilal Road, Pune-1. Tel : 020-26058308. E-mail : jtlepsa@rediffmail.com.
Submitted By	Sr. Regional Director (H&FW/GOI) and FSU / CBHI C/O ROHFW Bhopal, M.P.
Status	Active
Reference Files	
Reference Links	

225. Visual sensitisation of general mass on Iodine Deficiency and change their behaviour towards consumption of iodised salt.

Subject Area="Behavioural Change Communication."	**Objective="Raising sensitivity and awareness of health related issues."**
Details for Reform Option "• Visual sensitisation of general mass on Iodine Deficiency and change their behaviour towards consumption of iodised salt."	
Summary	Iodine Deficiency Disorders (IDD) are a major public health problem in Orissa. A study undertaken by the central Goitre Survey Team along with the three Govt. Medical Colleges of the state revealed that 90% of the state is not free from the IDD. In the view of the very high total goitre prevalence rate in the state, the district authorities have taken proactive steps in polularizing use and consumption of iodised salt in the district by trading of iodized salt through SHG in Athgarh Sub-Division.
Cost	Rs. 12,900/-.
Place	Athagarh, Cuttack, Orissa.
Time Frame	
Advantages	
Challanges	
Prerequisites	
Who needs to be consulted	
Risks	
Sustainability	
Chances of Replication	
Comments	
Contact	
Submitted By	
Status	Active
Reference Files	
Reference Links	

226. IODISED SALT TRADING THROUGH Self Help Group(SHG)

Subject Area="Behavioural Change Communication."	**Objective="• Visual sensitisation of general mass on Iodine Deficiency and change their behaviour towards consumption of iodised salt."**
Details for Reform Option "IODISED SALT TRADING THROUGH Self Help Group(SHG)"	
Summary	Iodine Deficiency Disorders (IDD) are a major public health problem in Orissa. A study undertaken by the central Goitre Survey Team along with the three Govt. Medical Colleges of the state revealed that 90% of the state is not free from the IDD. In the view of the very high total goitre prevalence rate in the state, the district authorities have taken proactive steps in polularizing use and consumption of iodised salt in the district by trading of iodized salt through SHG in Athgarh Sub-Division. **Results:** 1.Increased awareness on importance of iodised salt. 2. Availability of iodised salt at affordable price (with minimum profit margin thereby creating demand by lower price). 3. Phasing out of sale of non-iodised salt in the area.
Cost	Initial Expenditure: Rs. 12,900/-.
Place	Athagarh, Cuttack, Orissa
Time Frame	----
Advantages	•Availability of iodised salt at lower market to the general mass. •Increase consumption of iodised salt with minimum govt. intervention. •Less expenditure on IEC activities for iodine Deficiency Disordered Control Programmes. •Strengthening of financial condition of SHGs
Challanges	1.Selection of suitable SHGs 2.Training of SHG on trading and salt testing (to test the content of Iodine) 3.Involvement of Govt. Agencies which are implementing Mid Day Meal Scheme, State Nutrition Programmes etc. to initially procure from SHGs for their need. 4. Involvement of salt wholesalers to provide the salt at

	relatively lower profit margin price. 5. Procurement of salt testing kit.
Prerequisites	-----
Who needs to be consulted	Sri Rajesh P Patil, IAS, Sub-Collector, Athgarh, Cuttack-754029, Orissa. Phone / Fax : 06723-220311 Email : rajeshpatilias@gmail.com
Risks	-----
Sustainability	-----
Chances of Replication	-----
Comments	This is first of its kind in Orissa. It not only improves the public health but at the same time improves the financial condition of the Self Help Groups. It is an innovation, which integrates health, economics and the community in one umbrella.
Contact	Mr.S. Sahoo, Deputy Director, FSU(CBHI), Regional Office for Health &FW, BJ-25, BJB Nagar, Bhubaneshwar-751014. Phone / Fax – 0674-2431326. Email : rohfwbbs@rediffmail.com
Submitted By	Sr. Regional Director (HFW/GOI) & FSU/ CBHI, ROHFW Bhubaneshwar
Status	Active
Reference Files	
Reference Links	

227. Boost funds for research & development

Subject Area="Health financing."	Objective="To boost the measly annual fund received for research and development projects."
Details for Reform Option "Boost funds for research & development"	
Summary	**Background:** The SMS Medical College at present gets just Rs.1.80 lakh per year from the State Govt for its research and development activities. The Medical college would now be charging a fee from doctors and students residing abroad for providing them various services like verification of documents, drug trail clearances and faculty training. The new fee mechanism would raise the annual fund to around Rs. 1.5 crore. **Action:** In the new arrangement, the SMS Medical College would be charging up to USDollars 300 from verifying documents of its students residing in foreign countries. Similarly, it would be demanding USDollars 1,000 from NRI doctors enrolling for training at any of the college's various faculties. Even for the different medical conferences held on its premises the college would be taking a clearance charge from the organizers, Processing charges for research sanctioned be the state DST, central DST, ICMR and CSIR @ 7 percent cost will be charged. The college had so far been providing these facilities free of cost. **Result:** Better funding for research & development activities
Cost	Nil
Place	SMS Medical College, Jaipur, Rajasthan
Time Frame	-----
Advantages	To overcome fund scarcity for research & development activities / projects
Challanges	-----
Prerequisites	Government initiative / Order.
Who needs to be consulted	Dr.Ashok Panagariya, Principal & Controller, S.M.S. Medical College & Attached Hospitals, Jaipur-302004 (Rajasthan).
Risks	-----
Sustainability	-----
Chances of Replication	The AIIMS Delhi, the GB Pant Hospital and the Municipal Mumbai have hailed the idea and borrowed fee structure of S.M.S. Medical College to increase their research fund.
Comments	21st October 2009- • Levying of charges for a period of one year resulted into accumulation of fund to the tune of Rs.150.00 lakh.

	• This fund has been used for filling-up gaps in buying equipments, creating infrastructure, training people in advance basic sciences and informing people of importance of hands-on-training in advanced basic research areas. • SMS has been able to create advanced research area consisting of Real Time PCR, Virology Lab, HLA Organ Transplant and Stem Cell Lab. • Creation of associate specialities like the Renal Transplant, Bone Marrow Transplant, IVF Centre and future Cadaveric Organ transplant programmes. • People from world over have appreciated the initiative. • Development fund has also helped the medical library to grow. • There is a new enthusiasm in the environment amongst the faculty who had potential to deliver
Contact	Principal SMS Medical College & DD (FSU, Jaipur)
Submitted By	Sr. Regional Director (H&FW/ GOI) and FSU/CBHI, ROH&FW, Jaipur
Status	Active
Reference Files	
Reference Links	

228. Tracking the pregnant women & child tracking system

Subject Area="Health information systems."	Objective="Regularly looking after of pregnant women by ANM / AWW/ ASHA upto delivery"
Details for Reform Option "Tracking the pregnant women & child tracking system"	
Summary	**Background:** Regularly looking after of pregnant women by ANM / AWW/ ASHA upto delivery. Motivating the pregnant women for institutional delivery & family planning. A computer based "tracking system" would be developed to monitor the child's health. Under the project, mothers, volunteers and medical staff would be trained in child health care. Whenever a child falls ill, arrangements would be made to transport the baby to the nearest health centre in a vehicle. For this a child safety fund would be created in every village, in which Rs.2000 would be collected from public partnership and equal amount be contributed under the project. **Action:** • Registration of each pregnant woman by ANM / ASHA. • Data-Bank of all the pregnant women is available in the office of CM&HO and District Collector. • A cell has been set-up in the O/o CM&HO and DC for making enquiries through telephone from concerned ASHA / ANM on ANC and counselling/ motivation for institutional delivery & arrangement of transport etc. for the pregnant women that are expected to delivery in coming week/month for randomly selected pregnant woman. **Results:** Increase in institutional delivery and fall in maternal & neo-natal deaths.
Cost	None.
Place	Dungarpur district, Rajasthan
Time Frame	3-6 months to set up.
Advantages	Better supervision on health services delivery at district level.
Challanges	-----
Prerequisites	Govt. Initiative & telephone / mobile facility to all the SC / PHCs.
Who needs to be consulted	-----
Risks	-----
Sustainability	-----

Chances of Replication	Very High.
Comments	A successful initiative implemented in Dungarpur districts and other districts are following it for tracking the pregnant women and new born. Further it has been envisaged to extend this concept for new borne in terms of Child Tracking System(CTS) and ensure the service delivery.
Contact	District Collector, CM&HO & DPM of Dungarpur District of Rajastan.
Submitted By	Sr. Regional Director (H&FW/GOI) and FSU/ CBHI, ROH&FW, Jaipur.
Status	Active
Reference Files	
Reference Links	

229. ABHILASHA YOJANA – A home nursing scheme to help ailing senior citizens.

Subject Area="Access to service and coverage."	**Objective="To Provide medical care to the senior citizens at their doorstep. In this scheme nurses will visit the houses of ailing senior citizens."**
Details for Reform Option "ABHILASHA YOJANA – A home nursing scheme to help ailing senior citizens."	
Summary	**Background:** The older population is growing by a speedy pace, in todays time medical care of the senior citizens are not properly taken care. The present scheme envisages providing medical care to the senior citizens at a reasonable cost at their home only. In this scheme nurses will visit the houses of ailing senior citizens. **Action:** The scheme was launched from all government medical colleges and hospitals in the state. Notice for the scheme were pasted outside all medical colleges in the state. The charges will be decided by the hospitals concerned and these nurses will have to work on eight-hour shifts a day. In Jaipur Social Welfare Department has identified 20 women for the job. These women will be given six weeks training and be registered with government run Sawai Man Singh Hospital. **Result:** To made available medical services to the ailing senior citizens at their home. Senior citizen will not have to visit the hospitals. Expertise & experience of the Govt. Hospital & Medical college nursing staff will provide the best services to the most vulnerable.
Cost	-----
Place	The scheme has been launched in Jaipur, Ajmer, Kota, Jodhpur, Udaipur and Bikaner districts of Rajasthan.
Time Frame	-----
Advantages	To make accessible the medical care to the senior citizens at their door-step.
Challanges	-----
Prerequisites	Government initiative.
Who needs to be consulted	-----
Risks	-----
Sustainability	-----
Chances of Replication	It may be replicated through all govt. hospitals & medical colleges.

Comments	-----
Contact	Deputy Director(CBHI), ROH&FW, Jaipur.
Submitted By	Sr. Regional Director(HFW/GOI) and FSU/CBHI, ROH&FW, Jaipur.
Status	Active
Reference Files	
Reference Links	

230. To provide affordable medical & health services to the people of Below Poverty Line(BPL)

Subject Area="Public / private partnership (including NGOs)."	**Objective="To provide affordable medical and health services to the people of Below Poverty Line"**
Details for Reform Option "To provide affordable medical & health services to the people of Below Poverty Line(BPL)"	
Summary	**Background:** Treatment of people Below Poverty Line is purely based on the free services & medicines made available by the government health sector. Most of the time emergency medical needs eat up all the valuables of such families. **Action**: Under this scheme: 1) Govt. and private hospitals will be notified for taking treatments by the families of BPL. 2) Private Insurance companies will be involved in providing medical insurance. 3) Four members and head of household can take treatment. 4) A smart card will be issued to a BPL family. 5) Expenditure incurred will be subtracted from the limit of the card while discharging. 6) Medicines upto 5 days will also be given at the time of discharge. 7) Benefit of the scheme could be availed only in case of hospitalisation. **Results**: Involving private sector in providing health services and for risk pooling.
Cost	75% of the cost will be born by Govt. of India & 25% by state govt.
Place	This scheme will be launched in Jhalawar, Tonk, Sawai-Madhopur, Rajsamand, Karauli, jalore, Bikaner & Barmer Districts of Rajasthan State.
Time Frame	One year to operationalise in all districts.
Advantages	1) Hospitalisation risk of the BPL families will be shared. 2) Private sector will be involved in providing health care to BPL

	& risk pooling.
Challanges	-----
Prerequisites	Government Initiative.
Who needs to be consulted	-----
Risks	-----
Sustainability	-----
Chances of Replication	-----
Comments	Number of new additionality have been undertaken by the state in this regard.
Contact	Deputy Director(CBHI), ROH&FW, Jaipur.
Submitted By	Sr. Regional Director and FSU/ CBHI, ROH&FW, Jaipur.
Status	Active
Reference Files	
Reference Links	

231. Rajasthan Refresh Scheme

Subject Area="Public / private partnership (including NGOs)."	**Objective="To change the habit of women in rural area for their personal hygiene and to promote the use of sanitary Napkins among rural women."**
Details for Reform Option "Rajasthan Refresh Scheme"	
Summary	**Background:** According to a survey it was found that : 1. In rural areas 70% of women used cloth in their Menstruation Cycle. 2. Use of cloth is not good for personal hygiene and should be used to avoid infections. 3. It was reported during the survey that adolescence girls don't attend school during their Menstruation Cycle Period because of safety & other reasons. 4. Disposal of used cloth is not easy. 5. Women hesitate in discussing issues of Menstruation Cycle Period & use of Sanitary Napkins publicly. 6. There is lack of proper awareness & publicity on these issues. **Action:** 1. Total 1,06,554 Sanitary Napkins have been sold on concessional rates during Nov. 2008 to May 2009. 2. ASHA is distributing Sanitary Napkins to rural females & she is getting an incentive of Re. 1/= per packet. 3. The scheme is being implemented in PPP mode. Result: It is found after starting of 'Rajasthan Refresh Scheme' that – 1. Women once used Sanitary Napkin don't use cloth again. 2. 37% women started to use Sanitary Napkins though 63% still hesitate in using Sanitary Napkins. 3. 42% of adolescence girls used Sanitary Napkins and were also interested.
Cost	-----
Place	Rural Areas of Rajasthan State. Phased Manner – Four Districts (Dausa, Jaipur, Sikar and Tonk) – 3 Blocks of each District.
Time Frame	-----
Advantages	High level personal hygiene among adolscence girls and females.

Challanges	-----
Prerequisites	Government Initiative.
Who needs to be consulted	-----
Risks	-----
Sustainability	-----
Chances of Replication	Very High – (Copy of newspaper 'HINDUJA NEWS' dated 16.06.2010 on replication of this reform is enclosed)
Comments	-----
Contact	FSU (CBHI), Jaipur.
Submitted By	Sr. Regional Director (H&FW/GOI) and FSU/CBHI, ROH&FW, Jaipur.
Status	Active
Reference Files	
Reference Links	

232. Rajasthan Refresh Scheme

Subject Area="Public / private partnership (including NGOs)."	Objective="To change the habit of women in rural area for their personal hygiene and to promote the use of sanitary Napkins among rural women."
Details for Reform Option "Rajasthan Refresh Scheme"	
Summary	**Background:** According to a survey it was found that : 1.In rural areas 70% of women used cloth in their Menstruation Cycle. 2. Use of cloth is not good for personal hygiene and should be used to avoid infections. 3. It was reported during the survey that adolescence girls don't attend school during their Menstruation Cycle Period because of safety & other reasons. 4. Disposal of used cloth is not easy. 5. Women hesitate in discussing issues of Menstruation Cycle Period & use of Sanitary Napkins publicly. 6. There is lack of proper awareness & publicity on these issues. **Action:** 1. Total 1,06,554 Sanitary Napkins have been sold on concessional rates during Nov. 2008 to May 2009. 2. ASHA is distributing Sanitary Napkins to rural females & she is getting an incentive of Re. 1/= per packet. 3. The scheme is being implemented in PPP mode. Result: It is found after starting of 'Rajasthan Refresh Scheme' that – 1. Women once used Sanitary Napkin don't use cloth again. 2. 37% women started to use Sanitary Napkins though 63% still hesitate in using Sanitary Napkins. 3. 42% of adolescence girls used Sanitary Napkins and were also interested.
Cost	-----
Place	Rural Areas of Rajasthan State. Phased Manner – Four Districts (Dausa, Jaipur, Sikar and Tonk) – 3 Blocks of each District.
Time Frame	-----
Advantages	High level personal hygiene among adolscence girls and females.
Challanges	-----

Prerequisites	Government Initiative.
Who needs to be consulted	-----
Risks	-----
Sustainability	-----
Chances of Replication	Very High – (Copy of newspaper 'HINDUJA NEWS' dated 16.06.2010 on replication of this reform is enclosed)
Comments	-----
Contact	FSU (CBHI), Jaipur.
Submitted By	Sr. Regional Director (H&FW/GOI) and FSU/CBHI, ROH&FW, Jaipur.
Status	Active
Reference Files	
Reference Links	

233. Neonatal hearing screening programme

Subject Area="Access to service and coverage."	Objective="To detect hearing impairment in the infant using low cost appropriate screening device by Health Workers in the community."
Details for Reform Option "Neonatal hearing screening programme"	
Summary	Hearing impairment can result in an improved out-come if detected and referred early in childhood. Community Health Worker require 3 hours of training to use four low cost rattles that are standardized for producing sound at particular amplitude and frequency. Based on the response of a sleeping infants to the sounds that they are subjected to a Health Worker can detect whether the infant has a hearing impairment and can refer for further management.
Cost	Rattles : Rs.1,000/- for one set of four. Training programme: Rs. 500/- for resource person. Rs.500/- for refreshment.
Place	Community Health Training Centre, Mugalur, sarjapur Hobli, Anekal taluk, Banglore, Karnataka.
Time Frame	Half a day and then monthly follow-up for referrals.
Advantages	1. Simple to implement in a community. 2. Easy understanding and use by Health worker.
Challanges	1. Community Health workers must know the referral centre 2. Community Health workers must impress mothers that child has hearing impairment and requires referral.
Prerequisites	1. Source of standarised rattles. 2. Health Workers- Government / Private. 3. Referrals – Audiologist and speech Therapists, ENT surgeon, Hearing Aids
Who needs to be consulted	Primary Health Centre, Medical Officer. Panchayat Members of the Community to be informed of the programme.
Risks	-----
Sustainability	One time investment for a community and hence very sustainable.
Chances of Replication	Very easily replicable.
Comments	The trainers of the Community Health Workers require to be trained.
Contact	Dr. Ramesh A., Assistant professor, Department of ENT, St. John Medical College Hospital Bangalore, Mobile No. 9845236298. Mrs. Nagapoornima, Lecturer, Audiologist and speech Therapist, St.

	John Medical College, Banglore, Mobile No – 9880325712.
Submitted By	Dr. Domnic Misquith, Professor and Head, Department of Community Health, St. John Medical College, Banglore-34. Phone : 9448069470.
Status	Active
Reference Files	
Reference Links	

234. Aarogyam

Subject Area="Health information systems."	**Objective="To improve the quality of healthcare services by providing a state-of-the-art reporting system using e-connectivity."**
Details for Reform Option "Aarogyam"	
Summary	Aarogyam – "complete freedom form illness", is a concept that aims at health for all the family especially mother and child. Health, strictly speaking, is not only absence of disease but complete physical, mental and social well being of a person. Aarogyam, aims at this complete WELL BEING With ZERO TOLERANCE for disease, Aarogyam aims to provide healthcare services to citizens at their door steps, with special focus on mother and child to bridge the gap between goals and actual delivery. Aarogyam caters to both Safe Motherhood and Child Survival Components of RCH. For the former, it focuses on Ante Natal Care (ANC), Post natal Care (PNC) and emphasizes on 100% immunization for ensuring the latter. With these objectives, it uses modern ICT techniques for digital health mapping and pregnancy tracking. It therefore, prepares a complete health database with respect to the target group i.e. pregnant/lactating mothers and children in immunization age group. The database so generated from the backend through which a software system suo-moto generates calls on all aspects of child immunization, ANC, PNC, safe delivery, pulse-polio campaign etc, on telephone thereby ensuring health care for the entire family at their doorsteps. Having full knowledge of one's family health profile, one can be more informed and empowered to avail the required health facilities. However, this is not the end of it. The project also has an interactive platform wherein a citizen can enquire about various health parameters, and lodge a complaint on a given helpline number. Aarogyam therefore ensures that the government is reaching out to the people for providing responsive health care delivery. Purpose of Aarogyam is to develop a technology based health care delivery program to ensure:- • 100% immunization for children in 0-5 years of age group. • Tracking each pregnancy with the help of a technology based monitoring system. • Complete ANC/PNC care including early registration of pregnancy. 3 ANC and TT to mother, institutional delivery, promotion o Janani Suraksha Yojana (JSY) etc. • Development of a replicable model of technology based Pregnancy tacking and Child immunization system • Generation of awareness in community about health services and

	inducing a change in their behaviour by reinforcing the messages. With above specific priorities, the project uses ICT and mobile phones as a tool to generate telephone calls, aims (in Hindi for wider appeal) to the families of target group on/before the due dates of immunization schedule. Hence, the model has "Knowledge is power" as the underlying theme wherein, have-nots are converted to haves through information dissemination. It therefore becomes a potent vehicle for people living in low socio economic brackets to access healthcare at their doorsteps through the feedback mechanisms inbuilt in the system. Health till now is generally conceptualized as one way supply based approach. Aarogyam, on the other hand visualizes health as two way demand based approach.
Cost	Cost of establishing the project in a district depends upon available infrastructure and man power.
Place	The programme has been implemented first in district Bagpat on 10th October 2008, then in J.P. Nagar and Rama Bai Nagar (Kanpur Dehat), it is also being initiated in Moradabad, Rampur, Bijnour and Gautam Budh Nagar
Time Frame	Two Weeks are required after completion of Hard ware setup in starting the project. One month required for initial survey.
Advantages	The beneficiaries are well informed by telephone line individually about their date of vaccination also an SMS is sent to all of them so that they can get any information by dialling a toll free number.
Challanges	None
Prerequisites	A proper data base in mother server along with accurate phone numbers of beneficiary and skilled and trained persons along with proper hardware is required to established the system.
Who needs to be consulted	Ritu Maheshwari (IAS) DM Shahjahnpur U.P. Phone No. +919415500014 Email-catch ritz@yahoo.com Mayur Maheshwari (IAS) DM Badaun U.P. Phone No. +919415000026 Email – mayurmaheshwari@yahoo.com
Risks	None
Sustainability	Highly sustainable once the database has been set up.
Chances of Replication	It is possible to replicate it anywhere in India where broadband is available.
Comments	A very good initiative.
Contact	Ritu Maheshwari(IAS),DM Shahjahnpur
Submitted By	FSU,CBHI Lucknow
Status	Active
Reference Files	
Reference	

Links

235. Vatsalya Scheme, Hoshangabad district of Madhya Pradesh

Subject Area="Management structures and systems."	Objective="Improve the quality of service delivery."
Details for Reform Option "Vatsalya Scheme, Hoshangabad district of Madhya Pradesh"	
Summary	Malnutrition among children under 5 years is a big problem. In Hoshangabad we were taking weight of every child in each month and recorded it manually according to their age & then found out the nutrition status of child. We felt that it was a time taking exercise which gave us data without accuracy. In that process the reporting time was poor so that the response time was automatically unsatisfactory. So we introduced a software in which we enter data taken by Aaganwadi workers and software automatically give us childrens accurate malnutrition status as per WHO standards.This software is running successfully since more than 2 years and has helped us to reduce underweight from 20.28% to 14.59% & severe underweight from 3.72% to 1.47% & severe Acute malnutrition (SAM) from 1.07% to 0.08%.
Cost	Setup cost was 76,000/- & running cost is 15,000/- to 20,000/- per year
Place	Madhya Pradesh (Hoshangabad).
Time Frame	From May 2011 to August 2011.
Advantages	Data captured at a point as near as possible to the source.
Challanges	None.
Prerequisites	ICDS Department has approved and provided funds to run the systems. Other department like Health, Rural development etc are supporting it.
Who needs to be consulted	WCD department & its developmental partners. Private paediatricians, NGOs, Lions Club etc. are giving advise for mid course correction.
Risks	None identified.
Sustainability	It is likely to continue in future. Now department is appreciating it and funding the process.
Chances of Replication	It has been replicated in other district like Narsingpur, Chindwara, Balaghat etc.
Comments	Inspired with this initiative district has Introduced dal palak concept in which public private partnership concept is working effectively to reduce malnutrition since last 10

	Months.
Contact	
Submitted By	District Programme office, Integrated child development service, district - Hoshangabad, phone no. 07574-253254 Email-wcdhos@mp.nic.in
Status	Active
Reference Files	

236. Birth spacing by incentive to ASHAs

Subject Area="Behavioural Change Communication."	**Objective="Access to family planning."**
Details for Reform Option "Birth spacing by incentive to ASHAs"	
Summary	The programme was launched on 16.05.2012; under this scheme ASHA has to advise newly married couple to follow the norm of no issue up to 2 yrs and gap of three years between first child and second child and acceptance of permanent method of family planning after two children. For successfully counselling the couples, ASHAs are given incentives, Rs 500/-for no issue up to 2 years of marriage, anotherRs 500/- for keeping a gap of three years between the first & second child and Rs 1000/- for advocating permanent sterilization.
Cost	Bombay Govt. of Jharkhand.
Place	East Singhbum district of Jharkhand State
Time Frame	NA
Advantages	A feasible population control measure.
Challanges	Marriage Registration.
Prerequisites	Marriage registration is a prerequisite for the scheme, in rural areas it is too difficult to get Marriage registered.
Who needs to be consulted	For district; Addl. Chief Medical Officer (ACMO)
Risks	None
Sustainability	Yes
Chances of Replication	Can be replicated as ASHAs are present in every village.
Comments	It is a good initiatives taken by Govt. of Jharkhand to Control the population growth.
Contact	Dr. KALACHAND MUNDA, Additional Chief Medical Officer, 09430078786
Submitted By	D.FSU/CBHI PATNA
Status	Active
Reference Files	
Reference Links	

237. JPN apex trauma centre

Subject Area="Monitoring, evaluation and quality control."	Objective="Performance monitoring to improve services."
Details for Reform Option "JPN apex trauma centre"	
Summary	It is for the first time in the world that integrated online portal for AIIMS Trauma Centre project has been implemented. The project has been operational to set a benchmark for accountability and transparency in public funded health care in India since 1st March, 2011. There are some hospitals that are overburdened and on the other hand there are some which remain empty in spite of being "fully functioning". As a small initial step, we wanted statistics on the number of patients coming to a hospital, live waiting times for CT, X-ray, dressing of suturing as well as number of patients being admitted and discharged be available online publically in a real time manner or as close to real time as possible. This would make the overall working of a hospital transparent to the public. A second objective was to internally audit the clinical performance of each department and also have this audit available online publically so that it could be compared with other hospitals in India & abroad.
Cost	NA
Place	JPN Apex Trauma Centre, AIIMS, Ring Road, New Delhi - 110029.
Time Frame	NA
Advantages	1. Real time statistics on patient flow as well as performance audits of each department and live waiting times for CT, X-ray, dressing & suturing can be accessed online 24*7. 2. Accountability & transparency.
Challanges	1. Providing 24*7 online facilities is a big challenge. 2. Having performance audit of each department online seemed an insurmountable challenge as it would throw open the functioning of a department to critical review and that too of a government hospital.
Prerequisites	Big Govt. /Private Hospitals.
Who needs to be consulted	Dr. Deepak Agarwal, Head, IT & Assoc Prof, Neurosurgery, JPN Apex Trauma Centre, AIIMS, Ring Road, New Delhi - 110029.
Risks	None
Sustainability	High-end IT infrastructure is required for sustainability.
Chances of	Not easy to replicate but can be done by big govt./private

Replication	hospitals.
Comments	A very bold attempt by a govt. hospital.
Contact	Dr. Deepak Agarwal
Submitted By	FSU, CBHI,Jaipur
Status	Active
Reference Files	
Reference Links	

238. Nutrition Rehabilitation centre

Subject Area="Inter-sectoral links."	Objective="Controlling severe malnutrition among the children."
Details for Reform Option "Nutrition Rehabilitation centre"	
Summary	Nutrition Rehabilitation Centre (NRC) is established in all 38 districts of Bihar to provide institutional care for children with acute malnutrition. It also promotes Physical, Mental & Social growth of children with acute malnutrition. It builds capacity of primary care givers in home based management of malnourished children. Thus NRC is intended to function as a bridge between hospital & homecare. It has the following objectives: 1. To control Sever Acute Malnutrition (SAM) in children in the age-group of 7months to 60 months. 2. To reduce prevalence of SAM from 8.33% to 1% in children. 3. To train mothers of SAM children at NRC about nutrition, health & hygiene.
Cost	Rs. 10575400/- per month for 38 Districts of Bihar as a whole.
Place	Govt. Hospital of all 38 Districts.
Time Frame	Will depend upon the number of children suffering from malnutrition.
Advantages	1. Treatment & Patient management. 2. Nutritional support to inmates. 3. Nutrition education to his/her family members.
Challanges	Not yet noticed.
Prerequisites	By the order of Govt. of Bihar.
Who needs to be consulted	Paediatrician of the District hospital.
Risks	NA
Sustainability	Yes
Chances of Replication	Can be replicated at block/district level.
Comments	Very innovative.
Contact	Dr. N.K. Mishra ,State Programme Officer,Patna,M-09470003022
Submitted By	FSU, CBHI, Patna
Status	Active
Reference Files	

Reference Links	

239. Anti-Rabies Vaccine Project

Subject Area="Health financing."	Objective="Availability of low cost, quality drugs at Community Health Centres (CHC)."
Details for Reform Option "Anti-Rabies Vaccine Project"	
Summary	As per the study of data for the Anti Rabies vaccine project at district Drug, it was found that approximately 15-16 deaths occurred each year due to rabies. The affected people were mostly children and residents of rural areas belonging to lower class. The cause behind these deaths was found to be lack of awareness about rabies, shortage of vaccines and shortage of money as the cost of anti rabies is very high for general people. The aim to start the project is to fulfil the necessity of Anti Rabies Vaccine to all. Jeeven Deep Samiti was established in the district Hospital Durg .Red Cross Society was the main source of funding in this project.
Cost	12-13 lakh (Twelve to Thirteen lakh).
Place	Durg (Chhattisgarh)
Time Frame	Not defined.
Advantages	The accessibility of Anti Rabies Vaccine will be provided to BPL families, 0-5 years old children, handicapped person having more than 40 percent disability, pregnant women and freedom fighters and dependent family of freedom fighters at a low cost of Rupee 40/- per vaccine. The people who are not covered in the above criteria will be provided Anti Rabies Vaccine at the rate of Rupees 200/- per vaccine.
Challanges	No
Prerequisites	Cooperation of health personnel, district panchayat, NGOs, private facilities are indispensable.
Who needs to be consulted	Health Department, Govt. of Chhattisgarh
Risks	None
Sustainability	Yes. The funds come from the Jeeven Deep Samiti and Red Cross Society.
Chances of Replication	Yes, it can be reproduced elsewhere in the country.
Comments	NA
Contact	Dr. Prashant Shrivastava, Civil Surgeon, District Hospital Drug Mobile: 09826600104

Submitted By	Shri S.H. Syed, Assistant Director, CBHI, Bhopal
Status	Active
Reference Files	
Reference Links	

240. Shri Ram Murti Janhit Chikitsa Yojna

Subject Area="Access to service and coverage."	Objective="Financial support to BPL families for major surgical procedures in premier hospitals in or outside the state."
Details for Reform Option "Shri Ram Murti Janhit Chikitsa Yojna"	
Summary	The hospital started in the year 2002 with the aim to provide the best medical care facilities at low cost to the society. S.R.M.S. Janhit Chikitsa Yojna (JCY) was introduced on 4th July 2009 with the vision of making available the medical facilities to those who cannot afford it. Under this scheme, provision of admitting maximum 6 patients per day was kept. A committee was set up with the following members: Medical Superintendent/Assistant Medical Superintendent, Treating Consultant and Deputy Administrator- Patient Care. Every patient who is considered for the scheme is first recommended by the consultant of the department who also considers whether the patient is genuine or not. The Patient Care department then scrutinizes all the details and checks his/her fitness under this scheme. All the formalities are then verified and sanctioned by the Medical Superintendent/Assistant Medical Superintendent.
Cost	Provisionary budget allocated to this scheme by SRMS Trust is 45 lakh in the FY 2013-14 aiming at 1500 free patients for the treatment.
Place	Shri Ram Murti Smarak Institute of Medical Sciences, Bareily, Uttar Pradesh.
Time Frame	It was conceptualized in the year October 2008. Implemented on 4th July 2013, foundation day of Shri Ram Murti Smarak Institute of Medical Sciences.
Advantages	Poor patients who were not able to get any treatment due to poor financial condition can get world class treatment at no cost at all Fulfilling the social commitments towards the society. Creates an environment of empathy and social service amongst the staff of SRMSIMS.
Challanges	Unable to provide super specialty services due to cost factor. Unable to provide the services to the critically ill patients requiring ICU care due to paucity of funds.
Prerequisites	• Infrastructure: Since SRMSIMS is a 950 bedded Multi Super Specialty, Tertiary Care and Trauma Centre, moreover is Medical College with Pre, Para and Clinical departments. • Manpower: Medical, paramedical, technical and administrative

	staff and Class IV staff. • Finance: The TRUST is self funded and makes budgetary provision for this scheme from their own sources. • Co- ordination: Tremendous co-ordination required among the staff and the management. • Will power: To provide the best services to the needy. • Team work: Everyone needs to work as a team to help poor under this scheme.
Who needs to be consulted	Deputy Administrator (Patient care) is the person to be contacted first or Medical Suptd. /Addl Medical Superintendent.
Risks	The critically ill patient may not be able to wait for the procedure to follow.
Sustainability	Yes it is sustainable as it has been running successfully since 4th July 2009. Conditions required for sustainability are: finance and vision coupled with willingness and team work.
Chances of Replication	Yes it can be replicated as it is a good and successful model.
Comments	Excellent scheme which can be replicated in other corporate hospital and private medical college provided there is strong willingness as well as the inclination to help the poor.
Contact	Medical Superintendent, SRMS Institute of Medical Sciences, Bareily, Phone No. (0581) 2582014 to 25. Fax: 2582010, 2582030 Email: info@srmsims.ac.in, patient_care@srmsims.ac.in Website: www.srmssims.ac.in Mobile: 9412761868 (Medical Suptd.)
Submitted By	Vineet Verma Manager –SRMS Mob: 9412738652 Email: vineetverma@srmsims.ac.in
Status	Active
Reference Files	
Reference Links	

241. In house preparation & generation of bar coded smart cards for gas victims

Subject Area="Health information systems."	**Objective="Authenticating patients through bar coded smart cards"**
Details for Reform Option "In house preparation & generation of bar coded smart cards for gas victims"	
Summary	Bhopal Memorial Hospital and Research Centre, a 350 – bedded multi – specialty tertiary care centre situated at Bhopal, Madhya Pradesh, which is the centre / heart of India. The institute was stated as per the directive of the honorable Supreme Court of India to provide advanced tertiary level super – specialty care to the victims of the Bhopal Gas Tragedy (1984) as well as to extend its services to the public at large. The hospital is a referral and tertiary care centre for the thousands of gas tragedy victims who are first seen at the primary care level in the 8 mini units (satellite health centers) spread around in the city, and then referred to the advance and specialized departments at the hospital. The concept for generating in – house bar coded smart cards for the gas victims was conceptualized in October 2013, though BMHRC has introduced chip based smart card initially for gas victims with little success and in between BMHRC started making manual cards for gas victims with no benefits. It is evident and true that if we ask any hospital administrator the least efficient area of a hospital and the answer is unanimous: Registration. Each patient admission or visit requires patient verification, entry of patient data manually on admission form, and reason for admission. Each of these time – consuming processes can be tremendously foreshortened by having all of that information available on a bar coded smart card. The bar would authenticate the user, and provide access to the hospital's admissions software program, thereby, saving additional time, money, and headaches for all involved. Presently approximately 3.80 lakhs gas victims are registered with BMHRC and the number is increasing as even the dependants of gas victims also being provided treatment free of cost. Looking into the larger data base, chances of fraud cannot be ruled out. The idea was to check the fraud by authenticating patients through bar coded smart card.
Cost	
Place	BMHRC, Bhopal and the scheme was implemented in December 2013
Time Frame	Approximately 3 months

Advantages	a) Affordability – Cost – Bar coded smart cards held an important cost advantage over microchip cards. b) Durability – Much more durable in harsh, dirty or outdoor environment. c) User friendly cards.
Challanges	No disadvantages
Prerequisites	a) In house development of functionality of smart card services b) Testing of functionality of smart card services c) Deployment of functionality of smart card services in Admission, Discharge and Transfer module (ADT) d) Implementation of Standard Operating Procedures for distribution of smart cards to gas victims.
Who needs to be consulted	In house development
Risks	
Sustainability	The initiative is self sustaining and will continue for future.
Chances of Replication	Replication would be difficult as bar coded smart cards are generated through ADT module
Comments	Results achieved a) Savings in terms of time b) Prompt processing of generation of smart card c) Timely distribution of smart cards to mini units and patients d) Control on duplicate / missing cards
Contact	Nitin Bhatia Senior Manager Operations BMHRC, Raisen Bypass Road, Karond Chowk, Bhopal – 462038 Cell number +91 94256 08410 Tel. number +91 755 2742212 ext. 5005 Email – it@bmhrc.org
Submitted By	Nitin Bhatia Senior Manager Operations BMHRC, Raisen Bypass Road, Karond Chowk, Bhopal – 462038 Cell number +91 94256 08410 Tel. number +91 755 2742212 ext. 5005 Email – it@bmhrc.org
Status	Active
Reference Files	
Reference Links	

242. Weekly Dry Day, Chickballapur district, Karnataka

Subject Area="Community participation."	Objective="To disconnect the cycle of breeding mosquitoes in the community / pocket of a village"
Details for Reform Option "Weekly Dry Day, Chickballapur district, Karnataka"	
Summary	**Background:** The main aim of the scheme was to create the knowledge of not breeding the mosquitoes in the community, thereby reduce the morbidity conditions due to the mosquitoes of the locality. **Action:** The Government of Karnataka, in cooperation with the resident of a village, tried out a new concept of breaking the life cycle of mosquitoes breeding in their environment by cleaning all the containers in every house hold of the community. It devised a method that all the vessels or water containers in every house of the hamlet / village is to be emptied on forenoon of every Saturday. Then, they were to be put under Sun for drying, except the vessels kept water for drinking. There would be no water supply on Saturday morning from the local government. This prevents the life cycle (7 days) of mosquitoes. Hence, the breeding of mosquitoes become less. Responsibility: VHSC member, waterman, Health Worker Both male and female. Water man should supply water on the evening of Saturday, without fail. Health worker to propagate the purpose / advantages of the doing this to the community and get them involved to do so. Publicity / IEC: VHSC president should ensure to pass on the message to all residents by way beating of drum or any other manner. **Results:** The HI, CI and BI have been considerable reduced from 24, 9 and 29 to 12,5 and 13 Respectively. The comparative figures are recorded on 16.10.2014. and 16.01.2014. HI refers to House Index i.e., percentage of no. of houses having larva positive to all houses. CI: Percentage of containers (within the premises) having larva positive to all containers within the premises of all households. BI: No of containers (within and outside premises) for larva positive per 100 houses.
Cost	All work are to be carried out by the existing system, there is no much cost involved. A nominal amount may be incurred for the inaugural. At that time some nominal cost for advertising incurred, which may be met from the VHSC.
Place	Kattnakallu Village under Gaffreddyhall PHC in Chickballapur.
Time Frame	Within two months with the cooperation of the community.
Advantages	By practicing this, the breeding of mosquitoes will be reduced:

	thereby the residents of the village will be free from the vector borne diseases.
Challanges	Few of the residents may not cooperate because on that day water will not be supplied by the local government.
Prerequisites	IEC activities have to be taken to publicise the activity. Residents should be made well aware every Friday that there will be no water supply on the succedding day i.e. Saturday and make the resident to ensure that they should store sufficient water till the water is supplied. The cooperation from Health department, local government and political parties are solicited. It should be ensured that water is supplied during the evening of Saturday without fail on any cost.
Who needs to be consulted	The District Health Officer, District Malaria Officer, Zonal Entomologist Chikballapur district Karnataka.
Risks	
Sustainability	Sustainable. The public should be motivated during the initial period.
Chances of Replication	Can be replicated.
Comments	No
Contact	Contact Dr. K Babu Reddy, District Malaria Office Phone No. 08156275079 Shri Vinod Kumar, Epidemiologist No. 09972934566.
Submitted By	Field Survey Unit Central Bureau of Health Intelligence Regional Office for Health & Family Welfare Banglore
Status	Active
Reference Files	
Reference Links	

243. Sehat Sandeshvahini

Subject Area="Public / private partnership (including NGOs)."	**Objective="Mobilising community participation."**
Details for Reform Option "Sehat Sandeshvahini"	
Summary	State innovations in family planning services project agency, Lucknow was created in 1992. SIFSPA is a State Government led autonomous society, working as State Technical Support Unit of Govt. of U.P. in the field of RCH and family planning. SIFSPA also provides technical support to NRHM-UP. The project Sehat Sandeshvahini is approved by Government of India under NHM PIP 2012-13. The project has been assigned to SIFSPA by NHM-UP for implementation in June 2013. SIFSPA has engaged services of private providers for operation of video vans on turnkey basis for the publicity of NRHM schemes and the promotion of routine immunization in rural areas in all districts of Uttar Pradesh. 'Sehat Sandeshvahini' video van operators were selected through open bidding process. The 1st phase of Sehat Sandeshvahini has been launched on 20th February, 2014. In the initial phase, the project is being implemented in 11 divisions covering 526 blocks within 48 districts and a total of approximately 10520 villages would be covered for the show. In each block 20 villages have been selected for video van show. Villages selected are mainly media dark villages having sizable population, less beneficiaries of NHM schemes, less acceptors of family planning, poor sensitivity towards immunization etc. Program schedule of each block has been prepared by District PMU's/ MOIC's in consultation with Div PMU's. A total of 87 video vans have been engaged to cover these 11 divisions. A video film of one and half hours has been prepared to show in the villages which cover NHM issues like Janani Suraksha Yojana, JSSK, Ashirwad Bal Guarantee Yojana, Routine Immunization, ARSH, EMTS-108, UP Ambulance Services-102 and other schemes etc. Besides audio capsule has also been prepared for pre- publicity, and is used on the way to venue, market places etc. The Branding of video vans has been done in such a way that a glimpse of all the NHM schemes can be seen on the wall of the van. Each video van consists of one counselor and one operator to accompany the video van. Show timings are kept in the evening only. Pre-publicity is done by the van team with the help of Gram Pradhan, ASHA, AWW, ANM and other grass root level workers. The entire program is being monitored by different level officers. Block level health officers are monitoring each and every show being conducted in their block.

	All the shows are being certified by PRI member and ASHA and monitored by Block level officers whereas minimum 10% of the shows are monitored by Divisional PMU, District Program Management Unit- NRHM, District Health officials SIFSPA officers are also monitoring the shows time to time. Officers are filling the prescribed format developed for monitoring purpose. To encourage 100% monitoring of shows by ANM of the area small amount of honorarium is kept. Regular feedback is being given to agencies and monitoring is being done at SIFSPA and Divisional and District level.
Cost	Rs. 75000/- per cycle of 20 shows.
Place	Planned for 820 blocks within 75 districts of Uttar Pradesh.
Time Frame	6 months.
Advantages	Publicity of NHM schemes is being done in decentralized way which provides the opportunity to audience to conceptualize that these schemes are actually meant for them and they can avail those as per their need. Besides. It will help in changing health seeking behavior among rural community. The program also facilitates and provides platform for good use of existing audio video films/ material developed by various agencies.
Challanges	Selection of service provider is a big challenge. To ensure deployment of required number of vehicles, tracking of shows is a challenge. Ensuring monitoring of shows by block level health officials is challenging.
Prerequisites	Co-operation of health officials at field level, experienced mobile van service provider with good management capacity.
Who needs to be consulted	Mr. Amit Kumar Ghosh, Executive Director, SIFSPA
Risks	
Sustainability	Sustainable provided funding support is available for continuing such type of publicity programs. Program is cost effective.
Chances of Replication	There are good chances of replication in any far flung area where other means of health education and publicity is negligible.
Comments	In second phase seven new divisions would be covered. Program would be documented and shared.
Contact	
Submitted By	Ms. Savita Chauhan. General Manager (IEC), SIFSPA, June 2014.
Status	Active
Reference Files	
Reference Links	

244. SAMARPAN Scheme Hoshangabad

Subject Area="Community participation."	Objective="Maintaining good health of the people through preventive and curative health services."
Details for Reform Option "SAMARPAN Scheme Hoshangabad "	
Summary	The status of disabled peoples in India is very Pitiable. Low literacy, few jobs and widespread social stigma are making disabled people among the most excluded in India. Children with disabilities are less likely to be in school, disabled adults are more likely to be unemployed, and families with a disabled member are often worse off than average. As per Census 2001 more than 21.1 million peoples which is more then 2% population of India is disabled. When we are analyzing the data it is found that about 60% of the disabled persons from are from the age group 10-50 years; the reason is in most of the cases the symptoms of disabilities are overlooked in childhood stage. These figures can be minimized by the early intervention. District Administration Hoshangabad (MP) had taken an initiative SAMARPAN, which is an unique intervention for early identification, screening, treatment and rehabilitation of children with developmental delay or physically disability. It is a convergence model of Health, Women & Child Development and District Disabled Rehabilitation Centre (DDRC) with the leadership of District Administration. In this initiative all the children of age group 0-3 years are being examined at Aanganwadi level and scrutinized for further medical checkup. All these processes are specifically designed by the Institute of Post-Graduate Medical Education and Research IPGMR Kolkata for this initiative A unique initiative of Dist . administration hoshangabad Technical supported by Dr Arun Singh formally HOD Neo Natology Department of IPGMER, SSKM HOSPITAL Kolkata, Early Intervention clinic. The need was felt Dist Administration Hoshangabad in July 2010, that while the babies discharged from sick new born care unit would improve survival of very sick children, but we are aware that we are morally responsible for the quality of life of these children. The services are required, with the help of a multidisciplinary team to address this issue. The DDRC along with SNCU Hoshangabad could develop a center with tools and equipments for screening and intervention of children between 0-3 years. Over a period of time home based early intervention could be set up at village levels also. Thus this center would also built capacity of the district to screen and intervene at an appropriate time for any deviation from normalcy. The medical checkup and follow-up

	checkups is being carried out in DDRC by multiple disciplinary specialist. Equipments, kits, medicines and transportation are being provided free of cost. Also, the complete data of each children is being kept in the digital record in specially designed IT application for analysis and future reference.
Cost	About 1 crore to be utilized from existing fund of different departments.
Place	Samarpan DDRC Building Dist hospital campus Hoshangabad Madhya Pradesh.
Time Frame	Started from Aug 2010 required about 6 to 8 month to be functioning
Advantages	EIC Hoshangabad is a unique intervention for early identification, screening, treatment and rehabilitation of children with developmental delay or physically disability. It is a convergence model of Health, WCD and district disabled rehabilitation centre (DDRC) with the leadership of district administration.Tcehnical support of Dr Arun Singh (formally HOD Neo Natology Department) IPGMER Kolkata initiate the idea with State Health Society and district administration and contribute the financial support for provide technical support from Dr. Arun Singh head of the department of Neonatology IPGMER Kolkata. Under the guidance the establishment of EIC in Hoshangabad.
Challanges	1- Before the initiative, the first sign of any type of possible development delay U5 children was not being looked into at community level leading to late detection and loss of precious infant years thereby making the case difficult for intervention. Serious gap in terms of resource such as trained professionals (audiometric, psychologist etc.), equipments and accessories was present which further added to the challenge. 2- 2- Coordination issues, along with follow up without an incentive to parents/mobilisers also posed as major problem. 3- 3- It is based on convergence but main problem is ownership. 4- 4- Lack of technical expertise.
Prerequisites	Many Department has approved and provided funds to run the systems (List Enclosed). Many department like District Health services, Administrative services, NIPI, National Rural Health Mission, Woman Child Development and Health Rural development etc are supporting it.
Who needs to be consulted	A service can be as simple as prescribing glasses for a two-year-old or as complex as developing a complete physical therapy program for an infant with cerebral palsy. The goal is always to help the child achieve the highest possible

	functioning and interaction at home and in the community. An early intervention program can also provide support and guidance to your family. In a nutshell, early intervention is concerned with all the basic and brand new skills that babies typically develop during the first three years of life, such as: • physical (reaching, rolling, crawling, and walking) The need was felt in July 2010, that while the babies discharged from sick new born care unit would improve survival of very sick children, but we are aware that we are morally responsible for the quality of life of these children. The services are required, with the help of a multidisciplinary team to address this issue. The Dist. Administration Hoshangabad could develop a center with tools and equipments for screening and intervention of children between 0-3 years. Over a period of time home based early intervention could be set up at village levels also. Thus this center would also built capacity of the district to screen and intervene at an appropriate time for any deviation from normalcy.
Risks	
Sustainability	EIC is established with the technical support of Dr Arun Singh Kolkata. Basic District Disability Rehabilitation Centre is expanded as EIC with support of Social Justice Health, WCD. • Then AWW performed primary screening during her house to house visit i.e. called Samarpan screening test (SST annexure attached) for all 105550 children below 5 years of the district and upload their data base on Vatsalya software. • Since 4 Feb. 2012 Samarpan EIC rolled out its activities with joint active participation of all concern departments. • Administrative Officer DDRC is nominated as Nodal Officer for EIC by Collector. • Children identified with any symptoms of any disability are mobilized to EIC by AWW according to micro plan prepared for the screening by therapists. • In this exercise vehicle of health department is used for transportation of children. • 887 differentially abele children are identified after diagnosis 1624 children by all the concern specialists after screening children till 30 June 2014. • In which children required any higher level treatment like surgery are sponsored by Social Justice, DWCD and Health

	department relatively. • As per need aids also provided to children like hearing aid by social justice department. • After basic diagnosis as per need these children again mobilize to EIC as per their schedule for follow up. • This training was based on training module ShishuVikasSahayika basically developed by IPGMER Kolkata and Hindi version is develop. • Follow up completed of 689 children out of 1624 children earlier found abnormal till 30June 2014. • Heart Surgery 16 ,Cleft Lip & Palate surgery-9,Ctev Surgery-39,cataract surgery-1 lens disribution-03 ,aid & appliances 259 Etc.
Chances of Replication	Following services are being provided at Samarpan presently: 1. Medical services: common medical; preventive health and immunization. 2. General women & Child services: nutritional and related to feeding of babies. 3. Neurological assessment for excluding neurological deficits in high risk newborns. 4. Physical therapy: Services to prevent or lessen the movement difficulty or related functional problems 5. Occupational therapy: Services to promote self-help skills, adaptive behavior, adaptive play, sensory, motor and postural development 6. Psychological services: Administrating DSCII & DDST and thei interpretation for assessment of psychological development, behavioral characteristics of children and correction of related disorders. 7. Cognitive development: Assessment, learning and mental health and appropriate intervention of the related problem including play and socialization 8- Hearing: For identification and intervention of hearing deficits in babies with or without risk factors. 9- Speech & language: For Identification and intervention of speech language pathology delay in Oro- motor, language, communication and comprehension skill. 10- Vision: For identification and intervention of visual

	problems like refractive errors, cataract, glaucoma, amblyopia etc.
Comments	Early Intervention Centre Samarpan is the first of its kind model in the country demonstrating early identification, intervention for all U5 children registered in Integrated Children Development service (ICDS) and in district hospital district Hoshangabad for developmental delay. It demonstrates the efficacy of intersectoral, interdepartmental and inter institutional convergence model optimizing resources. It suo motu screens all U5 children in district en masse for detecting earliest sign of development delay facilitating their possible recovery to normal curve of development.
Contact	
Submitted By	Nishant Warwade Collector Bhopal Former Collector Hoshangabad Mo. No. 91-9425019888
Status	Active
Reference Files	
Reference Links	

245. Daati Matritva Beema Yojana, Pali

Subject Area="Access to service and coverage."	Objective="Promote institutional delivery and enhance immunisation coverage"
Details for Reform Option "Daati Matritva Beema Yojana, Pali"	
Summary	It is observed that Maternal Mortality Rate in Rajasthan is higher than that of other states in India. It is very said that many pregnant women die due to maternal reasons which are preventable. To reduce these Maternal deaths, a Pregnant Women Insurance Scheme named as “Daati Matritva Beema Yojana, Pali” has been launched by district administration of Pali, in coopration with state health authorities and a private trust (Shanidham Trust). The donor of this scheme is the “Shri Shanidham Trust”Alawas, Pali, Rajasthan. This insurance is totally free of cost and no woman need to pay any premium for it. However there are strict eligibility criteria. With the new insurance scheme district administration targets to bring down the maternal deaths in the district and also find out the actual figures of maternal deaths in the district which go “unreported”. So that on the basis of actual data we can take corrective measures. In this scheme there is the provision of four ante-natal check-ups for every pregnant woman. However there are some women who do not go for such check-ups at all. It is mandatory to get the check-ups for availing the benefit of this scheme. ANMs will spreads the awareness of about it and to facilitate and guide the pregnant women to go for ante-natal check-ups. This scheme is first of its kind policy in the country. The scheme is designed in such a way that it will help in increasing institutional deliveries, ante-natal check-ups, immunizations and marriage in legal age. There are some conditions/points which need to be fulfilled by pregnant women to avail the benefit of this scheme. If a women follow all these points, the maternal deaths would take a dip automatically, which is one of the major target of this scheme. This innovative maternal insurance scheme has been launched on 24th August, 2014 by the district administration of Pali, in cooperation with state health department and a private trust.
Cost	In present probable MMR of Pali district is 222 per lakh. Number of Pregnant women are 50000 per year in the district which implies that probable maternal death may be about 110. It is estimated that Rs. 38000 are to be incurred on a maternal death. Total estimated expenditure is 40,00,000/- (in words fourty lakhs) per year. But last year, MMR was reported only 26 according to data available in the department it is low due to under reporting.
Place	Whole Pali district of Rajasthan.

Time Frame	
Advantages	• This Yojana will help in increasing institutional deliveries in Pali district. • Institutional deliveries will further improve MMR and IMR of district. • According to Daati Matritva Beema Yojana-Pali, If death of pregnant women occurs due to maternal reasons, economic benefit will be given to her family for care of new born child.
Challanges	
Prerequisites	There are some conditions which need to be fulfilled by pregnant women so as to be eligible for benefit from this innovative scheme are given as: 1. Pregnant women are required to be 18 year of age at the time of Marriage. 2. Pregnant women dies due to any maternal reason. 3. Pregnant women should be registered in any govt. or approved hospital within first 12 weeks of pregnancy. 4. She should required to fulfill some other conditions also as per list attached. 5. There is no limitation/ceiling of children and number of delivery. 6. There is no limitation of any spacing criteria between two deliveries.
Who needs to be consulted	
Risks	
Sustainability	No issues
Chances of Replication	Very Good (other districts, states may replicate this innovative scheme).
Comments	
Contact	Sh. Rohit Gupta, (IAS) District Collector, Pali, Rajasthan. 9460387269 Dr. Madhu Rateshwar, Chief Medical & Health Officer,Pali 9166303567 Maa Shraddha, Director, Shree Shanidahm Trust,Pali 9414124575 Sh. K.C. Saini, District Coordinator, Maternal Insurance Scheme,Pali 9352934000
Submitted By	CBHI (ROH&FW) Jaipur
Status	Active
Reference Files	

Reference Links	

246. Mera Swasthya Meri Aawaz- (MS,MA)

Subject Area="Community participation."	Objective="Using Innovative Technology for Effective Mechanism in public health facilities"
Details for Reform Option "Mera Swasthya Meri Aawaz- (MS,MA)"	
Summary	The Mera Swasthya Meri Aawaz (MS, MA) project was designed to test whether an existing open-source software platform could be adapted and successfully used to increase the documenting of demands for informal fees for maternal health care services that, by law, should be free. SAHAYOG has been mobilizing rural women to organize around their entitlements in health and related social determinants since 2006, through the Womens Health Rights Forum (MSAM). Following awareness-raising sessions, these community women for years have been highlighting incidents of informal fees being demanded and consequent denial of care, for which SAHAYOG in collaboration with AMDD set up a mechanism in 2012 to report this using interactive voice response (IVR) and mobile phones. To serve the largely illiterate population in Uttar Pradesh, the system was adapted and integrated with an interactive voice response system. The project began in July 2011 in 2 district of UP (Azamgarh and Mirzapur) later it was up scaled in 5 more districts of Uttar Pradesh in September 2013 (Banda, Chitrakoot, Kushinagar, Gorakhpur and Chandauli). **Action:** 1- Set-up Technology- The system works as follows: Users call a toll free number which is connected to a phone line. An ATA device transfers the calls received to Tropo which handles the IVR operation and sends the data to Ushahidi. The information collected is mapped in an Ushahidi installation and can be viewed at: http://meraswasthyameriaawaz.org/ 2- District-level Campaigning- The first step in this pilot was to make communities aware about the free services they were entitled to, and the possibility of registering a complaint in case anyone asked them to make payments. For this a campaign was developed with many kinds of materials, using pictures and simple text. The content of the materials covered included: Information about entitlements during pregnancy and in the postpartum period under the JSSK such as free medicines, tests, blood, caesarian sections, ultrasounds, ambulance services and food while in the facility. Information about the Mera Swasthya Meri Aawaz helpline Instructions on how to register a complaint on the helpline

	including the IVRS messages and codes of the health facilities. In addition, the MS, MA sponsored wall writing promoting the campaign, street plays and community meetings. Letters were distributed to local decision makers and meetings with local government officials, health officials and frontline health workers were also conducted so that they were aware of the campaign and the helpline. 3- District-level Launch Workshops/Dialogues- Workshops/dialogues were organized in each district to familiarize the CBOs, local women groups (Mahila Swasthya Adhikar Manch), and other community members on the status of entitlements under the JSSK scheme and launch the website and campaign with and government health officials, while sharing women's experiences on paying informal fees. 4- Government Engagement- Throughout the project, SAHAYOG and CBOs met with government officials from the block up to the state levels. The government was included in all MSMA workshops and dialogues. In addition, SAHAYOG and CBOs initiated individual meetings with key health officials and providers (such as the Additional Director, the Joint Director, the CMO, the Dy. CMO, the Medical Superintendent, the District Programme Manager, the Community Health Mobilizer, the Health Education Officer and the Medical Officer in Charge). The pilot phase results were shared on 4th June 2013 in Lucknow, before the Additional Mission Director (NRHM-UP), Director General of the Directorate of Health & Family Welfare, the General Manager of Community Processes and the General Manager of HMIS (NRHM-UP). Two members of the NRHM national Advisory Group on Community Action (AGCA) were also present in the sharing. Additions in the up-scale phase: 5. Engagement with the Rogi Kalyan Samiti- Since the RKS is the mandated body for ensuring accountability of the public health providers towards the community, the Ushahidi data generated will be used to encourage them to perform this crucial role by enabling them to monitor in real time, the informal payments that women are forced to make. By making this data available and constantly advocating with the RKS to initiate remedial action, a culture of demanding informal fees for maternal health services will be discouraged thereby improving the quality of service provisioning. 6. Feeding back the data to the community- The Internet website was not referred to directly by the community women in the pilot phase; it was done periodically through workshops. In this phase, regular feedback of the data to the community women is planned through a publication in simple Hindi to motivate them to continuing reporting informal payments thereby promoting a call for improvement in the quality of

	services. **Results:** Based on the first year of its Pilot implementation in 2 districts- Between January 24th 2012 and May 24th 2013, the helpline has recorded 873 reports of informal payments collected at 40 district hospitals, community health clinics (CHCs) and primary health clinics (PHCs) across Azamgarh and Mirzapur districts. In the pilot period, 31 emergency calls were made through the helpline in these 2 districts. These calls were made for various reasons – denial of admission into the facilities, demands for money for obstetric treatment, ambulance payments or maternal examinations. The results of the emergency calls were that women received medical assistance and it also alerted health officials about the particular complaint.
Cost	The total cost of the pilot was Rs. 56,40,990 which included among other things: 1. Cost of the campaign activities in 2 districts -Rs. 6, 01,253. 2. The adaptation and set-up of the helpline and platform cost - Rs. 5, 33,489. Source of funding- MacArthur Foundation
Place	Currently the project is running in 7 districts of Uttar Pradesh, detail are given below- 1-Azamgarh- Gramin Punar Nirman Sanstha, Atraulia, Contact Person: Rajdev Chaturvedi, Contact No.-9451113651 2-Mirzapur- Shikha Prashikshan Sansthan, Chunar, Contact Person Sandhya Mishra, Contact No.-9450162867 3-Banda- Tarun Vikas Sansthan, Baduasa, Contact Person: Uma Kushwaha, Contact No.-8423283073 4-Chitrakoot- Ibtada Sansthan, Contact person: Urmila, Contact No.- 9450222821 5-Kushinagar- PGSS, Contact Person: Sudha, Contact No.-9450466951 6-Gorakhpur- Baba Ramkaran Das Gramin Vikas Samiti, Contact Person Awdesh Kumar, Contact No.-8858526664 7-Chandauli- Gramya Sansthan, Contact Person: Bindu, Contact No. 9415222597
Time Frame	During the pilot phase, it took 3 months to set up the IVRS system which included coding health centers in 2 districts.
Advantages	1. With the use of this technology, there has been a shift from anecdotal narration to systematically recorded evidence that informal payments are being demanded for free maternal health services. This has increased the value of the data as health officials in the districts and the state perceive it as being authentic. Health officials at all levels found the platform useful for supervision of health facilities 2. This technology could be used to monitor incidents where location is important but witness protection is ensured, such as incidence of violence against women or incidence of maternal deaths by frontline workers and community members.
Challanges	1- In cases where redress is not immediate, the complainant

	does not know the impact of their making complaints. 2- In some cases, when the people realize that their money would not be returned even if they complain, their interest in the helpline reduces. 3- There is a fear in the community that if they complain, there will be a backlash and so they are afraid to use their own mobile phones. 4- Some local health officials and elected council members have not taken the helpline seriously even though they were informed about the real-time data on the website. 5- One phone line was often busy when women were making reports. Multiple calls at the same time, would lead to a busy signal. Women would get discouraged from making reports if they had to make repeated calls to get through to the helpline. 6- Too many options in IVRS were confusing. However, another option to test in the future would be to have women leave a voice message which then could be manually fed into the Ushahidi. The problem with this option might be that there is no certainty that all the detail about the incident such as location, amount of payment, reason for payment, etc would be provided by the complainant. 7- Lack of good internet connection effected the reporting. 8- Given the fact that a large proportion of the rural population do not have access to computers, they could view the maps only when someone showed it to them.
Prerequisites	1. Technology and Hardware Requirements: The reporting system is built around Ushahidi, an open source tool used to crowd source information from multiple sources (e.g., phone calls, SMS, Twitter, etc.) and display the results on an interactive map. The system also uses Tropo, an application programming interface (API) used to integrate an interactive voice response (IVR) system with Ushahidi to collect the information from users. The IVR component is essential to the success of the project because many users of the system are unable to read or write. The system works as follows: Users call a toll free number which isconnected to one phone line. An ATA device transfers the calls received to Tropo which handles the IVR operation and sends the data to Ushahidi. The information collected is mapped in an Ushahidi installation and can be viewed at: http://meraswasthyameriaawaz.org/ 2. Importance of Active Citizen Engagement: It requires a level of 'active citizen engagement' to take the trouble to report informal payments. The mere provision of a free reporting help-line does not ensure that grievances are reported (especially

	since money paid out is not recovered). The presence of a rights-based organization like the Mahila Swasthya Adhikar Manch ensures that women invest in making complaints to improve and strengthen the health system, even if they do not personally benefit in any way. 3. Importance of health official's engagement: Involving of state and district-level government officials is needed for instant responses to save lives. Merely generating data is not enough, it needs strong follow-up action by the health authorities involved. There has to be an institutional mechanism of reviewing the complaints and taking action with the staff of the concerned health centres. 4. Importance the role of CBOs: Presence strong rights-based community based organizations in the project areas is crucial. CBOs need to be involved in the project who have a strong record of working with the community and have engaged in advocacy with district level officials by providing them with evidence from the ground
Who needs to be consulted	PraveshVerma-9235888222, praveshmasvaw@sahayogindia.org Dr. Shishir Chandra-9451507178, shishir@sahayogindia.org Dr.YK Sandhya-09868839789, sandhya@sahayogindia.org
Risks	
Sustainability	Technological innovations in the field of grievance redress alone are not Sufficient to promote greater accountability. As experience has shown, the presence of motivated individuals like local CBO partners in districts and an empowered citizens group like MSAM are critical to such innovations being used for its sustainability.
Chances of Replication	The technical parts of the project can be replicated anywhere. However for the project to be successful it is necessary to invest in building peoples knowledge about health entitlements, and mobilizing citizens to claim them by engaging in regular monitoring of services and seeking redress for their grievances.
Comments	The MS, MA proved that with assistance and training, poor, rural women were able to use mobile phones to make confidential complaints about informal payments thus exploding the myth that illiterate women could not use modern technology. It enabled community women to call for accountability withoutbeing victimized or punished for reporting, as it provided anonymity. The MS, MA experience also showed that technological innovations in the field of grievance redress alone are not sufficient to promote greater accountability. The presence of motivated individuals (CBO partners) and an

	empowered citizens group (Mahila Swasthya Adhikar Manch) are critical for such innovations being used. While using IT to generate data which is accepted by health providers is important, none-the-less unless we build pressure on officials (through various advocacy strategies using this data), improvements and greater accountability will not result automatically. Thus the MS, MA shows that while the generation of data on informal payments is essential, but without related official action to improve accountability, the practice of informal payments will not be stopped.
Contact	
Submitted By	Dr. Shishir Chandra (Programme Manager) and Pravesh Verma (Advocacy andICT Officer) at SAHAYOG
Status	Active
Reference Files	
Reference Links	

247. Bike Ambulances: First Response Unit

Subject Area="First Referral Units."	Objective="Access to RCH services."
Details for Reform Option "Bike Ambulances: First Response Unit"	
Summary	**Background:** In cities and towns, the population is increasing exponentially due to various socio economic reasons along with the number of motor vehicles. But the length of roads are constant, thereby the road traffic is increasing tremendously. Therefore, the opportunity of road traffic accidents, and hence fatality due to the accidents is increased. In bigger cities, the trauma accidents also happen in narrow roads and reaching the site by four wheeler Ambulances takes some more time comparatively to that of broader roads. **Action:** In order to reduce the fatality due to accident in the narrow roads, the Government of Karnataka introduced a new innovative scheme Bike Ambulance (First Response Unit) on 15th April 2015. The first-aid and medical care during the Platinum Ten Minutes is paramount to save the life of an accident victim, hence the pioneering attempt to start motorbike ambulance service. It is an unique initiative and is the first of its kind to be taken up in our Country. The motorbike ambulance service is a pilot and pioneering initiative to ensure first-aid to the victims during the Golden hours, where the chances of survival in case of critically injured patients increases. Bike Ambulances are useful for negotiating the small streets and heavy traffic in the large urban areas where it would be difficult to move four wheeler ambulances through crowd. The fleet of high-powered touring motorcycle is available when required to respond to various trauma/medical incidents. The programme will be implemented through GVK-EMRI who is already experience in providing such services through Arogya Kavacha- 108. Riders are paramedics or EMTs who are already recruited and trained on managing emergencies. Motorbike ambulance drivers would be fully trained in rendering first aid and would start resuscitation measures to save the victim. **Results:** Till July 2015, i.e., four months after inception, 177 emergency cases (both minor trauma and accidents) were attended by Bike Ambulances. Out of this, there were 5 critical cases.
Cost	The cost depends on the number of ambulances to be engaged. The manpower is being used from the existing GVK EMRI.
Place	The number of Bike Ambulances which are currently deployed in Bangalore are 19, in Mangalore are 2, and one each to the corporation areas of Mysore, Kalburgi, Belagavi, Hubballi- Dharwad, Davangere, Tumkur, Vijayapura, Shimoga and Kolar districts, where

	heavy traffic congestion and narrow streets would be easily overcome by the agile nature of the bikes.
Time Frame	Six months
Advantages	These motorbike ambulances would render first aid to emergencies such as accidents, heart attacks, brain attack, poisoning and fire accidents. Areas difficult to access in a conventional ambulance the rapid responder bike ambulances are able to arrive on scene and begin treatment of critical patients several minutes before the arrival of a conventional ambulance whilst still carrying all the essential equipment of an ambulance. Two-wheelers by virtue of their size could manoeuvre through narrow and busy roads and reach accident spots with ease while they will be followed by a fully equipped four-wheeler ambulance for shifting the victim to a nearest hospital for further treatment. Bike ambulance is able to respond to a medical emergency much faster than an ambulance or a car in heavy traffic which can increase survival rates for patients suffering cardiac arrest/ accident/ other emergencies. Even as the motorbike ambulance reaches the spot, it will be quickly followed by a fully-equipped ambulance which will shift the patient to the nearest hospital for further treatment. Chances of survival of many critical patients injured in accident who require immediate treatment can be saved. First aid to patients can be provided immediately in areas where there is heavy traffic.
Challanges	
Prerequisites	The drivers of the Bike Ambulances should be First Aid trained and capable of handling the patients who are in Trauma/Accident site.
Who needs to be consulted	Dr Parimala, Joint Director, Directorate of Health and FW Services Government of Karnataka Bangalore.
Risks	
Sustainability	Sustainable.
Chances of Replication	It can be replicated in cities and towns.
Comments	
Contact	The Director, Directorate of Health Services, Govt. of Karnataka, Ananda Rao Circle Bangalore.
Submitted By	FSU,Bengaluru
Status	Active
Reference Files	
Reference Links	

248. Megha Health Insurance Scheme, Meghalaya

Subject Area="Health financing."	Objective="Mobilising community participation."
Details for Reform Option "Megha Health Insurance Scheme, Meghalaya"	
Summary	Megha Health Insurance Scheme (MHIS) is an initiative of the Govt. of Meghalaya that has been designed in convergence mode with the Govt. of India existing Health Insurance Scheme – Rashtriya Swasthya Bima Yojana (RSBY). The Scheme excludes State and Central Government Employees (already covered), in addition to providing a top up for BPL families under RSBY. The Phase – I of the MHIS was launched on 15th December, 2012 and provides for an insurance cover of upto Rs. 1, 60, 000/- for a family of 5 members, each family having to pay only Rs. 31/- at the time of registration in the first phase of implementation, the Govt. had ICICI Lombard General Insurance Co. Ltd. as its partnering agency for implementation. In June, 2015, the Phase – II of the MHIS was launched and enhanced the coverage up to Rs. 2, 00, 000/- for each family, consisting of 5 members, having to pay only Rs. 30/- Currently in its due course of implementation, the Govt. of Meghalaya has partnered this phase of implementation with the New India Assurance Co. Ltd.
Cost	Premium per Household MHIS I: Rs. 478 * Number of Households Enrolled. (for one policy year subjected to renewal or policy extension). MHIS II: Rs. 431 * Total Number of Households Enrolled (MHIS II enrollment is under process).
Place	Meghalaya
Time Frame	MHIS I. May, 2013 – April, 2014. 1st Extension: May, 2014 – September, 2014. 2nd Extension: October, 2014 – April, 2015. 3rd Extension: May, 2015 – July, 2015. MHIS II: Policy period starts 1st August, 2015.
Advantages	1. Universal Health Insurance entitlement. 2. Effective Financing Mechanism. 3. No age limit in coverage and pre-existing diseases are also covered. 4. Absolute insurance coverage – primary, secondary and tertiary care.

	5.beneficiaries entitlement to a comprehensive spectrum of health services including super specialty treatment with main focus in cancer treatment, advance diagnostics,comprehensive outpatient services for pregnant women and children and long term consultation and treatment services for life style. 6. Beneficiary option to choose between public and private hospitals. 7. Scientifically designed packages prices. 8. Increase of coverage from 1036 procedures in RSBY to 1704 in MHIS II. 9. Hospital impanelment – Public and Private Hospitals including specialty hospitals outside the state. 10. Public hospitals Empowerment – Improving public hospitals infrastructure and health facilities. 11. It Server at the SNA office (one of the only state in the North East to have its own server) to maintain records during the enrolment process and to process the receipt and payment of claims.
Challanges	1. Enrollment Challenges: Climatic conditions, data mismatch, socio cultural issues, time management. 2. Empanelment: Unwillingness of some private hospitals in the state to be empanelled. 3. Low packages rates. 4. No normal OPD coverage. 5. Lack of awareness about the scheme among the beneficiaries and health care provides. 6. Lack of monitoring and control, MIS reporting mechanisms and IT challenges.
Prerequisites	Partnership with an insurance provide including its Third Party administrators
Who needs to be consulted	1. Different Government Departments for preparation of Beneficiary database for categories such as BPL, APL, Building and other Construction Workers, Weavers and Artisans, MGNREGA and ASHAs. 2. District Administration – Deputy Commissioners, District Medical Officers, Medical Officer and private hospital administrators. 3. Block Administration: Block Development Officers, Village

	Administrators, headmen, ASHA and Anganwadi workers.
Risks	Nil
Sustainability	1. Financial Stability – Utilization of the registration fee for various administrative costs to implement the scheme with financial assistance from both the central and the state government (RSBY – 90% Central Share and 10% State Share, MHIS – 100% State Share). 2. Public Hospitals involvement – A comprehensive claim utilization structure whereby 70% of the claimed amount is for development of hospital infrastructure and 30% is for staff incentives. 3. MHIS claim ratio which is more than 80% indicating complete utilization of the scheme by the beneficiaries which has cross Rs. 14 crores and public hospital facilities improvement which is about Rs. 4 crores approximately.
Chances of Replication	Citing India embankment to achieve Universal Health Coverage during the 12th Plan period, some states have already adopted similar schemes
Comments	Inspite of the challenges the scheme faced during its initial stages major strategies have been undertaken – The Government of Meghalaya has sought assistance from International Fiancé Corporation (IFC) to formulate and regulate the various features of the scheme, enhance awareness activities, training and capacity building of all stakeholders, involving of a data mining agency for beneficiary's database preparation, introduction of an incentive structure for Field Key Officers to boost enrolment, strengthening of monitoring and control activities and strengthening of MIS and IT systems
Contact	State Nodal Agency, Megha Health Insurance Scheme, Shillong
Submitted By	State Nodal Agency, Megha Health Insurance Scheme, Shilling
Status	Active
Reference Files	
Reference Links	

249. Special Medical Health Camps at Janeshwar Mishra Park, Lucknow

Subject Area="Urban Health."	Objective="Mobilising community participation."
Details for Reform Option "Special Medical Health Camps at Janeshwar Mishra Park, Lucknow"	
Summary	**Background:** Every day nearly fifteen thousand people visit Janeshwar Mishra Park, Lucknow. Keeping this in mind Dr. S.N.S.Yadav, Chief Medical Officer, Lucknow got an innovative idea to organize special medical health camps at Janeshwar Mishra Park so that through this outreach activity, health services could be provided to the morning walkers for free and health living behavior could be promoted. **Action:** Demonstrating convergence and leveraging of resources, the Chief Medical Officer or Lucknow coordinated with Lucknow Development Authority which made the arrangements for tentage and Drishti Advertisement which made the arrangement for providing healthy breakfast free of cost. **Results:** The timing of the camps was decided to be from 05:30am to 09:30 am to be held once a month. Allopathic doctors as well as specialist doctors including Ayush and Homeopathy were called to attend the camp. A team of 20 doctors and 50 paramedical staff conducted health checkups including testing blood pressure and diabetes. Medicines were provided free of cost. Three ambulances were stationed outside the park. An interactive talk is followed by Question and Answers and there are face to face consultations for assessment and counseling. The doctors and paramedical staff educate morning walkers about their health concerns, hygiene and provide counseling about ways of healthy living. Four health camps have been organized till date. 756 patients were screened on 12th April, 2015, 1245 patients on 17th May, 2015, 3171 patients on 14th June, 2015 and 2362 patients on 2nd August, 2015. Blood donation camp was also organized on 14th June, 2015 where 17 units of blood were donated by volunteers.
Cost	No budget was separately set aside for these camps which was done in coordination with Lucknow Devlopment Authority and Drishti Advertising.
Place	Janeshwar Mishra Park at Lucknow, Uttar Pradesh
Time Frame	Two months.
Advantages	Helping patients in need through spot diagnosis and treatment.

	Assessment of prevalence of diseases in the area. Planning for preventive treatment
Challanges	1. Coordinating with Lucknow Development Authority and Drishti Advertising. 2. Managing the large number of patients 3. Coordinating with the doctors and paramedical staff.
Prerequisites	1. Availability of suitable place to conduct a camp of such high turnout. 2. Availability of medical and paramedical staff. 3. Enthusiasm and active participation by citizens. 4. Active engagement by health officials.
Who needs to be consulted	Dr. S.N.S. Yadav, CMO, Lucknow, email- cmolko@up.nic.in, lkocmo@gmail.com
Risks	
Sustainability	Maintenance of quality health care delivery and active participation by local citizens can help in sustaining such a project.
Chances of Replication	Can be replicated in any district.
Comments	This camp is an efficient way of providing spot diagnosis and treatment of diseases and is helpful in prevention of prevalent diseases. It also provides information to citizens about how to lead a healthy lifestyle and healthy eating habits.
Contact	
Submitted By	Dr. A.P. Singh, Deputy CMO, Urban Lucknow, Ph: 9415454071, email- cmolko@up.nic.in, lkocmo@gmail.com
Status	Active
Reference Files	
Reference Links	

250. "PRIME (Programme for Improving Mental Health Care)" in Sehore district of Madhya Pradesh

Subject Area="Human Resources Development for Mental Health. "	**Objective="Implementation and Scaling up of Mental Health Programmes as a priority in primary health care."**
Details for Reform Option ""PRIME (Programme for Improving Mental Health Care)" in Sehore district of Madhya Pradesh"	
Summary	The PRIME (Programme for Improving Mental Health Care) is a consortium of research institutions and Ministries of Health in five countries in Asia and Africa (Ethiopia, India, Nepal, South Africa & Uganda), with partners in the UK and the World Health Organization (WHO). PRIME is funded by the UK government's Department for International Development (DFID), and is a six year programme which was launched in May 2011. Project focuses on three mental disorders (Alcohol use disorder, Depression and Psychosis) which contribute to the greatest overall burden of disease. PRIME aims to improve the coverage of treatment for priority mental disorders by implementing and evaluating the WHOs mental health Gap Action plan (mhGAP) guidelines. In INDIA PRIME is implemented by SANGATH and PHFI at Sehore district of Madhya Pradesh in collaboration with Department of Health services, Department of Medical education, State mental Health Authority. PRIME has three Phases for implementation. Phase one was Inception phase; in which a draft Mental Health Care Plan (MHCP) was developed after having in-depth discussion with stakeholders. In second phase MHCP is piloted and now being implemented to evaluate its feasibility, acceptability in the contexts of routine primary health care. Third phase will be to support Government in scaling up to cover at the level of District/ administrative health units (AHUs).
Cost	
Place	Sehore District in Madhya Pradesh. Implementation site:- -Bilkisganj -Shyamur -Doraha
Time Frame	2011 to 2017
Advantages	PRIME has three Phases: 1.Advantage of Phase one provided draft Mental Health Care Plan (MHCP) was developed after having in-depth discussion with stakeholders. 2. In second phase MHCP is piloted and now being implemented to evaluate its feasibility, acceptability in the contexts of routine

	primary health care. 3. Third phase will be to support Government in scaling up to cover at the level of District/ administrative health units (AHUs).
Challanges	Not as such
Prerequisites	Government support, support of DMHP, Regular funding support.
Who needs to be consulted	
Risks	
Sustainability	PRIME Post up scaling phase need support from Government to upscale to other districts and may need funding support to sustain itself.
Chances of Replication	Its simple and cost effective interventions and components have more possibility of replicability.
Comments	Nil
Contact	Dr.Sanjay Shrivastava 9893030901 http://www.prime.uct.ac.za
Submitted By	Dr. Sanjay Shrivastava Clinical Director PRIME, INDIA
Status	Active
Reference Files	
Reference Links	

251. Sanjeevani Beema Yojana in UT of Daman & Diu

Subject Area="Public / private partnership (including NGOs)."	**Objective="To provide affordable medical and health services to the people of Below Poverty Line"**
Details for Reform Option "Sanjeevani Beema Yojana in UT of Daman & Diu"	
Summary	The Sanjeevani Swasthya Bima Yojana is implemented in UT of Daman & Diu to provide facility of Comprehensive Health Insurance Scheme for the domicile Citizens of this UT who cannot afford to pay for the Health of their family members & themselves. Under the Scheme the premium amount has been borne by the UT Administration for BPL Families and for Domicile & Poor Families having Annual Income less than Rs. 1 Lakh. For other residents whose Income is more than Rs. 1 Lakh per annum the premium is paid by the beneficiaries. No. of Families Insured under the scheme for 2014 are 6215 & No. of Beneficiaries are 22265.
Cost	31.00 lakh (Approx.)
Place	UT of Daman & Diu
Time Frame	2 – 3 months
Advantages	Health Insurance of all the family members (Upto 5 members).
Challanges	
Prerequisites	Sanjeevani Beema card issued when registering themselves for the scheme.
Who needs to be consulted	The Director, Medical & Health Services, UT of Daman & Diu & Secretary (Health), UT Administration of Daman & Diu.
Risks	
Sustainability	Initially for life long or till the premiums are paid. The expenditure will be borne from UT Plan Fund (Other charges A/c).
Chances of Replication	Nil
Comments	
Contact	The Director, Dte. of Medical & Health Services, Fort Area, CHC / PHC, Moti Daman – 396220 Phone No. 0260-2230470 E-mail ID: kysultan64@yahoo.com
Submitted By	The Health Department in collaboration with United India Insurance Company Ltd.
Status	Active
Reference Files	

Reference Links

252. Matru Samruddhi Yojana in UT of Daman & Diu

Subject Area="Health financing."	**Objective="To Reduce Mal- Nutrition among lactating mothers and infants"**
Details for Reform Option "Matru Samruddhi Yojana in UT of Daman & Diu"	
Summary	This Scheme shall reduce Mal-nutrition among lactating mothers & infants. It was found that large number of women in UT of Daman & Diu were having the problem of anemia and Mal-nutrition. Hence it was planned to provide some financial help to lactating mothers for purchasing healthy and nutritional food.Yes the financial help made the lactating mothers happy &the stress free. The Monetary helped them to purchase health food for them also to use the same for pretty expenses when they are reach their homes after delivery.
Cost	Estimated Cost depends on the No. of Institutional Deliveries taking place in public health institutions of UT of Daman & Diu (App 20.00 lacs. Per annum (400x5000).
Place	UT of Daman & Diu
Time Frame	2 Months.
Advantages	Reduce Maternal Mortality & Infant Mortality & helps in promoting Institutional deliveries also discourages early marriages in the community.
Challanges	
Prerequisites	Resident Certificate, Marriage Certificate & Birth Certificate of the New born.
Who needs to be consulted	The Director, Medical & Health Services, UT of Daman & Diu & Secretary (Health), UT Administration of Daman & Diu.
Risks	
Sustainability	It will continue in future. The expenditure will be borne from UT Plan Fund (Other charges A/c).
Chances of Replication	Nil
Comments	
Contact	The Director, Dte. of Medical & Health Services, Fort Area, CHC / PHC, Moti Daman – 396220 Phone No. 0260-2230470 E-mail ID: kysultan64@yahoo.com
Submitted By	The Health Department UT of Daman & Diu.
Status	Active
Reference Files	
Reference	

Links

253. Hausala Sajheedari, Uttar pradesh

Subject Area="Public / private partnership (including NGOs)."	Objective="Scope and quality of primary health centre services."
Details for Reform Option "Hausala Sajheedari, Uttar pradesh"	
Summary	**Background:-** The state government, inviting the private health facilities and private sector surgeons to join hands with the government and complement in its efforts to stabilize the population growth, has launched a unique initiative called 'Hausala Sajheedari' wherein the state policy on accreditation of private health care facility and empanelling private sector qualified surgeons for family planning has been comprehensively revised and detailed guidelines issued. Hausala Sajheedari takes the help of ICT to deliver a smooth and efficient system wherein an online web-portal based interactive system has been designed and implemented under the program. GoUP has formed an apex committee called State Task Force (STF) and also established a Private Sector Partnership (PSP) cell at the state level for leadership and overall management of the program. =: Hausala Sajheedari makes engaging with the government simple and attractive for private health facilities and family planning surgeons. This web portal is a single – window solution where all the formalities can be completed quickly so that health facilities and surgeons can provide family planning services under various government schemes. Hausala Sajheedari is also an opportunity for health facilities and family planning surgeons to join hands with the government to work towards population stabilization in Uttar Pradesh. **Action:**- Health facilities and family planning surgeons can take a self – evaluation test at this portal to find out their eligibility. Facilities can apply for accreditation and surgeons can seek empanelment here. Accredited service providers can also put up the list of people to whom they have provided family planning services and claim reimbursement and compensation under government schemes. A private facility will be accredited for 5 years but an annual review of accreditation will be done for quality assurance by nominee/s of STF. Owners of health facilities approved for accreditation will be invited to sign a tripartite memorandum of understanding (MoU) between the Private Facility, the Chief Medical Officer, and SIFPSA. Surgeons

	who meet the eligibility criteria for providing surgical family planning services can also get empanelled with the office of the Chief Medical Officer. Empanelment becomes necessary for the surgeons to be indemnified against litigations in case of eventualities. Accredited facilities will be able to upload details of family planning services they have provided and seek reimbursement and compensation. PSP needs to upload details of provided services and beneficiaries on prescribed format on web, minimum 10% of the uploaded details will be physically verified randomly by the authorities and after successful verification only payment will be made. SIFPSA has been designated as the nodal agency at the state level to implement this program. A 4 member Private Sector Provider (PSP) cell serves as a secretariat to the State Task Force. The PSP cell, nested at SIFPSA, looks after the web portal management, problem solving and overall process oversight of the program implementation at the state level, including promotion of the program, online verification of the application, monitoring progress, and processing reimbursement of claims. (Presentation on working of web portal in pdf form is enclosed as Annexure – 5) **Results:** 392 surgeons have been empanelled under this scheme (List enclosed as annexure – 1). 368 Hospitals have been empanelled under this scheme (List enclosed as annexure – 2).
Cost	The portal has been developed by existing infrastructure of SIFPSA. The market cost of developing such portal is around Rs. 18 to 20 Lakhs approximately. Further, Annual data back up and Annual maintenance cost of the portal is around Rs 7 Lakhs per annum. Table of rate of reimbursement to Service Providers & Beneficiary is listed in GO dated 27.01.2015 enclosed herewith as annexure – 3.
Place	The scheme is being rolled out in all District of Uttar Pradesh.
Time Frame	As per the roll out plan, the initial time to set up including developing the software applications, conducting capacity building training of is 12 months.
Advantages	A couple seeking contraception can now gain access to family planning services in a private clinic, closer to home, and yet enjoy the benefits of government schemes. Private health facilities can now get accreditation by simply logging in to the web portal. Anyone seeking accreditation for his or her clinic simply has to follow the instructions given at every step. There is an audio – video tutorial as well on the home page. Facility owners can do their own evaluation against a checklist and if they meet the eligibility criteria the portal will automatically generate a letter of interest. The office of the corresponding Chief Medical Officer will also get an alert simultaneously to initiate the next step,

	that is, physical verification of the health facility. Health facilities can check their application status online. Facilities denied accreditation will be given reasons for rejection.
Challanges	Creating awareness & sense of trust among the Private Health Practitioners / Providers.
Prerequisites	Involvement of health officials =: Sound understanding of the State Government and GOI functioning =: Monitoring and supportive supervision mechanism
Who needs to be consulted	State Innovations in Family Planning Services Agency (SIFPSA) Om Kailash Tower, 19-A, V.S. Marg, Lucknow – 226001 Contact: 0522-2237497, 2237498 Fax: 0522-2237574
Risks	
Sustainability	Programme is sustainable if timely reimbursement of the bills is done by the concern departments. Further, proper awareness programme among the private service providers as well as beneficiaries should be made to ensure active participation.
Chances of Replication	Programme can easily be replicated.
Comments	Objective:- Uttar Pradesh is committed to contributing almost 26 percent of country's FP 2020 goal to achieve population stabilization. To fulfill this enormous task, the number of eligible couples using contraceptive needs to double in next 6 years which translates to increasing the current users of modern family planning from 1.27 crore to 2.45 crore eligible couples. Government of Uttar Pradesh clearly envisions a complementary role that the private health care providers can play alongside the public sector, to exponentially expand access to quality FP services for the potential clients to choose from, thereby increasing use of need for family planning.
Contact	E-mail: cbhi.lucknow@gmail.com Tele / Fax: 0522-2325268
Submitted By	Field Survey Unit, ROHFW, Lucknow
Status	Active
Reference Files	
Reference Links	

254. Dikri Development Scheme in UT of Daman & Diu

Subject Area="Behavioural Change Communication."	Objective="Improving sex ratio."
Details for Reform Option "Dikri Development Scheme in UT of Daman & Diu"	
Summary	The Sex Ratio of this UT was very low hence to motivate the community to save the girl child the Dikri Development Scheme was introduced. The UT Administration of Daman & Diu provide a term deposit in LIC / Bank for an amount of Rs. 41,799/- in the name of the Girl Child. This scheme helped to improve Institutional deliveries, reducing IMR & MMR and also improving the sex ratio. Estimated Cost is around Rs. 41,799 x 210 (No. of Girl child born)
Cost	85 - 90 lakh (Approx.)
Place	UT of Daman & Diu
Time Frame	2 months
Advantages	Save the Girl Child, Discourages Early Marriage, promotes registration of Marriages, promotes Institutional deliveries, reduces IMR & MMR.
Challanges	Girl taking birth in Private Hospitals / Institutions cannot take the benefit of the scheme.
Prerequisites	Domicile Certificate, Marriage Certificate & Birth Certificate of the New born.
Who needs to be consulted	The Director, Medical & Health Services, UT of Daman & Diu & Secretary (Health), UT Administration of Daman & Diu.
Risks	
Sustainability	It will continue in future. The expenditure will be charged from UT Plan Fund (Other charges A/c).
Chances of Replication	Nil
Comments	Documents & Illustrations: Domicile Certificate, Marriage Certificate & Birth Certificate of the New born.
Contact	The Director, Dte. of Medical & Health Services, Fort Area, CHC / PHC, Moti Daman – 396220 Phone No. 0260-2230470 E-mail ID: kysultan64@yahoo.com
Submitted By	The Health Department UT of Daman & Diu.
Status	Active
Reference Files	

Reference Links	

255. Sampoorna,Uttar Pradesh

Subject Area="Health information systems."	Objective="Optimum utilisation of the resources by timely collection of data to control epidemic of the diseases."
Details for Reform Option "Sampoorna, Uttar Pradesh"	
Summary	**Background:** Breast cancer is the most common cancer in Indian women and about every 8th woman suffers from Cervical Cancer in India which are preventable if screening is done on time and precancerous lesions are treated. **Action:** Sampoorna Clinics have been established exclusively for women, to provide knowledge, tests and management of selected non-communicable diseases, Cervical Cancer and Breast cancer. **Result:** Almost 30,000 women have been screened for diabetes, Hypertension, cardiovascular diseases, anemia & Cervical Cancer. The positive and borderline cases are managed by counseling / treatment / referral / follow up. The clients are also provided knowledge about self – breast examination.
Cost	50 Lacs in year 2014-15, 350 Lacs in year 2015-16.
Place	28 districts of Uttar Pradesh, 3 locations in each district (1 DWH and 2 select CHCs).
Time Frame	Started the project in April, 2015, established 1st clinic in Sept, 2015, scaled up to 28 districts in Jan, 2016.
Advantages	Enabling and providing women the knowledge and access to preventive health care which can not only improve their health but will impact on the family's health and the whole community.
Challanges	1. Women do not perceive need for such tests. 2. There is dearth of doctors and available doctors are busy in doing MNH work which is priority of the health department. 3. The device which is used for cryotherapy of the precancerous lesions is not very robust. 4. Uninterrupted supply of Nitrous Oxide is also a challenge.
Prerequisites	Training of doctors and screening assistants, training module, space in the hospital, community awareness etc.
Who needs to be consulted	Concerned officer
Risks	
Sustainability	GOI is providing all the fund therefore sustainable.

Chances of Replication	Already replicated to 28 districts.
Comments	
Contact	Dr. AB Singh, DGM, NCD, SPMU, NHM, Uttar Prades
Submitted By	Dr. Monica Tripathi, DGM, SIFPSA
Status	Active
Reference Files	
Reference Links	

256. OJAS (Online JSY And Shubhlaxmi Payment System), Rajasthan

Subject Area="Health information systems."	**Objective="Performance monitoring to improve services."**
Details for Reform Option "OJAS (Online JSY And Shubhlaxmi Payment System), Rajasthan"	
Summary	• "OJAS Software" is a web based system. • This is the password protected system and run by the authorized user only. • This system has been integrated with PCTS software. The master data base and users have been used for this system. OJAS is an online system which facilitates the user to capture beneficiary wise details of payment for JSY scheme and Shubhlaxmi Yojna, after due eligibility at CHC & above government health institutions. Online payment of JSY scheme and Shubhlaxmi Yojna to beneficiaries bank accounts and generate various kind of reports to monitor the progress of the programme and various health information. To ensure their timely and seamless online payment for JSY and Shubhlaxmi beneficiaries. The software popularly known "OJAS Software" has been conceptualized with following objectives:- • To monitor the performance of each delivery including female child every day/ month. • On line payments in JSY and SLY • To identify the Gap area and need assessment at facility level as well as at community level. • Timely and transparent payment for beneficiaries and system. The process flow of payment:- It is an unique initiative by NHM, Rajasthan. The software has been developed by NIC, Rajasthan state unit and the core group constituted by the Mission Director, NHM, Rajasthan. OJAS has been conceptualized and developed in a very short time span because of the keen interest shown by the authority to solve this major problem, which were being faced at grass root level. This online payment process has been implemented all over the state from 1 August 2015 at CHC and higher govt. health institutions. Various functionaries have been oriented for their responsibilities. Directions and circulars have been issued to States/Districts/Block/ PHC officials. Training for filling up the claim forms J-1 and J-2 has been done in all the districts up to CHC level and above level. For online payment, Bank of Baroda has been selected, which provides service without any additional charges.
Cost	NA
Place	Rajasthan
Time Frame	
Advantages	• It would be possible to monitor the physical and financial progress

	under the programme. • Simplification of payment system. • No more multi-channel payment. • Assessment of the health services provided at community level would be easier.
Challanges	Not listed till this period
Prerequisites	
Who needs to be consulted	Dr.Tarun Choudhary, Project Director, Maternal Health, 9829096525 Sh. Hemendra Baplawat, Consultant, (JSY) Janani Suraksha Yojna, 9828720304
Risks	
Sustainability	No issues
Chances of Replication	Very good(Other states may use this innovative scheme)
Comments	Successful working
Contact	Available at http://nrhmrajasthan.nic.in/OJAS.asp
Submitted By	Seema Mishra, Dy. Director(CBHI), Regional Office for Health and Family Welfare, Kendriya Sadan, Block-B, 2nd Floor, Room no. 208, Sector-10, Vidyadhar Nagar, Jaipur- Rajasthan.
Status	Active
Reference Files	
Reference Links	

257. Asha Soft, Rajasthan

Subject Area="Health information systems."	Objective="Performance monitoring to improve services."
Details for Reform Option "Asha Soft, Rajasthan"	
Summary	ASHA Soft is an online system which facilities the user to capture beneficiary wise details of services given by ASHA to the community, online payment of ASHA to their bank accounts and generate various kind of reports to monitor the progress of the programme. It is an unique initiative by NHM, Rajasthan. The software has been developed by NIC, Rajasthan State unit and the core group constituted by the Mission Director, NHM, Rajasthan. ASHA soft has been conceptualized and developed in a very short time span because of the keen interested shown by the authority to solve this major problem, which were being faced at grass root level. This online payment process has been implemented all over the state from 26th Dec, 2014. In the first phase, ASHA Soft has been implemented at those places, where PCTS data entry facility is there. That urban PHC / CHC will be included in ASHA Soft with the implementation of NUHM. Various functionaries have been oriented for their responsibilities. Directions and circulars have been issued to State / Districts / Block / PHC officials. Training for filling up the claim form has been done in all the districts up to PHC and ASHA level. For online payment, Bank of Baroda has been selected, which provides services without any additional charges. To ensure their timely and seamless online payment, ASHA software popularly 'ASHA SOFT' has been conceptualized with following objectives:- • To monitor the performance of each and every ASHA every month. • To identify the Gap area and need assessment for rendering better services at community level. • Assessing the quality of services in Remote and Vulnerable areas. It would be easier to assess the services delivery of ASHA in remote areas and marginalized community. • Timely Payment of incentives to ASHA to maintain their motivation level.
Cost	
Place	Rajasthan State
Time Frame	
Advantages	1. It would be possible to monitor the physical and financial progress under the programme. 2. Simplification of payment system. No more multi – channel payment. 3. To keep the motivation level high of each and every ASHA by timely and simplified payment process.

	4. Assessment of the health services provided at community level would be easier
Challenges	Not any still listed.
Prerequisites	
Who needs to be consulted	Mr. Sumesh Singh, Consultant, IT, DMHS, Govt. of Rajasthan. Phone: 0141-5142525
Risks	
Sustainability	No issues
Chances of Replication	Very Good (other districts, states may replicate this innovative scheme).
Comments	Three States Maharashtra, Punjab & Karnataka team have been visited in the state to see the implementation of ASHA Software and requested NIC & Medical Health & FW department of Rajasthan Government to provide the software to implement same in their states.
Contact	
Submitted By	Seema Mishra, Dy. Director (CBHI), Regional Office for Health & Family Welfare, Kendriya Sadan, Block – B, 2nd Floor, Room No. 208, Sector – 10, Vidyadhar Nagar, Jaipur, Rajasthan.
Status	Active
Reference Files	
Reference Links	

258. Providing Tablet to ANMs in the Health Sub Centers, Karnataka

Subject Area="Health information systems."	**Objective="To improve the quality of healthcare services by providing a state-of-the-art reporting system using e-connectivity."**
Details for Reform Option "Providing Tablet to ANMs in the Health Sub Centers, Karnataka"	
Summary	**Background:** The ANMs posted at Health Sub Centers was burdened with multiple registers for the Health and Medical Services provided to the community. She has to carry those registers during visit to the villages in her jurisdiction. At the end of the month she has to give different type of reports. **Objective:** To manage the health of rural population digitally, in order to provide the best healthcare service and health solutions to the community from a public health perspective. **Action:** A Tablet with pre designed software was given to the ANMs of the SCs functioning under the PHC, Karuna Trust has provided the tablet and the software was developed by EMC2. The Comprehensive preventive, curative and Promotive health care services (CPHM) is a tool introduced first time in India, under which all the data may fed and the reports be generated. CPHM enables to provide comprehensive preventive, curative and Promotive health care to the members of the community by bringing together health-workers and decision makers on one platform for better management of the PHC. This allows to address health comprehensively, by not only bringing all diseases and conditions, including reproductive, material, adolescent and child health, school health and nutrition, communicable and non-communicable diseases, public health and facility management, but also the individual and community, for better health management in a given region / village / area. CPHM also allows for all the health records of the community to be managed over a period of time, enabling the “life cycle” approach to health, as prescribed by the NHM. We are now looking into developing and adding an electronic medical record (EMR) component for PHC / Sub-center clinics to this tool. Currently, Gumballi PHC managed by Karuna Trust, has about 23,000 health records of the community that it serves. Every ANM has got Tablet. **Result:** The ANMs need not carry many registers. The ANMs at the Sub centers get the alerts on ANC and PNC care, immunization, follow up on treatment of TB and other illness. By this it empowers ANMs to provide best health care services to the community, without being overburdened.

Cost	The cost of the Tablet is around 8,000/- per piece. But, cost is also incurred in data management and rental of data server space, training the staff in the application / tool and continued monitoring of the activity. This excludes the software developed.
Place	All SCs in Gumballi PHC, Chamarajanagar Distt. Karnataka.
Time Frame	The product development took about a year to be completed. But, now that it is completed and is fully functional the time taken only includes deploying the tablets and training the staff. We have to note that continued training may be required to motivate the health workers to use the tablets.
Advantages	Having the data of the community and their demographic enables us to have a public health approach to the health care service provided. Effective analysis of the community data will ensure how to avert epidemics or how to effectively manage epidemics in case of one. Knowing the source of drinking water in the village from where maximum patients have sought medical help from the PHC, can provide an insight into how to prevent the same in the future. Or diabetic history of the family may make it possible for the health worker to alert a member of the younger generation on how to avoid the same fate by changes in diet and lifestyle etc. Presence of fluoride in drinking water can enable the health worker to conduct a demineralization campaign in the community.
Challanges	The application itself is immensely useful to the community and the health care professional. However, the challenge lies in low or nonexistent internet connectivity in rural India.
Prerequisites	Internet connectivity to sync data. This tool is for the ANMs and MHWs. Other than that the support of PHC admin, PHC Medical Officers, the district medical officers etc. is needed to implement this tool.
Who needs to be consulted	The Secretary Karuna Trust 686, 16th main, 4th T Block Jayanagar, Bengaluru - 560041
Risks	
Sustainability	In modern computer era, this is sustainable
Chances of Replication	It can be replicated.
Comments	
Contact	The Secretary Karuna Trust 686, 16th main, 4th T Block Jayanagar, Bengaluru - 560041
Submitted By	FSU Bengaluru
Status	Active
Reference Files	
Reference Links	

259. mSehat, Uttar Pradesh

Subject Area="Management structures and systems."	Objective="Integrated planning and management."
Details for Reform Option "mSehat, Uttar Pradesh"	
Summary	**Background :** The mSehat scheme has been developed to empower the FLWs (ASHAs and ANMs) by providing smart-phones/tablets with customized apps that will capture the complete Reproductive, Maternal, New borne, Child Health plus Adolescent (RMNCH+A) continuum of care services. The software will auto-generate the work-plans and will give alerts to the service provider as well as the registered beneficiary. The FLWs will be provided on-demand training and regular skill updates. There is a provision of mobile phone based multimedia job-aid for beneficiary counseling, registration, tracking, reporting, screening and referral. In due course of time, mSehat aspires to interact with the MCTS and RCH e-governance schemes of GoI which will help in real-time data update. The mSehat app mainly covers Family Registration, Beneficiary Registration, VHIR, VHND, ASHA Incentives alert, Training and Counseling, ASHA kit, Work plan, Grievance redressal, Referral, Stock Management for VHND, ASHA Sangini Module, Dashboards for ANM, MOIC and State, Reminders and alerts to the beneficiary. mSehat intends to achieve 100% coverage for timely and appropriate care for pregnant and lactating mothers, immunization of pregnant women and infants, nutrition for children below 6 years and adolescent girls and streamlining the process of data collection. The scheme covers a total population of 15.5 million in 5 High priority districts viz. Sitapur, Bareilly, Mirzapur, Kannauj and Faizabad of Uttar Pradesh. Goal: The goal of mSehat is to accelerate the reduction of maternal, neonatal, and child mortality and total fertility rate in UP by empowering frontline health workers (ASHA and ANMs) with an integrated mSehat service delivery platform leading to improved performance through effective planning, management and execution of their day-to-day work. The key goals of mSehat are to: (i) Provide on-demand training and information to FLWs using multimedia enabled content through the mSehat application for continuous capacity building.

	(ii) Provide mobile phone based multimedia job-aid to FLWs for beneficiary registration, tracking, counseling, reporting, screening and referral; (iii) Strengthen Mother and Child Tracking System (MCTS) through mobile phone based work plans, and real time updation of beneficiary-wise service delivery information. (iv) Facilitate VHND wise monitoring of stock demand, supply and consumption through mobile phone based application. (v) Create a mobile phone based incentive monitoring system for ASHAs for greater transparency and accountability in timely ASHA incentive calculation and payments. **Action:** The Agreement with the SI for mSehat scheme was signed on 1st July 2015 and the project was formally launched on 13th October 2015.Under the scheme approximately 10,000 ASHA workers, 1700 ANMs and 300 MO/MOIC, SIFPSA/NHM field staff and Head Quarter staff will be provided Smart-phones and Tablets. **Result:** The scheme has yet not completed one year of operation. As per the timeline mSehat application will be fully functional by end of June 2016. Till date the following have been the achievement in the 5 Districts: • All the ASHAs identified by the CMOs i.e. 10016 have been given Smart-phones, loaded with OS, SIM, mSehat apps and have been given 5 days hands-on training (1 day orientation and 4 days Phase I training. • All the Sub-centre ANMs i.e. 1552 have been given Tablets, loaded with OS, SIM and mSehat apps and have been given 5 days hands-on training (1 day orientation and 4 days Phase-I training.
Cost	The SI is responsible for the Operations & Maintenance of complete system at a total cost of Rs. 27,55,00,000/- (inclusive of all taxes except service tax) for three years.
Place	The scheme is being rolled-out in all the blocks of Bareilly, Kannauj, Mirzapur, Sitapur and Faizabad Districts of Uttar Pradesh.
Time Frame	As per the roll-out plan the initial time to set up including developing the software applications conducting capacity building training of FLWs etc is 12 months. The activities and timelines are mentioned below: 1. Go-live Phase (to be completed within 4 months of Agreement signing): Go-live is defined as the achievement of all of the following conditions by the System Integrator (SI) for at least 75 Percentage of the ASHAs and at least 75 Percentage of the ANMs in each district: •Provisioning of mobile device with OS and SIM installed with KYC process successfully completed and 2G data plan

	enabled •One day training of the ASHA/ANM in usage of the device and beneficiary registration process •Activation of the device from the ASHA/ANM location such that it is registered in the SI mobile device management system and •Successful registration of at least 5 (five) beneficiary by each ASHA/ANM to whom the device has been given using the mobile device to her and successful receipt of her data to the backend mSehat system. 2. Phase-I (within 6 months of Agreement signing): Includes 4 days training to both ASHAs and ANMs on the modules consisting of registration incentive alerts due and missed service alerts health messages check-list on HBNC and audio-visual job aids, my profile, HR database management and VHND. Plus registration, device management, technical support and issue management by SI. 3. Phase-II (within 9 months of Agreement signing): Includes 2 days training to both ASHAs and ANMs on the modules consisting of work plan, technical support, ASHA management, Dashboard, reminder and alerts, training and modules for MOIC on Dashboard, technical support. Plus training, data push/application integration by SI. 4. Phase-III (within 12 months of Agreement signing): Includes 2 days training to both ASHAs and ANMs on the modules consisting of ASHA kits, referral, ASHA dashboard, Counseling and modules for MOIC on Dashboard, technical support and Data Management by SI. 5. Ongoing operation, maintenance and support: (from 13 to 36 months of Agreement signing): The System Integrator (SI) is responsible for Operations and Maintenance of the system, Integration of mSehat system with Government of India and GoUP Systems, manage the data generated. 6. Handover (at least 3 months before the end date of contract period): Identify and create a detailed checklist of exit needs across hardware, software, people, process, documentation, training and other support functions and take a sign-off from the authority.
Advantages	•The scheme can be rolled-out across districts. •Empowers the FLWs by providing smart-phones with customized apps that capture the complete RMNCH+A continuum of care services. •The software auto-generates the work-plans and will give alerts to the service provider as well as the registered beneficiary. •The FLWs can be provided on-demand training and regular skill updates. •Mobile phone based multimedia job-aid for beneficiary counseling, registration, tracking, reporting, screening and

	referral. •Create a mobile phone based incentive monitoring system for ASHAs for greater transparency and accountability in timely ASHA incentive calculation and payments. •Real time updation of beneficiary-wise service delivery information/data.
Challanges	•Significant emphasis to be given on training, behavioral change and handholding of FLWs. •2G/3G Internet connectivity in remote villages.
Prerequisites	•Involvement of health officials •Sound understanding of the State Government and GoI functioning •Monitoring and supportive supervision mechanism
Who needs to be consulted	Ms. Shaheen Khan, DGM (Projects/Business Development), SIFPSA, Om Kailash Tower, 19-A, V S Marg, Lucknow Mobile: 9415403629 email id: shaheen19jan@gmail.com Mr. B K Jain, GM (REMI/ Business Development), SIFPSA, Om Kailash Tower, 19-A, V S Marg, Lucknow Mobile: 9415763843 email id: bkjain@sifpsa.org
Risks	
Sustainability	Mainstreaming through Government funding.
Chances of Replication	MSehat is a scalable and replicable model as the software is developed on open source technologies i.e. Android. The mSehat application is developed inline with the NHM, GOI guidelines and has been finalized based on the inputs given by the officials of SMPU, NHM-UP, Directorate, field staff and also from representatives of NIC and Department of Information & Technology, GoUP. Apart from this mSehat is a platform which has the flexibility to interact with the MCTS/ RCH systems of Government of India and/or GoUP Systems.
Comments	
Contact	
Submitted By	State Innovations in Family Planning Services Agency (SIFPSA) Om kailash Tower, 19-A, V S Marg Lucknow- 226 001 Contact: 0522 2237497, 2237498 Fax: 0522 2237574
Status	Active
Reference Files	
Reference Links	