National Health Systems
Resource Center

www.nhsrcindia.org

Annual Work Report

2011-12

NIHFW Campus, Baba Gangnath Road
Munirka, New Delhi – 110 067

COMMUNITY PROCESSES

The National Rural Health Mission (NRHM), now in its final year of implementation, committed in its vision document and in its operational framework, to a process of "communitization" as a cornerstone of its strategy for architectural correction. Key elements of this include:

- The ASHA and her support network at block, district and state levels.
- The Village Health, Sanitation and Nutrition Committee (VHSNC) and village health planning.
- Untied funds to the Sub Center and the VHSC to leverage their functions as avenues for public participation in monitoring and decision making.
- District Health Societies, the district planning process and the Rogi Kalyan Samitis as avenue for promoting public participation in facility management.
- Community Monitoring.
- NGOs and other civil society organizations to support the implementation of these components.

When the NRHM was launched in April 2005, the ASHA was intended primarily for the high focus states of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, Uttarakhand, the eight states of the North East, and Jammu and Kashmir, and in tribal and difficult areas of other states based on requirement. In 2008, however all non-high focus states barring a few states opted to scale up the programme statewide. In October 2011, the state of Himachal Pradesh where the ASHA selection was under litigation opted to train its Anganwadi Workers for a set of skills related to community mobilization and provision of community level care for mothers, newborns and children. Tamil Nadu now has an ASHA programme functional in a few of its tribal areas. Today the country has 846,309 ASHAs in place, except in the states of Goa, Pondicherry and the non-tribal areas of Tamil Nadu. All Union Territories except Lakshadweep also implement the ASHA programme.

Another major community processes component designed to provide mooring for the ASHA and undertake village level planning including social determinants for health is the Village Health, Sanitation, and Nutrition Committee (VHSNC). About 5 lakh VHSNCs are in place across the country.

Supporting the community processes component at the center and the state is one of NHSRC's major responsibilities.

Thematic Areas

- Provide strategic inputs for policy development at national and state levels
- Enable capacity building and competency based training at all levels in states
- Adapt and contextualize the programme in states
- Develop training modules
- Support states in implementing the ASHA program
- Build partnerships with civil society organizations to enhance support for the programme
- Conduct evaluations to inform implementation and policy

Key Achievements:

- Enabled ASHA training in Module 6 and 7 to be initiated in all states
- Round 2 training for state trainers completed for all states
- Guidelines for Home Based Newborn care disseminated to all states
- ASHA updates in July 2011 and January 2012 printed and disseminated
- Trainer manual for NACO's Shaping Our lives finalized
- ASHA module on Disability developed
- Facilitator Handbook ready for printing
- Part 2 of Trainer notes printed and disseminated
- ASHA Evaluation in the three states of Madhya Pradesh, Uttarakhand and Uttar Pradesh

Work Report:

1. Support for ASHA Program Implementation at state level

NHSRC continued to work with states to train the ASHAs in Modules 6 and 7. NHSRC directly supported the training of 126 trainers in Round 1, and 127 in Round II. All state training teams have been trained in most topics covered in Modules 6 and 7, except communicable diseases. In the states, training of ASHA trainers is underway, and ASHA training has been initiated. NHSRC has supported the states through the provision of Modules, trainer manuals and equipment kits to the training sites, and facilitated the translation and printing of the modules and manuals in selected states.

NHSRC has also designed a training programme for district and block level support teams for community mobilization that support the ASHA and VHSNCs. In Bihar, NHSRC conducted the workshop for district and block community mobilizers. NHSRC enabled the selection of state training agencies in Bihar in order to train district trainers and is part of a tripartite MOU with the state to provide support to the agencies. NHSRC also supported the State ASHA Resource Center (ARC), Bihar to develop the TOR and strategy for involving District Training Agencies (DTA) in ASHA training.

NHSRC supported the MOHFW in developing guidelines for state and district programme managers on Home Based New Born Care through ASHA, Trainer notes (Part 2) for ASHA Modules 6 and 7, and a handbook for ASHA Facilitators.

NHSRC organized a meeting of nodal officers for all states to share experiences on the ASHA and CP programme. A performance-monitoring plan for ASHA, a format for an ASHA database, and a plan for establishing a grievance redressal system was shared for feedback. These are to be disseminated after MOHFW approval.

Based on a request from the UP government and approval of the board, NHSRC selected and appointed three regional coordinators for the state to support the state nodal officer since UP has no state level structure for the CP programme. NHSRC has also supported the state in adapting the ASHA Modules 6 and 7 for a UP specific module since the state has already initiated training of ASHA in selected skills through the Comprehensive Child Survival Programme (CCSP) module.

In response to a request from the state, NHSRC in collaboration with members of the National ASHA Mentoring Group, developed a strategy for training AWW in Himachal Pradesh on skills to save newborns and children, and enabled training of district trainers.

NHSRC has submitted a proposal to the MOHFW to create centers for innovation in training and learning in the states and a concept note for accreditation of trainers and certification of ASHA through the National Open School System as a measure of certifying proficiency and to enable career progression for the ASHA.

2. Support to VHSNC

The NHSRC team developed a methodology and tools for the assessment of the VHSC in consultation with members of the National ASHA Mentoring Group. The pretest for this assessment is planned for late March, after which the evaluation will be conducted in a few states. NHSRC is also compiling through telephonic interviews and discussions guidelines on VHSNC in the states and available documentation of best practices.

3. ASHA Evaluation

NHSRC presented findings of the ASHA evaluation in all eight states where the evaluation was conducted and is working with the states to strengthen the ASHA programme through technical assistance in strategy development and training. The report of the evaluation has enabled states to relook the strategy and has catalyzed the training programme. NHSRC has initiated the evaluation in the states of Uttar Pradesh, Uttarakhand, and Madhya Pradesh, and supported the state of Karnataka to select an agency to undertake the evaluation in the state of Maharashtra. The NERRC is undertaking the evaluation in the state of Meghalaya, and Nagaland. The NERRC is expected to complete the evaluations in the states of Sikkim, Tripura, Manipur, Arunachal Pradesh and Mizoram by mid 2012.

4. New Initiatives for ASHA

In collaboration with the MOHFW, NHSRC organized workshops for nodal officers on progress of the menstrual hygiene scheme and planning for distribution of sanitary napkins procured through central procurement. ASHA training on menstrual hygiene is complete in all states except in Bihar. Except for Himachal and Haryana the states have not been able to activate the manufacture of sanitary napkins through SHGs, primarily on account of the low procurement cost per napkin.

NHSRC supported the MOHFW in developing a guide for Community Health workers, as a companion guide to NACO's Saving our Lives, and a module on disability for the ASHA.

5. ASHA Mentoring Group

NHSRC organized 2 meetings of the National ASHA Mentoring Group in July 2011 and February 2012. A meeting of state nodal officers was held in June and another is planned for April 2012. NHSRC also participated in the meetings of state ASHA mentoring groups in Jharkhand, Madhya Pradesh, Bihar, and West Bengal. One ASHA update was launched in July 2011 and another in February 2012.

Challenges:

In order to sustain and strengthen the program, the following are needed

- Policy clarity on a long term vision for the program
- Advocacy at the state and district levels to explain the program, its principles and possible expectations
- Institutionalization of technical & management support on a long term basis

QUALITY IMPROVEMENT

NRHM and Quality Improvement: the mission of Quality Improvement division is to make quality improvement as an inherent part of public health facility management. Every single health facility should aspire to improve its functions related to healthcare delivery as well as the intrinsic sourcing and be certified for Quality preferably by an external body and it should ensure that quality is continually improving. Given the nation's vastness and diverse level of objective development and subjective readiness in each state, the QMS should incorporate national and international norms of quality management and also be flexible to accommodate different systems of quality certification i.e. IPHS, ISO 9001, NABH or any other state or central government defined standard.

Thematic Areas

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

Key Achievement this year:

- Following two guidebooks were published and shared with States
    a. *"Quality Management in Public Health Facilities – Traversing gaps"*
    b. *"Quality Management in Public Health Facilities – An implementation Handbook"*
- Certification Audit of 74 Health Facilities to NHSRC propounded ISO 9001:2008 standards, and subsequently recertification audit of 05 facilities and surveillance audit of 57 health facilities in the current year.
- Scaling of the Quality Certification Program at 454 additional health facilities (Bihar-46, Jharkhand-03, Karnataka-38, Maharashtra-247, Odisha-08, Punjab-10, Tamil Nadu-90 and West Bengal-12)
- Technical support to Karnataka Govt. in implementation of Quality Management System at 38 Health Facilities, without any external technical support. NHSRC has entered into a formal MoU with Government of Karnataka
- Supporting State Health Society Tamil Nadu in implementation of Quality Management System at 90 Primary Health Centers
- Facilitated formation of State Quality Cells
- Capacity building training of State and District Quality cell
- Policy note on Quality in Public Health Facilities, which is under circulation
- Conducted 'As-is / Gap-analysis' for Patna Medical College Hospital, Patna and shared with the Medical College and Bihar Govt.
- Quality MIS is place in facilities, where QMS implementation is being undertaken
- Collaboration with Bureau of Indian Standards (BIS) for Development of Auditable standards for Public Health Facilities
- Revision of IPHS and submission of draft standards

Work Report

1. NRHM & Quality Improvement

The mission of Quality Improvement division is to make quality improvement as an inherent part of public health facility management. Every single health facility should aspire to improve its functions related to healthcare delivery as well as the intrinsic sourcing and be certified for its Quality, preferably by an external body and it should ensure that quality is continually improving. Given the nation's vastness and diverse level of objective development and subjective readiness in each state, the QMS should incorporate national and international norms of quality management and also be flexible to accommodate different systems of quality certification i.e. IPHS, ISO 9001, NABH or any other state or central government defined standard. Recently, QI Division has entered into collaboration with Bureau of Indian Standards (BIS) to develop Audit Standards for Public Health Facilities.

Policy Note on Health care Quality as relevant to Public Health Facilities has been developed and circulated for wider consultation.

2. Sustenance of Implemented Quality Management System in Pilot Phase

Eight Hospitals were selected by respective state governments in EAG States, namely Indira Gandhi Hospital Korba (Chhattisgarh), Dufferin Hospital Allahabad (U. P.), Doon Hospital, Dehradun (Uttarakhand), Sadar Hospital Deoghar (Jharkhand), General Hospital Karauli (Rajasthan), District Headquarter Hospital Puri (Odisha), Sadar Hospital Ara (Bhojpur - Bihar), and District Hospital Katni (Madhya Pradesh). All of these Hospitals have been ISO 9001:2008 certified and succeeded in successfully clearing the Surveillance Audit and recertification audits, as & when due. Handholding support has been instrumented through an economical model – Supportive Supervision.

3. Quality Improvement Initiative in NE States

One hospital in each of North East State was selected by the State Authorities in consultation with NERRC for implementation of the Quality Management System - STNM Hospital Gangtok, IGM Hospital, Agartala, Civil Hospital Aizawl, Naga Hospital Kohima, District Hospital Churachandpur, M.M.C. Hospital, Guwahati and Ganesh Das Hospital, Shillong, and Government Hospital, Pasighat.

All the hospitals have since been certified and they are being hand-held under the supporting supervision mode for limited period of 6-12 days in a month.

4. Scaling up of Quality Initiative

Currently NHSRC is overseeing 576 facilities for building/maintaining QMS. Following are the list of facilities in different state under QMS:

a. Andhra Pradesh: 2	b. Bihar: 47	c. Chattisgarh: 8	d. Rajasthan: 1
e. Haryana: 1	f. Jharkhand: 4	g. Karnataka: 38	h. Uttarakhand: 1
i. Madhya Pradesh: 1	j. Maharashtra: 247	k. North East: 8	l. Odisha: 9
m. Tamil Nadu: 48 +90	n. West Bengal: 12	o. Punjab: 10	p. Uttar Pradesh: 1

5. Quality Improvement Projects reaching certification stage

74 hospitals have so far been certified to ISO 9001:2008 Standard as detailed below:

- EAG States: 8
- NE States: 8
- Tamil Nadu: 48
- Haryana: 1
- Chhattisgarh: 7
- Andhra Pradesh: 2

Under the NHSRC propounded ISO Quality System, 24 additional procedures - 12 clinical procedures & 12 administrative procedures (as relevant to Public Health Facilities) are implemented and monitored, besides six conventional procedures of ISO 9001 Standards.

6. Capacity Building workshops

For the sustenance of the Quality initiative and its adoption by the system, it is important that internalization of implemented Quality System happens and 'ownership' develops. In order to meet this objective, QI Division has been working closely with State Health Missions & State Health Societies for formation of state quality cells and facilitating hospital performance monitoring through a robust MIS, its collation & analysis and sharing the analysis with the states. In this endeavor, among other actions following trainings have been conducted at State and Districts -

State	Location	Date
1. Orissa	Bhubaneswar	22nd-23rd December 2011
2. Karnataka	Bangalore	9-13 May 2011
	Bangalore	6-10 June 2011
3. Chhattisgarh	Raipur	24-26 August 2011
	Durg	3-4 August 2011
	Raipur	29th July 2011
4. Jharkhand	Ranchi	20th- 22nd October 2011
5. Haryana	Panchkula	12th October 2011
6. Bihar	Patna	16th -17th June 2011
	Patna	13th-14th September 2011
7. Maharashtra	Aurangabad	28th Nov-1st Dec 2011
	Nasik	1st-4th November 2011
8. West Bengal	Kolkata	13th-14th July 2011
9. Tamil Nadu	Chennai	19th-20th December 2011
PROPOSED / ON-GOING		
10. Bihar	Patna, Gaya, Muzafarpur, Darbhanga, Munger, Bhagalpur, Purnea, Chhapra	On-going in Feb & March 2012
11. Punjab	Chandigarh	15th March 2012
12. NE States	Guwahati	27th-28th March 2012

7. The following initiatives have been taken to improve the quality of healthcare services that could be used across all facilities

- Standardizing the clinical and administrative processes and developing templates for implementing 24 standard operating procedures in the health care facilities along with establishing and strengthening of "May I Help you Desk"
- Capturing Patient Satisfaction (both OPD & IPD) Survey and introducing Complaint Management System for Patients and Staff.
- Institution of Regular internal Audits and Management Review Meetings for continual improvement and Death Audits
- Developing Performance Indicators for different processes and services.
- Development of Specifications for Laundry, Sanitation and Security Services for strengthening the outsourcing services and ensuring food safety & food handlers' health checks
- Measuring Average Waiting Time for Registration, Consultation, Investigations and Pharmacy by conducting Time Motion studies.
- Calibration of Measuring Equipment and Validation of Lab Reports by external agencies.

- Instituting microbial culture surveillance in health care facilities to assess infection control practices.
- Instituting fire safety measures including Exit plan, mock drills and no objection certification from fire safety authorities.
- Bio Medical Waste Management-Training/display of WI/ strengthening hand washing practices.
- Compliance to Regulatory Requirements: Initiated the process of compliance to Atomic Energy Regulatory Board (AERB) guidelines, TLD Badges & Lead Apron for technicians in imaging services, Blood Bank/Storage License, PCNDT Compliance
- Display of work instructions at the point of use and improving signage
- Measuring of illumination level through 'Lux-Meters' and taking corrective action to comply with BIS Standards (IS:10905).
- Introduction of ABC/VED Matrix System in the Stores for better Inventory Management and detecting Near Expiry Drugs.
- Safety of staff and patients was enhanced by regular medical examination of food handlers and staff, vaccination of housekeeping and other staff (Injection TT & Hepatitis B)

8. ISO Certification at NHSRC

One Surveillance Audit completed in May 2011. Next Recertification is due in June 2012

9. Based on the experience at the above locations a policy frame on healthcare quality on Public health facilities has been developed

Challenges:

- Lack of enabling Policy framework for quality Management System (QMS) in Public Health Facilities due to which attention & resource allocation for introducing Quality Management System is not part of a larger plan for QMS in all facilities
- Lack of adequate capacity for infrastructural development & building maintenance and convergence amongst PHED, PWD, Electrical Department, Police & the hospital
- Human Resource Issues - Variability of skills amongst equally qualified personnel, frequent transfers of civil surgeons/ CMHO/ Key functionaries of the hospitals and shortage of key personnel- Anesthetist, Gynecologists, Nursing Staff, Radiographers, Laboratory & OT Technicians, which includes absence of service providers with & without permission.
- Apprehensions amongst the service providers about the quality processes- patient satisfaction, Medical audit, Death Audits, Internal Audit, and Management Review Meetings.
- Lack of seriousness towards regulatory & personnel Safety issues (Patient safety & Staff Safety)- BMW (Management & Handling) rules 1998, AERB guidelines, usage of TLD badges by Radiology Staff, Fire Safety, Disability Act, Management of SHARPS injuries etc.
- Insensitivity towards privacy/ Confidentially and Other right of patient and marginalized group of community.
- Poor availability of Data and records.
- Unsystematic & Unplanned Procurement of drugs, equipment and consumables.
- No system for Maintenance and calibration of equipment. Uncertain availability of maintenance agency takes an unduly long time even where the facility is eager to maintain the equipment.
- Absence of State Guidelines for outsourcing services like Cleaning, Security, Laundry, Kitchen, Supplementary Power Supply, Ambulance Services, Pest Control etc. resulting in poor management of contracts

HUMAN RESOURCES FOR HEALTH

Improvement in the health outcomes is directly related to the availability of the trained human resources. To ensure this, NRHM has set human resource norms necessary at each level of health facilities as defined under the Indian Public Health Standards (IPHS).

And given the current problems of availability of both medical as well as paramedical staff in the rural areas, the NRHM has also introduced a range of innovations and experiments to improve the position. These include setting up of new Medical Colleges & Nursing Institutions, contractual appointments to augment existing health workforce, compulsory rural posting, financial & non-financial incentives for serving in rural & remote areas, a fair & transparent transfer policy, rational deployment, skill up-gradation and multi-skilling of the existing Medical Officers, ANMs and other Para Medical staff.

Thematic Areas:

- Policy and Strategy Development.
- Research Studies in collaboration with the Planning Commission of India
- Strengthening State Human Resource Systems
- Study of Public Private Partnerships

Key Achievements:

- A research study entitled ***"To document the emerging patterns of Sub Centers to consider a differential and more appropriate Human Resource and Governance Policies for Sub Centers in place of a single nation-wide norm"*** in collaboration with the **Planning Commission of India** (work under progress)
- Research Proposals developed in partnership with Planning Commission
  a. ***"Causative Analysis for better dispersion of Skilled Health Professionals in Rural and Remote Areas"***
  b. ***"Defining hospitals workforce requirements for tertiary care hospitals and medical colleges' hospitals for strengthening the public health delivery system in India"***
- Summary Reports of NHSRC Studies on
  a. ***"Strategies for improving availability of Heath Care Providers in Rural and Remote Areas"***
  b. ***"Nursing & Midwifery Human Resources in Bihar, Chhattisgarh, Orissa, Rajasthan and Uttarakhand"***
- Part of GoI / MCI Committee on **Bachelor of Rural Health Care Program (BRHC) –** Developing Program Concept and Course Content and Competencies.
- Project Proposals / Concept Notes submitted to the Government of India:
  a. ***"Strengthening Training Capacity of District Training Centers and ANM Training Center in High Focus Districts"***
  b. ***"The Second Sub Center Health Worker- Multi Purpose Worker or Public Health Assistant"***
  c. ***"Public Health Management Issues at State and District levels"***

- Technical Support to the Vistaar Project in developing Human Resource Information System (HRIS) for Jharkhand & Bihar
- Final Report submitted on *"Determinants of Workforce Availability and Performance of Specialists & GDMOs in Bihar"* in collaboration with the Indian Institute of Development Management
- Evaluation of *"Public Private Partnership (PPP) for Health Care Delivery in Meghalaya"*

Work Report:

1. Policy and Strategy Development:

One of the core activities of the HRH Division in NHSRC has also been to provide technical assistance to the Ministry of Health & Family Welfare, Government of India in developing strategies and policies to, among others, increase availability of skilled professional through the expansion of professional and technical education and skill development of existing staff.

In this context, relevant project proposals and concept notes have been submitted to the MoHFW. The concept note on **"The Second Sub Center Health Worker - Multi Purpose Worker or Public Health Assistant"** has been prepared with an objective to select, train and deploy a second health worker in the sub-center who is able to provide public health services at the village level and complement the RCH services provided by the first health worker - the ANM.

Similarly the Project Proposal on **"Strengthening Training Capacity of District Training Centers and ANM Training Center in High Focus Districts"** looks at strengthening existing 131 ANMTCs and establishing 19 DTCs in the high focus districts by way of good quality faculty development and building up work organization, work culture and dynamism so that that all service providers have requisite skills and that there is good quality supportive supervision which ensures that these providers have the support, motivation and leadership needed to provide these services

To address the major constraints and weaknesses of the current public health management system and in the integration between State & District Health Societies with the Department of Health & Family Welfare of the state, a National Expert Committee was formed to devise strategies for effective implementation of NRHM through effective integration of key health functionaries. Subsequently, a concept note was prepared, outlining challenges and key areas for strengthening the directorates and the monitoring & evaluation systems

The NHSRC is also a part of GoI / MCI Committee on **Bachelor of Rural Health Care Program (BRHC)** and is closely associated in developing the program concept and course content & competencies. As a part of this process a proposal for research study titled **"To study the role of Rural Health Practitioners towards augmenting Sub Center Service Delivery in the High Focus Districts of Assam"** has been submitted to NRHM Assam, to understand the role of RHPs within the Health Care Delivery System and variation in results due to the infusion of this cadre at the grass root, in the only State where such an intervention is currently being implemented.

2. Research Studies in collaboration with the Planning Commission of India:

The Planning Commission of India had invited NHSRC for research to aid policy in areas related to "Human Resource Management in Health Care Cadre with a focus on retention of workers in rural and remote areas", "Review of norms for Sub-Center keeping in view their responsibilities as indicate in IPHS" and "Model for tertiary care and teaching institutions so as to make a difference to Public Health status of population in their catchment area".

In response 3 study proposals were developed - **"Causative Analysis for better dispersion of Skilled Health Professionals in Rural and Remote Areas"**, **"To document the emerging patterns of Sub Centers to consider a differential and more appropriate Human Resource and Governance Policies for Sub Centers in place of a single nation-wide norm"** and **"Defining hospitals workforce requirements for tertiary care hospitals and medical colleges' hospitals for strengthening the public health delivery system in India"**

The Sub Center Study is under progress and the draft report is expected to be complete by March 2012. The other two proposals are with the Planning Commission, awaiting approval.

3. **Strengthening State Human Resource Management Systems:**

A major hurdle to streamlining human resource management system in states is incomplete information on the available healthcare workforce, affecting rational deployment and proper planning & forecasting.

The NHSRC in collaboration with Intrahealth International, through the USAID-supported Vistaar Project, contributed towards developing a Human Resource Information System (HRIS) for the States of Jharkhand and Bihar. This system includes comprehensive information on the health workforce and will help managers and decision-makers to effectively plan, develop and support the healthcare staff. A knowledge-sharing workshop on **"Innovations in the Use of Information Technology for the Management of Human Resources in the Health Sector"** was held at NHSRC on 18.01.2012 with participation from various stakeholders and states where such innovations have taken place.

Final Report of the study titled **"Determinants of Workforce Availability and Performance of Specialists & GDMOs in Bihar"** done in collaboration with the Indian Institute of Development Management was submitted. This study was done to understand the human resource policies and practices in Bihar with an overall objective of enhancing the productivity, coverage and outreach of health system.

4. **Study of Public Private Partnerships**

Undertook the Evaluation of **"Public Private Partnership for Health Care Delivery in Meghalaya"**. The HRH division has provided technical assistance and coordinated the PPP study, which was conducted in Meghalaya. The division in collaboration with Community Participation Division has submitted the draft report.

Challenges:

Human Resource Management is mostly state-centric and involves commitment at the higher levels for policy decisions and sustained adherence, in addition to adopting or scaling up of successful innovations. Though states realize that health care delivery is human workforce intensive and there is still a long way to go in terms of adopting a comprehensive plan for human resources for health, which looks beyond contractual appointment and commits to reaching the IPHS in human resource deployment and builds a road map to achieving this. The NHSRC can provide evidence-based specifics to aid formulation of strategies and policies for better HR Planning and Management but it largely depends on the states to take up the challenge.

The center also needs to take a call on critical areas such as setting up training institutes in "HR-Constrained" Districts with preference to local candidates, reforms in recruitment policies; strengthening of existing training schools & skill-based training programs; inclusive package of financial & non-financial incentives to attract & retain skilled workers in remote areas; BRHC Program and Family Medicine as a Specialist Course etc.

HEALTH CARE FINANCING

The National Rural Health Mission (NRHM) aims at increasing the resources to health sector, including financial resources through greater public investments in health. It also envisages supplementing the public investments with private sector contributions to the public health goals, especially the non-profit sector. NRHM also brings in institutional reforms for greater efficiency in resource allocation and utilization through flexible financing approaches.

Thematic Areas:

- Policy and Strategy Development - at the national and state level.
- Expenditure Studies - budget tracking at national, state and district level expenditure
- Critical reviews and assistance to states regarding Public Private Partnerships and Alternative Financing - including Insurance and other Social Health Protection schemes.

Key Achievements:

- Paper - ***Public Health Expenditure and Expenditure on Drugs***
- Paper - ***Public Financing under NRHM*** (submitted for the Ministry's Working Group on NRHM for the 12th Plan)
- Note on Differential Financing
- Note on Publicly Financed Emergency Response & Patient Transport System under NRHM
- PPP Case Study - ***EMRI (Beneficiaries' Feedback) in Andhra Pradesh***
- PPP Case Study - ***Haryana Swasthya Vahan Sewa***
- PPP Case Study - ***HMRI (as a Model of MMU) in Andhra Pradesh***
- PPP Case Study - ***Janani Express Model in Nabarangpur district, Odisha***
- Insurance Case Study - ***Kerala CHIS Model of RSBY scheme*** (working report)
- Insurance Case Study - ***Rajasthan Model of Mukhya Mantri*** (BPL) ***Jeevan Raksha Scheme*** (Working Report)

Work Report:

1. Differential Financing and the District Health Plan:

The NHSRC assisted the central health ministry in terms of preparing notes on Differential Financing, which were approved by the Mission Steering Group (MSG) of NRHM. Many states like Karnataka, Madhya Pradesh, Tamil Nadu and Punjab also showed an interest in the idea of Differential Financing, and also proposed pilots in the PIP for 2011-12. But the major bottleneck in this regard has been converting this concept into operation at the district and health facility level.

In order to operationalize the concept of Differential Financing and develop District PIP in accordance with this concept, NHSRC teams visited Alwar (in Rajasthan) and Rajnandgaon (Chhattisgarh) and held discussions with district authorities and officials, apart from collecting data with a view of developing differential planning for the district. The PHP team of NHSRC also held two training workshops in Jammu and Srinagar to assist the state of J&K in developing differential district plans. The idea of differential district planning is still taking shape and needs to be tried out in some select districts, which will be the major thrust of NHSRC's Health Financing divisions work in the next year.

2. **Institutional and Financing strategies for Emergency Response and Patient Transport System**

In response to requests from states, NHSRC has been providing assistance in design of PPPs, in assessment of bids and in evaluation of ongoing PPPs. As a follow-up of the EMRI study, which has since been used extensively- by state governments, courts and even the EMRI management- to inform decision making, NHSRC undertook a user feedback study of the EMRI in Andhra Pradesh to address the issues and bottlenecks in designing a comprehensive and responsive ERS (Emergency Response System). To look at other alternatives of emergency response system, NHSRC also undertook a study of the Haryana Swasthya Vahan Sewa. A short case study was also developed for the Janani Express model (looking at the experience of Nabarangpur district in Odisha). With these evidence put in place, NHSRC is now poised to develop a concept of national EMS model. NHSRC reviewed the HMRI model in Andhra Pradesh to look at the design and efficacy of the MMU model of service delivery and also to differentiate it from the ERS.

3. **Social Health Protection/Financial Risk Protection measures:**

As a follow up, and as response to requests from Kerala, an evaluation study of RSBY was designed. After initial problems in obtaining the utilization data and patient profile, now the study is finally complete and the report is being finalized. Also, to look at other alternatives of financial protection, a study of the Mukhya Mantri (BPL) Jeevan Raksha scheme was initiated in Rajasthan and is currently in progress.

4. **Responsive Support to the MoHFW –** for costing of Urban Health Mission Plan and for development of different policy notes and papers

Challenges:

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

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

PUBLIC HEALTH ADMINISTRATION

The implementation framework and plan of action of NRHM stress on making the public health delivery system fully functional and accountable to ensure improvement in health indicators. The state capacity to plan and implement the plan is limited, especially in the high focus states. Planning process in the states have stabilized over a time, but implementation still requires a lot of technical and management support. This division works cross cutting, since many issues related to implementation that the states struggle with, are spread across various thematic areas like HR, Quality etc.

The division supports various generic or specific solutions that are supported across all states (e.g. Maternal Death Review, Skill Labs for competency based Training and Certification, Mobile mentoring etc.), depending upon the district and State plans that were submitted and approved. The division is doing focused work / support to the State of Bihar on implementation of various activities under NRHM.

Thematic Areas

- Quality Improvements in Public Health Institutions
- Planning and implementation at the State and District levels
- Legal Framework for Healthcare
- Capacity Building of Healthcare Workers and Administrators

Key Achievements

- Maternal Death Review – Cascade of trainings - conduct of State workshops (AP, Karnataka, Haryana, Pondicherry, Jharkhand) and regional workshops (Bihar)
- Legal Framework - Clinical Establishments Act, 2010 - Development of draft Central rules and Draft model State rules supporting the ministry; Notification of 'coming into force' of the Act
- Planning
    a. Decentralized Finance allocation (Bihar)- 2011-12
    b. Activity and budget compilation of DHAPs of Bihar – 2012-13
    c. District planning workshop and preparation of module on "Entitlement based Planning" organized by planning department in Bihar
- Review visits - CRM, JRM, RCH monitoring
- Establishment of Skill Labs in Bihar with support from Care India, UNICEF, Gates Foundation and facilitated state teams visit
- Capacity Building and Quality of Care
    a. Quality improvements in Public Health Institutions - FFHI Training in Bihar/UP/ Jharkhand; Orientation of UNICEF field level officers and DFID officers on Family Friendly Hospital Initiative in Bihar; Revival of Quality Assurance Cell & Supportive Supervision (Bihar) & Developed Job diary for Health Professionals (Bihar); Family Friendly Hospital Initiative undertaken in Bihar, UP, Jharkhand

b. FRU Operationalization training in Bihar

d. Participated in NRHM training to State Administrative officers in Bihar (3 batches) and Workshop on District Planning and Bihar model of Financial decentralized planning in Chhattisgarh

Work Report:

1. Family Friendly Hospital Initiative:

In order to support the high focus (and other states) in bringing out improvements in quality and performance among Public Health Institutions, the division conceptualized and advocated for an in-house certification programme called Family Friendly Hospital Initiative. This model focuses on building capacity among service providers. This was taken up by many states and the division is directly supporting the initiative undertaken in 3 states; Bihar, UP and Jharkhand. UP has taken 80 institutions and Jharkhand has taken 21 institutions for FFHI. Bihar has opted to take up all institutions for FFHI except the one's already taken up for ISO. So far in Bihar 162 institutions have opted for FFHI and the number is counting as the district level workshops progress. The handholding of these voluntarily opted institutions are done by development partners like UNICEF, BMGF etc. As part of the protocol training, which the FFHI stresses upon, Skill Labs are being established in all districts of Bihar. 4 skill labs are already established by the development partners. Post training in Skill labs mobile trainers (2 per district), are deployed in the district who will travel to various MCH centers and ensure actual practice of protocols. This mobile mentoring is an essential component of FFHI. As part of this initiative model hospitals are also developed where the institutions level teams from other hospitals can visit and learn.

2. Maternal Death Review:

After the conducting the National level and North Eastern Regional workshop, this year the division has conducted State workshops (AP, Karnataka, Haryana, Pondicherry, Jharkhand) on request from the states. Since state workshop was not organized in Bihar, Regional Workshops (9 divisions in Bihar) were also conducted by the division. The division is planning to conduct a National Review Workshop on MDR in August 2012.

3. Clinical Establishments Act, 2010:

After the notification of the CE act in August 2010 the all State consultation was organized for orientation towards further steps to be undertaken and also to receive inputs on the model state rules. After the state consultation, the team (with representatives from Ministry) drafted the Central rules and model State rules. The Central rules have been finalized by an iterative process and is now forwarded to Law ministry for notification in the gazette. The State model rules have been shared with the States upon request. The State model rules are undergoing a further revision based upon inputs from stakeholders. There is also a plan to establish a Secretariat to support implementation of the act at Central level. A concept note on the same has also been prepared and submitted to ministry. A case has been filed by the Indian Medical Association against implementation of the CE Act, 2010 in Chennai High Court. Division has submitted point wise reply for filing written statement in the high court and is also pursuing the case with the advocate. The division has also prepared a corrigendum (on the notified Act) for notification by the Law ministry. Notification of the National Council is underway. The division is also coordinating conduct of State level stakeholder workshops, for facilitating implementation.

4. **Family Medicine Programme:**

   The NRHM sponsored candidates form high focus States is graduating (first batch in May, 2012). The second batch of FM programme is also pursuing the course from CMC, Vellore.

5. **Review Visits:**

   (a) CRM visit to Andhra Pradesh, Sikkim

   (b) JRM visit to Bihar

   (c) RCH monitoring visit to Bihar (twice), UP

6. **Workshops/conferences/trainings:**

- Resource person for "State Consultation meeting on Clinical Establishments Act, 2010 at Nirman Bhawan, New Delhi
- Resource person the Stakeholder meeting on Vulnerability, Impact and Adaptation for Climate Sensitive Diseases at the Local level in India, held in New Delhi
- Conducted 3 days training on NRHM for Bihar Administrative Services officers at BIPARD, Patna
- Organized State workshop on Family Friendly Hospital Initiative for Bihar at SIHFW, Patna
- Resource person for the Technical Assistance meeting by FOGSI at Bangalore Developing National Guidelines for Gestational Diabetes
- Participated in workshop on Quality workshop organized by BTAST and SHS, Bihar
- Facilitated the introduction of Public Health Cadre and Chaired sessions on "Public Health Cadre" in the Regional workshop on "Strengthening Human Resources for Public Health In India" at Bhubaneswar
- Resource persons in the meeting at Delhi on preparation of "Maternal Health Tool Kit" developed by UNICEF AND MOIH
- Stakeholder meeting at Bangalore by PHFI and Aberdeen University, UK on Quality improvements in Public Health Institutions – also preparation of Criterion Based Clinical Audit for Family Friendly Hospital Initiative in collaboration with PHFI and Aberdeen University, UK
- Presentation made on Government of India and Tamil Nadu model in MDR meeting organized at CDC Atlanta
- Resource person for the Expert group meeting on development of "Quality Improvement of Perinatal Care through Mentoring" in Public Health Institutions by UNICEF at Jaipur

Apart from these, the Division also participated in other workshops - International conference on Screening of Pregnant women for Gestational Diabetes at Chennai, Development of curriculum for training program for introduction of newer vaccines for program managers and policy makers at Johns Hopkins University of Baltimore

Challenges

- The focus of the health administrators are more on planning than on implementation
- Coordinating the efforts of Directorate, State Society, SIHFW and Development Partners for better implementation of the State Plan

PUBLIC HEALTH PLANNING

One of the core strategies of NRHM as outlined in the Framework for Implementation document is preparation and implementation of integrated District Health Action Plans (DHAP). District Planning has been conceived by NRHM as a tool of decentralization. Further sanction of funds to states is made against State Implementation Plans. Review of the planning process during 5th Common Review Mission shows that participatory processes and technical capacity to make comprehensive plans at district level need to be strengthened. Mechanism of review of district plans and their alignment to the approved state plans also need to be strengthened. A lot therefore remains to be achieved.

Much of the work of NHSRC has been geared towards making the planning process in districts and states more effective. At the national level, it is focused on gathering evidence that can support development of strategies and guidelines. The team also works on development of guidelines, tools and manuals that improve quality of planning.

A continuous effort towards building institutional capacities at state level to provide technical assistance for ongoing planning process is one of NHSRC's primary roles. As states learn best practices from other states or come up with innovations, they integrate these into their State and District Program Implementation Plans (PIPs).

Thematic Areas:

- Support to Policy and Strategy Development through Evaluations, Studies, Program Reviews for evidence-based decision making
- Capacity Building for District Health Planning.
- Support to State and District Plan Implementation.
- Support to MoHFW for State Plan Appraisals, Monitoring and Supportive Supervision
- Building up of State Health Systems Resource Centers or equivalent bodies.
- Editing with technical inputs and Publication of Policy related documents
- Sector Innovation Council for Health

Key Achievements:

- Participated in, Synthesized and Published the 5th Common Review Mission Report.
- Report on User fee and Out of Pocket expenditure for 28 states- with reference to JSSK
- Secretariat for Sector Innovation Council (SIC)
- Background Work for Working Group NRHM for 12th Five Year Plan
- State PIP analysis and assistance to sanctions for 19 states and 2 UTs year 2011-12
- Part of Integrated Monitoring Visits to34 High Focus Districts in 11 states along with MOHFW.
- Capacity Building for District Health Planning in Haryana and Jammu & Kashmir and as resource persons to IGNOU PGDDHM Course and MPH Course at NIE Chennai.
- Coordinated Technical Resource group Meetings for Maternal Health and Child Health held at MOHFW.
- Policy inputs for
    a. Draft Child Health Strategy.

b. Draft Free drug scheme of GOI

c. Draft Operational Guideline for District Planning

- Training need assessment of SHSRC for 10 states with existing SHSRC and 2 state that are willing to start SHSRCs
- Coordinating and facilitating research studies - Effectiveness of Strategies that address unmet needs for contraception in the high focus states, PCPNDT, Family Planning Insurance Scheme and Public Private Partnership in Meghalaya.

Work Report:

1. Capacity Building for District Health Planning

Capacity building for district health planning continues to be a central theme of NHSRC's work. There are 3 packages on offer. The 1st is a 5-day basic package and the 2nd is a distance education mode - mentored training program with 18 days of contact programs, conducted in collaboration with the PHRN, or other state level agencies, with 16 module reading material available for this. There is also an 18-module course available, as an IGNOU course on District Health Management along with televised classes on key topics and contact programs.

The team of Public Health Planning division of NHSRC conducted 2 workshops each in Jammu & Kashmir and Haryana. 512 participants comprising senior officers of the Directorate and NRHM State Mission, CMHOs, DPMs and other health care functionaries involved in health care delivery and planning as well, attended these workshops. 22 DHAPs have been developed as an outcome of this exercise in Jammu & Kashmir.

2. Capacity Building: Development of SHSRCs:

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

As of now, 13 states have SHSRCs or equivalent bodies (11 States have SHSRCs and MP & Odisha are supported by TAST) and RRC-NES Consultants support all the 8 NE States.

A training need assessment has been performed by NHSRC by compiling training needs expressed by staff of different SHSRCs. The proposal for holding a workshop on these issues has been submitted to MOHFW in November 2011. Following subjects are identified from the training need assessment exercise with SHSRCs:

- Designing evaluation studies
- Designing surveys for HMIS Data Triangulation, Data Analysis & Data Quality Improvement
- Capacity Building for guiding District Health Planning
- Training on indicator development and outcome measurement methods & use of information (HMIS) for program improvement
- HR – Training on job mapping, compensation, performance evaluation
- Challenges in convergence for community based programs under NRHM
- Challenges in implementation of JSSK
- Managerial skill development

- Understanding on differential financing and budget tracking
- For Maharashtra & Himachal Pradesh – Orientation on all thematic areas

3. Sector Innovation Council:

The Sector Innovation Council set up by the ministry of health and family welfare has 15 members and is chaired by Shri PK Pradhan, Special Secretary of the Ministry and Mission Director for the National Rural Health Mission. Its first meeting was held on July 6th, 2011. There are four sub-groups:

I. Drugs and Pharmaceuticals- convened by Shri. Dinesh Abrol.

II. Medical Devices- convened by Dr. Sanjoy Guha

III. Information and Communication Technologies- to be convened by Dr SK Mishra

IV. Health Systems and Program Designs: convened by Dr. Dileep Mavlanker

Background papers and inputs from each sub group described the current situation; prospects & need for innovations, and these were put together and presented to the whole group, as a draft SIC Report. The next SIC Meeting is scheduled for 23rd March 2012

4. Common Review Mission - V

NHSRC has been facilitating this review mission for the last four years and had successfully continued to do so this year too. A total of 15 states were visited. Over 171 members- which include national and state health administrators, public health experts, academicians, development partners, and civil society members participated. NHSRC consultants were part of 14 of these teams. The final compilation, analysis and drafting of the report was done by the NHSRC team.

5. Support to MOHFW (RCH and NRHM)

a. Supportive Supervision

The 265 high focus districts in the country have been identified and RCH division of MOHFW has formed integrated teams of consultants for supportive supervisions. As a part of these teams 8 consultants visited 34 districts in 11 states.

State	No. of districts	Names of districts
Rajasthan	6	Bharat Pur, Sawai Madhopur, Sirohi, Alwar, Dausa, Pali
Uttarakhand	3	Dehra Dun, Tehri, Haridwar
Himachal Pradesh	1	Kinnaur
Madhya Pradesh	6	Khandwa, Katni, Shahdol, Ratlam, Dhar, Badwani
West Bengal	3	Jalpaiguri, Bankura, South 24 Parganas
Orissa	3	Nayagarh, Angul, Keonjhar
Jharkhand	2	Pakur, Godda
Chhattisgarh	4	Dhamtari, Rajnandgaon, Jagdalpur (Bastar), Kanker
Jammu & Kashmir	2	Leh, Kargil
Gujarat	2	Navsari, Dangs
Karnataka	2	Chamarajanagar, Kolar

b. Support to MoHFW for State Plan Appraisals:

- State PIP analysis for19 states and 2 UTs year 2011-12
- Assisted MOHFW in preparations of budget sanctions to19 state+2 UTs.

6. Evaluations

a. Effectiveness of Strategies that address unmet needs for contraception in the high focus states

Seven states are lagging behind with TFRs above 3.0. This study is being conducted to assess the exact form and reasons for the persisting high unmet needs in the high fertility states including barriers to access and effectiveness & current relevance and role of demand side inputs in contributing to population stabilization. Data collection is completed and analysis & report writing is ongoing

b. Family Planning Insurance Scheme with partner organizations.

The Family Planning Insurance Scheme (FPIS) study is being conducted in Assam, Haryana, MP, Maharashtra and UP to review the FPIS in implementation of the various processes and institutional structures specified under this scheme, adherence to protocols and quality improvement measures in place to ensure that claims are reduced, and to identify constraints blocking or facilitating the proper implementation of the scheme in all its aspects

7. Baseline study on User fee and Out of Pocket expenditure for 28 states

Out of pocket payment has been a major deterrent for pregnant women and children and their families in seeking health care in government health facilities. In July 2011, on the eve of the launch of the JSSK, a national level baseline study was carried out in order to assess the situation with regard to the out of pocket expenditure incurred by patients for availing OPD and IPD services in government health facilities as well as assessment of the status of implementation of free and cashless services for delivery and referral transport for pregnant women and children. Data for this study was collected from 28 states, which include the high-, focus eight EAG states, 8 North Eastern states, Himachal Pradesh and Jammu and Kashmir. The baseline report was submitted to the MoHFW in August.

8. JSSK Monitoring:

A quarterly monitoring report on the status of the implementation of JSSK for the period September-November, 2011 was prepared by PHP and submitted to MoHFW in November. The report was based on data collected from 21 states.

Challenges

The central challenge remains to make the district plans a much more effective and equity sensitive exercise. State plans must be based on the district plans, and resource allocation needs to have a correlation to district plans. The principle of resource allocation and the principles of participation need to be reconciled. The scientific basis of the plan, its use of information, its outcome basis and differential financing of facilities are all challenges. Inclusion of non-communicable and communicable diseases, other than the national disease control program also remains a challenge. Building institutional mechanisms of planning at state and district level are also a challenge.

HEALTH INFORMATICS

NRHM envisaged a fully functional health information system facilitating smooth flow of information and effective decision-making. Lack of indicators and local health needs assessment has been identified as a constraint for effective decentralization. All this requires a robust health management information system that would be essential for decentralized health planning. In order to meet the objectives, HMIS division of NHSRC works under the following thematic areas.

Thematic Areas

- Policy and Strategy Development.
- Research Studies and assessments.
- Capacity building and support.
- Development of database of HMIS data analysis.

Key Achievements

- Database of all districts data in terms of ready to use indicators developed for Annual HMIS data (FY 2010-11), Quarterly HMIS data (First two quarters of FY 2011-12), comparative data analysis (FY 09-10 & 10-11). Analysis disseminated through web, trainings, workshops etc.
- HMIS Assessment: District-level assessment of HMIS data quality and processes was done in 67 districts of 23 states. Feedback given to States and National Centre
- Competency-based HMIS Trainings: Conducted in state of Maharashtra, Uttarakhand, Punjab, Odisha and MP. Meant to train and develop pool of master trainers.
- HMIS Training Manual Volume-IV (Resource Persons' Manual) is finalized and print-ready. It is widely disseminated for review and comments from various stakeholders before actual dissemination to the states.
- Integration: Initial Integration Bridge has been developed between state applications and National HMIS Web Portal for seamless facility-wise data transmission.
- Open Source Health Informatics development: HR Information System (Bihar, Jharkhand); Hospital Information System (Himachal Pradesh), Mobile based SC data reporting (Punjab & HP), GIS Fully integrated open source (MP, Tamil Nadu, Odisha, Maharashtra); Child Tracking (Odisha); and Mother & Child Tracking System

Work Report

1. **Policy and Strategy Development:**

   One of the core activities of the HMIS Division in NHSRC has also been to actively engage with Ministry of Health & Family Welfare, Government of India and states in developing strategies and policies related to innovative e-health solutions development in HMIS.

   In this context, NHSRC has extended support to various partners for implementation of various e-health initiatives such as HR Information System, Hospital Information System, GIS, Use of Mobile phone for SC data reporting, Tracking of sick neonates and children using Tracking system from NRC and SNCU. All these systems are open source solutions and implementation of which will help boost innovations in e-health.

- **HR Information System:** In collaboration with Vistaar Project, NHSRC has helped state of Bihar and Jharkhand in implementing open source Human Resource Management Information System (iHRIS). This system aims to help not only to create a database of HR but also to help rationalize posting, transfers,

training and skill management, promotions, appraisals and ensure multi skilling. Initial implementation efforts have helped understand critical data quality gaps and will help rollout of system in the state. Workshop on "Innovation in IT for Management of HR in Health Sector" is conducted at NHSRC in January'2012

- **Mobile based Sub Center data reporting:** It is being successfully used in Punjab and is also now being piloted in two districts of Himachal Pradesh. GIS: Fully integrated open source GIS system is in use in MP, Tamil Nadu, Odisha. Integration is in process with Maharashtra DHIS application.
- **Tracking from NRC & SNCU:** To track sick neonates from NRC & SNCU has been started as pilot in Odisha using DHIS tracker. This will help tracking of those cases that required specific care and help improve program outcome.
- **Mother & Child Tracking System:** This is a name based patient follow-up system and the NHSRC has been involved in assisting the MCTS Committee in the MoHFW for rationalization of data elements.
- **Support to build state specific application:** NHSRC has provided the technical assistance to the state to upgrade the state specific free and open source application for facility & block-wise data analysis & use (Punjab, HP, Odisha, Bihar, Maharashtra, MP) for district and block level health programme managers for improved planning and programme management. In this regard bridge between Tamil Nadu State Application and DHIS has been created to enable direct export of facility data into DHIS2 and further export to Web Portal and to help data analysis and use of information.
- **As part of the ICT sub group of SIC** and Steering Committee of Planning Commission, NHSRC has worked on National e-health Architecture based on standards which provides liberty to the states and other programs to develop their own systems but to comply with standards defined in e-health architecture. Financial incentives will be attached with the state to comply with the national e-health architecture.
- **Hospital Information System:** Open MRS based Hospital information Systems has been fully implemented in DDU Hospital Shimla. System has helped rationalize reporting within the hospital and also automated billing and improved inventory management in the hospital. Following modules have been implemented in the hospital- OPD, IPD, Laboratory, Billings and Inventory Management etc. It is now being scaled up in two other district hospitals of Himachal Pradesh.

2. Research Studies and Assessments:

- NHSRC has done assessment of 9 Public Health IT Systems to understand the gaps and opportunities from these systems. These systems include HMIS Web Portal, DHIS-2, MCTS, eMAMTA, SIMS-NACO, IDSP, NAMMIS-Malaria, TN-HMIS, Andhra Pradesh historical HMIS development. The study included study of functional specifications of Public Health IT Systems. All systems had lot of similarities in gaps and learning and the input of this has been gone into the development of national e-health architecture as part of SIC-ICT report.
- Study of Telemedicine implementation in Tripura: Challenges and Opportunities - A background study of ICT subgroup of SIC is completed. The Kerala Tele-Oncology project is being assessed.
- On request of State of Punjab, feasibility study for data reporting via SMS for IDSP, Birth & Death registration and Mother & Child Tracking has been done in Mohali District of Punjab and report submitted to State Mission Director.
- NHSRC has done assessment of status of HMIS in 67 districts of 23 states.

3. Capacity Building and Support:

HMIS unit has been actively involved in capacity building at state, district and national level. HMIS unit has also played a key role in dissemination of filed understandings among various stakeholders through workshops, trainings etc.

As part of its routine capacity building support to the states, HMIS unit has participated in major capacity building programs at state and district level. HMIS trainings have been conducted in state of Maharashtra, Uttarakhand, Punjab, Odisha and MP. These trainings are done to develop pool of mater trainers who can lead training programs at district level. 177 trainees received trainings in these training programs and 30 master trainers identified based on the competency assessment. These master trainers have led training programs for service providers' upto the facility-level.

NHSRC has actively participated in building capacity among program managers for defining of indicator based data elements, reporting forms, flow of information, data analysis and use for various new programs in state of Odisha, Karnataka, Tamil Nadu, Andhra Pradesh etc. Odisha has been actively helped for developing innovative solution for tracking sick neonates from SNCU and NRCs.

NHSRC in collaboration of AIIMS and UNICEF has helped develop set of indicators from existing data sources that can help program managers track progress of child health.

The NHSRC has collaborated with Intrahealth International, through the USAID-supported Vistaar Project, contributed towards development of indicators for HR management in state of Bihar and Jharkhand.

4. **Development of Database of HMIS Data Analysis:**

HMIS unit is actively engaged in analyzing data and disseminating it widely through website. The division has done the following HMIS data-analysis during this FY.

- Annual HMIS data analysis for FY 2010-11 for all states and districts.
- Quarterly inter-district HMIS data analysis for all state (FY 2011-12).
- First 2-quarter inter-district HMIS data analysis for FY 2011-12 for all states.
- Comparative HMIS data analysis for FY 09-10 & 10-11 for all states.
- Developed Fact sheets for all states using DLHS III, SRS-2009, Census 2011 and NFHS-3 & RHS-2010-11 data for use in district planning.
- Analysis of sex ratio & literacy rate using Census-2011 data.
- Analysis of maternal Health Indicators from HMIS for FY 2010-11 for all states.
- Compilation and analysis of health data from various sources for use in District planning for all states and for some research studies.
- Analysis of mortality indicators using AHS-2011 data.
- Analysis of IMR, TFR & MMR using SRS data.

Challenges

- Consensus development among all stakeholders for implementation of National E-Health Architecture through National e-Health Authority.
- Challenge is also to define various standards to be used in the framework- data standards, interoperability standards, disease codes etc. These standards should be followed-up by all programs specific IT systems for seamless data interchange at all levels.
- Use of standardized protocols at all levels, use of information and feedback at district and block levels.
- Building capacity among various stakeholders to take lead in health informatics.

N.H.S.R.C. ADMINISTRATION

Administration includes

- General Administration
- Human Resources
- Accounts
- IT

Major Functions

I. Excellence in Routine:

- Annual Tenders & Procurement of Goods & Services includes:

  (a) Advertisement

  (b) Transport Hiring

  (c) Courier Services

  (d) Air & Rail Travel

  (e) Security

  (f) Grocery

  (g) Stationary

  (h) Printing

  (i) Web-Site Management

- Design / Development / Content Standardization of MOU, Work Orders & Purchase Orders.
- All Maintenance Activities of Establishment.
- RTI compliances – 4 Received & Replied Satisfactorily
- Organizing of Annual Day work shop & Retreat 2012
- Ensuring prompt and reliable support services at all times.
- Hosting of EC & GB Meetings.
- Transportation & Logistics arrangements for CRM & Dissemination of the findings of CRM.
- Internal Communication – NHSRC updates in Website.

II. Institutional Building:

- Total Consultants Supported by NHSRC (As of Feb - 2012)

NHSRC	MoHFW	RRC-NE	TOTAL
79 (Technical – 62 / Administrative – 17)	18	30	127

- Joining & Relieving Report - 2011

Joining	Relieving
46	51 (Includes Interns / Fellows / Short Term Consultants)

- NHSRC Website

  The website of NHSRC is being extensively used to upload information related to RTI Guidelines, various reports, books, Manuals, tenders etc. It also carries the information related to New Job Openings at NHSRC and Recruitments conducted by NHSRC for other States and MoHFW. A monthly report of all Divisions including Administration is uploaded on the Website regularly. The website of NHSRC has received stupendous response and is being visited by over 3000 people per month.

- Draft of Policy Manual / Revision of Rules and Regulations of NHSRC
- Total Numbers of positions closed 118 (Including NHSRC, State & the Ministry)
- Submission of Audit Report & Utilization Certificate
- Filing of Income Tax Return of NHSRC
- Internal audit till December, 2011 (FY 2011-12)
- Documentation & Recordkeeping.

Challenges:

As there is a need for organization to re appreciate their existing policies from time to time to meet the new challenges and cater to changes occurring in the professional world. The policies of NHSRC are being adopted by various NGOs and new Societies such as National Mission for Empowerment of Women, Jansankhya Sthirata Kosh and several others for improve the current working and meet DOPT rule of the land.

Since NHSRC is completing its five years of existence and the extension is likely to be granted, there is a need to look into existing policies in the areas related to Gratuity, Provident Fund & the status of the consultants. The Gratuity is likely to be applicable to consultants who will be completing 5 years from May 2012 onwards. It is provided for in the Bye- Laws. In fact Consultant's Feedback and Institutional experience encourages us to look positively at its implementation and corresponding rewards.

REGIONAL RESOURCE CENTER FOR NE STATES

Public Health Planning

The 'Framework for Implementation of National Rural Health Mission' envisaged preparation of State Program Implementation Plan (SPIP) based on the Integrated District Health Action Plans (DHAP) and the implementation there of.

Much of the work of Regional Resource Centre for North Eastern States (RRC NES) has been geared towards facilitating the planning process in districts and in states more participatory, qualitative and more effective. The focus was on capacity building of the available related manpower on planning. Different tools for assessing the existing situation have been utilized, many districts have used these tools in the field for assessing the situation, and the findings of these exercises and recommended activities have also been incorporated in the Annual Health action Plan. The primary role of RRC NES is the continuous effort towards building institutional capacities at State/ district level for providing technical assistance for the Annual Health Action plan.

Thematic Areas:

- Facilitating Planning Process for the NE States including Support to States and districts for formulation of SPIP and DHAP.
- Support to State and District Plan Implementation of NE States
- Monitoring and Supportive Supervision of NE States

Key Achievements:

- Need based SPIPs and DHAPs for the NE States
- Capacity Building of State and District Health Planners and Managers
- Facilitating in analyzing the output indicators of the High Focused districts of NE States and supporting them in proper implementation.
- Short listing of Public Health Facilities to ensure universal access to entire range of RCH services
- Induction Training of newly inducted Managers.

Work Report:

1. **Capacity Building Training for new State and District Health Planners**

   A capacity building training for the newly recruited State and District Planners was conducted by NE-RRC. The workshop was held to induct the new recruits on the various mechanisms and the tools and techniques of decentralized health planning, with a focus on preparation of the Block and Village planning along with community monitoring and supportive supervision under NRHM at the district level and below.

2. **Planning Process for SPIPs - 2012-2013**

- Facilitated State Program Implementation Planning process in all the 8 NE States. Technical assistance was provided especially for understanding the Revised Guidelines for RCH and NRHM and formulating the SPIPs accordingly.
- For the initial process of preparation of SPIPs 2012-2013, RRC-NE Team visited all NE States.

- Facilitated in DHAP appraisal of Assam, Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Tripura and Sikkim.
- Draft PIPs were submitted timely for all the 8 NE States.

3. **Rapid Assessment of Functionality of 24x7 Health Facilities:**

   This study was conducted in Assam to assess the status of functional 24x7 PHC/CHCs of the State with a focus on essential services provided and availability of manpower, infrastructure and equipment. This has been carried out to address the gaps and improve service quality and plan accordingly for the coming years.

   A report was published and disseminated to all the concerned stakeholders for ensuring a need based planning and providing quality services.

4. **Output Indicator analysis of all 24X7 and FRUs:**

   Quarterly analysis of all functional 24X7 and FRUs of all NE States has been done in order to assess the existing infrastructure, manpower and service delivery. This activity has been carried out to further enhance the performance of the 24X7 and FRUs. This will also ensure effective need based planning.

5. **Complete database of Delivery Point of all public health facilities of NE States:**

   Mapping of the Public Health Facilities (CHC, PHC and SC) in terms of human resource availability, delivery load, infrastructure and equipment available etc. was done in consultation with all the NE States for the operationalization of feasible delivery points and improving the quality of RCH services.

   Following this exercise the States have initiated deliveries at SCs and till date, 261 SCs in Assam, 33 SCs in Meghalaya and 1 SC in Tripura have started conducting deliveries.

6. **Co-ordination and Monitoring for Training:**

   Co-ordination and monitoring of EmOC, BEmOC and LSAS training of all NE States was done at Guwahati Medical College as well as at the District Hospitals.

7. **Analysis of MMR & IMR data of Assam:**

   MMR is declining in Assam but continues to be a cause of concern as it accounts for the highest MMR in India (Source: Annual Health Survey, 2011). Therefore, a Review of secondary MMR data of Assam has been done to initiate corrective measures at the different facilities and hospitals of Assam to reduce MMR and IMR in Assam.

   Protocols for the management of Anemia and Hypertension in pregnant women was developed and disseminated to the districts and health facilities.

8. **Tracking of Pregnant Women and its outcome at Guwahati Medical College Hospital of Assam:**

   The yearly analysis of Maternal Deaths in Guwahati Medical college Hospital of Assam shows that the maternal death is a cause of great concern. The need for bringing down the maternal death significantly at the hospital has been stressed at the policy level. With the advice of the Secretary, Health & family Welfare, Govt. of India it is being initiated to track all the pregnant mothers admitted at the Guwahati Medical College Hospital up to its outcome to study the factors / cause associated for the maternal deaths. Hence it is desired to have the cause analysis of maternal death at the Hospital, so that the policy makers can take appropriate and effective strategies to reduce maternal death with help of such valuable information.

9. **Monitoring and Supportive Supervision:**

Visits to all the high focus Districts of NE states for monitoring and supervision were carried out. The gap analysis reports based on the visits were shared with the respective State & District officials for further action.

10. Studies and Evaluations Conducted:

- A feasibility study for up-gradation of Khawzawl PHC (Champai District) in Mizoram from 26th to 30th June'2011 was carried out.
- A feasibility study for up-gradation of Ukhrul District Hospital Manipur from 8th to 11th June'2011 was carried out.
- Facilitated the ISO - 9001:2008, 1st surveillance audit in MMC Hospital, Guwahati.
- Assessment of ASHA Facilitator in Assam was conducted.
- Evaluation of VHSC & RKS was done for the states of Tripura, Manipur and Meghalaya.
- Evaluation of VHSC & RKS was done for Dhemaji District of Assam.
- Studies and Evaluations in process:
  a. A proposal was designed for the MNGO evaluation of Tripura and was approved by NRHM, Tripura.
  b. The TOR for concurrent evaluation of JSY in Assam and Meghalaya was prepared and approved. Fieldwork is under process.

Community Mobilization

Community mobilization attempts to bring not only community participation but also ownership and accountability among community in health programs, and is one of the important strategies under National Rural Health Mission (NRHM) for increasing accessibility to and utilization of health care services, and thereby leading to a healthy community.

Thematic Areas:

- Facilitating in rolling out of ASHA training program at State / District / Block / Facility / ASHA.
- Identification of problem areas and providing technical assistance to States for dealing with it.
- Capacity building of district, block level community mobilization coordinators / media staffs.
- Assessment and Evaluation of ASHA Program.
- Assisting states in translation of training modules and also in developing or modifying the training modules so as to suit to the State specific situations.
- Post-training follow-up support.
- Regular Supportive Supervision of the ASHA program

Key Achievements:

- 1st round of Training of Trainers from Assam on ASHA Module 6& 7 at SEARCH, Gadchirolli, Maharashtra (National Training site for ASHA Module 6 & 7). 15 persons from Assam (NGO staff, ANM, GNM, DCM from Assam) were trained.

- 2nd round of Training of Trainers from North East States on ASHA Module 6& 7 at SEARCH, Gadchirolli, Maharashtra (National Training site for ASHA Module 6 & 7). 33 persons from NE states and RRC Staffs were trained.
- ASHA Module 6 and 7 available in local dialects like; Assamese, Bengali, Bodo, Mizo, Manipuri, Khashi and Garo.
- Regional level consultative meeting on ASHA Program for all eight North East States held at Guwahati in June 2011.
- Supported States in development of State specific roll out plan of ASHA Module 6 & 7 training.
- Conducted 4 days refresher training on Module 6 & 7 at Guwahati in coordination NHSRC.
- More than 500 ASHA/District trainers trained in all eight North East States on ASHA Module 6 & 7.
- Supported State in development of strategies for operationalization of various support structures (ARC) in the States.
- Supported state in development of strategies for oeprationalization of ASHA help desk/rest house in selected health facilities
- ASHA evaluation in Nagaland is on progress
- ASHA Facilitator Assessment in Assam conducted
- Assessment of VHSC and RKS in Manipur, Meghalaya and Tripura completed.
- Ongoing regular monitoring and assessment of program on selected parameters on monthly basis through State Facilitator/Consultants.
- Ongoing regular technical support to the States through field visits of RRC, NE staff and providing inputs to the State for effective ASHA program.
- As part of documentation, report of "Progress Made and Challenges Faced along with experiences from the field - Because I am an ASHA" published.

Work Report:

Training of National/State Trainers and Nurse tutors at National Training Site, and Creating State Training Sites & training of District ASHA trainers on Module 6 & 7

RRC, NE along with NHSRC and the State Health Society of eight States of North East, coordinated in training the National/States Trainers and Nurse Tutors from North East States in SEARCH, Gadchirolli which acts as one of the national training sites for ASHA Module 6 & 7.

RRC, NE worked rigorously with all the North East States, and state specific roll out plan for ASHA Module 6 & 7 were developed. Training of District/ASHA Trainers on first round conducted in all NE States, and 2nd round training of ASHA Module 6 & 7 was conducted in all NE States except Assam.

In all the North East States, RRC, NE not only helped the States in developing the roll out of plan of ASHA Module 6 & 7 training for ASHA/District trainers and ASHAs, but also supported the States by providing trainers from RRCNE and its partner institutions/agencies who were trained in SEARCH, Gadchirolli.

1. Refresher training of ASHA/District Trainers on Module 6 & 7:

As a follow up of refresher training of State trainers held in Guwahati during July 2011, refresher training of District ASHA trainers for ASHA Module 6 & 7 was conducted in seven out of eight NE States.

2. **Monitoring visit of ASHA Training on Module 6 & 7:**

Monitoring visits is also conducted to see/observe the quality of ASHA Training on Module 6 & 7 in all the States (except Assam). A monitoring checklist format was developed and accordingly training was monitored. Staff of RRC HQ as well as its consultants based at State made the visit.

3. **Meeting of the State ASHA Mentoring Group:**

Meeting of State AMG was held in all the States. State Facilitator/Consultants of RRC, NE provided support to the States in organizing the State ASHA Mentoring group meeting as well as follow up with the states to ensure that various decisions taken and suggestion given by the AMG members during the meeting are given due importance by the States, and their suggestions as considered for effective functioning of ASHA program in the State. These meetings were attended by officials from RRC, NE to add value in the form of providing various inputs as well as sharing information of other states too which could be learning for the State.

4. **Assessment of ASHA Facilitators in Assam:**

RRC- NE has taken up a study to understand the effectiveness of ASHA facilitator in improving the healthcare service delivery in the state of Assam. Six districts of Assam from different regions have been identified and taken for study so as to have representation of various regions / zones. The final report has been published and disseminated.

5. **VHSC and RKS Assessment:**

Assessment of VHSC and RKS was conducted in the State of Tripura, Meghalaya and Manipur. And the report has been published.

6. **Best Practice Documentation in Dhemaji District, Assam:**

Dhemaji is one of the most difficult districts of Assam with difficult terrain as well as affected by natural calamities especially flood every year. However, the district has shown improved status of health parameters especially in immunization and decreasing maternal death. Therefore, RRC-NE took up the initiative of best practice documentation of Dhemaji District of Assam so as to understand the various contributions, which has lead to improvement in health status.

Data collection is completed and analysis is on progress. The report will be published soon.

7. **Other Support to States:**

RRC NE is providing regular technical support/assistance to the States through its State Facilitator and Consultant- Community Mobilization, and also through regular visits to the States by its regional level staff. In addition, regional level meeting and consultations were organized to develop state plans and strategies as well as share various progresses in ASHA program with each other. This is an opportunity for the State to share their learning as well as learn from other States too.

The major area where Community Mobilization Team of RRC, NE has supported states includes;

- Providing technical support in developing various state specific strategies and TORs for effective ASHA support structure (ARC) in the States

- Helping the State in creation of ARC; State specific Support Structure/ARC exists in Assam, Meghalaya, Tripura, Arunachal Pradesh and Nagaland. And the same is on process in Manipur, Sikkim and Mizoram.
- Capacity building of staff of ARC in collaboration with State health Societies and other agencies
- Supporting the state in establishment of ASHA help desk and rest house in various health facilities.
- Providing technical assistance to the State for community monitoring
- Other technical assistance for streamlining the overall ASHA program in the State.

8. **Reports, Publications:**

- Monthly reporting on the ASHA program of all eight North East States (the ASHA Matrix) continued on a regular basis.
- Assessment of ASHA Facilitator in Assam
- VHSC and RKS assessment in Manipur, Meghalaya and Tripura
- Progress made an challenges faced- A report on progress of community processes under NRHM in NE States

Challenges

In smaller states like Nagaland, Sikkim and Mizoram establishment of support structure for ASHAs at all level (State, District and Block/Sector) with full time staff remains a challenge due to lesser amount of budget allocation as their number of ASHAs are very less. So, at present, in these states either it is incomplete support structure or somehow state is managing with its already existing staff instead of having full time staff only for support structure of ASHAs at all level. Other challenge is weak support structure in ASHA program in State wherever support structure has been created. Therefore, strengthening ASHA support structure will be one of the priority activities for the community mobilization team of RRC-NE.

Health Management Information System

The reporting system under RCH I was area specific which results into duplication of data and inclusion of unusable data elements to compromise the data quality.

Under NRHM facility based reporting system with usable data elements has give an opportunity to use the information locally and to take necessary policy decision. The important era of the HMIS started after launching NRHM HMIS Web Portal on 21st October 2008.

Thematic Areas:

- Maintenance of Record Keeping & Timely proper reporting
- Facility based Data uploading in HMIS web portal.
- Capacity building of the different level of Data Managers
- Finding the correlation between different indicators to improve data quality
- Use of information for planning & program management
- Analysis & Review of the data to improve data quality and necessary feedback to the NE States

- Conducted different surveys
- Frequent field visit at different level of facilities to improve the reporting system

Key Achievements:

- Developed Maternal Health & Immunization Register compatible to Mother & Child Tracking System
- Interpreting the correlation between different Maternal & Child Health indicators to monitor the data quality and the same relation being used for formulating plan of action
- Capacity building of the Different level of Data Managers for the data collection and facility wise data uploading in the NRHM HMIS Web Portal in Assam, Meghalaya and Tripura.
- Capacity building of the Program Managers, Health Officials and Data Managers on Mother & Child Tracking System
- District / State wise comparative analysis of Key Indicators of 2009-10 & 2010-11 has been done so that the states can use the information available in the report to take corrective measures and use of information in District Health Action Plan & State Program Implementation Plan.
- District / State wise fact sheets of North Eastern States on Key Indicators of 2009-10 & 2011-12 (Up to November) has been prepared and shared.
- Data quality assessment of HMIS data has been completed for the state of Assam, Manipur, Meghalaya, Mizoram and Tripura.
- Rapid Assessment of functionality of 24 X 7 facilities of Assam has been completed.
- Coverage Evaluation Survey of Assam on Maternal health (JSY Evaluation) & Immunization 2011-12 have started.
- Data analysis has completed for the studies "Assessment of Community Perception towards Health Issues, Services & their Health seeking behavior" for the State of Manipur, Meghalaya & Tripura.
- Preliminary work for the Coverage Evaluation Survey on Maternal Health & Immunization, IMR & MMR in Nagaland being started.
- Preliminary work for the MNGO Evaluation in Tripura being started.
- Exposure visit of Meghalaya HMIS team to Morigaon District of Assam regarding Record Keeping and Reporting System at different levels.
- Routine field visit at different level of health facilities to improve the reporting system of all eight North Eastern States.

Work Report:

1. HMIS Implementation in North East:

HMIs team of RRC-NE worked in close association with NHSRC & Statistics Division of Ministry of Health & Family Welfare, Govt. of India, to implement the revised facility based reporting system in North Eastern States. The NRHM HMIS Web Portal started functioning from 21st October 2008.

At the beginning of the implementation of NRHM, the District Consolidated Reports were being uploaded in HMIS Web Portal. Facility wise data uploading process in the NRHM HMIS Web Portal started from 2010 in Assam, Meghalaya, Nagaland and Tripura. From the year 2011, the other 4 states have started facility

wise reporting in HMIS web portal. Now, all the 87 districts of North Eastern States are regularly uploading the facility based report as well as Quarterly Report in the NRHM HMIS Web Portal.

2. **Data Analysis:**

District-wise comparative analysis of Key Indicators of 2009-10 & 2010-2011 has been done by RRC-NE and shared with all the NE States. The report has been sent to all NE States so that the state as well as district can use the information available in the report to take corrective measures. District wise fact sheets of North Eastern States on Key Indicators of 2009-10 & 2010-11 & 2011-12 (up to November'11) has been prepared and shared.

3. **Data Quality:**

During the frequent field visits of the HMIS team to different facilities of NE States, it was found that the reasons for poor quality data are common and few are area specific, the prime cause being the recording system. RRC-NE has tried to address this issue during capacity building workshops whereby the key stakeholders in the state can lay emphasis on strengthening the recording system at all levels so that the reporting system and data quality can be improved

4. **Capacity Building:**

For an effective Health Management Information System, continuous capacity building is necessary since Data Managers at different levels are not from the medical background. If the Data managers are well versed with frequently used medical terminologies then the analysis part and data quality of the reporting system will be improved. Hence RRC-NE has conducted induction level training as well as different need-based workshops.

5. **Monitoring and Supportive Supervision:**

The key points discussed during the field visit were maintenance of records, validation of reported data with the records & registers, any analysis based on reported data & preparation of charts and compilation process at PHC/ BPHC / District level and status of Mother & Child Tracking System. The schedule of visits was as follow:

Dates	Name of the district	Name of the State
27.06.11	Nalbari District	Assam
01.07.11	Darrang District	Assam
04.08.11 to 05.08.11	Nagaon District	Assam
13.07.11	Aizwal	Mizoram
09.08.11	Kamrup (Rural) District	Assam
16.08.11	Morigaon District	Assam
18.10.11 to 21.10.11	West Tripura District	Tripura
8.11.11 to 12.11.11	Dimapur and Kohima	Nagaland
1.12.11 to 3.12.11	Imphal West and Bishnupur	Manipur

Workshops held

1. Review Meeting on HMIS Data and Mother & Child Tracking System for the State Nodal Officer/ Program Manager, State HMIS Manager or State Data Manager, State Nodal Officer for MCH Tracking and State NIC Health Coordinating Officer for MCH Tracking of NE States on 4th & 5th March 2011 at Guwahati was conducted by RRC-NE in collaboration with Statistics Division, MoHFW, Government of India.
2. 25.04.11 to 26.04.11: A Regional Workshop to Review the HMIS Data and Mother & Child Tracking System (MCTS) at Gangtok, Sikkim for all eight North Eastern States was conducted by RRC-NE in collaboration with Statistics Division, MoHFW, Govt. of India for improving the data quality, analysis the data and use the information for public health planning as well as an emphasis on proper implementation of MCTS so that the actual benefit goes to the Mother & Child

Quality Assurance

Work Report (Oct-Jan'11):

- Verified all the ISO 9001:2008 Supportive Supervision Reports (of 8 District Hospitals of NE States) & suggested the TSP regarding areas of improvement for improving the delivery outcomes.
- Was involved in PPP Evaluation study of Meghalaya undertaken by NHSRC in the month of Nov'11 (28th, 29th & 30th Nov.).
- Facilitated 1st surveillance audit of MMC Hospital, Guwahati in the month of Oct.'11 (17th & 18th)
- Supported in preparation of SPIP/DHAP for the year 2012-13 of Meghalaya & Tripura in the month of Jan'11 (9th-11th).

OTHER ACTIVITIES OF RRC-NES

1. Appraisal of the SPIP 2011-12 for all NE States was done in association with MoHFW, from 8th – 10th Feb 2011 at Guwahati.
2. Review meeting on HMIS on MCTS was done on 4th and 5th March 2011 at Guwahati.
3. NE level workshop on Maternal Death Review was done in association with MoHFW, on 16th March 2011 at Guwahati.
4. ToT of BEmOC for NE States was done in conjunction with NIHFW, on 2nd and 4th May 2011 at Guwahati.
5. Workshop on HMIS and MCTS in conjunction with the MoHFW, was conducted on 25th and 26th April, 2011 at Gangtok, Sikkim.
6. Review meeting on Measles SIA was conducted on 2nd May 2011 at Guwahati.
7. Capacity Building training for the DPM and DME was conducted from 23rd-28th May 2011 at Guwahati.
8. Facility based training on NRHM HMIS Web Portal was conducted for Arunachal Pradesh and Meghalaya from 1st to 11th June 2011 at Guwahati.
9. Review meeting on Measles Catch up Campaign for NE States was conducted on 2nd June 2011 at Guwahati.
10. Review workshop for ASHA program was conducted on 21st and 22nd June 2011 at Guwahati.

11. Workshop on Maternal Death Review was held on 4th and 5th July 2011 at Agartala, which was attended by Director, RRC-NE.
12. Refresher training for ToT of ASHA module 6 & 7 was conducted from 6th-9th July 2011 at Guwahati.
13. Review workshop on implementation in the high focus district plan of Assam was held on 8th September 2011 at Guwahati.
14. Mid-term review of NRHM implementation of all NE States, except Arunachal Pradesh and Sikkim, in conjunction with MoHFW, was held from 13th-15th October 2011 at Guwahati. The mid-term review of Arunachal Pradesh and Sikkim was held on 25th November at Nirman Bhawan, New Delhi.
15. RRC-NE facilitated State level workshop on Community Monitoring from 29th-30th November 2011 in Meghalaya.
16. RRC-NE facilitated State level workshop on IEC/BCC on 2nd and 3rd November 2011 at Agartala, Tripura.
17. North East level Review meeting on forthcoming immunization week and strengthening Routine Immunization was held on 5th and 6th January 2011 at Guwahati.
18. RRC-NE facilitated SPIP preparation for all NE States for 2012-13.
19. Facility based data uploading on HMIS web portal training for all districts of Sikkim on 27th and 28th April 2011 at Sikkim.
20. Facility based data uploading on HMIS web portal training for East Khasi hills, West Khasi Hills, Ribhoi and Jaintia Hills of Meghalaya on 16th and 17th May 2011 at Shillong.
21. Workshop on Facility Level Data uploading in the HMIS Web Portal for Mizoram on 14th and 15th July, 2011 at Mizoram.
22. Reorientation training on Facility based data uploading on HMIS web portal training for East Khasi hills, West Khasi Hills, Ribhoi and Jaintia Hills of Meghalaya on 21 & 22nd July'11 at Meghalaya.
23. Reorientation training on Facility based data uploading on HMIS web portal training for all districts of Tripura was conducted on 18th November'11 at Tripura.
24. RRC-NE facilitated District level ToT on ASHA module 6 & 7 in Assam during 1st -14th August 2011 at Cachar district of Assam.
25. RRC-NE facilitated a two day refresher training on ASHA module 6 & 7 in Meghalaya and Tripura on 8th and 9th August, 2011 and from 17th – 20th September, 2011 respectively
26. Visit to West Khasi and Jaintia Hills as a team member of Joint Review Mission in Sept'11.
27. Coordinated with NHSRC in user fee data collection of 8 NE states.
28. RRC Officials visited States as a member of Common Review Mission team.
29. RRC Officials coordinated with NHSRC team for the PPP Evaluation in Meghalaya.
30. RRC Officials coordinated with NHSRC team for the Family Planning Evaluation in Assam and Meghalaya with NHSRC