



Ministry of Health & Family Welfare  
Government of India



# GUIDELINES ON HUMAN RESOURCES FOR HEALTH NATIONAL HEALTH MISSION (NHM)

2022

NATIONAL HEALTH SYSTEMS RESOURCE CENTRE  
MINISTRY OF HEALTH AND FAMILY WELFARE



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HUMAN RESOURCES FOR  
HEALTH FOR  
NATIONAL HEALTH MISSION (NHM)**

**2022**

**NATIONAL HEALTH SYSTEMS RESOURCE CENTRE  
MINISTRY OF HEALTH AND FAMILY WELFARE**





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व रसायन एवं उर्वरक मंत्री  
भारत सरकार  
**Minister for Health & Family Welfare  
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Government of India**

### **Message**

The sustenance of a strong primary and secondary healthcare delivery system, as envisaged by the National Health Mission (NHM) is contingent on the deployment of a competent, motivated, and accountable health workforce. Human resources for health are the keystone to developing and sustaining a capable and resilient health system, as has been evidenced during the unprecedented COVID-19 pandemic.

It is imperative to construct a rational and inclusive framework for human resource management and development, for successful implementation of health strategies and delivery of comprehensive healthcare. To this end, concrete and concerted efforts have been taken by all the States/UTs, over the course of the last fifteen years, to streamline recruitment, deployment and management processes for NHM employees. This document draws upon all the evidence and initiatives that have charted the growth of the NHM workforce, and sets out to assist States/UTs in developing an efficient, acceptable, and motivated health workforce. It is envisioned as a holistic procedural guide to action for engaging and valuing a committed health workforce that is positioned to meet current and future needs of the health system.

Given the diversity in health sector needs across the States/UTs, these guidelines are intended for interpretation and adaptation as per the States/UTs health system contexts. The guidelines shall facilitate the States/UTs in drafting robust human resource policies, thus enabling effective short-term and long-term planning for enhanced employee management.

I hope that these guidelines will serve as the springboard for the States/ UTs to undertake strategic and coordinated initiatives to foster and assess the development of their health workforce. Ministry of Health and Family Welfare is committed to supporting all the key stakeholders in the realization of the intent of these guidelines, and in reviewing the document periodically to ensure that it remains appropriate to the evolving needs of the health system of the country.

**(Dr. Mansukh Mandaviya)**







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**MINISTER OF STATE FOR  
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GOVERNMENT OF INDIA**



#### MESSAGE

It gives me immense pleasure to know that National Health Mission is releasing guidelines on Human Resource for Health. Human resources for health form the backbone of the health system. Our health workers have steadfastly shouldered the dual burden of ensuring continuous provision of routine health services while also responding to the new pressures arising in the wake of the COVID 19 pandemic.

The National Health Mission, since its inception, has successfully served as a foundation for tackling challenges pertaining to the health system of the country. Human resources for health have always been one of the priority areas for the NHM towards developing a resilient, efficient and adaptive health system. To develop an adequate, skilled and robust health care workforce, many states/ UTs have introduced various praiseworthy interventions such as monetary and non-monetary incentives for rural postings, on-job training and other regulatory measures. The Ministry of Health and Family Welfare has also provided constant support through various directives on the matters regarding human resource development for the health care workforce in the States/ UTs. These guidelines will serve as a compounded vision for developing comprehensive human resource policy and employee welfare practices under the NHM.

The Government of India, under the visionary leadership of Hon'ble Prime Minister Shri Narendra Modi ji, is committed to meet all the health needs of the people of India. I strongly believe that these guidelines shall assist the States/ UTs in making sound decisions as per their specific needs and requirements. To this end, I look forward to all of us working together in successfully employing the provisions of these guidelines to inform and guide our future planning and actions in managing our health care workforce.

It is an ideal time to harmonize the efforts undertaken till now and pump in more initiatives to mark this new era for the National Health Mission. My hearty and sincere acknowledgements to all the valuable contributors who have committed to bringing about this pertinent document at such an opportune time when health systems and priorities are being reshaped to improve and expand the health landscape of India.

  
(Dr. Bharati Pravin Pawar)

**“दो गज की दूरी, मास्क है जरूरी”**







राजेश भूषण, आईएएस  
सचिव

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SECRETARY



भारत सरकार  
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Government of India  
Department of Health and Family Welfare  
Ministry of Health and Family Welfare



#### MESSAGE

Health workforce is one of the fundamental elements required for accelerating, achieving and sustaining the progress of a health system. Human Resources for Health are also pivotal in attuning and aligning the health institutions to the changing priorities of the communities and the beneficiaries. This crucial role of the Health workforce has been manifested vividly during the trying times of the Covid -19 pandemic.

These guidelines strive to reinforce the need for systematic measures to improve the overall management and development of the workforce engaged under the National Health Mission (NHM). The document encompasses all the key components of human resource policy and strategic planning for the Health workforce. The guidelines also integrate lessons and experiences from innovations and best practices in the area of human resources for health from many states.

This document is a culmination of all human resource practices evolved over the last many years of the NHM to guide the States/UTs in developing their own comprehensive Human Resource policy. The current guidelines have been designed keeping in mind the health workforce engaged under the NHM. However, they have the potential to be adopted for the whole health workforce of the States/UTs. The States/ UTs may suitably customize and apply the principles and processes detailed in the document to the entire public health workforce as per their specific requirements.

While there is no one-size fits all approach, there must be a shared understanding of basic principles and strategies for effective health workforce management. I hope that the States/UTs will take assistance from these guidelines and operationalize effective management and welfare systems for their NHM employees. I also look forward to the feedback of the States/UTs based on their experiences to keep the guidelines abreast of the evolving health needs of the Country.

Place : New Delhi  
Date : 16<sup>th</sup> October 2021

(Rajesh Bhushan)





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### MESSAGE

Human resources for health are tasked to run all the facets of the health system and manage the allocated resources towards health sector development. The year 2021 has been declared as the 'International Year of Health and Care Workers' to ensure that they are supported, protected, motivated and equipped to deliver safe health care at all times. This strategy document on human resources is therefore most timely.

The National Health Policy 2017 draws attention to the need for developing leadership skills and strengthening human resource governance in the public health system through the establishment of robust human resource management systems and policies for workforce management and development. These guidelines are designed to ensure that there is a coordinated approach towards the attainment of an adequate, competent and motivated health workforce through comprehensive management and welfare practices. It is imperative that we think beyond traditional human resource management and turn our attention to development and welfare of the workforce.

Challenges are likely to be different and evolving for each State /UT, and a "one size fits all" approach may not work out across states. These guidelines provide a suggestive framework for decision making for planning, recruitment, training, deployment, management and welfare of human resources for health which can be tailored to respective health system needs in a State/ UT.

I hope that these guidelines will help states develop and implement effective HRH Policies and strategies.

(Vikas Sheel)

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### FOREWORD

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Human resources for health are the life-blood of any health system. The COVID 19 pandemic has been a veritable testimony to the critical role they play in keeping the health system steady in the face of unforeseen adversities. Undoubtedly, appropriately skilled, adequate and quality workforce can catapult desired health outcomes, and conducive human resource management and welfare practices are essential to maintain the workforce motivated.

I am sure many of the States/UTs have been able to develop comprehensive human resources policy as per their requirements and specific contexts. Time and again, many directives have been shared for improving human resource management practices for the human resources deployed under NHM in the States. This guidance document comes as a compilation of those directives to assist all the States/UTs towards developing an overarching management system for the health workforce, one that encourages them to work with the National Health Mission and boosts their overall productivity.

This guidance document shall serve as a broad outline and the States/UTs may adapt the provisions as per their health system needs, adhering to the underlying principles of NHM. The guidelines encapsulate suggestive principles and strategies for the whole human resource lifecycle, from recruitment and retention to employee separation. The States may seek direction from the formats provided in the annexure and refer to the compendium of letters for various processes pertaining to human resource management under the NHM. Some of the acclaimed best practices have also been annexed so that the states/UTs can explore the possibility of replication of such practices and innovations in their respective regions.

I encourage the States to adopt a comprehensive and inclusive approach to advance towards formulating their human resource policy for NHM workforce and I am hopeful that these guidelines shall assist them in doing so.

  
(Vishal Chauhan)



# List of Abbreviations

ANM	Auxiliary Nurse Midwife
ASMD	Additional Secretary and Mission Director
CV	Curriculum Vitae
DA	Dearness Allowance
DHFW	Department of Health and Family Welfare
DHS	District Health Society
EAG	Empowered Action Group
ESI	Employee's State Insurance
HR	Human Resources
HRH	Human Resources for Health
HRMIS	Human Resources Management Information System
IPHS	Indian Public Health Standards
JD	Job Description
MEITY	Ministry of Electronics and Information Technology
MoHFW	Ministry of Health and Family Welfare
MPW	Multipurpose Health Worker
NHM	National Health Mission
NHP	National Health Policy
NIC	National Informatics Centre

NHSRC	National Health Systems Resource Centre
NPCC	National Programme Co-ordination Committee
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
PF	Provident Fund
PFMS	Public Financial Management System
PM	Programme Management
PMU	Programme Management Unit
PPP	Public Private Partnership
PSC	Public Service Commission
ROP	Record of Proceedings
SHS	State Health Society
SOP	Standard Operating Procedure
SNCU	Special New-born Care Unit
TA	Travel Allowance
TOR	Terms of Reference

# CONTENTS

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<b>Chapter 1. Introduction</b>	<b>1-2</b>
1.1. Purpose of the Guidelines	2
<b>Chapter 2. Human Resource for Health under NHM</b>	<b>3-4</b>
2.1.1. Service Delivery	3
2.1.2. Programme Management	3
2.1.3. Support Service	4
2.1.4. Other HR	4
<b>Chapter 3. HRH Policy, Principles and Strategies</b>	<b>5-7</b>
3.1. Human Resource Principles in NHM	5
3.2. Key Strategies	6
<b>Chapter 4. Modes of Engagement under NHM</b>	<b>8-10</b>
4.1. Engagement of Staff on Contractual Basis	8
4.2. Engagement through Outsourcing	8
4.3. Engagement through Deputation	9
4.4. Engagement of Interns/Fellows	9
4.5. Engagement of Retired Government Officials	9
4.6. Engagement of HR through Partner Agencies	9
4.7. Other Engagements	10
<b>Chapter 5. Recruitment</b>	<b>11-16</b>
5.1. Bodies Conducting Recruitment	11
5.2. Recruitment Committee	12
5.3. Process of Recruitment	12
5.3.1. Identification and Validation of Vacancies	12
5.3.2. Review Job Description (JD) / Terms of Reference (ToR)	13

5.3.3.	Advertisement for Vacancy	13
5.3.4.	Stages of Selection	14
5.3.5.	Review CVs and Shortlist Applications	14
5.3.6.	Proceed through the Selection Stages	14
5.3.7.	Reference Check	15
5.3.8.	Final Result and its Dissemination	15
<b>Chapter 6.</b>	<b>Appointment and Onboarding</b>	<b>17-18</b>
6.1.	Joining Formalities	17
6.1.1.	Appointment / Offer Letter	17
6.1.2.	Issuance of Identity Card	18
6.1.3.	Attendance	18
6.2.	Orientation	18
6.3.	Probation	18
<b>Chapter 7.</b>	<b>Capacity Building/Capacity Development</b>	<b>19-21</b>
7.1.1.	Induction Training	19
7.1.2.	In-Service Training	20
7.1.3.	Programmatic Training	20
7.1.4.	Skill Enhancement Training	20
7.2.	Nodal Agency/Apex Body for Capacity Building	20
7.3.	Training Management	21
7.4.	Training Material	21
<b>Chapter 8.</b>	<b>Employee Management</b>	<b>22-27</b>
8.1.	Contract Management	22
8.2.	Performance Appraisal	22
8.2.1.	Rewards and Recognition	23
8.3.	Expenses Policy	23
8.4.	Leave Policy	23
8.4.1.	Public Holidays	23
8.5.	Employee Welfare	23
8.5.1.	Occupational Health, Stress Management and Employee Safety	24
8.5.2.	Living Quarters	24
8.6.	Compensation/Salaries and other Benefits	24
8.6.1.	Compensation/salaries and Increments	24
8.6.2.	Allowances, Incentives and other Benefits	25
8.7.	Posting and Transfer	26
8.7.1.	Career Progression	26
8.8.	Grievance Redressal Policy and Procedure	26
8.9.	Employee Separation	27
8.10.	Tools for HR Management	27
8.10.1.	Human Resource Information Management Systems (HRMIS)	27

<b>Chapter 9. Code of Conduct</b>	<b>28-29</b>
9.1. Contents of Code of Conduct Policy	28
9.2. Breach of Code of Conduct	29
9.3. Anti-Harassment Committee	29
<b>Annexure I. Suggestive Procedural Formats</b>	<b>30-88</b>
Deputation Principles and Process	30
Process of Designing Job Description/ToR	32
Sample ToRs/ Roles and Responsibilities	34
Stages of Selection	51
Contents of Offer Letter	53
Contents of the Contract	54
Induction Training Schedule of M&E Officer	58
Training Needs Assessment	59
Process of Performance Appraisal	60
Expenses Policy	68
Sample Travel Approval Form	70
Sample Requisition for Advance Form	71
Sample Claim of Local Conveyance Form	72
Sample Transport Requisition Form	73
Leave Policy	78
Principles and Processes for Salary Determination	79
Process of Rationalization	81
Redressal Mechanism	83
Exit Policy	84
<b>Annexure II. Compendium of Letters</b>	<b>89-125</b>
1. Dated: 19 <sup>th</sup> January, 2015, Competency Based Assessment in Recruitment of HR under NHM	89
2. Dated: 17 <sup>th</sup> April, 2015, JS(P) HRMIS- OSS & Open APIs Reg	90
3. Dated: 21 <sup>st</sup> April, 2015, JS(Policy) GoI or NHSRC Observers for Recruitment Process	91
4. Dated: 3 <sup>rd</sup> February, 2016, Strengthening Specialist Support in Public Health Facilities	92
5. Dated: 8 <sup>th</sup> March, 2016, Applicability of Employee Provident Fund Act, 1952	98
6. Dated: 13 <sup>th</sup> June, 2016, Applying Health Systems Approach in HR under NHM	100
7. Dated: 22 <sup>nd</sup> July, 2016, Remuneration of Existing DEOs to be Paid from Lumpsum Budget	102
8. Dated: 6 <sup>th</sup> December, 2016, JS(Policy) Roadmap for implementing Health Systems Approach	103
9. Dated: 8 <sup>th</sup> February, 2017, JS(Policy) Guidance Note to States on Empanelled Recruitment	104

10.	Dated: 30 <sup>th</sup> June, 2017, Attracting Specialist Doctors under NHM	105
11.	Dated: 13 <sup>th</sup> July, 2017, Equal Pay for Equal Work for HR under NHM	107
12.	Dated: 1 <sup>st</sup> March, 2018, Improving Human Resource for Health Availability at Public Facilities	109
13.	Dated: 17 <sup>th</sup> May, 2018, PIP and HR Approval	110
14.	Dated: 28 <sup>th</sup> June, 2018, Attracting and Retaining Quality Skilled HR under NHM	112
15.	Dated: 18 <sup>th</sup> December, 2018, Experience Bonus for HR under NHM	113
16.	Dated: 9 <sup>th</sup> January, 2019, Placement of Male MPW at HWCs	114
17.	Dated: 6 <sup>th</sup> March, 2019, Placement of MPW at SHCs	115
18.	Dated: 4 <sup>th</sup> July, 2019, Letter from Secretary (HFW) to CS All States Strategies for HR	119
19.	Dated: 2 <sup>nd</sup> August, 2019, ESI Act for HR under NHM	121
20.	Dated: 15 <sup>th</sup> April, 2019, Minimum Performance Benchmark for Programme Management Staff	122
21.	Dated: 13 <sup>th</sup> July, 2019, Reviewing the Performance Indicators with the Programme Managers	124
<b>Annexure III. Learnings from Other States</b>		<b>126-149</b>
	Promoting Better Integration of Health Information Systems: Best Practices	127
	Part 1 : Human Resource Information Management System in Chhattisgarh	127
	Part 2 : Swasthya Sewa Dapoon: An Integrated MIS-GIS System in Assam	128
	Bringing Accountability in Health: The Madhya Pradesh Experience	130
	Strengthening Human Resource for Health in Remote and Difficult Areas	132
	Part 1 : Odisha's Approach in Attracting and Retaining HR	132
	Part 2 : Recruiting and Retaining Specialists and other HRH— Bijapur Model, Chhattisgarh	133
	Appraisals and Rationalization of Human Resources in NHM, Madhya Pradesh	135
	Person-Centred Care through Shared leadership- Banka Model of Bihar	138
	Public Health Cadre: Experience and Learning	141
	Part 1 : Public Health Cadre in Maharashtra	141
	Part 2 : Public Health Cadre in Odisha	142
	Part 3 : Public Health Cadre in Tamil Nadu	142
	AMANAT - Nurse Mobile Mentoring Programme - Bihar	144
	Buddy-Buddy model of EMOC-LSAS- Uttar Pradesh	146
	Paying for Performance- Odisha (P4P)	148



# Introduction

The National Health Mission is a flagship health sector reform initiative started in 2005 as National Rural Health Mission (NRHM) and was later renamed National Health Mission (NHM) when National Urban Health Mission (NUHM) was conceptualized as a sub mission under NHM. The vision of NHM is: “Attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people’s needs, with effective inter-sectoral convergent action to address the wider social determinants of health<sup>1</sup>”

Over the years, the NHM has initiated multiple health system reforms to strengthen primary and secondary care. NHM is both flexible and dynamic and is intended to guide States towards ensuring the achievement of universal access to health care through strengthening of health systems, institutions, and capabilities. One of the objectives of the NHM is to provide access to quality healthcare to all by reducing Out of Pocket Expenditure (OOPE) and eliminating catastrophic health expenditures and improve utilization to minimize disparity on account of gender, poverty, caste, other forms of social exclusion and geographical barriers.<sup>1</sup> The NHM adheres to the values of community engagement at all levels, flexible financing, efficient monitoring, management and innovation.

The Core Values<sup>1</sup> driving the National Health Mission are:

- Safeguard the health of the poor, vulnerable and disadvantaged, and move towards a right-based approach to health through entitlements and service guarantees.
- Strengthen public health systems as a basis for universal access and social protection against the rising costs of health care.
- Build an environment of trust between people and providers of health services.
- Empower the community to become active participants in the process of attainment of the highest possible levels of health.
- Institutionalize transparency and accountability in all processes and mechanisms.
- Improve efficiency to optimize the use of available resources.

The National Health Mission is an umbrella programme covering over 25 programmes, focussing

<sup>1</sup> Ministry of Health and Family Welfare, 2014, Framework for Implementation- National Health Mission 2012-2017 [www.nhm.gov.in/images/pdf/NHM/NHM\\_Framework\\_for\\_Implementation\\_\\_08-01-2014\\_.pdf](http://www.nhm.gov.in/images/pdf/NHM/NHM_Framework_for_Implementation__08-01-2014_.pdf)

on reproductive and child health to communicable and non-communicable diseases, across rural and urban areas. The scale of the programmes may vary in different States and Districts depending on the stage of epidemiological transition/ disease burden of the region and level of maturity of the programme implementation. To make all the programmes successful and provide quality healthcare services that are accessible to all, it is imperative that we have adequate number of skilled and motivated Human Resources (HR).

The innovations in governance, decentralized planning and flexible financing have enabled many changes, including an unprecedented expansion of health workforce. The Central government leads the formulation of guiding principles, policies and strategies based on global evidence and provides technical assistance to the States. Health being a State subject, State governments are responsible for implementation.

## 1.1. Purpose of the Guidelines

The overall Human Resources for Health (HRH), including all regular, contractual, outsourced and any other, is a State subject. From time to time, brief directives have been issued to assist the States regarding management of NHM HRH. However, now at the behest of the States, consolidated guidelines are being shared only to assist States in their HRH management.

These guidelines have evolved through the practices of the last 15 years of NHM. A guideline, that is to guide 36 States and UTs of varied population, levels of health service delivery, different socio-cultural and economic contexts, can provide only the broad principles and guidance which will continue to change with changing context and maturity of implementation. We will continue to update the guidelines as the policies and processes that shape the practices of human resources in health Sector keep evolving.

The States are encouraged to take assistance from these guidelines and adopt/adapt them as per their population health needs, community requirements, disease burden and socio-cultural and economic contexts. All processes, job descriptions, formats etc. given in these guidelines are only indicative and are suggestive in nature. These guidelines come at a time when the COVID-19 pandemic has come as a reminder that management of HRH within the public Health system is of utmost importance. We expect that the following chapters shall serve as a reference for the States to develop a well-rounded Human Resources Policy, based on their specific context and need.

# Human Resource for Health under NHM

Health workforce is one of the fundamental elements required for accelerating, achieving and sustaining the progress of any health programme. The National Health Mission (NHM), over the last 15 years, has added approximately 4.5 lakhs additional human resources in the country with the aim of providing quality healthcare services to the community.

The National Health Mission supplements Human Resources for Health who are directly engaged in healthcare service delivery as well as the ones who are engaged in administering various programmes. Broadly, based on the nature of work, Human Resources for Health under National Health Mission may be categorised into the following:

## 2.1.1. Service Delivery

This includes the staff who are directly involved in delivery of health services and are placed at the health facilities. For example: Medical Officers/Doctors, Staff Nurses, Auxiliary Nurse Midwives (ANMs)/ Multipurpose Health Workers (MPWs), Laboratory Technicians, Counsellors, etc.

Service Delivery staff also includes the staff providing health care services outside of the health facilities such as the staff of Mobile Medical Units, Rashtriya Bal SwasthyaKaryakram (RBSK) etc.

## 2.1.2. Programme Management (PM)<sup>2</sup>

The NHM has Programme Management Units (PMUs) to facilitate planning and implementation of all programmes under it at National, State and District levels. All the HR placed at the Programme Management Units and/or are engaged in performing administrative or managerial functions at the health facilities or other associated institutions like Training institute etc. constitute the PM Staff. They may be categorized into two broad groups:

- a) **Managers and Supervisors:** This includes all the functionaries of Programme Management Units (PMU) who are directly involved in planning, monitoring and supervision of programmes such as Nodal Officers, Programme Managers, consultants, etc.

<sup>2</sup> Programme Management cost must not exceed 9% / 14% (for smaller NE states and UTs) of the total RE of NHM

- b) Administrative Staff: This includes the staff performing administrative tasks to support the managers and supervisors such as the programme coordinators, accountants, administrative assistant etc.

### 2.1.3. Support Service

The HR under support services include Data Entry Operators, support staff<sup>3</sup> such as ward orderly, security staff, cleaners, cook, care takers, drivers etc. To the extent possible, these are to be engaged under NHM through outsourcing.

### 2.1.4. Other HR

The staff that cannot be readily categorised in the three categories i.e., service delivery, programme management and support services are included in this category<sup>4</sup>. For example, the trainers, Bio-Medical Engineers, Refrigerator Mechanics etc.

3 As per IPHS 2012 services of Mali, Dhobi, Waste handler, Aya, Peon, OPD Attendant, Ward Boys, Parking attendant, Plumber, Electrician, Mistry, Vehicle drivers, Security and Sanitary workers etc. are to be through outsourcing

4 The categorization in IPHS or ISCO (International Standard Classification of Occupations) should be adhered to, so that analysis and comparisons etc. across States as well as across countries are possible.

# HRH Policy, Principles and Strategies

HRH Policy should be guided by the overall National Health Policy, State Health Policy (if any) and NHM framework. While the broad principles drawn from the core principles of National Health Policy and NHM remain the same for all the States/UTs, the HRH policy and its strategies will have to be tailor-made for each State to suit its context.

While the current guidelines have been made specifically for the NHM employees, the States may apply the principles and processes to entire health workforce. HR policy and the strategy cannot be only for NHM, it must be holistic and preferably for the entire sector, or at least for the public sector. As it has to be specific to the requirement of the State, it is expected that the States will develop HRH policy and Strategic Plan for themselves with the help of the technical experts, including those at national level in NHM.

As these guidelines are specifically for NHM, we have adopted the NHM principles as our guiding principles and all HRH interventions and activities shall be guided by the NHM framework document:

## 3.1. Human Resource Principles in NHM

1. HR under NHM is to supplement the existing HR: regular and others who have been engaged through other sources of funding. NHM human resources should not replace any existing HR.
2. Human resources under NHM belong to the health system and the facilities. The HRH is to be considered holistically in an integrated manner and never in programmatic verticals.
3. Under NHM in a state, there should be parity in salary. Salaries for similar qualifications, skills, and workload should be fixed keeping in view the experience and length of service. Inter-state comparison is not possible because of unequal labour market conditions.
4. All required labour laws, pertinent regulations of the land and rules, including minimum wages act and equal opportunity for employment are to be followed by all the States/SHS.

5. The HRH requirement should be guided by the Indian Public Health Standards (IPHS) and case load.
6. Efforts should be made to place HR effectively using the concept of rational placement and towards increasing the efficiency along with sustained quality. States/SHS are to provide supportive supervision and mentoring for capacity building.
7. Local recruitment criteria should be adopted and preferably there should not usually be any concept of transfer under NHM<sup>5</sup>.
8. Decentralized recruitment, wherever feasible, should be preferred but there should be no compromise on the quality of skilled HR. Competency-based skill test for front line workers is mandatory.
9. Ensure motivation for the human resources by recognition, reward, and work towards finding the fit between the job description and the job holder.
10. States must encourage learning and promote an environment of respect and dignity at the workplace for employees, management, programme beneficiaries and other stakeholders alike.
11. Professionalize the management of human resources. HR practices must be implemented in a way that the workforce perceives them to be fair. Move from mere administration and establishment to development of human resources.

### 3.2. Key Strategies

Some key strategies applicable to all States /SHS include:

- Ensure availability of HR by creating adequate number of regular posts as per the IPHS in the long run and using NHM posts in the short to medium term to fill critical gaps.
- Address shortages of skilled workers in remote, rural areas and other under-served pockets through appropriate monetary (differential salaries and allowances) and non-monetary incentives.
- Ensure that personnel looking after Human Resource Management of HRH are trained in human resources, organization behaviour etc./ are specialised in the field.
- Establish special recruitment board to streamline and fast-track the recruitments in public health system, including in the Health department and in the NHM.
- Reward performance through recognition and Performance based Incentives (PBI) for individual and teams as per the framework developed by the State based on contextual customisation of the norms given from the national level from time to time.
- Establish Human Resource Management Information System (HRMIS) for better planning and quality monitoring.
- Create Specialist Cadre (if not already in place) to strengthen the secondary care.
- Create Public Health Cadre to strengthen primary care.
- Strengthen Programme Management Units and create institutional structures to ensure better coordination between the Directorates and the NHM and develop appropriate programme management capacities.

<sup>5</sup> Preference may be given to the existing NHM staff with requisite qualification and experience in case s/he applies for any post in other District/ Block as there could be a personal reason for relocation.

- Revive and strengthen the Apex body for training in the State, viz. SIHFW, thereby improving training systems to maintain the continuum of enhancement in skills and knowledge of the workforce.
- Undertake long term futuristic human resource planning, taking into consideration the demography, disease burden, and expected case load in the facilities.

Over the years of NHM implementation, the MoHFW and States have agreed to abide by some norms which govern the management of human resources of NHM on day to day/ year to year basis. These guidelines are the collation of directives sent earlier and have been developed based on discussions that have taken place in various meetings over the last few years. As HRH policy and strategy are state-specific and may take some time to develop, these guidelines in the meanwhile will help the States streamline, tackle and manage the human resources under NHM.

*Note: All HR related policies of the State, including relating to code of conduct, sexual harassment, Workplace violence, Grievance Redressal etc. must be made available in public domain through NHM/State Health Department Website.*

# Modes of Engagement under NHM

The engagements under NHM are mostly contractual. They are essentially to make the deficient skills and human resources available to the government system. Based on the duration, and the primary agency which engages the HR, the engagements under NHM could be broadly categorised into following:

## 4.1. Engagement of Staff on Contractual Basis

The recruitment of staff in NHM at the State/District level, in general, is on a fixed tenure (contract) basis. The primary agency in such cases is the State Health Society (SHS) or the District Health Society (DHS). The duration of the contract could be for three years at a time or till the age of retirement (as has been done by a few States namely, Bihar). The year-to-year continuation would be based on the performance of the individual and availability of the funding under NHM. The States should make sure that all appointments are done through competent authority, against the set requirement, with formal contracts detailing all the roles and responsibilities, performance benchmarks as well as terms and conditions of the engagement with the NHM.

## 4.2. Engagement through Outsourcing

The IPHS and the National Health Mission encourages the engagement of HR for support services (such as data entry, cleaning, security etc. where the staff is either semi-skilled or unskilled) on outsourcing basis. This helps in reducing the burden of recruitment of personnel for such services. The SHS however must ensure that the staff engaged through outsourcing are paid at least the minimum wages and all benefits as per the extant laws such as PF and ESI etc. The selection of the agency should be based on the efficiency of services, quality of people, and lower service charges for the agency but not at the cost of salaries of the outsourced staff engaged.

Some States have also engaged most of the Human Resources through outsourcing to do away with the hassles of recruiting and managing Human Resources. This should not become a common practice in case of service delivery HR. However, if this is the case, the agency engaging the HR is the employer and not the SHS/DHFW. While the suitability of the mode of engagement depends on the context, the State must protect the human resources from any



predatory practices of the outsourced agency. Outsourcing of SNCU staff in Chhattisgarh has worked well in case of staff nurses.

### 4.3. Engagement through Deputation

When recruiting for any position, especially in programme management, where a specialized technical and thematic role is to be performed, the existing government employees may also be allowed to apply. If such candidates fulfil the requirement of the posts, they will be placed directly on the shortlist but will still go through the same formal selection process applicable to all other applicants. Finance is one such area where regular cadre officers with requisite qualifications and experience of handling financial matters have proven useful in NHM.

The 'deputation to SHS' is considered as any other case of deputation outside parent department and if required NHM pays for the salary and associated benefits. The parent department remains the original employer, and services are taken by the SHS.

The deputation process is annexed with the document.

### 4.4. Engagement of Interns/Fellows

If the SHS so intends, it can engage interns (for a period of 1 month to 1 year) or fellows (for a period of 1 year), who would work dedicatedly on a subject/ topic of their internship under the guidance of the programme officer concerned. The topic chosen should be such that it is mutually beneficial, for the intern as well as the programme. Interns could be given a nominal stipend or could be engaged free. In cases where stipend is paid, the SHS should follow a selection process to choose the right intern/fellow (Refer Section 5.3.4.).

### 4.5. Engagement of Retired Government Officials

There is also the provision of engaging retired officials for consultancy services under the NHM where their specific technical skills and strengths are required. In such cases, the services of the retired officials are generally till the date they attain the age of 65. Instead of having such posts under NHM, it is desirable that the retired officials be given assignments with milestones to achieve in specific cases as required by the programme or SHS. However, hiring retired human resources on a routine basis and without any particular technical area should be avoided.

The total monthly consolidated fee and the pension drawn by the consultant should be decided as per the HR Policy of the State (usually pay minus pension and not more than the last pay drawn by official, calculated at the current rates of Dearness Allowance).

### 4.6. Engagement of HR through Partner Agencies

In cases where a programme is to be implemented by any partner agency at initial stages and is later to be handed over to the Department of Health for further implementation or rolling out, a standard contracting guideline should be prepared. It should detail the conditions in case of any possibility for any subsequent engagement of HR through the NHM. This would ensure sustainability as terms of engagement of various partners may vary from that of NHM. Remuneration of HR should be carefully decided keeping in view the financial implications at the time of transition, e.g., e-VIN staff.

## 4.7. Other Engagements

There could be engagements that are on per case basis, per session basis, or where the HR is contracted-in on special terms or the services are contracted out (in cases where infrastructure required is not available in the public health facilities but is available in private non-profit or for-profit institutions), along with the requisite skilled HR. E.g., engagement of specialists, engagement of auditors, legal experts etc. NHM provides the flexibility to the SHS to engage the requisite skilled HR by all the modes possible, provided it helps to further the goals of NHM/ NHP.

# Recruitment

As the National Health Mission is expected to help the States supplement their existing Human Resources for Health, the recruitment by SHS/DHS should ensure transparency, speed, and quality. Recruitment must be based on merit and should take into consideration the required skill, knowledge, qualifications and demonstrated experience.

Recruitment should be the responsibility of the Human Resource Cell. The necessity of the position, budget availability and approval from the competent authority should be ensured before the recruitment process is initiated. In the NHM, all posts and budget approved are mentioned in the Record of Proceedings (RoP) of the meeting of National Programme Co-ordination Committee (NPCC). The HR Cell should ensure that all recruitment and overall number of personnel are within the prevailing budgetary norms, structure and ratios. The time taken from the identification of vacancy to the announcement of results should not be more than 45-60 days. The States with good and robust HRH practices do it routinely, run about 4 rounds of recruitment drive in a year and do not have more than 10% of vacancy at any given point of time.

## 5.1. Bodies Conducting Recruitment

Ideally the recruitment of NHM HR should follow the same procedure followed for the recruitment of regular cadre and should be carried out by the same organization/ institution/ body that administers regular cadre appointments. Generally, the regular cadre recruitments for gazetted officers are carried out by the State Public Service Commission (PSC). However, as the PSC has the load of all the departments, the recruitment cycle in most cases is exceedingly long, ranging from 1.5 Years to 3 or more years. To overcome this problem, some of the States such as Tamil Nadu and Haryana have constituted a separate Recruitment Board for Health. The board takes care of both the regular as well as the contractual recruitment for all health cadres. All the States are encouraged to establish such a board. Meanwhile, the State Health Society may conduct recruitment under the NHM as per its norms approved by the Governing Body or as per its by-laws.

While more specialized recruitments are done at the State level, NHM gives flexibility for decentralization of recruitment. Any recruitment, as per the district's requirement and capacity could be conducted at the district level following the laid down processes. Local decentralized recruitments are faster and better in the cases of specialists through walk-in Interviews and

support staff (such as cooks, cleaners, etc., mostly hired through an agency). Presence of a medical college or a nursing school in the district makes it easier for the district to recruit the passing out students.

State may determine as to which posts could be recruited by the districts, based on their capacity to undertake the recruitment processes. The HR cell should support and monitor the process even if the recruitment is delegated to the district. While the responsibility can be delegated, the accountability remains with the State.

To enable speedy and professional recruitment, the State or district may use the empanelled Recruitment agencies of MoHFW or empanel their own agencies<sup>6</sup>. These agencies would carry out the recruitment up to the interview as per the State's/District's directions. While the responsibility can be delegated, the accountability remains with the State.

## 5.2. Recruitment Committee

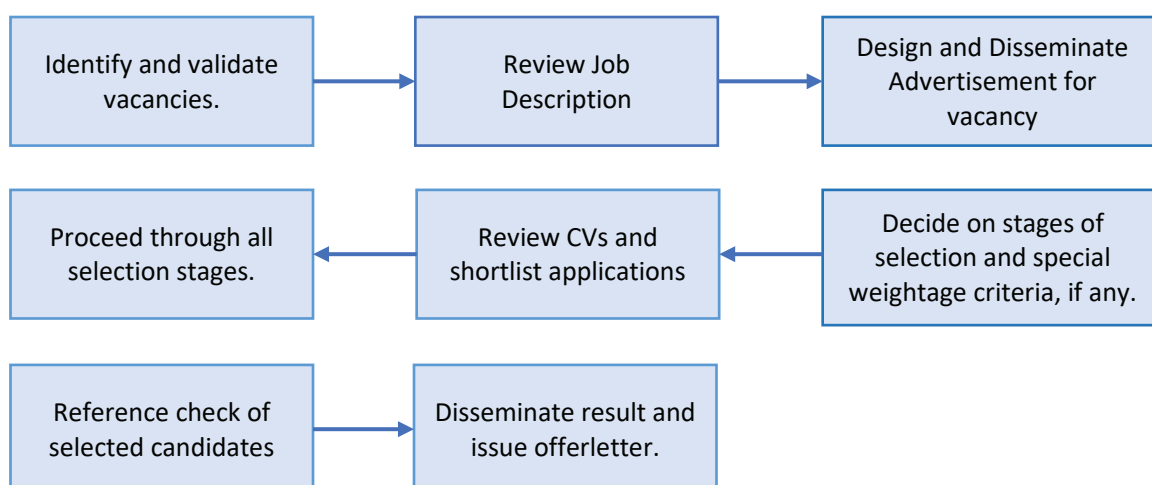
In order to bring objectivity in recruitment, there should be a provision of recruitment Committee to guide the matters of recruitment. The committee could be of 3-5 members depending on the strength of SHS and should be drawn from HR cell and programme divisions and may be rotated each year. The committee should ideally have a provision to invite a member from the programme division whose recruitment drive is on the anvil. Such a provision should be kept even in cases where the recruitment is through a recruitment board.

## 5.3. Process of Recruitment

The recruitment process should be relevant, aptitude/ skill-based, transparent and equitable. It should be applied consistently to all candidates.

The key steps in the process of recruitment are shown in Exhibit 1 and explained below:

**Exhibit 1: Key steps in the Process of Recruitment**



### 5.3.1. Identification and Validation of Vacancies

A systematic process to identify vacancies and requirement of HRH should be periodically undertaken, ideally once in every quarter. Potential transfers, promotions, retirements and

<sup>6</sup> Refer: Annexure 2: Compendium of Letters 'Dated: February 8th, 2017, JS(Policy) Guidance note to States on empanelled recruitment' [http://nhm.gov.in/New\\_Updates\\_2018/Om\\_and\\_orders/HR/D\\_O\\_JS\\_\(Policy\)\\_dt\\_8th\\_Feb\\_2017\\_Guidance\\_note\\_to\\_States\\_on\\_empanelled\\_recruitment\\_agencies\\_20.pdf](http://nhm.gov.in/New_Updates_2018/Om_and_orders/HR/D_O_JS_(Policy)_dt_8th_Feb_2017_Guidance_note_to_States_on_empanelled_recruitment_agencies_20.pdf)

attrition are some of the reasons that lead to vacancies. A fully functional Human Resource Management Information System (HRMIS) and an HRH strategic plan make the process of identification of posts evidence based and smooth.

### 5.3.2. Review Job Description (JD) / Terms of Reference (ToR)

Any position created under National Health Mission should have clearly defined roles and responsibilities along with measurable deliverables. A job description or ToR defines the key responsibilities, requirement and qualifications for a specific position and creates a benchmark for performance review. A detailed job description (JD) of all staff should always be available with the HR Cell. However, prior to any recruitment, the JD/ ToR should be reviewed by the HR Cell and the programme division (if associated) as the specific requirements of the same position may change over time depending on the phase of the programme, changed disease burden or needs of the health system in general. The most recent guidelines of the programme should be referred. In case of any confusion, the State should get in touch with the Division in MoHFW or HRH team in NHSRC.

Any preferential qualifications or experience required for a certain position may be added to the ToR. This is to be done where some specific qualification or relevant experience is expected to equip the candidates to do a better job in that specific role. For example, an additional degree in finance may be desirable for the role of Programme Manager or prior experience at district level may be desirable for a state level position or an additional course on critical care by an MBBS Doctor may prove more useful if the post is for Emergency services.

The reviewed JD/ToR should then be again approved by the competent authority as per the HR Policy of the State. The process of designing Job Description/ToR and a few sample ToRs are annexed for reference. At this stage, the approved ToR can be handed over to the recruitment agency, in case the State is engaging any, to carry out the recruitment.

### 5.3.3. Advertisement for Vacancy

A precise and clear job advertisement is essential to attract the right people for the job. The advertisement should evoke interest and a desire to work with the National Health Mission among the prospective talent pool. It should clearly mention the Job Position/title, JD/ ToR, salary, application fee (if any), details of application form to be submitted, last date and time of submission, mode of submission, address and all other relevant details including the reservation norms followed in the State. The State should develop a standardized application format where the relevant parts as applicable to the post could be filled by the candidates. As the internet facilities and ability to use it are still uneven in the country, the State should ideally give the option of filling the application form online and send soft-copy or hard copy through registered post/speed post/courier- as is convenient to the applicant.

A short advertisement should be published in one National English and two leading local newspapers (State / District's Local Language) with the details of the website and its links. The detailed online version of the advertisement should be put on NHM National / State / District and Health Department website along with other relevant job portals. The State may also circulate the digital advertisement and the web link on social media. The advertisement must remain in public domain for at least 15 days or more for its proper dissemination and give adequate time for the applicants to apply.

The HR Cell or the agency (as is the case) should be responsible for coordinating the process of receiving, collecting, and managing the applications. It must be ensured that the applications are date-stamped, numbered and filed properly- both in physical format and online database.

### 5.3.4. Stages of Selection

It is essential to identify the pertinent stages of selection for the specific post/position. This ensures that people with desired knowledge, skills and competencies are hired. The Stages should ideally be pre-determined for each category of HR. However, any fine tuning, if at all required, must be done by the HR Cell before the last date of submission of applications.

Depending on the job position, multiple stages of selection may ensue, ranging from written test, skill test, computer proficiency test to personal interview. Different weightage may be given to different selection stages as per the skills and competencies required for the job. The following exhibit shows some commonly used stages of selection for service delivery, programme management and technical experts engaged in NHM.

**Exhibit 2: Some of the common Stages of Selection**

Stages	Service Delivery	Programme Management	Technical Experts/ Master Trainers/ senior posts
Written Test	✓	✓	✓
Skill Test	✓		
Computer Proficiency		✓	
Group Discussion		✓	
Presentation		✓	✓
Personal/ Panel Interview	✓	✓	✓

Details on some stages of selection have been annexed for reference. States may also consider existing national or state level reputed entrance examinations such as PG NEET for selection in NHM. While the State is free to choose the pertinent technique/tool to assess the candidates, a competency-based skill test for service delivery staff, especially the ones who are to serve as frontline workers, must be conducted.

The Stage of Written examination may not be required in case of specialists where the number of candidates are less and available posts/ vacancies are more.

### 5.3.5. Review CVs and Shortlist Applications

Usually, the first step is to screen the ineligible applications. The shortlisting criteria for the applications should be developed as per the requirements mentioned in the advertisement along with the reservation norms applicable in the State / District. This would prune-out ineligible and below par applications.

The list of shortlisted candidates should be put on the State/district website as well as the SHS/ DHS office. The candidates should be informed by email and other appropriate means about the selection process, date and timings.

### 5.3.6. Proceed through the Selection Stages

Candidates should be selected on the basis of the pre-determined criteria. The core team of recruiters and interviewers should be well trained in transparent selection procedures.

The ratio of applicants shortlisted to the number of posts vacant depend on many factors and an informed decision must be taken for the same. In cases where there are lot of applicants, especially in service delivery the screening should be strictly based on competence and skills.

Better skilled and competent candidates, i.e., candidates acquiring more points in these tests should be selected. The HR cell should try to anticipate the number of likely applicants and make adequate provisions in the advertisement as well as the selection process to choose the best. If need be and if there are more candidates with higher qualifications who are better skilled and competent, priority could be given to better qualified candidates.

In case of specialists and super specialists (if any), there are not many applicants and hence having a fixed ratio in these cases may not be possible.

In case of programme management posts, more caution must be taken as not only the posts are limited but since most programme management incumbents are responsible for supervising others, the selection has to be such that along with technical skills, capacity to manage, and proven experience of delivering expected results are also assessed.

In case of qualifications such as MBA or MPH or Health Management, there are good number of applications. In such cases, if the basic criteria are met, the applicants shortlisted to posts ratio could be kept at 5:1<sup>\*7</sup>.

In cases of programme management posts that are heads of division and may require higher qualifications and much more experience, a minimum ratio of 3:1\* should be aimed. In case of single applicant for a crucial post, it is better to readvertise. However, this clause should not be applied to specialists and super specialists as their availability is limited.

The final candidature should be established based on cumulative assessment score as per the weightage from all the stages of selection.

As the last step in selection, the documents and certificates submitted by the candidate as proof of the qualifications and experience should be verified. It can also be done by an outsourced agency, which should co-ordinate with the university /institutions to get it verified. However, selection result could be declared even if document verification is pending with the condition that selection will remain valid only if the documents are found correct during the verification.

### 5.3.7. Reference Check

Once the final list of candidates is prepared, a reference check may be carried out before the final job offer is made. All candidates at the final stage of selection should be asked to provide contact details of two or three professional references not related to them.

These references should be contacted by the HR Cell to enquire about factors such as workplace behaviour, reasons for leaving, health matters, any disciplinary proceedings etc. regarding the selected candidates. A reference check ensures that the selected candidates are competent enough and can adjust well in their new workplace.

*Note: It is imperative that reference check be carried out for all supervisory posts.*

### 5.3.8. Final Result and its Dissemination

After necessary referral checks, the final results should be submitted to the competent authority to seek approval for its public release. The results should be published in the SHS/ DHS website and health department portals in which the advertisement had been published.

All selected candidates should also be sent an official email, requesting them to complete the joining formalities and convey their joining date along with a copy of the offer letter for

<sup>\*7</sup> Only suggestive, based on expert opinion and large-scale recruitments

conveying acceptance of the same. If required, they also could be contacted on phone after the final results have been published and put on the website.

A detailed list of contents of Offer letter is annexed for reference.

Waiting List: A Waiting lists should be kept which should remain valid for a period of one year after the result has been declared. Waitlists are useful in finding substitutes and avoiding delays/ additional costs in case the successful candidate is not able to join.



# Appointment and Onboarding

## 6.1. Joining Formalities

The formalities and the processes of appointment and onboarding should be simple and make the incumbent feel welcome. The aim should be to provide adequate information to make their work and assimilation in the team easy.

### 6.1.1. Appointment / Offer Letter

On the day of joining, the new employees should get the original appointment letter (of the same offer letter that had been sent on email after selection). The appointment letter should then be signed by the employee and the employer (SHS/DHS). The original copy of the letter should be handed over to the employee and a copy should remain with the employer. The appointment/ offer letter must include the designation of the post, place and date of joining, details of reporting officer, duration of the contract, remuneration/ honorarium offered (including information about tax deduction) and TA / DA as applicable. The contents of the contract along with a model contract are annexed for reference.

Ideally the HR cell should develop a set of documents and forms as a joining kit. The kit should have a checklist for joining that should be fulfilled by the HR cell and once all the activities are completed, the checklist should be signed by the HR cell, the appointee/ incumbent, and the supervisor.

### Documents for Verification

It is imperative that all required documents (including address proof) of the candidates are collected and sent for verification on the day of joining.

### Personal Details, Bank Account and Email Id

The employee details should preferably be uploaded on the Human Resource Management Information System. The bank account details etc. should be taken, and the employee may be registered on PFMS for salary purposes.

An official email id should be created for each employee for the purpose of all official communication (if applicable and in use).

The new employee should be introduced by someone from the HR cell to her/his immediate team members. The new employee should also be shown the designated workstation.

### 6.1.2. Issuance of Identity Card

An Identity Card should be issued to the new employee. Along with name, designation, photograph, it should also have blood group and emergency contact number.

In case of misplaced or stolen I-card, information should be registered at Police Station and such information should also be shared with the issuing office.

### 6.1.3. Attendance

The new employee should be registered on the biometric-based attendance system (or the manual system). The attendance should be linked with the monthly salary preparation of the employee.

## 6.2. Orientation

New recruits should get a brief orientation to their new workplace and the organization. This helps in acclimatizing them to the new team, the work being done at the new organization and the expectations to be met.

A peer-mentor or a buddy may be provided to the new recruits for a specific time-period to get them settled in their new role.

A structured induction or orientation programme of half a day or one day must be provided to the new employee within a month of joining. Induction should cover all three aspects: 1. administrative rules and processes, 2. overall induction to NHM and SHS/DHS, 3. programme or role specific induction.

## 6.3. Probation

All employees engaged with the SHS/DHS remain on probation for a period of three months, which may be further extended for another three months, if needed. The same should be conveyed to the new employees on their day of joining (along with the written intimation on the appointment/offer letter).

Confirmation after the probation period remains at the discretion of the SHS/DHS, based on the performance review done by the immediate supervisor and verified by the HR cell. The HR Cell must ensure that all probationers get a letter of confirmation or of extension of probation (as the case may be) at the end of the probation period.

The probation period may or may not be applicable for the short-term consultancy positions of less than a year.

# Capacity Building/Capacity Development

Emerging health needs determine the Health System priorities. Therefore, to respond to the ever-evolving requisites of the system, skills and knowledge of HRH need regular upgradation. Capacity Development aims to enhance the existing skills and knowledge in a way that helps the organization and the Mission achieve their goal through the human resources.

Capacity development inter alia includes all types of orientation and trainings, improvement in institutional processes and its management. Here we will focus on the training part.

In the NHM we primarily require 4 types of training programmes viz. induction/orientation training, in-service skill development training, programme-related skill enhancement and training, including multiskilling. Training not only improves the productivity and efficiency of the organisation but also enables employees to perform their role more effectively, acquire additional skills, in turn facilitating their career advancement as well.

## 7.1.1. Induction Training

Induction training helps employees understand their roles and expected contribution at their workplace. The induction programme should be an informative and enriching experience for the new incumbent, helping them understand the culture of the organisation. The employees should be sensitized about the health challenges of the State/District and the various population groups and stakeholders, especially the vulnerable sections of society. Employees of NHM should have an empathetic approach towards addressing these challenges.

The induction training could be of three to five days at a stretch, encompassing knowledge dissemination regarding NHM, its programmes and, administrative and financial processes. It is expected that by the end of the induction training programme, the employees shall have a good working understanding of the health system and overall dynamics of working within the organization, including its culture, communication processes, both external and internal, work environment and its beneficiaries.

While the overall responsibility of initiating the induction training would be of the State HR cell, depending on the recruiting body and the place of posting, others (e.g., DHS or Regional teams etc) would also contribute. An example of an induction schedule for M&E Officer is annexed for reference.

### 7.1.2. In-Service Training

Apart from the knowledge and skills acquired during pre-service training, there should be a systematic programme of in-service training to update/ upgrade the skills of the staff so that they provide quality health services to the public. It also helps to better equip them to deliver their specific roles and responsibilities in their current position. Ideally the skill training should be undertaken after the employee has undergone competency- based skill test. There could be refresher courses or additional training to reorient and revise the set of skills. Wherever possible, this should be accompanied by a mechanism for supportive supervision and mentorship so that employees feel adequately supported.

The duration of in-service training could vary from cadre to cadre. While a simpler knowledge-based training could take only one to three days, more technical skill-based training could take weeks, such as Skill Birth Attendant (SBA) training for three weeks, Emergency Obstetric and Neonatal care (EmONC) training for 16 weeks etc.

### 7.1.3. Programmatic Training

These training programmes will be designed and scheduled by the programme divisions at the State level with the help of SIHFW, SHSRC, development partners, regional and District teams primarily using the MoHFW guidelines contextualised to suit the State requirements. These training programmes will train the programme managers and service delivery human resources in new programme, as well as to update the knowledge about the existing programmes and any changes in those programmes.

### 7.1.4. Skill Enhancement Training

In addition to the previous three kinds of training programmes, there should be many training programmes for employees at each level for enhancement of their skills. These programmes should be available to the employees on a choice basis, and information on all available training programmes, its duration, timing, place, and institute/organization offering the training should be made available by the HR cell at the beginning of the financial years.

Skill enhancement training would include multiskilling training such as EmONC, Life Saving Anaesthesia Skills(LSAS), New born and Child Health, which are of longer duration and may result in new posting at CHC or higher-level institutions. Application from the employee/doctors for such training along with consent to be posted to new institution (if required) should be obtained before the training.

A few training programmes for each level should ideally be linked to performance and be available on demand to those employees who have performed well on the job and want to further improve their performance. The HR Cell should develop the process and details regarding the same. At a minimum, 5-day training/seminar, with a training fee of Rs.10,000/-(TA/DA, accommodation charges extra) for a training relevant to their work area should be allowed.

## 7.2. Nodal Agency/Apex Body for Capacity Building

Capacity Building/ training is a continuous process and requires robust mechanisms and institutions for its design and implementation. An apex body for training should be identified at the State level. Ideally a strengthened and vibrant SIHFW should be looking after the training. In case it is not possible, State must identify any equivalent body(e.g., SHSRC). The Apex body should then identify training sites and nodal centres in all the Districts of the State.

Note: Ideally, the training of primary health care functionaries should be conducted within the district. Residential arrangements and transport facilities for field visits should be provided. Other allowances including TA/DA for training should be provided as per the State norms and policy and, should be similar across all programmes.

The Apex Body should undertake regular assessments of all trainings programmes that have been conducted to evaluate their efficacy (pre and post training assessments) as well as effectiveness (evaluation of actual practice in the field) and review them for any course corrections.

### 7.3. Training Management

To establish a well-equipped training mechanism, state should develop an annual training plan using Training Needs Assessment process and subsequently publish a training calendar. The process of undertaking Training Needs Assessment is annexed for reference.

At each stage all available training programmes, skills/knowledge they impart, duration, timing and institutions/ places where they are available, should be mentioned by the SHS. All the employees who are in the A+ or A category in their appraisal should be awarded with at least one training programme of their choice.

The training planned and undergone by an employee should be synchronised with the comprehensive Human Resources Management Information System to create a database for training requirements/ schedules of all employees. As and when the training programmes get completed, such a database should facilitate identification of HRH who have undertaken a particular type of training. It should provide clear indication of which trainings each employee has undergone along with the total number of HRH who undertook a particular training. This shall provide a complete progress report of trainings at all levels. No separate TMIS (Training management Information System) should be run. It must be a module of HRMIS.

A database of identified master trainers should also be prepared within the HRMIS so that they can be called upon to deliver training programmes as per the annual schedule. If there is a paucity of trainers within the state, external consultants may be contracted, or an external agency may be hired to conduct the training in accordance with pre-agreed criteria and guidelines.

The SHS must be ready to build and develop the capacities of its human resources, provide mentoring and supportive supervision wherever required.

### 7.4. Training Material

It must be made sure that employees get easy access to videos/ modules of trainings conducted for future references as well. All the training material can be made readily available through the State NHM Website.

# Employee Management

Employee management begins with the joining of the employee and continues throughout the entire work life of an employee within the organization.

## 8.1. Contract Management

Contract Management is crucial for smooth management of Human Resources in any organisation. Contract Management has to be done from the moment an employee joins the NHM till the time s/he leaves as per the NHM Policy of extension/termination or voluntary basis. It should aim at protecting the rights of the organization as well as the employee and make the conditions of the job and job responsibilities clear. Contracts need to be altered and signed afresh if any clause or job responsibility is changed during engagement.

In NHM, the SHS /DHS can give a three years' contract. The contract renewal is based on annual performance appraisal (refer section 8.2.). Some States have assured job till the retirement age (generally 60 Years) for the NHM employees, provided they continue performing well at their job.

## 8.2. Performance Appraisal

Performance appraisal process is an essential part of Human Resource Management in terms of assessing the improvement in skill, knowledge, ability and overall performance of the staff. All staff under NHM should undergo performance appraisal annually/ biannually and the State should develop assessment and grading mechanism to provide objectivity to the assessment process.

At the minimum, States must appraise and track the performance as per the minimum performance benchmarks shared by MoHFW. Those who do not reach the minimum benchmarks should be asked for explanation and if in next 6 months their performance does not improve, their contract may not be extended. Odisha has added a clause that such employees will not be eligible to apply for any post under NHM for the next 2 years.

Beyond the contract extension on fulfilment of the minimum performance benchmarks, States should also incentivise good performance of the employees with higher increments.

In addition to the increments that are budgeted on an average at 5% and could be given between 0 to 15% based on the State policy, the SHS/State could also make provisions for performance-based incentives. States should have a good framework and robust monitoring mechanism to monitor the performance in order to institute a performance -based incentive that is fair to all.

Process of performance appraisal under NHM is annexed for reference.

### 8.2.1. Rewards and Recognition

The HRH division of NHM should come up with ideas to recognize and reward the employees for their good performance and contribution to the mission.

The reward need not be monetary. Non-monetary incentives like recognition of good work in annual meetings, a letter of recognition/commendation by the Mission Director or sending the employees for exposure visit or training in their work area could motivate the employees.

For outstanding performance, the programme team or an entire unit or the facility team could be recognized and rewarded. A token amount could also be given for organizing a small team get-together.

### 8.3. Expenses Policy

The Expenses Policy should be based on the state specific policy or as per the decision approved by the Executive Committee and Governing Body of the State Health Mission. Specifications related to travel and utility reimbursements are provided in the annexure along with the process of claiming expenses.

### 8.4. Leave Policy

The State NHM leave policy should be applicable to all NHM Staff. If the state NHM has not adopted any leave policy, it may adopt the leave policy of its Health and Family Welfare department.

Maternity and Paternity Leave, and benefits for NHM employees should be commensurate with the policy followed for departmental employees of the State.

Leave application form and approval procedure is annexed for reference.

#### 8.4.1. Public Holidays

The fixed gazetted and restricted holiday list for the calendar year would be circulated to all staff members at the beginning of the year and will be available on demand from the HR Cell of NHM.

### 8.5. Employee Welfare

The States should take measures to develop innovative mechanisms to ensure that the employees have a vibrant, motivating, supportive and safe working environment- both physically and mentally- that can help improve employee morale and productivity by reducing stress, job burnout, and absenteeism.

The States may explore the idea of introducing cafeteria/ recreational room and regular access to counselling sessions for encouraging sound mental health for all HRH. An annual get



together with social/cultural programmes should be planned. Such event that develops informal interaction and bonding should be encouraged.

### 8.5.1. Occupational Health, Stress Management and Employee Safety

The health and safety of the workforce should be of vital concern to the management. Effective plans have been demonstrated to reduce the number and severity of work-related injuries and illnesses.

Facility In-Charge/ head of the organization should take adequate steps to:

- Identify health and safety risks and ensure that the health and safety plan is relevant to the needs of the facility
- Develop hazard prevention (including fire, biomedical and chemical hazard) and control to reduce the number of hazards in the facility.
- Ensure supply and availability of appropriate personal protective equipment.
- Records of all staff work-related injuries must be kept.
- Train and educate (new and current personnel) and designate specific staff to undertake responsibility for overseeing work safety and health policies and their implementation.

### 8.5.2. Living Quarters

The States should make sure that living quarters/lodging facilities are provided to the HRH, especially in rural and difficult areas, close to the health facilities. The State may also explore the option of providing creche facilities for women working with the NHM in the Block/District/State offices.

## 8.6. Compensation/Salaries and other Benefits

### 8.6.1. Compensation/salaries and Increments

Salaries under the National Health Mission (NHM) should facilitate attraction and retention of talent and therefore offering competitive salaries is important to attract qualified HRH, motivate the existing staff and reduce turnover. The salary disbursement process of the NHM Staff should be carried out through the Human Resources Management Information System (HRMIS) in an automated manner.

Principles and processes for salary determination and annual increments are annexed for reference.

Note: In the Record of Proceedings (ROP), in principle 5% of the total HR budget is approved as lump sum for increment. The increment for individual staff is to be decided by the State. It may range from 0% to 10% and should be linked to performance appraisal process.

The annual increment may be a maximum of 15% in case the State is undertaking HR Rationalization.

Rationalization of compensation should be undertaken, wherever required. The process of rationalisation is annexed for consideration.

## 8.6.2. Allowances, Incentives and other Benefits

### Hardship Allowance

The State may decide to divide its area into categories based on the level of difficulty in providing healthcare services and provide differential salary or allowance to motivate staff for serving in these difficult areas for a fixed tenure. For example, based on the level and nature of difficulty, Odisha has categorised all its health institutions into 5 types from V0 to V4<sup>8</sup>, taking into consideration their vulnerability status. Place-based incentives are provided to the HRH based on the category in which the particular health institution falls. Such differential incentive system can be adopted by other states.

Ultimately, the definition of 'hardship' should be contextualized by each state as per their specific conditions, including but not limited to factors such as physical geography, political or civil unrest, disaster prone conditions, availability of good housing, schools etc.

Note: States may also identify about 10-20% facilities/places that are most difficult to access and offer a fixed tenure posting for 2-3 years, after which staff can be posted for at least 3 years in their chosen place and facility. It would be preferable to mention the date of relieving from the hard posting and the next place of posting to their chosen facility in the initial posting/transfer order itself, thereby generating confidence in the adherence to this policy and assuring staff of their fixed tenure in difficult/hard areas.

### Incentives

Performance-based incentives may also be designed and implemented by the State keeping in mind the long-term sustainability of contractual staff. These should be closely monitored and evaluated at regular intervals. The incentives could be designed in two ways – individual performance-based or team performance-based.

Performance-based incentives should be linked to a robust appraisal system. States should develop specific, measurable, realistic and time-bound key performance indicators to assess the performance of the HRH. The indicators must be valid, attainable and relevant.

In some states, employees are nominated for advance trainings or specialized training courses related to the programme they are working with. We may add these as one of the possible ways of promoting retention.

### Experience Bonus

Employees may become eligible for experience bonus after completion of either 3 years or 5 years of service under NHM. Regarding experience bonus, please refer to ASMD's letter (DO. NO: Z-18015/23/2018-NHM-II-Part 1) dated 18 December 2018 (annexed in Compendium of Letters).

### Other Benefits

Apart from salaries, allowances and incentives, some States have also made provisions for accidental and life insurance. It is mostly done either by including NHM employees in the State insurance scheme or making a corpus or paying a part of the insurance premium.

During the COVID pandemic, frontline workers were covered under the Pradhan Mantri Garib Kalyan Package: Insurance Scheme for Health Workers Fighting COVID-19.

<sup>8</sup> Place Based Incentive.pdf (dhsodisha.nic.in)

Many States have also introduced free health check-ups for all the employees in the District Hospitals once a year.

## 8.7. Posting and Transfer

Under the NHM, recruitment is done for a particular position at the State, Division, District or Block level, and it could be at a Health Service delivery institution or at the State apex body. The employees should be given the choice of their posting to the extent possible. Only if there is no vacancy, should the nearby district choice or second choice be given. In case of healthcare providers, the husband and wife should be co-located or as near each other to the extent possible and any other family members maybe given preferential posting in the same district and if possible same block.

NHM employees should not be subjected to any routine transfers. Transfers may be entertained in certain exceptional circumstances such as spousal colocation and mutual transfer where both the employees at same level or the job that requires same educational qualifications want the transfers because of personal/family reasons. Another exception could be transferring an employee to a post which is vacant because the employee so desires because of family/personal reasons.

*Note: While considering the mutual transfer of specialists, it should be ensured that there is no mismatch of specializations and no irrational deployment as a result of such transfers.*

### 8.7.1. Career Progression

In NHM, any person having the requisite qualification can apply for higher level posts and be selected for it. NHM staff should ideally be given weightage of marks (up to 25%) for the jobs within health department as they are well-versed with the nature of work, organizational culture and the Mission. In many States, block level managers have progressed by becoming district and regional managers and reached the level of State managers.

States should also consider recognition and promotion for exceptional employees, and the EC and GB of the SHS may deliberate on such promotions for its approval. It may not become a routine affair but it is good to have such a provision.

Career advancement tracks for all cadres of employees should be available so that employees are aware of the options available to them with the NHM/health department.

## 8.8. Grievance Redressal Policy and Procedure

NHM recognises the right of its employees to express their grievances and seek solutions concerning disagreements arising from working relationships, working conditions, employment practices or differences of interpretation of policy etc. that might arise between the management and the employees.

A Grievance Redressal Committee shall be formed at different levels to cater to grievances/matters of their concerned jurisdiction. The States should create an online as well as offline facility through the HRMIS for receiving grievances<sup>9</sup> of the employees and ascertain time bound resolution. Grievances must be treated with utmost confidentiality and sensitivity.

Redressal mechanism procedure is annexed with the document.

<sup>9</sup> Complaints pertaining to Sexual Harassment shall be referred to Anti-Sexual Harassment Committee

## 8.9. Employee Separation

The State should have a clear policy on employees leaving the State/ District Health Mission due to any reason, including resignation, termination of contract, superannuation etc. A detailed procedure, entailing the specified notice period, return of office supplies/ ID Card, exit interviews etc., should be laid out for the process and formalities of employee separation/exit.

Exit interviews must be conducted with all the employees exiting the organization. The inputs obtained should be used to improve the working of the organization and retention of skilled and motivated employees.

A suggestive format on the process of exiting the NHM is annexed for reference.

## 8.10. Tools for HR Management

### 8.10.1. Human Resource Information Management Systems (HRMIS)

HRH, being the most important health systems building block that drives the other blocks, needs a comprehensive, reliable, up to date (preferably real time) and transparent information system. Various studies across the globe have shown that a well-functioning HRMIS could give good evidence base on which host of decisions, ranging from availability to productivity, could be taken. A robust HRMIS can improve the HRH management manifolds and facilitating rational posting decisions is one of the most important areas of support provided through a well-functioning HRMIS.

A comprehensive HRMIS facilitates a linkage among all activities pertaining to HR Management. Ideally, following aspects must be incorporated in the HRMIS:

- **HR Planning-** It includes information that could assist human resource mobilisation, career planning, succession planning and inputs for skill development.
- **Hiring of Human Resources-** It includes advertisement module, recruitment sources, applicant's profile, selection procedure, appointment and placement.
- **Personnel Administration-** It includes records of each employee regarding leave, travel, transfer, deputation, promotion and increments.
- **Training and Development-** It provides information for designing course material, training schedule, training module, training methods and appraisal of training programme etc.
- **Appraisal-** It contains information about performance rating of employees, which serves as an input for contract renewal, promotion, increments etc.
- **Pay Roll-** It consists of information concerning salary, incentives, allowances, taxes etc.

The State HR cell / Specialized Unit should be responsible for the development of HRMIS either through coordination with National Informatics Centre (NIC) or internal NHM resource or by hiring an IT agency. It must be ensured that the HR handling HRMIS at all levels are provided orientation and proper handholding as and when the System is transferred to them for operation.

**Guidelines of MEITY must be followed.<sup>10</sup>**

<sup>10</sup> Refer: eHRMS Manav Sampada  
Microsoft Word - ManavsampadaHRMS Write up.docx (ehrms.nic.in)

# Code of Conduct

The Code of Conduct is designed for the guidance and protection of staff. Every office under the State Health Mission should formulate an appropriate Code of Conduct Policy, following the laws and regulations of the land in general and uphold the principles of NHM. A breach of such policy may well result in disciplinary action, even dismissal and, in cases so requiring, criminal prosecution.

## 9.1. Contents of Code of Conduct Policy

The Code of Conduct Policy of the State should, in detail, underline accepted behaviour in the workplace relating to:

- accepting gifts and entertainment
- procuring contracts (or any other financial misconduct)
- conflict of interest
- use of organizational information that is not available publicly without prior permission in any form, including social media
- use of official infrastructure for personal use
- any political affiliation or association with any political organisation/ entity
- intellectual property
- concurrent employment or business at another place
- absolute non-tolerance for sexual harassment
- conduct after exit

*Note: As part of the Code of Conduct, no staff shall be allowed to take up any other paid employment, even if part time, whilst employed with the NHM unless permission from the Mission Director is obtained in writing.*

## 9.2. Breach of Code of Conduct

The Policy should define malpractice and fraud, actions indicating favouritism and bias at the workplace and should lay down penalties in the instance of any breach.

Any observation that indicates abuse, fraud, malpractice, or any other breach of the Code of Conduct must be reported with supporting evidence.

## 9.3. Anti-Harassment Committee

NHM is committed to an environment of mutual appreciation and respect. The organization and its members must be gender sensitive and socially inclusive.

In case of any incident of harassment, the staff members should be encouraged to report such incidents at the earliest.

All offices under NHM fall under the jurisdiction of THE SEXUAL HARASSMENT OF WOMEN AT WORKPLACE (PREVENTION, PROHIBITION AND REDRESSAL) ACT, 2013.

As per the Act<sup>11</sup> every workplace shall, by an order in writing, constitute a Committee to be known as the “Internal Complaints Committee” at all levels of administrative units or offices.

It is the duty of the State to ensure the formation of the committee and follow the procedure laid out by the Act for resolution of complaints of sexual harassment at the workplace.

<sup>11</sup> The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 | Legislative Department | Ministry of Law and Justice | GoI

# Suggestive Procedural Formats

## Deputation Principles and Process

Deputation may be undertaken to ensure that the NHM has an available pool of suitable personnel to occupy critical positions in the organization, whenever required.

## Deputation Process

State may appoint staff on deputation under NHM for a specific period of time as decided by Executive Committee/ Governing Body. The Mission Director shall be the approving authority for all staff appointed on deputation to the SHS. No posts under service delivery HRH to be appointed on deputation under NHM.

While publishing the job advertisement, it shall be explicitly mentioned that the positions are also open for the in-service candidates on deputation. The eligibility and shortlisting criteria should follow the same procedure as for external candidates. The job applications of the in-service candidates would be routed through their respective Head of Departments to the HR Cell along with the applicant's No Objection Certificate (NOC). In case, they are deputed at District level, it is expected of them to formally visit and introduce themselves to the chairperson of the District Health Society i.e., the DM.

The staff should be engaged through contract with State Health Society on deputation as per the standard term of engagement. Once appointed, the deputed staff will be governed by the rules and regulations of the SHS. All staff on-deputation must undergo performance appraisal as per the laid guidelines. In general, the period of deputation is to be a maximum for three years or as prescribed by the EC/ GB, subject to the outcome of the performance appraisal.

## Terms & Conditions

The terms and condition for staff on deputation is detailed below:

- The MD (NHM) shall be the approving authority for all staff appointed on deputation to the NHM.
- **Mode of Appointment:** Staff on deputation would be engaged through a contract,



detailing the terms of engagement with NHM. Once appointed, the deputed staff will be governed by the rules and regulations of NHM.

- **Duration & Contract Renewal:** In general, the period of deputation would be for three years or as prescribed by the state, subject to the outcome of the performance appraisal conducted every year.
- **Performance Appraisal:** All staff on deputation should undergo performance appraisal as per the Staff Performance Management Policy of NHM.
- **Remuneration:** The contract should mention the consolidated salary per month and applicable deductions (TDS etc.) clearly.
- **Leave:** The contract should mention the number of days of annual leave available for employees during their period of employment.
- **Service Entitlements:** The contract should also mention the TA/DA and other entitlements the candidate is allowed as per the state policy.
- The location of posting and the reporting authority should be clearly identified.
- The contract should also include the roles and responsibilities related to the deputed position.
- **Termination/ End of Contract:** The posting of the contractual staff on deputation may be terminated if their performance is found unsatisfactory or if any criminal offence is proved against them in a court of law. They can also be terminated as a consequence of disciplinary action. They could also end their contract voluntarily and on termination, the staff on deputation will return to their parent department.

## Process of Designing Job Description/ToR

A well-designed ToR helps to streamline employee management. While developing or reviewing of JD /TOR, the following critical components should be taken into consideration:

- a) **Position Details:** This section must include general information about the job including job title/ position, job type of engagement, department, place of posting, compensation to be paid, number of posts, job description summary.
- b) **Job Responsibilities:** This section should provide details of scope and level responsibility associated with the job. This is to include: 1) Key Accountabilities/ Key Functions; 2) Detailed list of tasks to be performed associated with each of the key functions; 3) Performance Standards: to convey expectations of the job and provide a basis for measuring performance.
- c) **Key Requirements:** This section should outline the knowledge, skills, experience and standards required for entry into the job. This should also include other conditions applicable to the job.

Position Details	
Job Title	Role Name: e.g., Finance Manager, Doctor, Staff Nurse
Department	Department under NHM: SHS-RNTCP Division; District Hospital
Place and location of Posting	Specify facility/ place where the position is established: district hospital/ district/ block along with the geographical location
Type of Engagement	Job Type: e.g., Contractual, Full-time, Part-time, time period of probation, if applicable
Position Number	Number of position available: e.g., 4 posts of Staff Nurse at district hospital; 2 posts of staff nurse at CHC xyz
Compensation	As per state norms and compensation approved in the Records of Proceedings of PIP
Job Responsibilities	
Roles and Responsibilities	Detailed description of tasks to be performed: e.g., prepare budgetary reports, analyse expenditure, monitoring
Reporting Structure	Mention the immediate reporting officer and other reviewing officers.
Performance Standards	Performance expectations associated with Key Functions: e.g. complete administrative tasks on time; reviewing and analysing financial reports, carry out routine supervision and monitoring of accounts staff at district/ block level
Key Requirements	
Required Qualification	What qualifications, licences or education level is need: e.g. Bachelor's Degree in Finance, Accounting or related field (MBA preferred)
	This may be further detailed into essential and preferred/ desirable
Minimum Experience Level	What type and how much experience is needed: e.g., 3 years of previous experience in a similar role/ sector
Desired skills and competencies	List skills needed for the job, including any technical or interpersonal skills: e.g., ability to work well in a large team, presentation and analytical skills, knowledge of Microsoft Office Suite

Other key information that could be elaborated during the development of JD / TOR:

- a) Background information regarding NHM in the state could be mentioned along with sources for further information regarding the Mission
- b) **Relaxation:** The State Selection Committee may wish to consider appropriate relaxations for candidates. For example, this could include current employment under NHM for more than 3 years or candidates working in inaccessible or hard to reach areas under NHM. In addition, the committee could decide to set local selection criteria for situations where attrition is particularly high. The flexibility provided by the NHM may be used to provide suitable financial and non-financial incentives.

## Sample ToRs/ Roles and Responsibilities

### Service Delivery Staff

#### Job Responsibilities of Specialist – Obstetrics & Gynaecology

- Provide OPD and IPD services related to Obstetrics & Gynaecology.
- Provide quality maternal care in the diagnosis and management of Antenatal, Intranatal & Postnatal period of normal and abnormal pregnancy including emergencies
- Round the clock management of normal and complicated deliveries.
- Round the clock provision of Caesarean deliveries facilities for all indicated cases.
- Management of assisted vaginal deliveries.
- Provision of Safe abortion services.
- Diagnosis and management of all types of gynaecological problems.
- Perform Hysterectomy and other gynaecological surgeries in indicated cases.
- Administration of Inj. Iron sucrose and blood transfusion in indicated cases.
- Provision of ultrasonography services, in case the specialist, is trained in ultrasonography.
- Counselling and provision of family planning services and performing family planning operations (conventional and laparoscopic).
- Management of common neonatal problems.
- Post-Partum management.
- Provision of services regarding RTI/STI and infertility.
- Perform duties regarding MTP/MVA services.
- Providing services under PMSMA and other maternal health schemes.
- Conducting Maternal Death Review both in the institution as well as by home visits.
- Management of Medico-Legal Cases (Rape, Sexual Assault, etc.).
- Work with other physicians and surgeons to decide on treatments and procedures before, during, and after surgery.
- Follow standard operating procedures / clinical protocols, evidence-based practice, rational prescription of medication while treating the patient.
- Collect, record, and maintain patient's information, such as medical history, reports, and examination results; from patients, family members, or other medical professionals.
- Provide consulting services to other physicians.
- He/ she shall be responsible for all the special cases referred to her/him; providing curative prescription/ procedures/ surgeries; based on need, emergency and availability of resources.
- Refer the patient to other specialists/ practitioners when necessary.
- Disclosure of any crime to the police, if during the course of treating the patient, he/

she becomes aware of the commission of or intention of committing an offence.

- Keeping himself/ herself up to date with recent medical developments, new drugs, treatments and medications, including complementary medicine.
- Maintaining the highest standards of ethical practices by adhering to the code of medical ethics.
- Following the Acts, Rules, Regulations made by the Central/ State Governments or local administrative bodies or any other relevant act relating to the protection and promotion of public health.
- Provide Teaching/ Training/ Capacity building to doctors and other healthcare staff, as and when required.
- Participate in community outreach programmes (e.g., anaemia prevention, pulse polio, save the girl child, adolescent and school health, etc.) throughout the year.
- Ensure his/her attendance and availability at the Hospital/ Health Centre, during prescribed working hours, as well as during emergency duty hours, as ordered.
- He/ she must also ensure availability to the hospital over the residential landline/ mobile, whenever necessary.
- Monitor the patient progress or response to treatments.
- Visit patients admitted under speciality treatment under her/him in the hospital, at least twice a day and as many times as required.
- Address concerns or answer the questions that patients or their relatives have about patient's health and well-being
- Ensure that each patient under her/his care, receive a bed-head ticket, on which all instructions regarding diet and treatment and complete details about the patient's medical history and diagnosis, are recorded.
- Ensure that all instructions written by her/him on the bed-head ticket/ OPD-ticket are strictly complied with by concerned staff, reporting any laxity or carelessness to the Superintendent/ Officer-in-charge of the Hospital/ Health Centre, for appropriate action.
- Ensure that sick patients under her/his care are properly treated and cared for in every way.
- S/he must resolve observed deficiency (if any) in the patient care immediately or report it in writing, to the officers-in-charge.
- Ensuring the privacy and confidentiality of the patients.
- Provide health and wellness advice to patients, parents or guardians, and community members concerning diet, exercise, activity, hygiene, and disease prevention.
- Ensure patient-centric and patient-friendly attitude (through smiling face; by being compassionate, polite, humble, etc.) and thereby enhance the patient's satisfaction and cooperation in the provision of quality of healthcare.
- Ensure that all instruments and equipment of the Hospital/ Health Centre kept under her/his charge, are carefully stored, and guarded against deterioration from whatever cause.
- Submit all indents and reports to the Superintendent / Officer-in-charge of the hospital/ Health Centre, on the prescribed date and time.
- Supervise patient care personnel.

- Managing nursing staff and delegates tasks appropriately.
- Prepare government or organizational reports on disease statistics, workforce evaluations, or the medical status of individuals.
- Write-up all books and records as directed by the Superintendent /Officer-in-charge of the Hospital/ Health Centre.
- Obey orders of the Superintendent/ Officer-in-charge, on all matters connected with the patient and management of the Hospital/ Health Centre.
- Any additional responsibility, as assigned by the authority.

### Job Responsibilities of Specialist – Paediatrician

- Provide paediatric OPD and IPD services.
- Attend all paediatric emergencies.
- Examine infants, adolescents, and young adults to evaluate their mental and physical growth and development. Also, Plan and execute medical care programmes for this.
- Examine paediatric patients and interpret diagnostic tests to obtain information on the medical condition and determine a diagnosis.
- Prescribe or administer treatment, therapy, medication, vaccination, and other specialized medical care to treat or prevent illness, disease, or injury in infants and children.
- Monitor paediatric patients' conditions and progress and re-evaluate treatments as necessary.
- Explain procedures and discuss test results or prescribed treatments with paediatric patients and parents or guardians.
- Attend all high-risk deliveries, caesarean and attend to all neonatal emergencies.
- Round the clock management of paediatric Indoor patient department, Sick New Born Care unit (SNCU) / New-born stabilization Unit (NBSU)/ Paediatric Intensive Care Unit (PICU) and Nutritional Rehabilitation Centre (NRC)/Comprehensive Lactation Management Centres(CMTC) in the district.
- Management of cases of Protein Energy Malnutrition and Vitamin Deficiencies.
- Perform the review of Child Death.
- Follow standard operating procedures / clinical protocols, evidence-based practice, rational prescription of medication while treating the patient.
- Collect, record, and maintain patient's information, such as medical history, reports, and examination results; from patients, family members, or other medical professionals.
- Provide consulting services to other physicians.
- He/ she shall be responsible for all the special cases referred to her/him; providing curative prescription/ procedures/ surgeries; based on need, emergency and availability of resources.
- Refer the patient to another specialist/ practitioners when necessary.
- Attend and treat all medico-legal cases without an unnecessary referral.
- Disclose crimes to the police, if during the course of treating the patient, he/she becomes aware of the commission of or intention of committing an offence.

- Keeping himself/ herself up to date with recent medical developments, new drugs, treatments and medications, including complementary medicine.
- Maintaining the highest standards of ethical practices by adhering to the code of medical ethics.
- Following the Acts, Rules, Regulations made by the Central/ State Governments or local administrative bodies or any other relevant act relating to the protection and promotion of public health.
- Provide Teaching/ Training/ Capacity building to doctors and other healthcare staff, as and when required.
- Participate in community outreach programmes such as school health programme, pulse polio programme, breastfeeding promotion in the community.
- Ensure his/her attendance and availability at the Hospital/ Health Centre, during prescribed working hours, as well as during emergency duty hours, as ordered.
- He/ she must also ensure availability to the hospital over the residential landline/ mobile, whenever necessary.
- Monitor paediatric patient progress or responses to treatments.
- Visit patients admitted under speciality treatment under her/him in the hospital, at least twice a day and as many times as required.
- Address concerns or answer the questions that patients or their relatives have about patient's health and well-being
- Ensure that each patient under her/his care, receive a bed-head ticket, on which all instructions regarding diet and treatment and complete details about the patient's medical history and diagnosis, are recorded;
- Ensure that all instructions written by her/him on the bed-head ticket/ OPD-ticket are strictly complied with by concerned staff, reporting any laxity or carelessness to the Officer-in-charge of the Hospital/ FRU/ CHC, for appropriate action.
- Ensure that sick patients under her/his care are properly treated and cared for in every way.
- S/he must resolve observed deficiency (if any) in the patient care immediately or report it in writing, to the officers-in-charge.
- Ensuring Privacy and Confidentiality of the patients
- Provide health and wellness advice to paediatric patients, parents or guardians, and community members; concerning diet, exercise, activity, hygiene, and disease prevention.
- Ensure patient-centric and patient-friendly attitude (through smiling face; by being compassionate, polite, humble, etc.) and thereby enhance the patient's satisfaction and cooperation in the provision of quality of healthcare.
- Ensure that all instruments or equipment of the Hospital/ Health Centre kept under her/his charge, are carefully stored and guarded against deterioration from whatever cause.
- Submit all indents and reports to the Superintendent / Officer-in-charge of the hospital/ Health Centre, on the prescribed date and time.
- Supervise patient care personnel.



- Managing nursing staff and delegates tasks appropriately.
- Prepare government or organizational reports on disease statistics, workforce evaluations, or the medical status of individuals.
- Write-up all books and records as directed by the Superintendent /Officer-in-charge of the Hospital/ Health Centre.
- Obey orders of the Superintendent/ Officer-in-charge, on all matters connected with the patient and management of the Hospital/ Health Centre.
- Any additional responsibility, as assigned by the authority.

### Job Responsibilities of Specialist – Anaesthetist

- OPD (Pre-Anaesthetic check-up Clinic and Pain Clinic) and IPD services.
- Attending OT sessions.
- Provision of anaesthesia and perioperative medical services for patients as required.
- Perform bedside Pre-Anaesthetic check-up for the patients who cannot move or be shifted from their beds.
- Provision of appropriate post-operative care, with special attention to acute pain and adverse effects which may be related to anaesthesia.
- Work with other physicians and surgeons to decide on treatments and procedures before, during, and after surgery.
- Provide services as an intensivist, in management of critical cases.
- Clinical management of acute pain services and participation in pain medicine units where applicable.
- Provision of acute resuscitation services for all emergencies.
- Management of patients in the intensive care unit, particularly when there is non-availability of General Medicine specialist.
- Management of anaesthesia in remote locations, as and when required, like surgical camps, surgeries conducted at SDH/ CHC, etc.
- Follow standard operating procedures / clinical protocols, evidence-based practice, rational prescription of medication while treating the patient.
- Collect, record, and maintain patient's information, such as medical history, reports, and examination results; from patients, family members, or other medical professionals.
- Provide consulting services to other physicians.
- He/ she shall be responsible for all the special cases referred to her/him; providing curative prescription/ procedures/ surgeries; based on need, emergency and availability of resources.
- Refer the patient to other specialists/ practitioners when necessary.
- Attend and treat all medico-legal cases without an unnecessary referral.
- Disclosure of the crimes to the police, if during the course of treating the patient, he becomes aware of the commission of or intention of committing an offence.
- Keeping himself/ herself up to date with recent medical developments, new drugs, treatments and medications, including complementary medicine.

- Maintaining the highest standards of ethical practices by adhering to the code of medical ethics.
- Following the Acts, Rules, Regulations made by the Central/ State Governments or local administrative bodies or any other relevant acts relating to the protection and promotion of public health.
- Provide Teaching/ Training/ Capacity building to doctors and other healthcare staff, as and when required.
- Participate in community outreach programmes.
- Ensure his/her attendance and availability at the Hospital/ Health Centre, during prescribed working hours, as well as during emergency duty hours, as ordered.
- He/ she must also ensure availability to the hospital over the residential landline/ mobile, whenever necessary.
- Monitor the patient progress or response to treatments.
- Visit patients admitted under speciality treatment under her/him in the hospital, at least twice a day and as many times as required.
- Address concerns or answer the questions that patients or their relatives have about patient's health and well-being.
- Ensure that each patient under her/his care, receive a bed-head ticket, on which all instructions regarding diet and treatment and complete details about the patient's medical history and diagnosis, are recorded.
- Ensure that all instructions written by her/him on the bed-head ticket/ OPD-ticket are strictly complied with by concerned staff, reporting any laxity or carelessness to the Superintendent/ Officer-in-charge of the Hospital/ Health Centre, for appropriate action.
- Ensure that sick patients under her/his care are properly treated and cared for in every way.
- S/he must resolve observed deficiency (if any) in the patient care immediately or report it in writing, to the officers-in-charge.
- Ensuring the privacy and confidentiality of the patients.
- Provide health and wellness advice to patients, parents or guardians, and community members; concerning diet, exercise, activity, hygiene, and disease prevention.
- Ensure patient-centric and patient-friendly attitude (through smiling face; by being compassionate, polite, humble, etc.) and thereby enhance the patient's satisfaction and cooperation in the provision of quality of healthcare.
- Ensure that all instruments or equipment of the Hospital/ Health Centre kept under her/his charge, are carefully stored and guarded against deterioration from whatever cause.
- Submit all indents and reports to the Superintendent / Officer-in-charge of the hospital/ Health Centre, on the prescribed date and time.
- Supervise patient care personnel.
- Managing nursing staff and delegates tasks appropriately.
- Prepare government or organizational reports on disease statistics, workforce evaluations, or the medical status of individuals.

- Write-up all books and records as directed by the Superintendent /Officer-in-charge of the Hospital/ Health Centre.
- Obey orders of the Superintendent/ Officer-in-charge, on all matters connected with the patient and management of the Hospital/ Health Centre.
- Any additional responsibility, as assigned by the authority.

### Job Responsibilities of Staff Nurse

#### *Duties & Responsibilities related to Patient Care*

- S/he will assess the needs of the patients in the ward and make a nursing care plan for all patients consulting with ward sister.
- S/he will give direct patient care (bed making, changing of bed sheets, mouth care, back care, bed bathing, hair wash, changing of position, etc.) and allotted responsibility to her/him by the ward sister.
- S/he will provide attention to pressure points of the patient four hourly, or more frequent.
- S/he will ensure the provisions of bedpans, urine pots, and hot water bottle to the patient.
- S/he will fulfil all basic needs (hygienic need, nutritional need, etc.) of the patients.
- S/he will provide comfort to the patient and maintain the safety of the patient (universal safety precaution).
- S/he will talk to pre-operative patients to reduce their tension and give them confidence.
- S/he will take over the charge from duty nurse of previous shift, regarding patients (bed to bed), instrument supplies, drugs etc. and handed over the same to the next shift.
- S/he will carry out procedures of admission, discharge and transfer of patient of the ward.
- S/he will take care that discharged patients goes home with a proper understanding of the follow-up procedures and details of the diet, medication, exercise, etc.
- S/he will be responsible for taking a history of the patient.
- S/he will be especially responsible for the care of acutely ill patients in the ward.
- S/he will prepare and assist in the diagnostic procedure in the ward.
- S/he will provide minor dressing in an emergency.
- S/he will administer drugs by injection upon written order of the Doctor.
- S/he will learn the handling of special gadgets & equipment.
- S/he will distribute diet, milk, etc.
- S/he will meet normal and special nutritional needs of the patient and give a special type of feeding, e.g., gastrostomy feed, nasal feeds, etc., supervise the distribution of diet and report, if necessary.
- S/he will maintain a duty room in readiness for all time.
- S/he will be responsible for observation of the patient's condition, take prompt action

and report to the concerned medical officer.

- S/he will give health education to the patients and their family members under care.
- S/he will make records of all procedures of her/his patients and keep them up to date.
- S/he will maintain case papers, investigation reports, etc. in the proper file or board. She will take care that all reports get attached to the correct case paper. E.g., temperature charts, in taking output charts or any special chart maintained.
- S/he will take care that case papers are not allowed to be handled by anyone except the doctor-in-charge of the patient. This is specifically for medico-legal cases.
- S/he will render pre-operative, post-operative and intensive care to the patient in any critical care unit.
- S/he will provide assistance and instructions to the patients and their relatives.
- S/he will collect, label and dispatch the specimens.
- S/he will escort the patient to and from the department.
- S/he will receive the reports and give it to the patients as well as inform the doctor.
- S/he will listen to the patient's problems and help to solve them through various means.
- S/he will ensure the privacy of the patients (e.g., close curtains or doors during exams and procedures, discuss confidential or sensitive information only with appropriate parties, etc.)
- S/he will respect the cultural and religious differences of the patients.

### *Duties & Responsibilities related to Operation Theatre*

- S/he will be responsible:
- To maintain the aseptic environment of the Operation Theatre
- To autoclave the instruments, gloves, linen, equipment, etc. of the unit
- To check and verify all the electrical points for working condition
- To lay out the trolley according to the operation list
- To prepare the trolley of anaesthesia
- To check Oxygen, Carbon dioxide, Nitrous Oxide, emergency drugs, crush trolley etc. & keep them ready at hand
- To carry out the instruction of O.T. Sister when necessary
- To assist the Surgeon and Anaesthetic in operation theatre
- To count all instruments and mops before closing the wounds
- To monitor the condition and take care of the patient during the operation and postoperatively in the recovery room
- To act as O.T. Sister in her/his absence
- To fumigate the O.T. room periodically

### *Duties & Responsibilities related to MCH Care*

S/he will be responsible to provide antenatal, intra-natal, postnatal care as taught in the nursing curriculum.

- Labour Room Management –
- To carbolise the labour room daily
- To autoclave instruments, gloves, linen, equipment, etc. of the unit
- To keep ready the confinement trolley & episiotomy tray, forceps tray etc.
- To keep ready emergency drugs, fluids, equipment, Boyle's apparatus and other necessary gadgets
- To keep ready the baby resuscitation table, warmer, oxygen, pre-warmed linens etc. for the resuscitation of the new-born
- To check all electrical points are in working condition
- To assess the progress of labour by using partograph
- To assist the doctors in any procedure the labour room
- To supervise the students and ancillary staff
- To conduct normal delivery and provide care to the new born
- To resuscitate new-born if needed
- To repair episiotomy wounds accordance the laid down policy of the hospital.
- To carry out the duties as instructed by the unit in-charge
- To follow the waste management protocol
- To maintain a Logbook properly
- To maintain all records, outcome indicators as per LaQshya guidelines

### *Duties & Responsibilities related to Critical Care Unit (I.C.U./ Burn Unit/ H.D.U./ S.N.C.U. unit)*

- To maintain the standard protocol of asepsis strictly
- To maintain the hand washing protocol, dress protocol as prescribed
- To autoclave and disinfect necessary articles, instruments, linen, gadgets, equipment, etc. and keep ready for use
- To check all electrical points, pipeline oxygen, inbuilt suckers for proper working condition
- To communicate with a concerned person for proper maintenance of the unit
- To carry out the instructions of the sister-in-charge as allocated by her
- To prepare the drugs, crash trolley, etc. properly
- To check Oxygen, Carbon dioxide, Nitrous Oxide etc. for proper use.
- To check monitor, ventilator, all life-saving gadgets for proper working condition
- To provide special care to the patient guided by the Medical Officer, e.g., endotracheal suction
- To fumigate the department periodically

- To keep records of all the procedures of the patient neatly

#### *Responsibilities related to Ward Administration:*

- S/he will ensure to make the ward clean and tidy, including the bed
- S/he will keep all articles well-arranged and maintain the inventory
- S/he will take the report, make bed to bed round at the time of changing of the shift of the unit
- S/he will maintain all records and mandates
- S/he will orient the new patient with the ward
- S/he will help the ward sister for the supervision of work of Group D allotted in the ward for maintenance of cleanliness and sanitation
- S/he will make a list of patients belongings and keep in safe custody, according to the laid down policy of the hospital
- S/he will keep a sub-stock of drugs, linen and other supplies for ward maintenance
- S/he will maintain poisonous/ scheduled drugs registered
- S/he will sterilize all articles, maintain all equipment, gadgets, electrical connections, light, fan etc.
- S/he will indent drugs, diet, and other supplies if necessary
- S/he will vigilant to protect the patient from injury or accident by providing side rail
- S/he will write a report of each shift and sign the report after checking it
- S/he will assist the ward sister in orientation programme of new staff and students
- S/he will accompany with doctors and senior nursing officers during 'ward round'
- S/he will help ward sister in indenting and checking of drugs, supplies and maintaining inventories
- S/he will be deputed for the ward sister during her/his absence
- S/he will hand over the charge and will take charge of the shift
- S/he will prepare surgical supply, bandages and splint
- S/he will take care of disinfection of linen, beds, floor and bedpans

#### *Responsibilities regarding Teaching of Students*

- S/he will assign patients to student nurse keeping in mind the level of knowledge of the student, the learning objective and need of the patients
- S/he will provide direct supervision over patient care by the students in the ward
- S/he will teach, demonstrate, supervise and guide nursing procedure performed by student Nurses
- S/he will instruct students correct ways of handling bedpans, urinals, sputum cups, kidney trays, soiled dressings, bandages, binders, linens, etc.
- S/he will teach and demonstrate methods of disinfection, cleaning and biomedical waste management
- S/he will guide and help the students in giving health education to the patient of the ward.

- S/he will participate in the clinical teaching programme of the student nurses
- S/he will assist and participate in any in-service education programme

### *Others*

- S/he will assist in orientation of new staff nurses
- S/he will participate in staff education and staff meeting
- S/he will participate in professional development activities
- S/he will maintain good interpersonal relations with all other staff
- S/he will give information about MLC cases to Head / Officer in charge
- S/he will maintain the BPL patient's records & DOTS patient's record
- S/he will co-operate in activities related to the National Health Programmes
- S/he will carry out field works as and when assigned to her/him, in addition to medical care
- S/he will ensure safe disposal of biomedical waste
- S/he will keep herself/himself up to date with nursing knowledge by taking part in in-service education programmes
- S/he will perform any other duty that may be assigned to her/him from time to time

### **Job Responsibilities of Lab Technician**

#### *Sampling and Testing*

- He/ she will receive and process samples.
- He/ she will draw blood samples for testing (primarily by performing vein punctures).
- He/ she will label specimens/vials accurately and distribute them to the appropriate departments/ processing centres at the recommended transportation condition.
- He/ she will prepare samples/slides for testing using various types of laboratory equipment.
- He/ she will conduct all the necessary laboratory investigations (urine, stool, blood, sputum, pregnancy, swabs, semen, smear preparation and staining, RTI/STD, biochemistry, Electrolytes, pH, bacterial culture, clinical, serological tests like VDRL and Widal test, card-based tests, others)
- He/ she will perform routine microscopy
- He/ she will perform biochemical tests and analyses using electrophoresis or chromatography.
- He/ she will examine and analyse bodily fluids
- He/ she will perform blood grouping and crossmatching
- He/ she will perform anti-microbial susceptibility testing
- If required in certain cases, he/she will be expected to go to the field for sample collection (for fluorosis etc.)



### *Patient-Centric Care*

- He/ she will give instructions to the patient regarding sample collection
- He/ she will provide counselling to the patients regarding laboratory procedures whenever necessary
- He/ she will be friendly, courteous and sympathetic while working with patients.
- He/ she will write/ print and issue the laboratory reports to the patients
- He/ she will ensure that patient confidentiality is maintained at all times
- He/ she will collect feedback form from patients regarding laboratory work

### *Laboratory Stock Maintenance*

- He/ she will be responsible for the upkeep and routine maintenance of the instruments in the laboratory and update of instrument maintenance records
- He/ she will control laboratory equipment (pipettes, inoculating loops, test tubes, etc.) and adjust instruments to perform laboratory procedures
- He/ she will clean/sterilize and maintain work area and all lab equipment, accessories and supplies
- He/ she will make timely indents for chemical, reagents & equipment repairs
- He/ she will prepare chemical reagents, stains, solutions and biological media according to formulae
- He/ she will accurately label all reagents and other stock in the laboratory

### *Quality of Services*

- He/ she will take care of all quality assurance and quality control norms in the laboratory, including EQAS, IQAS
- He/ she will follow all safety protocols and standard operating procedures to maintain hygiene and for prevention of the infection

### *Data/Record Keeping*

- He/ she will maintain the data about all lab procedures
- He/ she will submit weekly/monthly reports of the laboratory work
- He /she will perform online data entry of medical tests, clinical results or any other programmes
- He/ she will maintain records of supplies, stock and investigations that are done

### *Knowledge/ Skill upgradation*

- He/ she will keep himself/ herself informed about new laboratory techniques.
- He/ she will participate in the development of new medical laboratory procedures and techniques.
- He/ she will participate in trainings, workshops and continuing education programmes.
- He/ she will keep himself/ herself updated regarding various guidelines on hospital infection control and management of spills (e.g., Mercury, Chemicals, Body fluids)

## Programme Management Staff

### Job Responsibilities of District Programme Manager (DPM)

- He/she will assist the Chairperson of the District Health Society (GB & EC)/ CMHO in planning and implementation of all the Public Health programmes in the district
- He/she will assist CMHO in preparing agenda, agenda notes, proceedings of the DHS and other meetings and follow up action on the decision taken
- He/she will prepare the District Health Action Plan
- He/she will coordinate and deal with all correspondence related to NHM at District level
- He/she will disseminate all Guidelines in respect of all programmes among all functionaries at all levels within the district
- He/she will circulate a copy of all the necessary reports/documents/minutes of the meetings to all related officers within the district
- He/she will create and maintain district resource databases for the health sector
- He/she will ensure distribution of / communication of Resource Envelope (along with physical and financial targets) (through District Accountant Manager) to all the health facilities in the district within \_\_\_\_ days from the receipt from the State
- He/she will assess training load and needs in consultation with the blocks/talukas, prepare training plans and organise district level training
- He/she will do monitoring and following up of health activities at all levels within the district
- He/she will ensure through regular follow-ups at district, block and below level that all the necessary reports of the district are prepared timely in the prescribed format.
- He/she will undertake necessary coordination with other divisions at district, block and below level; and coordinate all programmes running at district level, monitor underlying gaps and provide supportive supervision
- He/she will ensure that all data/reports of the district are regularly entered in different e-portals
- He/she will analyse all data/reports of the district, and take corrective measures for improving outputs of the district
- He/she will submit various reports to the State Programme Management Unit as and when required
- He/she will identify the cause of any unreasonable delay in the achievement of milestones, or in the release of funds, and will propose corrective action/solution to the problem.
- He/she will monitor the implementation of IEC/BCC activities in the districts.
- He/she will ensure that the meetings of all RKSs/VHSCs in his/her District organised in time, and will collect a copy of the minute of the meetings. (RKS/VHSC Member Secretary has to convene the meeting, but DPM will facilitate and ensure that the meetings take place in time).
- He/she will ensure timely renewal of HR Contracts for employee working under NHM.

- He/she will prepare an advance monthly work plan, including a tentative travel plan in consultation with CMHO.
- He/she will visit at least \_\_\_\_ Block/Taluka Health offices, \_\_\_\_ CHC, \_\_\_\_PHC, \_\_\_\_ HWCs in a month and submit field visit report to CMHO.
- He/she will coordinate the collection and distribution of NHM supplies/logistics to all health institutions in the district. He / She will also maintain the record related to these supplies
- He/she will develop strategies or plans to improve the quality of service provision to the people
- He/she will keep watch on the vacant position under District Health Mission, and inform appropriate authority to fill the vacant positions. When required, he/she will facilitate the recruitment process
- He/she will coordinate with respective monitoring division and conduct field- level studies to identify gaps for ascertaining intervention requirements and district action plan scope
- He/she will coordinate with development partners (aid agencies, UNICEF, WHO etc. & other NGOs) in the field and ensure convergence of programme activities
- He/she will liaise with other consultants/ Managers/ Officers/ Staff of the NHM programme at all levels
- He/she will perform any other role/duties that may be assigned by the competent authority

### Job Responsibilities of District Accounts Manager (DAM)

- He/ she will be responsible for the overall financial management of NHM funds released to the district
- He/ she will be responsible for the development of Annual Financial Plan and Budget for their district
- He/ she will be responsible for maintaining books of accounts and managing other finance-related aspects for the district Programme Management Unit
- He/ she will ensure the implementation and maintenance of PFMS in the district
- He/she will ensure disbursement the funds to all the health facilities of the district as per the guidelines
- He/she will maintain all necessary books of accounts, in accordance with prescribed guidelines
- He/ she will collect, compile, analyse and submit financial monitoring reports (FMR)
- He/ she will prepare and submit monthly/ quarterly /annual statement of expenditure (SoE) in prescribed formats
- He/she will ensure timely issue and submission of UCs for the utilized funds.
- He/she will manage the petty cash account of district and monitoring of it for all the health facilities of the district (if any)
- He/ she will ensure that reconciliation is done for all accounts under the district
- He/ she will ensure that salary and incentives are paid timely to all employees working under DHM

- He/ she will ensure timely deduction of TDS and submission of tax returns as per provisions
- He/ she will adhere to the system for periodic Internal Audit and established accounting system
- He/ she will ensure timely conduct of external audit for the facilities under the district
- He/ she will manage all the registers and records related to financial matters
- He/ she will be responsible for implementation, maintenance and updating of computerized financial system/PFMS
- He/she will do field visits regarding the financial functioning of the district with supportive supervision
- He/she will manage the accounts of the Society, including grants received from State Society as well as funds mobilized from donors and or user fees/membership fees etc.
- He/she will do supervision of accounts of BPMUs/TPMUs and at facilities including periodic inspection of accounts and funds management at BPMUs/TPMUs and all the facilities getting fund from NHM.
- He/she will ensure adherence to laid down accounting standards as may be adopted by the Governing Body of the District Health Society.
- He/ she will prepare an advance monthly work plan, including a tentative travel plan in consultation with DPM/CMHO.
- He/ she will liaise with other consultants/ Managers/ Officers/ Staff of the NHM program at all levels.
- He/ she will perform any other role/duties that may be assigned by the State Programme Management Unit and District Health Society.

### Job Responsibilities of District Data Manager (DDM)

- He/she will analyse physical progress reports and recommend measures for improving programme performance in the district
- He/she will prepare feedback on the progress reports received from all the facilities under the district and disseminate it to concerned authorities
- He/she will monitor data quality (timely, completely, correctly) in preparation of periodic and annual reports
- He/she will follow up with blocks/talukas for regular submission of necessary data
- He/she will prepare and maintain all the databases for the district
- He/she will provide expert technical inputs in the monitoring and evaluation of NHM/ health programmes
- He/she will ensure data entry and analyse data of MIS systems/ all healthrelated web portals in the District
- He/she will ensure training of all the district health personals on safe data storage practices/ data management practices
- He/she will monitor the recording/reporting system/maintenance of registers by health workers through field visits and submit a visit report with appropriate suggestions/ actions for improvement

- He/she will provide technical and managerial support to State/ District level Programme Managers and grass root functionaries on monitoring and evaluation
- He/she will assist the CMHO and DPM in all the matters relating to monitoring & evaluation of health programmes
- He/she will supervise the functioning of M and E assistant and Data Entry Operator working in the district
- He/she will assist DPM in preparation of monthly reports, development of DHAP and routine monitoring
- He/she will organise the maintenance of IT hardware and software for the entire district
- He/she will ensure that problems of e-connectivity, get solved by an appropriate person
- He/she will liaise with other consultants/ Managers/ Officers/ Staff of the NHM programme at all levels
- He/she will perform any other role/duties that may be assigned by the competent authority

### Job Responsibilities of District Community Mobilizer (DCM)

- He/she will prepare a de-centralised annual plan regarding ASHA programme, VHSNC, VHND, MAS and other related community processes activities (related to health) in the district
- He/she will ensure the selection of ASHAs & ASHA Facilitator as per norms (Population & Area)
- He/she will ensure the identification of inactive ASHAs and coordinate with appropriate authority for their removal
- He/she will keep ASHA Database of the district updated
- He/she will ensure regular training (capacity building) of ASHAs, ASHA Facilitators, VHSC members, Block/Taluka Community Mobilizers.
- He/she will do regular field visits in the district and will provide supportive supervision
- He/she will ensure the progress of the activities conducted by ASHAs and ASHA Facilitators
- He/she will ensure timely payment of Performance Incentive to ASHAs & ASHA Facilitators
- He/she will establish and operationalise the grievances redressal mechanism for ASHA/ ASHA Facilitator and will ensure that grievances are addressed timely
- He/she will ensure the formation of VHSNC, MAS and RKS, and also that its meetings held regularly
- He/she will facilitate and supervise the functioning of Block Community Mobilizers
- He/she will ensure inter-sectoral coordination with other Government Departments within the district. (e.g.WCD, ICDS, PR Water and Sanitary, Education etc.)
- He/she will resolve day to day problems faced by ASHAs and ASHA Facilitators
- He/she will ensure and monitor that all ASHAs and ASHA Facilitators have drug kits (and other necessary supplies) with them

- He/she will organise district level ASHA Sammelan for recognition of their excellent work and contribution to NHM/Community
- He/she will establish a support system for enhancing coordination between DPMU and ARC
- He/she will be responsible for NGO coordination to ensure district-level support for ongoing community processes
- He/she will facilitate the community mobilisation process in the district
- He/she will liaise with other consultants/ Managers/ Officers/ Staff of the NHM program at all levels
- He/she will perform any other role/duties that may be assigned by the State Programme Management Unit and District Health Society

## Stages of Selection

### 1. Written Exam

The written exam helps in assessing an individual's knowledge, skills, and competencies and, to some extent, attitude. To regulate the number of selections, minimum passing marks criteria should not be set very high or very low. All selected candidates should be informed for the next level of assessment through proper medium.

- The following procedure should be adopted for conducting written test: The written test may either be descriptive or objective. Positions requiring expertise in reading, writing and comprehension skills may be evaluated separately. For e.g., in case of IEC expert, Communication Expert, Media Expert etc.
- If the number of candidates is very high due to large number of vacancies, written test should primarily be objective.
- The duration of written test may be nearly an hour.
- HR division / agency should identify the venues; preferably an educational institution for the written test on paper or OMR sheet and Computer Centre for online written test.

\*In case of contingent/ unforeseen circumstances (as have been during COVID time), online mode for taking the written test may be explored.

### 2. Skill Test

Skill Test is strongly recommended by government to ensure the quality of selected candidates. It should be conducted to assess skills that are critical for the advertised position, e.g., demonstrating how to measure blood pressure or plotting a partograph for a Staff Nurse. Skill assessment can be conducted alongside the written exam and interview or independently, as appropriate.

- Skill based assessment should preferably be conducted either at skill labs or in hospitals
- Logistical arrangements with identified institutions should be agreed in advance to ensure smooth conduct of the competency skill tests.
- A panel of subject matter experts must be identified in advance to assess the candidates.
- Photography and videography should be conducted as an evidence of conducting skill test and to ensure fairness.
- A suitable marking sheet should be developed for scoring skill tests.
- This, along with the written test and /or interview shall form the basis for selection of candidates to the National Health Mission.

### 3. Interview

Interview plays an integral part in selecting the right candidate and is usually the last stage of selection procedure. It may be ensured that selection procedure meets the minimum standard of 3:1 i.e., against each available position/ engagement to be made, there be minimum 3 candidates undertaking the last stage (interview) of selection procedure. During the interview, all submitted

documents of each candidate should be verified with the original documents.

- The Interview Panel should consist of a minimum of three members, preferably: (i) One subject matter expert (ii) One division or programme head (iii) One external or internal HR expert. The panel should have one woman panellist and one representative of SC/ST/OBC.
- It is important that interviews objectively assess candidates and avoid personal bias; a semi-structured questionnaire could be developed in advance to guide the interview process. It is also important that appropriate questions (ideally same) are asked to all candidates and a rating scale is used for all responses. The panel should also be oriented on consistent use of the rating scale. It will be useful to incorporate situation-based questions to understand how a person would respond to specific situations. The interview should aim to assess knowledge, attitude and soft skills of the candidate.
- Individual scoring sheets should be given to each panel member before commencement of the interview process and the marking process should be discussed to avoid inconsistency and/or bias.

## Suggestive Principles for Calculation of Weightage for Education and Experience

### Weightage on Educational Qualification

- Weightage points based on percentage of marks obtained in the desired education qualification should be calculated for each candidate. For example, if the weightage point of educational qualification is 60 and candidate has 70% marks, then it becomes  $0.60 \times 70 = 42$ .
- Similar policy for calculating the points should be developed for the candidates with grades rather than percentage in their qualification.

### Weightage on Experience

- The maximum point and per year points for experience in the relevant field must be decided before calculating the candidate's individual points. For example, if the maximum point is 10, and per year weightage point is 2. Then for a candidate who has 5 years or more than five years of experience gets maximum points i.e.,  $10 \times 5 = 10$ . A candidate with less than 1 year of experience will get 0 point.

In all the calculations, rounding up of fractional points can be done for convenience.

### Final List for Selection

The final list of selection should be based on the aggregate points earned in the various stages of selection, as per the decided weightage for each stage.



## Contents of Offer Letter

The offer letter issued to the selected applicant by SHS/DHS should have the following Information:

- Name of the Applicant
- Father's/Husband's Name
- Date of Birth
- Category (UR/OBC/SC/ST)
- Name of position (for which selected)
- Name of Place of posting (Complete details)
- Last date of joining
- Time of reporting at joining place
- Complete address of joining place
- Type of recruitment (Contractual / Outsourced/ any other mode)
- Duration of recruitment/ contract
- Monthly Honorarium (also mentioned if any Tax applicable)
- Any other terms and conditions
- Documents required during the joining formalities

*Note: A copy of the offer letter should also be sent to office of Reporting Officer to facilitate the joining process and document verification.*

## Contents of the Contract

The contract of every employee under NHM shall contain a statement relating to the following terms and conditions of employment:

- Agreement of confidentiality with State/ District Health Society with a clause of ethics and integrity: The staff shall not share any data or information with any person or institute outside Department of Health Services without the prior approval of the appropriate authority in the department. Prior approval of the department must also be taken by the staff prior to publication of any article or research paper based on the data, inputs and information obtained as part of the work under NHM.
- Remuneration to be paid including specifications related to increase in compensation in future in case of continuation/ renewal of the contract. It should also specify the method of payment.
- Effective date and duration of the period of employment
- Agreement on the Probation period
- Specific deliverables during the period of contract with specific timelines
- Leaves: The contract should mention the annual leaves available for employee during the period of employment
- Service Entitlements: The contract should also mention the TA/DA entitlements for the candidate as per state policy and other entitlements. In case of any additional charge, the work order contract for the same should clearly mention the reimbursement provision of additional travel expenses.
- Location of posting and reporting authority should be explicitly mentioned in the contract.
- Code of conduct and support provided by the State or District Health Society should also be mentioned.
- Transfer
- Termination of Contract

## Model Contract Format

### AGREEMENT OF CONTRACT APPOINTMENT UNDER STATE / DISTRICT HEALTH SOCIETY - \*\*\*

This agreement is made on ....., **BETWEEN** Mission Director / Member Secretary of DHS on behalf of \*\*\* State / District Health Society, hereinafter referred as **SHS/DHS**, \*\*\*.

#### AND

....., Son/Daughter of, date of birth ..... and residing at .....

#### WHEREAS

..... has been selected to provide his/her services to the SHS/DHS

#### THE PARTIES HEREBY AGREE AS FOLLOWS:

1. **SHS/DHS** hereby engages you to render services, as ..... (name of position) or any other role authorized by the SHS/DHS from time to time.
2. You would be assigned to provide services for any of the programs being implemented by SHS/DHS. In the event of these programs are transferred to any other Society or Project at a later date, your services may be transferred to the said Society or the Project.
3. Your appointment has been made on a clear understanding that you have supplied all necessary information to enable SHS/DHS to judge your fitness for the job and that the information provided by you is true to the best of your knowledge and belief. Should it be found later that you have given wrong or insufficient information or misrepresented facts; your services would be terminated immediately.
4. The position offered to you is on contract for ..... (e.g. one year; extending not more than three years), starting from ..... (date of contract) subject to satisfactory performance. The contract would be reviewed annually by SHS/DHS based on your performance during the contract period. SHS/DHS might rescind the contract before completion, if your performance has been found to be unsatisfactory. If the performance is found to be satisfactory SHS/DHS may consider extending the contract period for a further period of ..... (e.g. three years) on the same terms & conditions.
5. You will be on probation for a period of three months from the date of joining. The period of probation can be extended further for three months at the discretion of the appropriate personnel in the society. During the period of probation, in case SHS/DHS is not satisfied with the performance/services, the employee can be terminated without any notice period.
6. Your place of posting (headquarter) is ..... You would report to ..... (Name of reporting officer, with designation). This may be subject to change within the SHS/DHS depending on administrative requirements.
7. You will not be entitled to compensation if you will fully neglect or refuse or be unable to perform any of the duties under this engagement. SHS/DHS may suspend your salary due to such neglect, negligence or inability as aforesaid and may further immediately terminate your engagement without giving any notice or making payment of salary in advance.

8. This appointment is terminable by SHS/DHS by giving you one month's notice in writing or payment of one month's remuneration in lieu thereof. You may also terminate this appointment by giving one month's notice in writing or payment of one month's remuneration in lieu thereof.
9. That SHS/DHS during the continuance of your service would give you as compensation a sum of Rs..... per month The detailed break up (optional) is given as under:

Basic	
HRA	
Conveyance Allowance	
Communication Allowance	

10. Your compensation is a consolidated package and includes all expenditures you are required to make for high quality performance of your duties. Apart from the sum mentioned in Clause 9 for duties to be performed outside your work jurisdiction you will be eligible for a daily allowance and reimbursement of travel costs as per SHS/DHS Travel Policy.
11. In case your contract is renewed after satisfactory completion of one year, SHS/DHS may offer an increment based on your performance assessment as per their Performance Management Policy.
12. SHS/DHS works in an IT enabled environment and as a service provider to SHS/DHS you are expected to be fully conversant with IT enabled way of working, including use of email, uploading data on internet enabled data bases, reading notices and assimilating information from web sites and use of a basic IT enabled devices. You would also be expected to provide a mobile number through which you can be contacted at all times. You must inform SHS/DHS of any change in number.
13. You would be entitled to an annual leave of ..... (e.g., twenty days), on a pro-rata basis. This is inclusive for all types of leaves (including casual leave and sick leave). Apart from this, you may be entitled to Maternity/ Paternity Leave as per the terms and conditions of SHS/DHS Leave Policy. This is in addition to one day weekly off to be fixed by the SHS/DHS.
14. You would also be entitled to National holidays and other holidays as per provisions made by the State Government declared by SHS/DHS.
15. All other terms and conditions of your engagement including other benefits and entitlements, if any, transfers, exit and termination, etc. will be governed by the rules and regulations of SHS/DHS, as amended from time to time.
16. Your engagement with SHS/DHS will stand terminated if you are absent for seven working days or more, continuously from duty without taking permission from the competent authority.
17. You shall not be entitled to any other benefits except those mentioned above.
18. You may be transferred to another location by SHS/DHS in the interest of the programme. You may seek transfer only after completion of at least one year of your contract. All transfers would be guided by the Staff Transfer Policy laid out in the HR Manual of SHS/DHS.
19. Apart from work in the office, your work includes field duties at places you are required to work in as directed by SHS/DHS or its authorized representative. You

may have to visit the field/ villages and stay overnight for extended periods as and when required.

20. You shall not take up any part time/full time employment or assignments elsewhere or do any business during the period of the contract with SHS/DHS without written permission of the competent authority.
21. Your engagement will be automatically terminated, if you join any other organization or take up any assignment without obtaining prior permission.
22. SHS/DHS may terminate your services if you have committed irregularities and impropriety of administrative and financial nature, negligence of care, unsafe practices, inefficiency and insincerity, professional misconduct or false reporting of information or fabrication of data in the maintained records, or any other inappropriate action as prescribed by the SHS HR Policy.
23. While in contract with SHS/DHS and at any time thereafter, you shall not divulge any information or knowledge gained and acquired by you during the period of contract, which could be detrimental to the interests of SHS/DHS.
24. The title rights, copyrights and all other rights of whatsoever nature in any material produced by SHS/DHS under the period of this contract shall be vested exclusively in SHS/DHS, unless otherwise vested in Government by virtue of project document etc.
25. During the period of contract, you shall not stand for election as Member of a Municipal Committee, Municipal Corporation, District Board, Panchayat or any other legislative body.
26. You shall conduct yourself at all times with fullest regard for the purposes and principles of SHS/DHS and in a manner befitting your relationship with SHS/DHS under the contract. You shall not engage in any activity that is incompatible with those purposes and principles or the proper discharge of your duties. You shall avoid any action and in particular any kind of public announcement which may adversely reflect on the relationship, or on the integrity, independence and impartiality which are required by the relationship. You shall not accept any favour, gift or remuneration from any source external to SHS/DHS without first obtaining approval in writing for the same.
27. You shall stay at your place of posting unless you are on pre-approved tour.
28. Notwithstanding anything contained herein before, rules, regulations, bye-laws, instructions, lawful orders, etc. as and when framed and issued by SHS/DHS relating to the conditions of the service and additions, amendments, modifications, alterations, etc. made in the said conditions of service from time to time shall apply to you irrespective of whether these matters are provided for herein or not.

IN WITNESS WHEREOF, the candidates hereto have caused this contract to be signed in their respective names as of the day and year first above written.

#### **Signature of the Candidate**

#### **Witnesses:**

- 1.
- 2.

**Mission Director/ Member Secretary of DHS**

**For and on behalf of \*\* SHS/DHS**

## Induction training Schedule of M&E Officer<sup>12</sup>

Day	Thematic area	Description
Day 1- Day 8 Initial Orientation		
Day 1	Introduction to National Health Mission	Objective and strategies, structure and function of NHM
Day 2	Orientation of Duties and Responsibilities	Role of the incumbent, overall responsibilities specific to monitoring and evaluation
Day 3	Monitoring and evaluation system	Constitution of M&E Division, Basic duties of each team member. Details of all process related to Resource allocation and utilization
Day 4	Introduction to the partner departments	Sessions on the role and involvement of water & sanitation, women & child development
Day 5	Administrative Orientation	Reporting details of the various programs under NHM
Day 6	Introduction to policies under NHM	Various policies- transfer, posting, promotion, code of conduct
Day 7	Introduction to leadership and Orientation to management strategy	Types of leadership and their applications, supportive supervision; Exercise on Communication, presentation skills and on team building,
Day 8 – Day 11: Local (facility level) Orientation		
Day 8	Facility orientation	District office and District hospital
Day 9	Facility orientation	Sub district hospital and Block level office
Day 10	Facility orientation	CHC, PHC and SC
Day 11	Presentation from trainees	Presentation on the observations of field visits. (May also include other relevant areas for presentation)

<sup>12</sup> The induction training should preferably be three to five days at a stretch. The completion of training could be done in two to three phases.

## Training Needs Assessment (TNA)

- a. This is the first step in the training process and entails a situational analysis of the gap between what is currently practiced and what is required. The process includes an assessment of skills and knowledge currently required by various employees to perform current and future tasks. Need assessment helps in identification of performance gaps that can be bridged through training.
- b. There are two ways to conduct training needs assessment:
  - The first is to conduct a job analysis, by identifying necessary knowledge, skills and abilities to perform a specific job and compare it with the skills that the employee already possesses. A training program is then structured based on the identified gaps.
  - The other is to conduct performance evaluation surveys for various employees to identify training gaps, taking into account observations of immediate supervisors, feedback from the subordinate staff and other colleagues, as well as any changes in program priorities or introduction of new programs.
- c. For clinical staff, the National Training Strategy (prepared by NIHFWS) is already in place and specific training can be rolled out based on the needs and requirements of the job.
- d. This process requires an accurate and up-to-date record of the skills and competencies of individual employees, supported by a comprehensive and operational Human Resource management Information System. The state must develop a database of trained personnel which should be updated routinely for planning and needs assessment for training. This data-base should document information about in-service trainings attended by employees and results of any assessments/evaluations.
- e. If the training load is very high, the following criteria can be used for priority selection of candidates for in-service training:
  - Employees from high priority districts should be given preference.
  - Employees from high case load facilities should be preferred over those with lesser foot fall.
  - Those candidates who have demonstrated successful utilization of training skills in the past should be given preference.
  - There should be a gap of 3-6 months between two training courses so that employees have adequate opportunity and time to practice newly acquired skills.

## Process of Performance Appraisal

The performance of staff under NHM may be assessed on a periodic basis at least once every year, and a six-monthly interim appraisal should also be carried out. The annual assessment should be linked to the compensation review, as the performance rating would determine the hike in remuneration that may be provided to the staff. The six-monthly assessments should be conducted twice: first in the month of October (to be completed before 31st October) and a second/final assessment in the month of April (to be completed before 30th April). The assessment should ideally incorporate a 360-degree feedback, but as a minimum, the process should include both self-appraisal and the reporting officer's feedback. Decisions related to contract renewals, annual increments and performance-based incentives should be based on these appraisals.

The State HR Cell should set KRAs/indicators for assessment. The State HR Cell should discuss these with the districts and assist them in tweaking the same, if required, as per the district's context.

While measuring the work performance, the staff/ personal (assessee/ appraisee) may score themselves as per the rating system and provide justification or record their achievements against each indicator. The self-assessment forms may then be submitted to the Nodal Officers/ Reporting authorities/ Supervisors (assessor/ appraiser) for assessing and recording their score and are expected to consider previous performance of the department/facility while evaluating individual performance. The self-appraisal formats once completed between the employee and their supervisor should be submitted to a performance appraisal committee for verification, arbitration, if needed, and further action – in terms of incentive approvals, contract reviews and corrective actions, as appropriate or third-party evaluation may be conducted by any other official or representative identified by Mission Director (3rd Party Assessor). A copy of the assessment score sheet should be shared with the staff being appraised.

If there are significant differences in the scores between self-appraisal and the assessment of the reporting officer, this should be discussed to ascertain the reasons for this discrepancy and take corrective actions, if needed.

The final scoring may be done through weighted average of the scores received in Work Performance Based Assessment and Knowledge and Competency Based Assessment indicators.

Weightage of 60% is to be given to the Work Performance Based Assessment Indicators, while 40% weightage is to be given to Knowledge and Competency Based Assessment Indicators.

The final rating sheet should be duly signed by both the assessors. The completed forms should be kept in the custody of the HR department.

## Indicative Rating System for Performance Appraisal

Overall rating may vary from 0 to 5 (or a grading system as developed by the State) wherein the assessee will be rated between 0 to 5 for each of the KPI wherein the score may be defined as:

### Exceeds Expectation (Score= 5):

- Consistently performs and assists other staff with work assignments that are thorough and well-organized; staff is proactive in identifying improvements to enhance performance; implements and customizes best practices.
- Uses time efficiently to consistently meets deadlines; consistently checks own work



and the work of co-workers and corrects errors; quality of work consistently exceeds set standards; assists in the re-work of others; pays attention to details and accuracy; sets the standard for quality of work performed in the department; successfully performs additional responsibilities as needed.

### Meets Expectations (Score= 3):

- Has the knowledge, skills and abilities to successfully perform duties; assignments are well organized and thorough; implements best practices; most duties are performed with minimal supervision.
- Consistently meets deadlines; produces work that is typically free of errors; consistently checks own work and corrects errors for accuracy; uses time wisely by assisting other staff/ co-workers and performing tasks without having to be asked; consistently generates acceptable quantity and quality of work.

### Requires Improvement (Score= 1):

- Does not consistently exhibit the knowledge, skills and abilities to successfully perform duties, for most assignments, close supervision still necessary; does not consistently perform routine duties; fails to implement and/or lacks knowledge of the best practices; additional guidance and/or training is required to successfully perform duties.
- Needs to minimize errors in work; is not consistent in producing accurate work or volume of work, and/or does not complete work assignments according to pre-established deadlines or quality standards set; takes on additional responsibilities and fails to perform primary duties.

### Below Expectations (Score= 0):

- Has not exhibited the knowledge, skills and abilities to successfully perform duties, close supervision is required to successfully perform duties; does not ask questions when unclear or continues to ask questions about duties that have been reviewed several times; has been provided with the resources and support; but is not able and/or willing to successfully perform duties.
- Does not produce the standard volume of work, and/or complete work assignments according to pre-established guidelines; multiple errors in work; work assignments may need to be re-worked; does not pay attention to detail and accuracy; employee fails to find own errors; work not completed on time; has been provided with the resources and support to succeed, but is not able and/or willing to produce the quality or amount of work required.

## Final Scoring

For calculation of final score, the following method may be followed:

- 1) The Nodal Officer and 3<sup>rd</sup> party Assessor will calculate the weighted average score of each staff.

2) Final score will be calculated using average of total score:

	<b>60% of Work Performance Based Assessment (A)</b>	<b>40% of Knowledge and Competency Based Assessment (B)</b>	<b>Total Score</b>
Weighted average Score of Nodal Officer (C)	$60\% \times (\text{Total average score in Part A}) = C.1$	$40\% \times (\text{Total average score in Part B}) = C.2$	$C = C.1 + C.2$
Weighted average Score of 3rd Party Assessor (D)	$60\% \times (\text{Total average score in Part A}) = D.1$	$40\% \times (\text{Total average score in Part B}) = D.2$	$D = D.1 + D.2$
Final Score	$(C+D) / 2$		

All staff who have completed at least 3 months of service in either of the assessment months should be eligible for performance assessment. All staff who have completed probation period during the final performance appraisal will be eligible for a remuneration review based on the performance rating provided by their supervisor. The staff who have completed one year should get the total increment amount added in their past remuneration and the ones who have not completed one year will get the remuneration on pro rata basis i.e., total increment amount divided by 12 months and multiply by the number of months in doing the assignment/job. The next increment should be done after next year final performance assessment. The person must complete 3 months' probation period for any increment in remuneration.

### Performance Improvement Plan

The Performance Improvement Plan is designed to give a nonperforming employee a short-term window period of minimum 1 month and maximum 3 months to level up with the expectations of the job profile. This can be utilized only in certain specific circumstances as listed below:

- In the event of employee obtaining the rating 1 (rating range 0 to 5) at the end of annual / yearly performance
- In the event of employee having repeatedly obtained the rating 2 at the end of several annual/half yearly Performance Reviews (two of such rating in three reviews)
- In the event of a probationer employee having obtained the rating of 1 and therefore not been confirmed in the first probation period of 3 months
- Employees undergoing Performance Improvement Plan will not be eligible for the rewards process of that particular Performance Management System cycle.

In case the staff do not secure a rating of 3 for the performance of 1 to 3 months of Performance Improvement Plan period then the contract with the staff will be ended and will be determined as per the provision of clause of Termination.

## Sample Performance Appraisal Form

### Staff Member's Particulars

Name :  
Designation :  
Date of Joining the Organization :  
Date of joining the Current Designation :  
Validity of Current Contract :

### Activities:

- Distribution of APA forms
- Self-Evaluation
- Appraiser's evaluation
- Final review by the Reviewer
- Feedback to the personnel

### GENERAL GUIDELINES

#### PURPOSE:

- To assess the performance of a personnel against the Key Deliverables
- To identify personnel's strength and areas of improvement
- To serve as one among various inputs for career development planning
- To provide inputs for compensation decisions

#### PROCEDURE FOR EVALUATION:

**Self-evaluation:** Each personnel will receive the Appraisal forms through his/her immediate senior officer/reporting officer (here onwards referred as the appraiser). After filling Part- A of the form, it is to be returned to the appraiser.

**Performance Evaluation Dialogue:** The appraiser is required to schedule a discussion with the appraisee for performance evaluation. Performance of the entire period to be reviewed against agreed deliverables.

**Superior Evaluation:** After the dialogue, the evaluator will assess the performance of the appraisee and put his/her views in Part B of the form.

In case where an appraisee has worked under two or more superiors in the appraisal year, the appraisal will be done by the one under whom the appraiser has worked for a minimum of three months (excluding period of long leave by appraisee and or reporting officer)

Ideally when a reporting officer/ appraiser is leaving the service of the organization, he/she must undertake the appraisal of his/her appraisee for that particular appraisal cycle before leaving. the

**Final review by the Reviewer-** The appraiser and the reviewer will fill the performance ratings in Part C.

**Feedback to the Personnel:** This is a very important step of the cycle whereby the appraisee is given feedback by his appraiser on his annual performance and also about his strength and areas of improvement. This is to be done after the whole process is over i.e., after appraiser evaluation and Moderation of scores.

**Appraise Comments:** The personnel, after receiving the feedback, writes his comments in Part D and signs the APA forms.

## PART – A

### SELF EVALUATION

- Please list your key deliverables for the year as specified in the annual work plan initiatives. Against each deliverable, mention your actual achievements (and constraints, if any).
- Also, mention other deliverables that were assigned / taken up during the course of the year.
- The below mention format is to be used, but as space would be inadequate, take as many sheets as required.

S. No.	Key Deliverables	Achievements

Additional Responsibilities & Other Areas of Contribution (Area which are not covered above)

Please mention constraints in your work during the review period

### DELIVERABLES FOR YEAR 20.....-.....

Key Deliverables:

S. No	Deliverables

Signature of the Appraisee:

Date:

## PART – B

(TO BE FILLED IN BY APPRAISER)

### I. PERFORMANCE SUMMARY AND TREND

(Summarize your view of appraisee's accomplishments and comment on performance trend during the past year)

### II. STRENGTHS

(Describe appraisee's strengths and how they have contributed to the current assignments)

### III. ACTION FOR PERFORMANCE ENHANCEMENT

(Identify specific areas needing improvement and development actions you feel would enhance the appraisee's current or further performance)

## PART – C

(TO BE FILLED IN BY APPRAISER)

- Please read the Guidelines for Performance Rating
- Please tick on the rating (whichever and corresponding to the score applicable)

S. No.		Part- A (by Reporting Officer)	Part - B (by Reviewer)
		(Each Attribute is to be marked; Max. Marks – 10 for each Attribute)	
1.	Quality of Deliverables		
2.	Application of Professional Knowledge		
3.	Timeliness of Deliverables		
4.	Initiative		
5.	Willingness to shoulder extra responsibility		
6.	Attitude		
7.	Interpersonal Relations & Team work, Co-operation with Supervisors & Colleagues, Peer support.		
8.	Communication Skills (Written & spoken)		
9.	Punctuality & Contribution to other tasks (beyond Division's work).		

10.	Efforts undertaken to improve knowledge(papers, presentations, conferences etc.)		
	Aggregate Marks (Max. 100)		
	Average of Marks		

Signature of Reporting Officer	Signature of Reviewing Officer	Signature of Consultant/Staff

Grade	Overall Marks	(Please Tick)
A	More than 79	
B	More than 64	
C	50 to 64	Repeat Assessment (Mid-Year Review)
D	Less than 50	Served notice

Reviewer's Comments on overall performance & Potential

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HR/Administrative Section:

Integrity / Disciplinary Action / Propriety: (Tick the relevant Choice)

Conduct:

Above Board	Questionable
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Disciplinary:

Initiated	In Progress	Completed	Findings	Not Guilty / Guilty
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		Signature of Administrative Officer
		Name:
		Date :

*Note:*

1. The appraiser in all cases will be the immediate supervisor
2. The reviewer in all cases will be Functional / Organizational Head of Appraiser
3. In case of difference of opinion between Appraiser and Reviewer in score, the average of the two will be considered.

**PART - D**

**(FEEDBACK FORM)**

1. Part 'A' has been taken into consideration while evaluating the Appraisee.
2. Part 'B' and 'C' have been shown to Appraisee.

Comments of the Appraisee

Comments of the Appraiser

**(Signature of the Appraisee)**

**(Signature of the Appraiser)**

## Expenses Policy

### Process of Claiming Expenses (Example- Travel Policy):

- The travel approval by any NHM Staff on the Travel Requisition Form should be taken from the competent authority i.e., Reporting Head or as designated by the state specific travel policy.
- A travel advance can be claimed and it may be mentioned in the Travel Requisition Form or a separate "Travel Advance Form" is to be used for the same. The advance amount should be based on the estimated cost.
- The travel advance form will be signed by the Reporting Head and send to the finance division for the further process. The Finance division approved the estimated cost, then 80% amount should be credited to staff account within 2 working days
- After completing the travel staff must prepared tour report and its will be part of the claim form, without tour report the settlement will be uphold till it submitted.
- The claim should be made and all advances/ expenses to be settled within a week of returning from the travel.
- The following attachments are extremely important for claiming the expenses:
  - > All supporting bills for travel e.g., the ticket/ boarding pass or the train ticket or a bus ticket
  - > All bills pertaining to hotel stay
  - > All bills pertaining to costs incurred on food.
  - > All bills related to hiring taxi
  - > All bills related to other expenses
  - > Tour report
- All reimbursements to be claimed/submitted only on the travel expense form with all bill details well numbered and attached sequentially.
- If the bills will be not available for expenses incurred on auto/ taxi/ food, please specify the reason for the same and expenses amount should be written on a blank sheet and it also self-attested.
- Any amount beyond the maximum limit has to be refunded by the staff member immediately by cash, cheque or instruction to deduct automatically from the salary payment of the following month.
- If an employee elects to combine personal travel with a work trip, NHM will reimburse the cost of direct return travel between posting and work trip destination. Employees are expected to cover the extra costs.
- If travelling for more than 5 days at a stretch, an employee can claim for a reasonable amount of laundry
- Is an employee returns back to his place of posting after 1600 hours (4 PM) on a working day then he/ she could report to work only on the next working day. However, depending on the workload, the supervisors could take a call whether the employee is required to be at work or if he/she could report the following day.



- If an employee is travelling for a full week inclusive of the weekends, in consultation with his/her supervisor he/ she can claim a day off (Compensatory Off) at any working day within the week following his/ her return from the trip.
- Cancellation charges would have to be borne by the employee unless otherwise approved by the Supervisor.
- If any employee misses a flight or a train for reasons beyond his/ her control then only the loss incurred from the “No show ticket” will be borne by the employer in any other situation, the employee has to bear 100% cost incurred therein including booking charges.

## Sample Travel Approval Form

Name :

Designation:

Period of travel: Date (from) (to) \_\_\_\_\_. No. of days \_

Purpose of travel:

Budget Head: \_\_HRH \_\_\_\_\_

Travel date	Place	Mode of travel	Approximate expenditure (Rs.)		Remark (if any)
			Travel cost	Boarding/ lodging	

Estimated expenditure to be incurred by consultant Rs. \_\_\_\_\_/-

Previous advance (if any): \_\_\_\_\_ Advance requested (if any): Rs. \_\_\_\_\_

Specific approval need for (if any): Air tickets booked by myself of both tickets Hyderabad

Submitted for approval please.

Signature of consultant

Date: \_\_\_\_\_

Approved By \_\_\_\_\_

Remark by Admn/Accounts (if any):

Sample Requisition for Advance Form

Date: .....

Name: .....

Designation: .....

Purpose: Meeting / Workshop / Others

Details: .....

.....

Advance required Rs (in figure) .....

Rs (in words) .....

Previous advance balance (if any) .....

Signature

Budget head - .....

Reporting Officer

Verified by

Approved by

## Sample Claim of Local Conveyance Form

Name: ..... Designation: ..... Date: .....

Date	Place		Purpose	Mode of travel	Vehicle Number	Distance in Kilometre	Amount (in Rs.)
	From	To					
	Total:						
	(Rupees in words):						

Signature of Claimant

Approved by

Verified by

## Sample Transport Requisition Form

Requisition No \_\_\_\_\_ Date \_\_\_\_\_

Department / Section \_\_\_\_\_

Name of the User \_\_\_\_\_

Date on which vehicle is required \_\_\_\_\_

Time \_\_\_\_\_ to \_\_\_\_\_

Place from \_\_\_\_\_ to \_\_\_\_\_

Purpose of journey \_\_\_\_\_

Details of meeting etc. \_\_\_\_\_

Special Instruction (if any) \_\_\_\_\_

Sign of Requisitioner

Designation \_\_\_\_\_

Sign of In-charge personal

Vehicle may be / may not be provided

Vehicle No \_\_\_\_\_ provided.

Coordinator (Transport)

Administrative Officer

## Sample Travel Claim Form

### PART-A To Be Filled Up By the Personal

1. Name :
2. Designation :
3. Division :
4. Office :
5. Details and purpose of journey(s) performed:

Departure		Arrival		Mode of travel and class	Fare paid (NHM/ SELF)	Distance in Kms for road mileage	Duration of halt	Purpose of journey
Date & Time	From	Date & Time	To		(Rs)			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)

6. Mode of journey:

(i) Air

a) Air Ticket Booked (Agency/ State/ Self) Yes/No

(ii) Rail

(a) Rail Ticket booked (Agency/ State/ Self)

(b) Travel by admissible booking. Yes / No

(c) Travel on Tatkal Ticket Yes / No

(iii) Road (Please ✓)

Mode of conveyance used, i.e., by Office transport/by hiring taxi, /a single seat in a bus or other public conveyance/by sharing with another person of the same organization in a cab/ personal car

7. Date of absence from the place of halt on account of RH / CL/ Consolidate Leave during the tour

8. Dates on which free board and/or lodging provided by the State or any other organization financed by the State Fund.
- (a) Board only.....
- (b) Lodging only.....
- (c) Board and lodging
9. Particulars to be furnishing along with hotel bill etc. for stay in hotel/other establishments providing board and/or lodging as per entitlement.

Period of stay		Name of the Hotel/ establishment	Daily rate of boarding/ lodging charged (Inclusive of all taxes)	Total amount paid
From	To			

10. Particular of journey(s) for which higher class than the one to which the NHM Personnel is entitled:

Date	Name of Places		Mode of conveyance used	Entitle Class	Class by which travelled	Fare of the entitled Class
	From	To				

If the journey(s) by higher class then the prior approval of the competent authority taken.

11. Details of journey(s) performed by road between places connected by train:

Date	Name of Place		Fare paid
	From	To	

Date of prior approval of competent authority

12. Amount of Advance, if any, drawn: ...../-

**PART-B**

The net entitlement on account of Traveling Allowance works out to Rs. ....as detailed below:

- a) Railways/Air/Bus/Steamer fare .....
- b) Total Amount paid on Road travel (between districts) .....
- c) Total Amount paid on Accommodation .....
- d) Daily Allowance:
- i. \_\_\_\_\_ days @ Rs. \_\_\_\_\_ per day
- ii. \_\_\_\_\_ days @ Rs. \_\_\_\_\_ per day
- iii. \_\_\_\_\_ days @ Rs. \_\_\_\_\_ per day
- e) Local Conveyance/ Others (Specify) .....
- Gross amount .....
- f) Less: Amount of TA advance drawn, if any .....
- g) Previous amount is to be debit able (if any) Rs. \_\_\_\_\_
- Net Amount Rs. \_\_\_\_\_

I certified that the information, as given above, is true to the best of my knowledge and belief.

Signature of the claimant with date

Claim Verified by Authorized person with date

**CERTIFICATE FOR TRAVEL CLAIMS**

1. Certified that I actually travelled by the class for the T.A. claimed in this bill.
2. I have submitted boarding pass for Air travel. If not then please provide reason and confirm not submitting to any other organization for claim.....
3. Certified that number of kilometres shown in this bill is in accordance with google map distance.
4. Certified that I was actually in outstation on Sundays and holidays for which daily allowance is claimed.
5. Certified that I was not on leave/ weekend during the period for which daily allowance has been claimed.
6. Certified that I incurred running expenses a personal car in this journey.
7. Certified that the road journeys in entitled class for which kilometre has been claimed were performed in my own car and approve by appropriate authority. (RTO rates)
8. Certified that the road journeys for which mileage is claimed were performed by road but were charged by rail in entitlement class. The number of kilometres.....actually travelled by road.



9. For all hotel booking through web portal (Make My Trip, OYO, Yatra etc.) a confirmation from hotel regarding occupancy on letter head/ web portal booking is mandatory, if not then hotel bill should be attached.

Signature of the claimant

Approved by Appropriate Authority

(Signature & Designation of the controlling officer/ supervisor)

-----

**For Accounts Section**

Scrutinized & Passed Amount.....

Checked by.....

Verified by.....

## Leave Policy

### Process of Applying Leave

Through HRMIS a proper leave management module should be developed for online leave management and its approval should be granted on it. The individual staff and Reporting Head can see the updated leave status.

If the leave management on the HRMIS is not functional or under development, following process should be adopted:

- Each individual is responsible for submitting the leave details in the approved “Leave Application Form” to Reporting Head and he /she forwarded to nodal officer / in-charge of Human Resource to make sure the correct amount of leave balance is maintained. Finally Reporting Head approved the leave on the basis of balance leave and it's again forwarded to nodal officer / in-charge of Human Resource for further necessary action.
- In the leave application form the staff needs to submit the contact details where he / she is visiting and persons' name holding charge of work for that time period, to the Reporting Head well in advance.
- In unscheduled absence, it is expected that intimation of leave should be shared through phone, sms, email etc. by the employee or employee's other relative or friend or any one on behalf of the employee to the Reporting Head and nodal officer / in-charge of Human Resource definitely within a reasonable time following the beginning of your scheduled work in the office.
- The monthly leave data of staff of NHM is recorded by nodal / in-charge of Human Resource after receiving Monthly Attendance Sheets from the respective Reporting Head. Overall leave record will be maintained by nodal / in-charge of Human Resource after reconciliation with respective Reporting Head.

\* For maternity leave, a separate leave application is to be put up with all related documents.

## Principles and Processes for Salary Determination

Salaries under NHM should facilitate attraction and retention of talent and therefore offering competitive salaries is important to attract qualified staff, motivate existing staff and reduce turnover. Following are essential principles which should be considered while determining an appropriate salary range for a job:

- Equal pay for equal work should be applicable to all the jobs with adequate weightage for educational qualification and experience.
- State should ensure that there is parity in salary across various pools (RCH, NRHM, NUHM, NCD and DCPs) in NHM.
- Minimum wages in each category for all workers must be ensured.

Following points should be considered while determining the compensation and salaries of NHM Staff:

- The compensation should not be higher than the compensation of the existing staff of same category and with similar nature of work, qualification and experience. In case, no such posts exist under NHM, the HR Cell should undertake a market analysis on the compensation component and put it forward to higher authority for further discussion.
- The compensation and allowances to be paid (if any) to the NHM staff should be as per the approvals of Record of Proceedings of Programme Implementation Plan. Any deviation from the same is to be discussed at the level of Executive Committee and Governing Body; thereafter, it needs to be put forward to MoHFW during National Programme Coordination Committee (NPCC) for final approval.
- States may determine a range of compensation organised as 'compensation grades' for each staff category depending upon the nature of work required to perform. This should be commensurate with the educational/other qualifications, skills and experience possessed by the staff. However, the maximum compensation should not exceed the compensation approved by GoI in the Record of Proceedings of Programme Implementation Plan.
- The base/ entry level compensation of all staff category may be revised every five years. It is to be discussed at the level of Executive Committee and Governing Body, thereafter put forward to MoHFW during NPCC for final approval.

## Salary Increment

The Incentive / yearly salary increment should be linked to performance appraisal of the individual employee. The performance rating should determine the salary increment to be provided to contractual staff. The following table provides an indicative list for linking service assessment ratings with the offer of increments.

**Table: Year increment based on performance appraisal**

Rating	Performance Description	Increment
5	Exceptional – staff member demonstrates superior performance greatly exceeding job requirements in all areas.	10%
4	Exceeds job requirements – staff member consistently performs above job requirements.	8%
3	Satisfactory – staff member performs well in all areas of responsibility consistently meeting all job requirements.	5%

2	Requires development – staff member has not yet fully achieved minimum performance levels for all job requirements, needs further development and training in functional areas.	3%
1	Unsatisfactory – staff member's performance is inadequate, consistently fails to meet minimum job requirements.	No Increment/ Notice / Termination

In the Record of Proceeding (ROP), in principle 5% of the total HR budget is approved as lump sum for increment. The increment for individual staff is to be decided by state. It may range from 0% to 10% and should be linked to performance appraisal process.

### Salary Payment Process

Each employee should be registered on HRMIS and automated salary calculation process should be adopted, considering the daily attendance of employees monitored through HRMIS. The monthly remuneration must be calculated on the last day of month. If last day of the month is a holiday, then it should be calculated a day prior. Disbursement should be done on the 1st of the succeeding month, and if 1st is a holiday, then it should be disbursed on the next working day. An employee may also get the monthly pay slip generated through HRMIS.

Any advance taken by the individual employee must be settled prior or shall be adjusted from the monthly remuneration. The travel expenditure or allowance must be reimbursed within 15 days after submission of bills.

The process should be monitored by the competent authority during the monthly process meeting.

## Process of Rationalization

### Rationalization of Compensation should be undertaken wherever required.

Compensation of all staff engaged under different programmes under NHM is to be at par based on nature of engagement, qualification and experience. In case of differences, states to take adequate steps to rationalise it using rationalization budget approved in the Record of Proceedings of Programme Implementation Plan. Following steps for rationalization of compensation

- The Human Resources (HR) under NHM have been brought together under Health Systems Approach from different programmes. As a first step towards salary rationalization, all HR are to be grouped together based on qualification required and task to be performed. E.g., All Lab technicians to be grouped together as Lab technicians under NHM.
  - Similarly, all HR under programme management (across all programmes) are to be grouped together based on qualification required and task to be performed, irrespective of the nomenclature provided in different programme guidelines. E.g., Accountants approved under different programmes are performing similar task are to be grouped together.
  - Entry level salary is to be determined for each staff category/ group based on years of experience, qualification and previous relevant experience. E.g., For a consultant level position, the entry level salary for MBBS+PG qualified candidate will be different from that of non-MBBS+PG candidate (demonstrated in table below).
- a) Approximate incremental salary based on years of experience should also be determined, for programme management staff. In case any candidate selected for any post has more experience than the minimum required qualification, the same may be take into consideration for deciding the entry level salary (refer to table below).

**Table: Example of determining entry level salary for the position of consultant based on experience and qualification**

Years of Experience	Position: Consultant*					
	Medical Graduate with PG		Full-time Masters / PG in Health/ Rural/ Hospital/ Other Management Sciences (AICTE Approved regular course of 2 years)		Full-time PG / Masters in Science / social science background	
	Entry level Salary	Salary of existing staff with 5% increment	Entry level Salary	Salary of existing staff with 5% increment	Entry level Salary	Salary of existing staff with 5% increment
0	45000		35000		30000	
1	47000	47250	36000	36750	31000	31500
2	49000	49350	37000	37800	32000	32550
3	51000	51450	38000	38850	33000	33600

4	53000	53550	39000	39900	34000	34650
5	55000	55650	40000	40950	35000	35700
6	57000	57750	42000	42000	36000	36750
7	59000	59850	44000	44100	37000	37800
8	60000	61950	40000	46200	30000	38850

*\*Note: The salary mentioned in the table are indicative*

At no point, the salary of the new HR to be higher than the existing staff under NHM with similar qualification or experience. However, in case state has to revise the entry level salary of certain staff category, the existing staff may apply for the same position through open recruitment process and in-case he/ she gets selected, may be paid the revised remuneration. This provision should be used sparingly and only in cases where the salary levels are very low.

- b) While revising the entry level salary for any staff category, market assessment should be conducted to find out:
  - i. Availability of candidates with required qualification in the state or region.
  - ii. Educational institutes/ Colleges in the state or region providing the required course and their annual intake.
  - iii. Market rate for the desired qualification.
- c) In ROP an additional 3% of the total HR budget is approved as lump sum for HR rationalisation. This along with the annual increment may be utilised for salary rationalization wherein the annual increase in salary of staff may be increased up to maximum 15%. However, prior to salary rationalization process, the qualification, workload and skills of individuals must be taken into account. In case an individual is at a higher salary level without any difference in educational experience and workload, may be given lower rate of increment.

The principles of salary rationalization are to be approved by Governing Body (GB) of State Health Society whereas the details are to be approved by Executive Committee (EC) of the State Health Society.

## Redressal Mechanism

All necessary contact information/ email ID for grievance redressal should be boldly displayed at various places of the facility, especially at administrative rooms and Staff rooms. A transparent drop box for receiving written complaints should also be introduced in areas where it can be visibly noticed by the Staff and the administration.

Ideally, any complaint/grievance should abide by the following protocol:

**Step 1:** The person lodging a grievance should provide all relevant details (in writing) to the nodal person. This could be done online, through an email or a written letter or application. In case of an emergency, initial contact can be over phone, but a written confirmation should follow as soon as possible. The concerned nodal person must immediately acknowledge receipt of the grievance in writing, informing the employee of the receipt of grievance. If the online system is used, an automated reply should be sent to the employee about registration and a notification should be sent to the nodal person about receipt of the application.

**Step 2:** The nodal person should determine whether the grievance relates to local issues/ staff or to the policies of the NHM. In case the grievance relates to local issues or staff, the nodal person at the facility or institution should determine whether it can be handled under their jurisdiction or would need to be escalated to District/ State Grievance Redressal Committee.

- The nodal person at facility should try to resolve the grievance at the Facility level grievance committee through a patient hearing to the aggrieved employee and through proper counselling or by taking suitable remedial action.
- In case the grievance cannot be handled under the discretion of the Facility level grievance committee, then facility Nodal person should escalate this grievance to the District Grievance Redressal Committee, where the district level nodal person should place it before the committee within seven days of receipt of the grievance. The District Grievance Redressal Committee should convene, review the grievance and resolve it within two weeks of the referral of the grievance. The Committee should also provide a written report to the Facility and State level Grievance Redressal Committee through the nodal person. The same process should be adopted for the matters that are registered at State Grievance Redressal Committee.
- In case, the District Grievance Redressal Committee fails to resolve the issue, or the grievance is beyond its remit, this should be referred by the nodal person to the State Grievance Redressal Committee within the prescribed period of seven days. The State Grievance Redressal Committee should convene, review the grievance and resolve it within two weeks of the referral of the grievance.
- In case, the State Grievance Redressal Committee fails to resolve the issue, or the grievance is beyond its remit, this should be referred by the nodal person to the Mission Director, NHM within the prescribed period of seven days. The MD, NHM may place the matter to Executive Committee of NHM for final decision on the concerned grievances within 1 month.

Each committee should maintain a grievance register with the concerned nodal person as the custodian of this register. There should be a separate minute book with each of the committees to record the proceedings (Minutes of Meeting) of all meetings.

All grievances should be attended to promptly in a time bound manner and dealt with utmost empathy and consideration.

### Appeal:

For any appeal against redressal of a grievance of any nature pertaining to NHM employees, the final authority will be the MD, NHM whose decision will be final and binding.

## Exit Policy

### Employment Separation

Employment separation may be in the form of resignation, dismissal or discharge, suspension, retrenchment.

### Notice Period & Relieving

All staff members will have to abide by the notice period as mentioned in the appointment letter. Prior to being relieved from employment, he/she shall be required to handover all official materials in his/her possession, obtain a Clearance Certificate from the concerned division/office/department, Finance, Administration and Human Resource division, validating the same before issuing the relieving letter and experience certificate (on request).

Please note that as part of procedural adherence, the following documents must be placed on record:

1. Resignation letter/end of contract letter
2. Letter of acceptance on resignation/ letter of end of contract – acceptance (Signed by the respective staff)
3. No dues certificate from the respective division/office/department through the respective In-charge of those division/office/department
4. Leave status from the HR Division to be documented and sent to Finance to be processed for Full and Final Settlement.
5. Handing over note to be submitted by the respective staff member to the immediate supervisor. The same with full documentation and signatures will be forwarded to HR division.

All the above should be sent well ahead of time so as to obviate administrative and other delays. Relieving letter, experience certificate and full and final settlement of accounts will be issued not later than two weeks after the staff member is relieved from service, provided all other relieving formalities have been completed satisfactorily along with satisfactory hand over.

\*In exceptional circumstances (relating to medical or personal emergency etc.), a special permission may be obtained from the Mission Director of the State to relax/ reduce/ waive off the notice period.

### Exit Interview

All employees exiting are expected to provide advance notice as specified in their appointment letters. The HR team will then request the employee to initiate 'No dues' formalities and will schedule an in-person or telephonic exit interview.

An exit interview is conducted to enable NHM to understand the reasons for the employee's decision to resign and also to solicit feedback from the employee about NHM. The exit interview provides NHM with an opportunity to improve its processes and systems and hence genuine feedback from the exiting employee is expected and appreciated.



## Sample Exit Interview Form

(Please Note: You can use extra sheets of paper if the space provided is not enough)

CONSULTANT INFORMATION			
Name			
Date of Joining			
Designation			
Division / Dept			
Head of Division/Dept			
Resignation Date		Last Working Date	

FUTURE CONTACT DETAILS			
Apartment/ House No.			
Street / Area			
City / District		State	
PIN Code			
Phone / Mobile Number			
Email Id			

1. Please select the factors which have prompted you to leave us.

S.No.	Reason	Details (Prioritize If More Than One)
1	Further studies	
2	Health Factors	
3	Marriage / Family	
4	Better Opportunity / Salary	
5	Overseas Opportunity	
6	Job Different from expectation	
7	Work not challenging	
8	Work culture	
9	Working Hours	
10	More responsibilities	
11	Lack of Co-operation	
12	Recognition	
13	Others: specify	

2. List your expectations when you joined the Organisation & have your expectations satisfied?

S.No.	Expectations	Were these expectations met?

3. What according to you are the positive points about the Organisation?

S.No.	Positive Points	Additional Suggestions

4. What according to you are the negative points about the Organisation?

S.No.	Negative Points	Suggestions To Address These

5. Where are you joining now and at what capacity? [Company Name, Location, Designation, Salary]

### Undertaking

I hereby undertake that I shall not violate any of the Confidentiality clauses of NHM in future.

Signature:

Date:

Nodal Officer/ In-charge

Human Resources Department

Comments (If Any) -----

## Sample Exit Clearance Form

(Kindly complete this form and ensure clearance from the individual Unit Heads. Then submit the form to the HR Department for further processing. No salary or relieving letter will be released if signatures from the respective units are not completed.)

Full Name & Signature: \_\_\_\_\_

Designation: \_\_\_\_\_ Division/Department: \_\_\_\_\_

Date of Resignation / Contract End Date: \_\_\_\_\_

Last Working Day: \_\_\_\_\_

DIVISION / DEPARTMENT	ITEM (Please specify if not indicated)	REMARKS (Please tick if cleared, N/A for not applicable and specify others)	NAME & SIGNATURE
REPORTING UNIT	• Hand Over Sheet		
	• Files / Folders		
	• Passwords		
	• Softcopy Locations		
	• Books/Manuals/ Reports		
	• Others		
IT	• Email Id		
	• Laptop / Bag		
	• Mouse		
	• Data Card		
	• Pen drive		
	• External Drive		
	• External DVD Drive		
	• Mobile		
	• SIM Card		
	• E file Account		
	• NIC email ID		
LIBRARY	• Books / Periodicals		
	• Others		
ACCOUNTS	• Advance / Loan		
	• Other Outstanding		

ADMINISTRATION	• Temporary Pass -		
	• Keys		
	• Stationeries		
	• Others		
HR	• Resignation Letter		
	• Notice Period Recovery		
	• ID Card		
	• Others		

-----TO BE COMPLETED BY HR DEPARTMENT-----


Received On: \_\_\_\_\_ Received By: \_\_\_\_\_

Relieving Status: \_\_\_\_\_ Relieving Letter Issued On: \_\_\_\_\_




# Compendium of Letters

## 1. Dated: 19<sup>th</sup> January, 2015, Competency Based Assessment in recruitment of HR under NHM



**C.K. Mishra, IAS**  
Additional Secretary &  
Mission Director, NHM  
Telefax : 23061066, 23063809  
E-mail : asmd-mohfw@nic.in



भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011  
Government of India  
Ministry of Health & Family Welfare  
Nirman Bhavan, New Delhi - 110011

**D.O. No.7 (45)/2014- NRHM 1**  
**Dated the 19<sup>th</sup> January, 2015**

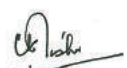
*Dear Mission Director,*

The Ministry has been regularly emphasizing on the critical importance of quality of Human Resources (HR) in the improvement of health care service delivery and betterment of health outcomes. In this regard, kind attention is drawn to this Ministry's letter dated 22 September, 2014 wherein it was conveyed that for all future recruitment of health HR under NHM such as Staff Nurse, ANM and LT, competency-based assessment would be mandatory and States were advised to associate NHSRC in the recruitment process (Copy enclosed). However, it has been observed that the recruitments are not being conducted in the said manner.

It is hereby reiterated that, all recruitments under NHM should be based on competency-based tests that assesses the knowledge and skills of the HR being recruited and a representative from GoI/NHSRC should mandatorily be associated as an Observer at the time of the conduct of competency assessment and final interview. It may be noted that, no support for HR under NHM would be provided unless recruitments under NHM are done as per the above guidance.

*With regards,*

Yours sincerely,

  
(C. K. Mishra)

**MD (NHM) –All States/UTs**

## 2. Dated: 17<sup>th</sup> April, 2015, JS(P) HRMIS- OSS & Open APIs reg



**Manoj Jhalani, IAS**  
Joint Secretary  
Telefax : 23063687  
E-mail : manoj.jhalani@nic.in



भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली – 110011  
GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011

D.O.No. 7 (221)/2013-NRHM-1  
Dated the 17<sup>th</sup> April, 2015

Dear

*Colleague,*

This Ministry, vide the National Health Mission PIP conditionalities, has been emphasizing the establishment of web-based Human Resource Management Information Systems (HRMIS) in the States and UTs for better management of human resources. It is encouraging to note that many States and UTs have established or have initiated measures for setting up online HR management information systems.

In this regard, it is stated that Government of India has adopted the policy on 'Open Source Software for Government of India' where under for all e-Governance systems implemented by various Government organizations, Open Source Software should be accepted as a preferred option in comparison to Closed Source Software.

Further, GoI is also in the process of finalizing and adopting the Open Application Programming Interface (API) Standards so as to enable quick and transparent integration of e-Governance applications and systems implemented by various Government organizations.

In light of the above policies, you are requested to ensure that the HRMIS set-up in your State/UT duly complies with the above policies of Government of India. Further, all the HRMIS applications should be so designed that it is integrated with the process of appointment, transfer, promotion, drawl of salary, etc. so that the HR database always remains updated.

*With regards,*

*Manoj Jhalani*  
Manoj Jhalani

Addressed to Principal Secretary (H& FW), All States/ UTs

Copy to

- Joint Secretary (Urban Health), MoHFW.
- Mission Director, NHM (All States/UTs)



3. Dated: 21<sup>st</sup> April, 2015, JS(Policy) GoI or NHSRC Observers for recruitment process



Manoj Jhalani, IAS  
Joint Secretary  
Telefax : 23063687  
E-mail : manoj.jhalani@nic.in



भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011  
GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011

D.O. No. 7(45)/2014-NRHM-I  
21<sup>st</sup> April 2015

Dear Mission Directors,

I would like to draw your attention to the D.O. letters of even number dated 22<sup>nd</sup> September, 2014 and 19<sup>th</sup> January, 2015 written by AS&MD in respect of the requirement to ensure that all recruitments under NHM are based on competency based tests that assess knowledge and skills of the HR and that a representative from GoI/NHSRC be mandatorily associated as an observer at the time of conduct of competency assessment and final interview.

In this regard, it is also reiterated that competency based assessment was also a key conditionality in respect of the PIP along with initiation of corrective measures thereon, if required. The States were also required to provide a report in this regard. However, response from your State is still awaited.

It is requested that an action taken report in respect of HR recruitment and competency based assessment be provided within a fortnight.

With regards,

Yours sincerely,

  
(Manoj Jhalani)

Mission Directors of all the States/UTs

4. Dated: 3<sup>rd</sup> February, 2016, Strengthening Specialist Support in Public Health facilities



**C.K. Mishra**

Additional Secretary &  
Mission Director, NHM  
Telefax : 23061066, 23063809  
E-mail : asmd-mohfw@nic.in



*Speed Post*  
भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011  
GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011

D.O No. 7(162)/2015-NRHM-I  
Dated the 3<sup>rd</sup> February, 2016



There is a significant shortage of Specialists in CHCs, Sub District Hospitals or Area Hospitals and District Hospitals in many States. There is also need to expand range of specialist services beyond RCH services. It is noticed that despite flexibilities afforded under the Framework for Implementation of NHM and RKS guidelines, many States/secondary care facilities have been unable to engage specialists. To facilitate the States to obtain Specialists services where specialist staff is inadequate, the Ministry has prepared a guidance note on 'strengthening specialist support in public health facilities (DH/SDHs/CHCs that are FRUs)' which is enclosed.

I hope that the States find the note useful and leverage the flexibilities provided under the NHM to ensure availability of specialist services. The States may seek lumpsum funds to hire 'specialist services on part time basis' under the head A.8.1.3.

I would appreciate a feedback on your experience in this regard.

Yours sincerely,

Sd/-

(C.K. Mishra)

Encl. : As above.

Principal Secretary/Secretary (Health & FW)  
All States/Union Territories.

Copy to:

Mission Director, NHM (All States/UTs)



*C.K. Mishra*  
(C.K. Mishra)



## **Mechanisms for Strengthening Specialist Support in Public Health Facilities (DHs/ SDHs/ CHCs that are FRUs)**

The revised '*IPHS Guidelines for Public Health Facilities 2012*' make recommendations for the number and type of specialists required for District Hospitals, Sub Divisional/District Hospitals and Community Health Centers. However, states have generally found it increasingly difficult to recruit Specialists and in most of these facilities there is a significant shortage in their numbers. Alarming, only 18% of required Specialists are in position at the Community Health Centers.<sup>1</sup>

Measures such as offering competitive and negotiable compensations - in tune with market forces - to attract specialists to the government sector under the National Health Mission (NHM) have not been able to address this shortage in any significant way. It is noticed that may States have failed to utilize the flexibility provided under the NHM and in the provisions of the Rogi Kalyan Samiti to address the problem of non-availability of certain specialist services.

Hence, this briefing note suggests various mechanisms that are admissible, through which specialist services can be obtained in the Public Health Facilities. It also further outlines suggestions to improve the efficiency of the specialist work force already in service/proposed to be engaged.

### **1. Sourcing Specialists to Work in DH/SDH/CHCs that are FRUs**

Experience shows that the number and mix of specialists available at DHs/SDHs/CHCs are insufficient to meet the requirements for even providing the essential services as per IPHS. The suggested pool from which the Specialists could be drawn from include:

- (i) Specialists retired from Government Service but continue to be physically & mentally active/ fit for service;
- (ii) Specialists employed in Government Medical Colleges/Teaching Hospitals in the local area but who could come on fixed days of the week/ fortnight/ month
- (iii) Specialists from Charitable Trusts and NGO run Hospitals.
- (iv) Specialists from the Private Sector/ Private Medical Colleges in the surrounding area

<sup>1</sup> RHS 2015

From the options mentioned above, a pool of specialists for each DH/SDH/FRU will need to be identified to support existing medical workforce already employed at the Public Health Facilities. These additional '*contracted-in*' specialists should be for specialties for which there are no specialists at the facility or where the number of available specialists is insufficient to meet current caseloads and HR augmentation is required or where periodic shortages occur.

**Specialists' Requirement at Different Levels of Health Facilities (IPHS):**

No.	Specialty	DH	SDH	CHC
1	Medicine	✓	✓	
2	Surgery	✓	✓	✓
3	Obstetric & Gynecology	✓	✓	✓
4	Pediatrics	✓	✓	✓
5	Anesthesia	✓	✓	✓
6	Ophthalmology	✓	✓	
7	Orthopedics	✓	✓	
8	Radiology	✓	✓	
9	Pathology	✓		
10	ENT	✓		
11	Psychiatry	✓		
12	Dermatology	✓		
13	Microbiology	✓*		
14	Forensic Specialist	✓*		

However apart from these specialists, others such as Endocrinologists, Cardiologists, Neurologists etc. can be engaged, especially for fixed-day/date clinics.

Currently, the practice is to attempt recruitment of full-time Specialists, even for contractual services under the NHM and this has not proved to be adequately effective. Therefore, other arrangements to obtain the services of Clinical Specialists are called for.

The services to be provided are likely to include elements of (a) elective or routine work and also (b) emergency/on-call service provision. While determining the payment structure for



service provision, *Rogi Kalyan Samitis (RKS)* may wish to consider additional payments to cover the expenses for out-of-hours on-call services (e.g. travelling allowance; an extra percentage for the same elective intervention delivered out-of-hours or some other mechanism to compensate for on-call service provision).

A general distinction between elective and emergency work will be useful. A suggested distinction could be along the following lines:

- Elective/routine service provision: This includes elective surgeries, routine OPDs/consultations and in-patient reviews, where appropriate.
- Emergency/on-call service provision: This could include any service provision outside of agreed contracted-in hours and/or for those services for which an emergency *call-out* is requested.

## 2. Governance Arrangements

The *Rogi Kalyan Samitis (RKS)* should be the main mechanism for the ‘*contracted-in*’ services. While the RKS cannot make regular permanent appointments, it can *contract in* the services of specialists, Medical/Para medical staff, and professional counselors etc. The contracts would be approved by the Executive Committee of RKS and reviewed periodically (say one year) and renewed if appropriate.<sup>2</sup>

There are various mechanisms through which ‘*contracted-in*’ services can be negotiated with specialists. In principle, the timings agreed with them should coincide with the general working hours and the scheduled pattern of work at the facility. Some of the arrangements by which services can be contracted in include:

- A. Annual contract at competitive market rate for specialists whose services are required on a daily basis
- B. Fixed number of hours/working day(s)
- C. Fixed day/date/week
- D. Fixed number of hours/week
- E. Fixed surgical sessions/week (or fortnight/month) according to need/disease condition
- F. Block of doctors from single or multiple specialties

<sup>2</sup> Rogi Kalyan Samities in Public Health Facilities 2015

G. Case by case basis, on call e.g. anaesthetist, obstetrician for each c-section

The following processes are essential before engaging these specialists.

**Step 1:** The RKS need to do a situational analysis of current availability of specialists and the caseload per specialist and gaps in relation to desired specialty services for that facility and map the specialist resources in and around the district etc that could be available.

**Step 2:** Define clear terms and conditions that will outline the list of services to be provided; key performance indicators and arrangements for performance measurement; compensation mechanisms and mechanisms for ensuring accountability.

**Step 3:** The compensation mechanism and terms of engagement will essentially depend on the nature of the contracting in arrangement. However, the provision for post-operative care and follow-up in case of specialists should be provided. Similarly, additional compensation for emergency on-call work may be considered.

Accountability mechanisms should also include checks & balances for appropriate referrals and ensuring referrals to government facilities in the first instance, wherever appropriate. Such matters should involve approval of the Facility-in-Charge.

**Step 4:** Design a system for grievance redressal and/ or for obtaining feedback from patients as well as '*contracted-in*' specialists

### 3. Improving the Efficiency of Available Specialist Resources

Another important issue is the inefficiencies arising from the inadequate use of the specialists already employed at the DH/SDH/CHC. There are various reasons for specialties being rendered non-functional, e.g. irrational deployment such as Surgeons and Obstetrician posted at a facility with no Anesthetist, lack of appropriate equipment/infrastructure, inadequate support staff, absenteeism, vested interests (diverting government patients towards personal practice/private hospitals) and using Specialists for General MO Duties etc.

States will need to consider measures to enable greater efficiency from the specialists employed at the DH and ensure optimum functionality of existing specialties. Certain suggested measures are:



- A. Adopting a policy of rational deployment, e.g. a health department order that Surgeons and Obstetricians are posted only at a facility with adequate numbers of Anesthetists or LSAS trained doctors or having Anesthetists empaneled with the facility; Pediatricians are posted where Obstetricians specialists are present - to improve MCH services
- B. Ensuring availability of adequate support staff
- C. Review committees - with active participation of specialists - to ensure the availability of appropriate equipment/infra-structure
- D. Active participation of the DQAC and DQAU to ensure quality provision of services
- E. Developing and implementing a system of performance management against key indicators and targets to introduce accountability <sup>through</sup> ~~under~~ the RKS
- F. Introducing a system of league tables for different facilities and different specialties in DH/SDH/CHCs across the state to encourage a spirit of health competitiveness and encourage better performance
- G. Social audits (including *Jan Sunwai* and *Jan Samwad*) to investigate and address issues of absenteeism and conflicts of interest
- H. Introducing a system of team based performance linked incentives to encourage and motivate team of performers
- I. Seeking funds under the NHM PIP, wherever required, to hire specialist services ~~and~~ on part time basis and for team based intervention under ~~head of NHM~~ —  
— of PIP of NHM.

## 5. Dated: 8<sup>th</sup> March, 2016, Applicability of Employee Provident Fund Act, 1952.



**Manoj Jhalani, IAS**  
Joint Secretary  
Telefax : 23063687  
E-mail : manoj.jhalani@nic.in



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स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011  
Government of India  
Ministry of Health & Family Welfare  
Nirman Bhavan, New Delhi - 110011

D.O. No. G.27034-8/2015-NHM(F)

Dated: 08<sup>th</sup> March, 2016

Dear

This is with reference to the clarification on the applicability of the Employees Provident Fund and Miscellaneous Act, 1952 on the State Health Societies funded by Central and State Governments registered under the Societies Act, 1860 owing to expiry of the exemption notification SO no. 1431 on 31.03.2015.

It has been confirmed by the Ministry of Labour and Employment that the said notification which had earlier granted exemptions to certain organizations like State/District Health Societies under the Employees Provident Fund and Miscellaneous Act, 1952 will not be extended and these will now come under the purview of the Act.

Therefore, the States/UTs are requested to provide for the statutory liabilities in reference to the wage limit for mandatory contribution under the EPF Act which is Rs. 15000/- in the PIPs for the current financial year and complete the necessary formalities for registration and compliances under the Act. The compensations proposed in the PIPs in future should be inclusive of the EPF obligations.

Yours sincerely,

Sd/-

(Manoj Jhalani)

To

Principal Secretaries (H&FW) of 36 States/UTs

Copy to : Mission Directors, NHM of 36 States/UTs

  
(Manoj Jhalani)

## ROADMAP FOR IMPLEMENTING HEALTH SYSTEMS APPROACH IN HR

<b>Phase-1</b>	<b>December, 2016</b>
	Designate nodal officers at State and district level
	Estimate HR required on the basis of IPHS (for facilities based on Population norms and time to care) and work load*
	Find out the gap between required and current HR (Current HR to be entered in HRIS and HMIS)
	Calculate utilization of current HR on the basis of HMIS reporting
	Identify cadres and facilities where multi-skilling is required
	Prepare supplementary proposals for strengthening HR Cell (if required), orientation workshops, multi-skilling training, and pay parity in the contractual cadres
<b>Phase 2</b>	<b>January, 2017</b>
	State to communicate to all facility in charges regarding 'health systems approach'; workshops for orientation to orient about changes including changes in DDOs, salary disbursement chain, attendance, leave and contract renewal/ granting authority, revised delegation of administrative authority
	Chalk out plans for rolling out HR integration including multi-skilling training
	Finalize multi-skilling training modules for LTs and counsellors*
	Initiate multi-skilling training, at two batches to be trained
	At least 25% of the facilities identified as having HR but not performing optimally to be re-organized
	Organize Skill and competency tests prior to implementing pay parity
	Fully operational HRMIS, Corresponding entries to be made in HMIS
<b>Phase 3</b>	<b>February-March, 2017</b>
	Complete multi-skilling training of LTs and counsellors, Add more cadres as required (e.g. physiotherapists, audiologists, psychologists etc.)
	Roll out universalization of NHM programs especially Elderly, NoHP, NMHP, NPCDCS etc.
	All facilities to be re-organized to follow health systems approach
	Workshops and meetings to review progress
<b>Afterwards</b>	<b>April, 2017 onwards</b>
	State NHM Review meetings to review progress of health systems approach to HR every quarter
	Performance of facilities to be monitored based on reporting in HMIS
	Organize refresher training as and when required (but at least once a year)

\* MoHFW to send work load estimates and integrated training modules



## 6. Dated: 13<sup>th</sup> June, 2016, Applying Health Systems Approach in HR under NHM



NRHM/NHM has been focusing on strengthening health systems in States/UTs including supplementation of regular HR. However so far, a systematic effort to integrate the programmatic Human Resources and follow health systems approach has been slow.

2. I am happy to share that the Mission Steering Group (MSG) in its meeting held on 29<sup>th</sup> March 2016 has approved the proposal for applying health system approach to HR under NHM. The gist of the decisions is as under:

- Optimize utilization of HR and avoid duplication by bringing all facility based service-delivery HR together and applying health systems approach as opposed to programmatic approach. Hence, from now onwards there would be no program specific HR.
- Implement IPHS and workload as the basis to determine the number of HR and for considering any additional human resource including programme management posts.
- Apply similar norms of performance appraisal and increment for all contractual HR.
- Bring parity in remuneration for posts under the NHM in the particular State Health Society commensurate with qualifications and experience.

3. These strategic decisions are expected to bring about transformative improvements in the way we operate our health system. If implemented properly we will get far better outputs from available HR and help us provide services as per IPHS, even with available human resources. States/UTs should carry out facility-wise HR-analysis based on IPHS/ Caseloads and rationally deploy the HR from facilities with excess HR to those deficient in that particular HR. The HR should take into account the positions available under regular workforce, contractual positions approved under State Government and those approved under NHM and NACO. Any new HR should be recruited and posted only if there is an overall gap in a particular HR category at the State/UT level.

4. The states/UTs are also being supported and encouraged to move to an electronic application that captures the HR position facility-wise on real-time basis so as to facilitate

o/c



optimal HR utilization on a regular basis. A detailed guidance note on how these decisions can be implemented is being sent separately.

5. To ensure that the performance under vertical programmes doesn't suffer, all the facility in-charge should be trained and oriented to report progress on all disease control programmes to State Programme Divisions besides the Directorate and NHM. Further, States must undertake refresher/multiskilling training of common HR under various programmes such as LTs, Nurses, Counsellors etc particularly where the staff is required to render services under different programmes.

6. States may submit a supplementary PIP to effectively operationalize the decision of MSG including bringing parity in remuneration for posts under NHM commensurate with qualification and experiences.

7. I expect the States to fully integrate the HR and implement these decisions positively within six months. There could be some teething problems in few states. Let me assure you that our team would be available to work by your side whenever you require our support. I look forward to hearing on the successes and challenges you face in implementing these decisions.

Your sincerely

-sd-

(C K Mishra)

To

Additional Chief Secretary (H&FW)/Principal Secretary (H&FW)/Secretary (Health – All States/UTs)

Copy to:

(1) MD NHM – All States/UTs

(2) JS(AP)/JS(VG)/JS(KRR)/JS(SS)/JS(DP)/JS(KCS)

(3) DG, DGHS

(4) All Programme Divisions, NHM

  
(C K Mishra)

## 7. Dated: 22<sup>nd</sup> July, 2016, Remuneration of Existing DEOs to be paid from Lumpsum Budget



**Manoj Jhalani**

Joint Secretary & CVO

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Government of India  
Ministry of Health & Family Welfare  
Nirman Bhavan, New Delhi - 110011

D.O.No 10(36) /2016-NRHM-I  
22<sup>nd</sup> July, 2016

*Dear colleague,*

Pursuant to issue of RoPs for 2016-16, some States have sought clarification regarding lump sum amount approved for data entry.

2. In the RoP 2016-17, specific approvals for the posts of DEOs have not been given, though the funds required for the same has been approved as a lump sum under A.8, A.10, B.15 and other heads. This is based on the decision in the NPCC that the data entry should be done, to the extent possible, on task rate basis or through outsourcing. Some States have expressed inability to outsource the existing DEOs. In such cases, states have the option to continue the existing posts. However, no new DEO positions have been approved and no new DEOs should be recruited under NHM. States may note that the remuneration for existing DEOs /data entry operations is to be paid out of the lump sum budget already approved under A.8, A.10, B.15 and other heads.

*With regards,*

Yours sincerely

*MJ*  
(Manoj Jhalani)

To,

- (1) Additional Chief Secretary (HFW)/Principal Secretary (HFW)/Health secretary –All States/UTs
- (2) MD, NHM- All States/UTs

8. Dated: 6<sup>th</sup> December, 2016, JS(Policy) Roadmap for implementing Health systems approach



**Manoj Jhalani**

Joint Secretary & CVO

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स्वास्थ्य एवं परिवार कल्याण मंत्रालय

निर्माण भवन, नई दिल्ली - 110011

Government of India

Ministry of Health & Family Welfare

Nirman Bhavan, New Delhi - 110011

D.O. No. V-11011/3/2016-NRHM-II

Dated the 6<sup>th</sup> December, 2016

*Dear colleague,*

Please refer to this Ministry's D.O letter of even number dated 13<sup>th</sup> June, 2016 conveying the decisions of the Mission Steering Group (MSG) for applying Health Systems approach to HR under NHM. (Copy enclosed for ready reference). To facilitate the States/UTs, the Ministry has prepared a roadmap for HR integration.

May I request you to implement the health systems approach under NHM as per the timelines indicated in the roadmap.

*With regards,*

Yours sincerely,

*(Signature)*  
(Manoj Jhalani)

Encl: as above

To

Additional Chief Secretary / Principal Secretary / Secretary (HFW) – All States/UTs

Copy to:

- 1) MD, NHM – All States/UTs
- 2) DG, DGHS
- 3) JS(AP)/ JS(VG)/ JS(KRR)/ JS(SS)/ JS(DP)/ JS(KCS)
- 4) All Programme Divisions, NHM

## 9. Dated: 8<sup>th</sup> February, 2017, JS(Policy) Guidance note to States on empanelled recruitment



**Manoj Jhalani**  
Joint Secretary & CVO  
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GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011

D. O No. Z-18015/10/2015 – NRHM –II  
Dated the 8<sup>th</sup> February, 2017

Dear *colleagues,*

I would like to draw your attention to the D.O letters of even number dated 22<sup>nd</sup> January, 2016 and 8<sup>th</sup> March, 2016 wherein a list of 10 HR Recruitment agencies empanelled (list enclosed for reference) for assisting States/UTs in recruitment of contractual Human Resources under NHM was forwarded.

In this regard, please find enclosed a Guidance note along with Model of Request for Financial Bid (RFB) and a Model Agreement for utilization of services of these empanelled agencies. As conveyed earlier also, your State/UT may call for financial bids from these empanelled agencies for recruitment services.

I hope that these documents will help the State/UT to fill up all the vacant positions under NHM in a professional and transparent manner.

For any further query, your State/UT may consult NHM Division (Capt. Kapil Chaudhary, Director at kapil.chaudhary@aera.gov.in) or NHSRC (Dr Dilip Singh, Advisor, HRH at drdilipsingh@gmail.com).

*With regards,*

Yours sincerely,

*M*  
(Manoj Jhalani)

Encl: As above

Additional Chief Secretary/Principal Secretary/Secretary (Health), All  
States/UTs



## 10. Dated: 30<sup>th</sup> June, 2017, Attracting Specialist doctors under NHM

*R&I*  
*Pl. issue (72) letters*  
*4/7/17*

**NATIONAL HEALTH MISSION**  
राष्ट्रीय स्वास्थ्य मिशन

**Arun Kumar Panda**  
Additional Secretary &  
Mission Director, NHM  
Tele : 23063155, Fax : 23063156  
E-mail : asmd-mohfw@nic.in

*Dear Secretary,*

Availability of Human Resources for Health, especially the availability of specialists and doctors still remains a challenge in most of our states and districts. NHM over the years has supported the States in supplementing their efforts of getting these scarce resources. However, analysis of data shows that in many of the States, the posts of specialists and Medical Officers remain vacant year after year. This is a matter of grave concern. While interacting with the functionaries at various levels on this issue, I have come across some good practices which I want to share with you:

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GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
DEPARTMENT OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011  
D.O.No. Z. 18015/6/2016 – NHM-II(Pt.III)  
30<sup>th</sup> June, 2017

*SPEED POST*

*04 JUN 2017*

- Salaries offered to the Specialists need to be lucrative enough to attract the candidates. NHM provides unprecedented flexibility in salaries for specialists, which the States must take advantage of. State may keep the salary flexible and depending on the remoteness, difficulty of terrain/area and availability of specialists, determine the exact amount for a particular facility. The ultimate objective should be to make services available in the remotest districts and their FRUs. One can provide different remuneration to specialists posted in different facilities and can also provide different remuneration to different specialists posted in same facility based on market reality
- These provisions could also be extended to the specialists available in regular cadre as a top-up from the NHM and given as additional hardship allowance to specialists who are ready to work in remote/difficult facilities. It would always be better, however, if hard area allowances were also linked to some minimum performance outcome related to that speciality.
- States may identify about 10-20% of the facilities/places which are most difficult and offer a fixed tenure posting of say 2-3 years, after which the specialists / doctors are posted for at least three years in their chosen place and facility. The policy should be such that it allows the regular doctors to choose a time period in their career when they are prepared to go for such a posting. It would be good to mention the date of relieving from hard posting and the next place of their posting to their chosen facility in the initial posting /transfer order itself, thereby generating confidence to adhere to this policy and assuring doctors of the fixed tenure in hard area.
- In order to ensure good performance from the HR posted, States may also provide performance based incentives to their team for achievements over and above a defined threshold of performance.
- Though remuneration may be one of the prime motivators, many other factors such as proper working conditions, availability of team of support staff e.g. staff nurse, OT attendants, equipment and supplies to practice the specialty, living quarters, family accommodation, opportunity for professional growth etc. also need to be looked into. Some States have arranged for porta-cabins in remote areas for specialists and doctors on duty to stay while at the same time have provided free residential accommodation to their families wherever they want to stay.

- Doctors on remote rural posting at times may feel professionally isolated. To encourage continuous professional learning, the doctors posted in such areas could be supported to attend conferences and workshops of their choice for a week or two within the country or even in a neighbouring country with good public health systems, say every two years.
- One of the biggest hurdles in regular systems specialist recruitment is the absence of specialist cadre in some states. Such states must create specialist cadre based on identification of facilities and speciality-wise posts, and recruit PGMOs on a higher salary slab. States are encouraged to do regular recruitments including campus recruitments from states having large number of medical colleges for specialists to overcome the high turnover. States may also seek help of recruitment agencies empaneled by NHSRC in attracting, screening and finding quality candidates.
- We also need to strengthen our district hospitals, start DNB and CPS courses to supplement the pool of specialists and improve quality of services in our district hospitals. Age of retirement is another area which may need reconsideration.
- Another key measure to encourage MBBS doctors to go for rural/remote posting is to give weightage of rural and remote posting in the post graduate degree / diploma courses, which most States have already done.
- In order to operationalize FRUs, 4 months quality EmOC and LSAS training skills training for MBBS doctors also needs to be explored fully.
- At places where there is limited availability of specialists in public health facilities, private doctors may be empanelled for 'on-call service' at an appropriate per case or per day basis rate to ensure assured EmOC and other services. The specialists/ super-specialists could also be invited on a fixed day basis. This is a practice regularly resorted to by private hospitals and could be well leveraged by public hospitals too.

Some of the steps or initiatives enumerated above may require policy reforms. Some may need change in the existing recruitment and promotion rules. Some may merely require a proposal to be included in NHM PIP for budget. While HR remains one of the most difficult issues to tackle, the steps taken to resolve the issues are also an indicator of good governance and our willingness to take tough decisions and to do 'whatever it requires' to ensure requisite HRH in facilities to provide assured quality services to the public. Let us make 2017-18 the year when all required steps including progressive steps in changing the HR policy are taken to ensure availability of HR. I see it not as an option but as an imperative for strengthening the health system and making it future ready.

I look forward to hearing from you on the initiatives you plan to take in your state.

Regards,

Yours sincerely,

  
(Arun K Panda)

To,


The Addl. Chief Secretary/Principal Secretary/Secretary, Health and Family Welfare – All States and UTs

Mission Director - All States and UTs


*c/c*



## 11. Dated: 13<sup>th</sup> July, 2017, Equal Pay for Equal Work for HR under NHM

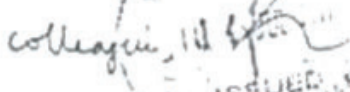


**Manoj Jhalani**  
Joint Secretary & CVO  
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GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NHMAN BHAVAN, NEW DELHI-110011

D.O. Letter No. P-17020/19/2017-NHM-IV  
13<sup>th</sup> July, 2017

Dear *colleague*, 

As you may be aware, Hon'ble Supreme Court has pronounced judgment dated 26.10.2016 in Civil Appeal No. 213/2013 in the matter of State of Punjab & Ors. Vs. Jagjit Singh & Ors and several other tagged cases, through which the apex court has granted similar benefit to the petitioners, who are temporary employees, as granted to regular employees on the basis of the principle, 'equal pay for equal work'. The Operative portion of the Judgment dt. 26.10.2016 is as under:-

*'In view of the position expressed by us in the forgoing paragraph, we have no hesitation in holding, that all the concerned temporary employees, in the present bunch of cases, would be entitled to draw wages at the minimum of the pay-scale (-at the lowest grade in the regular pay-scale), extended to regular employees, holding the same post.'*

- After passing of the judgment, this Ministry is receiving representations from contractual employees engaged under NHM seeking application of the order to their cases. The contractual Staff Nurses engaged under NHM, Odisha have submitted petitions seeking enhancement in remuneration paid to them in terms of Judgment dt. 26-10-2016 pronounced by Hon'ble Supreme Court in Civil Appeal No. 213 of 2013 - State of Punjab Vs. Jagjit Singh & ors. on the principle of 'equal pay for equal work.' Some of the States/UTs such as Jharkhand and Govt. of NCT of Delhi, who have received similar representations have requested the Central Govt. to consider the issue of pay parity of these employees in terms of the judgment. Some States have sought advice/suggestions in the light of representation received from contractual employees.
- The contractual employees engaged under NHM might approach CAT and other courts for implementation of Supreme Court's Judgments in their cases. It is observed that there are significant variations in regular and contractual employees in the manner of their selection, duties and responsibilities etc. The engagement of contractual HR is not against regular sanctioned posts of the State. The duties and responsibilities of contractual HR under NHM cannot be said to be similar and equivalent to regular employees and in many cases it is unlikely that there would be corresponding positions. The contractual HR under NHM are engaged by the State District Health Societies and not by the State Government against regular sanctioned post.
- The matter has been examined in this Ministry and advice has been obtained from the Ministry of Law. It has been observed that the relief has been granted by the Hon'ble Supreme Court to concerned temporary employees who were parties in the bunch of cases.
- The Ministry of Law has opined that the aforesaid judgment dated 26.10.2016 passed by the Hon'ble Supreme in Civil Appeal No. 213 of 2013 appears to be not applicable to NHM contractual employees and the parameters laid down by the Hon'ble Supreme Court in

para 42-45 of the aforesaid judgment appears to be *Judgment in Rem* i.e. applicable to all persons that come under the same status as discussed in the aforesaid proposal.

6. In view of the aforesaid, there is no basis for enhancing remuneration of the NHM contractual employees in terms of aforesaid judgment. The States/ UTs may dispose off representations received by them in terms of above advice. In view of the possibilities of the Court Cases arising on this count, the States/ UTs may contest the cases effectively. In connection with this subject, I am forwarding a copy of CAT order dated 22-03-2017 in the matter of OA/060/00308/2017 for reference purposes.

With Regards,

Yours sincerely,

  
(Mahesh Jhalani)

All Pr. Secretaries/Secretaries (Health) of States/ UTs.



## 12. Dated: 1<sup>st</sup> March, 2018, Improving Human Resource for Health Availability at Public Facilities



प्रीति सूदन  
सचिव  
PREETI SUDAN  
Secretary



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Government of India  
Department of Health and Family Welfare  
Ministry of Health & Family Welfare

D.O.No. Z.18015/6/2016-NHM(Pt.XI)  
Dated : 1<sup>st</sup> March, 2018

Dear Chief Secretary,

Subject : Improving Human Resource for Health Availability at Public Health Facilities – Reg.

As you are aware, under the National Health Mission the Government of India is supporting States and UTs in strengthening the health systems, including overall availability of Human Resource for Health (HRH) as per IPHS standards. However, despite this report availability of health human resource still remains a challenge in most of our States. In a recent review with Collectors of Aspirational Districts, one of the foremost problems listed by them was shortage of health human resources in these districts.

You are requested to fill up vacancies and rationalize the postings. Further, you should consider authorizing District Collectors to fill-up the vacancies at their level so that vacancies get filled up expeditiously.

*Kind regards,*  
Yours sincerely,

*(Preeti Sudan)* 1.3.18

Chief Secretaries of all States/UTs

Copy to : Shri Amitabh Kant, CEO, NITI Aayog, New Delhi – 110 001.

### 13. Dated: 17<sup>th</sup> May, 2018, PIP and HR Approval



**Manoj Jhalani**

Additional Secretary & Mission Director, NHM

Telefax : 23063687, 23063693

E-mail : manoj.jhalani@nic.in



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स्वास्थ्य एवं परिवार कल्याण मंत्रालय

निर्माण भवन, नई दिल्ली - 110011

GOVERNMENT OF INDIA

MINISTRY OF HEALTH & FAMILY WELFARE

NIRMAN BHAVAN, NEW DELHI - 110011

D.O.No.10(36)/2017-NHM-I

17<sup>th</sup> May 2018

*Dear colleague,*

Subject: **PIP and HR Approvals**

MoHFW with the aim of strengthening and simplifying the planning process, has brought in major changes in the PIP budget sheet in FY 2018-19. Adopting health system approach, the PIP has been categorised into 18 heads required for implementation of any programme.

As mentioned in PIP guidelines any programme/ initiative planned were to be broken and budgeted in 18 given heads, as applicable. However, appraisal of PIPs show that few states have clubbed many activities together thereby defeating the very purpose of budget revamp. As informed in the NPCC meetings, any human resource (Programme Management or Service Delivery) proposed in the clubbed activities, which has not been proposed under dedicated heads for HR will not be considered for appraisal. Even if the lump sum amount is approved unknowingly by the programme divisions, **no HR would be considered as approved.**

Further, to initiate HR integration and ensure rationalization of salaries of staff with similar qualification, workload and skills, additional budget (3% of the total HR budget) was approved by NPCC in FY 2017-18 as per state's proposal. **This budget was approved with the condition that the exact amount of individual increase should be decided by state in its EC and HR rationalization exercise and its principles including increases to be approved by SHS GB. States were directed to ensure that increases are approved in such a way that it smoothens the process of HR integration. In cases where the salary difference among similar category position with similar qualifications and experience is very high (say more than 15%), it was to be done in parts as it may take 2-3 years to rationalize it fully.** The same principle applies to the approvals of FY 2018-19. Therefore, we continue to approve additional 3% of the total HR budget in FY 2018-19 for HR integration, subject to the states asking for it.

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Salaries of all staff have been approved in the ROP (FY 2018-19) as proposed by the state assuming that any increase/ decrease of salary has been approved by the EC and GB. In case, **any of the proposed salary has not been approved by the State EC and GB, the individuals will not be eligible to receive higher salary as approved in the ROP FY 2018-19** and only 5% of annual increase is to be provided on base salary approved in FY 2017-18. Any additional amount already paid would have to come from state budget. States must undertake HR integration process using the additional budget approved last year and this year. The details are to be submitted to MoHFW along with a signed letter from Mission Director and a copy of minutes of meeting held with EC and GB based on which decision has been taken.

Any deviation from the above would be treated as contravention of Record of Proceedings of NPCC and would apart from inviting audit objection would be flagged to Chief Secretary for disciplinary action.

*With regards,*

Yours sincerely,



( Manoj Jhalani )

Principal Secretary (Health) / Secretary (Health)/Commissioner (Health) of all States / UTs

Copy to:

Mission Director (NHM) of all States / UTs



# 14. Dated: 28<sup>th</sup> June, 2018, Attracting and Retaining quality Skilled HR under NHM



मनोज झालानी  
Manoj Jhalani

अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)  
Additional Secretary & Mission Director (NHM)



भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011  
GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011

D.O. No.: Z15015/9/2018 - NHM I  
Dated the 28<sup>th</sup> June 2018

Dear colleague,

The NHM country wide HR Heroes campaign was initiated with the objective to attract and retain quality skilled human resource in the health system. In this regard, I am very happy to share with you the prototypes of the HR advertisements which were developed for the States of Jharkhand and Uttarakhand for the professionals who have excelled in their respective fields. These will also enable you to reach professionals with the right attitude along with the skills and at the same time boost the morale of the currently engaged Human Resources for Health (HRH).

2. These prototypes also include a redesigned print media advertisement which were developed to improvise on the HR recruitment advertisements under NHM. A soft copy of the same shall be shared electronically.

3. May I request you to ensure that similar prototype templates are customised for your State/local heroes and used both in print and on-line advertisements extensively, as deemed appropriate.

I look forward to seeing the utilization of these advertisements and your suggestions.

With regards,

Yours sincerely,

(Manoj Jhalani)

**Additional Chief Secretaries / Principle Secretaries / Secretary (Health & FW) – All States / UTs**

Copy to:

1. Mission Directors, NHM All States / UTs
2. Executive Director, NHSAC
3. Mona Gupta, Advisor (HRH)

स्वच्छ भारत-स्वस्थ भारत

Telefax : 23063687, 23063693 E-mail : manoj.jhalani@nic.in

15. Dated: 18<sup>th</sup> December, 2018, Experience Bonus for HR under NHM



मनोज झालानी  
Manoj Jhalani

अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)  
Additional Secretary & Mission Director (NHM)



भारत सरकार  
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निर्माण भवन, नई दिल्ली - 110011

GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011

*D.O. No.: Z-18015/23/2018-NHM-II-Part 1*  
*Dated the 18<sup>th</sup> December, 2018*

*Dear colleague,*

This is regarding the experience bonus approved for HR under NHM in F.Y 2017-18 and 2018-19. The experience bonus has been designed to address the problem of experienced HR getting equal or even less compensation/emolument than the new HR being recruited at the same or similar positions. It is also to retain the experienced HR who are competent, skilled, and can implement NHM well.

Those HR who have been in the system for more than 3 years under NHM could be given 10% additional increment, over and above the annual increment. Those having 5 years or more could be given 15% additional increment. The NHM HR who has received 10% additional increment on completing 3 years of service, would be eligible for only 5% additional increment (and not 15%) on completion of 5 years. Please note that experience bonus (like any increment) would be added to the base compensation next year. The annual increment next year would be calculated on this enhanced compensation so as to retain the person at an increased level of emolument.

If a person has applied and already moved up, to a better and higher paid position within the system, it will not warrant experience bonus. However those who are at same or similar positions for longer period should receive compensation higher than the more recent recruits for the same/similar positions, with similar educational qualifications, skills, and work load.

Although the State governments have the flexibility to decide the compensation/emoluments for new positions, I would like to reiterate that the State must look into the existing compensation structure in the State NHM before deciding emoluments of a new post.

I hope you would propose and disburse the experience bonus keeping in view the principles of HR rationalization and integration and make progress in retaining skilled HR and keep them motivated.

*With regards,*

Yours Sincerely


(Manoj Jhalani)

**Additional Chief Secretary / Principal Secretary / Secretary** (Health & Family Welfare):- All States / UTs


स्वच्छ भारत-स्वस्थ भारत

Telefax : 23063687, 23063693 E-mail : manoj.jhalani@nic.in

16. Dated: 9<sup>th</sup> January, 2019, Placement of Male MPW at HWCs



**मनोज झालानी**  
**Manoj Jhalani**  
अपर सचिव एवं मिशन निदेशक (श.स्वा.मि.)  
Additional Secretary & Mission Director (NHM)



सत्यमेव जयते

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GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011  
D.O. No. : Z-28015/445/2018-TB -Pt (1)  
Dated the 09<sup>th</sup> January 2019


*Dear Sir,*

As you are aware, Sub Health Centres are being transformed to the Health and Wellness Centre to expand comprehensive primary health care closer to the community. To effectively delivery essential package of services, Ministry of Health and Family Welfare is considering placement of Male Multi-Purpose Health Worker (MPW) at the Health and Wellness Centres (HWCs).

State/UTs are requested to make suitable provisions of placement of Male MPWs at the Health and Wellness Centre in their PIP Proposals for F.Y. 2019-20. The State may propose to deploy a Male MPW at the Sub Health Centre as the 2<sup>nd</sup> MPW, which may be supported under the NHM subject to the approval for the scheme from the Mission Steering Group and condition specified by EPC as under

- 1) Additiognal MPWs appointed after 01.04.2018
- 2) MPWs who conform to the norms for curriculum and certification of trained Male MPWs, as may be prescribed by the MoHFW
- 3) Either a Male MPW or a 2<sup>nd</sup> Female MPW at the HWC, but not both

*With regards,*

Yours sincerely,  
  
**[Manoj Jhalani]**

**Additional Chief Secretary / Principal Secretary / Secretary (Health & Family Welfare):- All States / UTs**

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स्वच्छ भारत—स्वस्थ भारत  
Telefax : 23063687, 23063693 E-mail : manoj.jhalani@nic.in



17. Dated: 6<sup>th</sup> March, 2019, Placement of MPW at SHCs



विकास शील  
संयुक्त सचिव  
VIKAS SHEEL  
Joint Secretary



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भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011  
Government of India  
Ministry of Health & Family Welfare  
Nirman Bhavan, New Delhi -110011  
Phones : 23061481, 23063506 (T/F)  
E-mail : sheelv@nic.in

D.O. No. Z-28015/445/2018-TB - Pt (1)

Dated the 6th March 2019

*Respected Madam/ Sir,*

Please refer to the D.O. No. Z-28015/445/2018-TB - Pt (1), issued from the Office of AS&MD (NHM) on 9<sup>th</sup> January 2019. For effective delivery of essential package of services at Sub Health Centres, Ministry of Health and Family Welfare has considered placement of Male Multi-Purpose Health Worker (MPW) at the SHCs. The Mission Steering Group of National Health Mission in its 6th meeting on February 2nd, 2019 has approved the same. Details of the initiative are placed at Annexure.

This is for your information and necessary action.

*With warm regards*

Yours sincerely

Encl: As above.

*(Signature)*  
6/3/19  
(Vikas Sheel)

To

Additional Chief Secretary/Principal Secretary (Health)/Secretary (Health) – All States/UTs

MD-NHM – All States/UTs

**Scheme for supporting Multipurpose Health Worker (MALE) under the NHM****1. Background**

1.1 The concept of Multi-Purpose Health Workers (Male and Female) was introduced in 1974 for the delivery of preventive and promotive health care services to the community at the level of Sub-Health Centres (SHCs).

1.2 The Multipurpose Health Worker (Male) is the grass root health functionary for the control of communicable diseases including Malaria, TB, Leprosy, Water Borne Diseases, as well as Environmental Sanitation, detection of disease outbreaks and their control, health education etc.

1.3 During the past two decades, availability of MPHWS (Male) has dropped down considerably leading to a critical gap in the healthcare delivery structure against as envisaged under the IPHS.

1.4 Non-availability of MPHWS (Male) across the states has been one of the critical issues in implementation of national programmes including National Vector Borne Disease Control Program (NVBDCP), Revised National Tuberculosis Control Programme (RNTCP), and National Leprosy Eradication Programme (NLEP). Government of India has set a goal to achieve elimination of Tuberculosis (TB), Malaria, Leprosy, Kala Azar and Lymphatic Filariasis under the National Health Policy 2017. Non-availability of the MPHWS (Male) has been one of the important causes for underachievement in these programmes.

1.5 With epidemiological transition, non-communicable diseases, introduction of several national health programs for non-communicable diseases and targeting numerous communicable diseases during 12th five year plan period and beyond, also required the services of MPHWS (Male) for their effective implementation at field level.

1.6 Under the Ayushman Bharat Programme, the PHCs and SHCs are now being transformed to Health and Wellness Centres (HWCs) to expand comprehensive primary health care, and to take care closure to community. It is envisaged under the NHM that there should be a male and a female health worker at the Sub Health Center level. Indian public health standards (2012) also recommend one male health worker as an essential requirement at the SHC.

1.7 Provision of a MPHWS (Male) at the Sub Health Center level will not only increase the reach of the public health systems to the whole spectrum of population



but is also likely to lead to better public health outcomes in general and specially for disease control programmes such as RNTCP and NVBDCP.

## 2. **Support for Male MPW:-**

2.1 The states will be incentivized for creating and filling up posts and for reviving the cadre of MPHWH (Male).

2.2 Provision of MPHWH (Male) in the states' PIPs may be supported under NHM under the following conditions –

2.2.1 For creating and filling up posts of MPHWH (Male) –

2.2.1.1 The status of created posts and filled posts in states as on 01.04.2018 as per the Rural Health Statistics data will be taken as benchmark.

2.2.1.2 Support will be sanctioned if the state creates more posts of the MPHWH (Male) after 01.04.2018. However funds will be released only after the state fills up such posts.

2.2.1.3 Support will be given to states only to the extent of number of posts filled after 01.04.2018, i.e. support will not be given for the posts already filled as on 01.04.2018.

2.2.1.4 If a state proposes to deploy a 2<sup>nd</sup> MPWH at the SHC, the proposal may be supported under the NHM for either a Male MPWH or a 2<sup>nd</sup> Female MPWH at the HWC, but not both at this stage.

2.2.1.5 State are encouraged to consider provision of the MPHWH (Male) instead of a 2<sup>nd</sup> ANM at the SHC level. States may also be supported if they decide to drop already sanctioned positions of the 2<sup>nd</sup> ANM and seek support for MPHWH (Male) at the SHC.

2.2.1.6 Support for salary of additional Male MPHWHs appointed by the state, as per the existing norms for supporting the salary for Female MPHWHs under the NHM.

2.2.1.7 The Ministry shall prescribe the training curriculum for the course of male MPWH and the process of certification of qualified MPHWH (Male). Support shall be given only for such qualified and certified Health Workers.

2.2.2 For training capacities for MPHWH (Male) –

2.2.2.1 Grants for salaries of faculties in the male MPHWH Training Centers (setup prior to 2012) are already being provided to states under the infrastructure grants under the NHM. States may be advised to fill up faculty positions in these institutions.

-: 3 :-

2.2.2.2 States may also be supported for increasing training capacities for male MPHWs. This support may be given according to the existing norms for supporting MPHw training centers, supported under the infrastructure grant. Such additional support may be given under the Health Systems Strengthening Pool & within the resource envelop of the state concerned.

2.2.2.3 Support may also be given under the Health Systems Strengthening Pool for recurring expenses of the training centers such as rental and administrative expenditure and stipend for the students if sought by a state. The Ministry will prescribe appropriate norms for the same.

## 18. Dated: 4<sup>th</sup> July, 2019, Letter from Secretary (HFW) to CS All States Strategies for HR



प्रीति सूदन

सचिव

**PREETI SUDAN**  
Secretary



भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण विभाग  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
Government of India  
Department of Health and Family Welfare  
Ministry of Health & Family Welfare  
D.O. No.Z-18015/23/2018-NHM-II-Part(1)  
Dated: 4<sup>th</sup> July, 2019

Dear Chief Secretary,

The availability of Human Resources for Health – especially specialists and doctors, still remains a challenge in most of our States despite support extended under National Health Mission over the years. However, many good and innovative practices have been observed in the States/UTs towards improving the HR availability and improving the service delivery at public health facilities. I would again like to draw your attention towards some of these solutions/practices to attract and retain HR in health sector.

1. There is provision of providing attractive monetary benefits to doctors by way of
  - a. Flexible/negotiable remuneration for doctors and specialists as per the market reality for that area/ facility and for that specialty
  - b. Hard area allowance to doctors, especially specialists, for serving in remote/difficult areas subject to achievement of minimum number of performance outcomes identified and agreed upon. This can also be provided to doctors in regular cadre as a top up from NHM.
  - c. Performance Based Incentives, preferably as Team based incentives with a definite proportion to be paid to individual HR (for performance beyond a minimum threshold), so that individual HR performing well can take home higher amounts and service delivery at these facilities improves.
2. Provision of non-monetary benefits including:
  - a. Construction of residential facilities within the campus of hospitals or residential facilities or Transit Hostels with pantry support, especially in areas where doctors may not be interested in staying with their family
  - b. Provision of professional advancement opportunities such as attending conferences and workshops for skill and knowledge upgradation, which will help in addressing concerns related with professional isolation of serving in remote and difficult areas.
3. Policy level interventions such as
  - a. Creation of PGMO Cadre wherein doctors with PG Degree/Diploma are recruited at higher pay scale vis-à-vis MBBS doctors.
  - b. Formulation/adoption of transparent HR Policies for transfer, posting, promotion, etc.
  - c. Fixed tenure clubbed with choice posting thereafter, wherein doctors are posted for a pre-defined fixed tenure (of say 2-3 years) with posting at a place of choice thereafter.
  - d. Fixed tenure posting in hard areas clubbed with another order wherein the posting order itself contains relieving order after the fixed tenure so that the health personnel do not have to wait for the next incumbent to join before getting relieved from such areas.

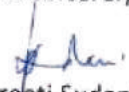


- e. Augmenting the recruitment practices with campus recruitment, walk- in interviews, innovative advertisements, 'You bid, we pay' wherein doctors are requested to quote the desired remuneration, etc
- 4. Measures related with professional education in healthcare including
  - a. Initiation of DNB and CPS courses through the District/ Sub-district Hospitals in the State to increase the pool of specialists
  - b. Stipends to students from remote areas for pursuing nursing education with the condition to serve in such areas for a minimum time period.
- 5. Other interventions including
  - a. Skill –upgradation of GDMOs to undertake identified specialist functions (Eg: 4 month long LSAS, EmoC trainings)
  - b. Utilizing the services of external agencies to assist in recruitment processes, so that the recruitment is completed smoothly and timely.
  - c. Setting up web-enabled HRMIS with provision for salary bill generation so that the HR data is available and updated on real-time basis.

I would also like to emphasize that while each measure listed itself has potential to improve the human resource availability in the State/UT, it is always advisable to comprehensively address the issue by undertaking recruitment on a regular basis of all the vacant posts in public health sector. I am sure you will like to consider the above strategies for ensuring availability of qualified and committed HR in public health sector in your State/UT and utilize the flexibility and support available under NHM to implement them effectively.


With warm regards,

Yours sincerely,


  
( Preeti Sudan)

Chief Secretaries of all States/UTs

19. Dated: 2<sup>nd</sup> August, 2019, ESI Act for HR under NHM



**मनोज झालानी**  
Manoj Jhalani  
अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)  
Additional Secretary & Mission Director (NHM)



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निर्माण भवन, नई दिल्ली - 110011  
GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011


D.O. No.: G-27034/182/2018/NHM (F)  
Dated the 02<sup>nd</sup> August, 2019

*Dear colleague,*

This is in reference to the clarification on the applicability of the ESI Act, 1948 regarding coverage for the NHM Staff forwarded to the Employees State Insurance Corporation (Ministry of Labour and Employment) vide D.O. letter of even no. dated 27<sup>th</sup> June 2019.

In this context, the reply has been received from Employees State Insurance Corporation (Ministry of Labour and Employment) vide No. X-11/14/11/2016 - P&D dated 17<sup>th</sup> July, 2019 stating that the Employees States Insurance Scheme of India is a multi-dimensional Social Security Scheme which is uniformly applicable to employees of factories and notified establishments, located in implemented area **who is earning wages up to Rs. 21,000/- per month (Rs. 25,000/- in case of differently abled employees)**. Furthermore, all casual and contractual staff engaged by NHM are coverable under the ESI Act, 1948, provided they are engaged through a contractor registered under ESI Act, 1948 **and not directly as contract workers by the State/District Health Societies. All the State/ District Health Societies should be informed that the ESI Act, 1948 is not applicable to those contractual employees that are directly engaged on contract by them.**

Therefore, all the States/UTs are requested to follow the guidelines and clarifications provided by the Ministry of Labour and Employment letter (copy enclosed) for applicability of ESI Act.

*With regards,*  
Yours faithfully,  
  
(Manoj Jhalani)

Encl: As Above

**Addl. Chief Secretary/ Principal Secretary/ Secretary** (Health and Family Welfare) - All States/UTs

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**स्वच्छ भारत-स्वस्थ भारत**  
Telefax : 23063687, 23063693 E-mail : manoj.jhalani@nic.in



## 20. Dated: 15<sup>th</sup> April, 2019, Minimum Performance Benchmark for Programme Management Staff



मनोज झालानी

**Manoj Jhalani**

अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)  
Additional Secretary & Mission Director (NHM)

*Dear colleagues,*



भारत सरकार

स्वास्थ्य एवं परिवार कल्याण मंत्रालय

निर्माण भवन, नई दिल्ली - 110011

GOVERNMENT OF INDIA

MINISTRY OF HEALTH & FAMILY WELFARE

NIRMAN BHAVAN, NEW DELHI - 110011

DO No. - 10(36)/2018-NHM-I (Part 2)

Dated the: 15<sup>th</sup> April, 2019

National Health Mission intends to provide accessible, affordable and quality healthcare to the entire population, especially to the vulnerable sections of the community. One of the key approaches of NHM is providing programme managerial support at various levels through the Programme Management Units (PMUs). The program managers/ HR in these units are to function as facilitators who would help in resolving issues, speed up implementation and monitor both physical and financial progress closely. While number of program managers has gone up over the years, it is felt that there hasn't been a commensurate improvement in program and service delivery in all the states, across all the areas. It is often seen that the program managers are not aware of their actual performance and State/district officials are not monitoring program management performance.

In order to facilitate systematic review of program management, minimum performance benchmarks have been developed. These performance benchmarks are to be implemented in all the States/UTs for all program management staff on a quarterly basis. The nomenclature of the positions may vary from state-to-state; hence, State/UT may align and assign the performance indicators to the closest possible designation/post. In case, the list doesn't include the indicator for any particular programme management staff, it is to be developed by the State/UT based on the Terms of Reference/ Job Description and shared with us.

As communicated earlier through the RoP document and in NPCC meetings, these indicators **must** be linked to renewal of contract of program management personnel. Every nodal officer/consultant/HR under NHM would have to achieve the minimum performance benchmarks as set by Government of India/ State Government. The state is free to add more performance criteria and revise the benchmarks even for such positions for which the GoI has provided the performance benchmark. If required, the states may revise the performance benchmarks (given in %) to suit their present context. While the maximum increase could be up to 100%, the decrease in any existing benchmark should not be more than 15%. In case of non-attainment of minimum performance benchmark, NHM will not provide budgetary support for the incumbent. The performance indicators list along with a brief note on the process is attached with this letter. This approach should also be used for other technical HR positions in the health system that are not covered in the Note. It will also generate positive competition and improve performance.

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I request you to make the performance benchmarks a part of the contract of the Programme Management Staff engaged at different levels under various programmes and disseminate this well among all concerned.

May I further request you to implement and use these indicators and benchmarks to review the performance of PMUs and share the progress with MoHFW by end of each quarter. You are also requested to provide your feedback on the intervention, indicators and the performance benchmark levels. Due to enhanced accountability to performance, I am sure this endeavour will lead to improved overall performance.

*With regards,*

Yours Sincerely,




(Manoj Jhalani)

To,


Addl. Chief Secretary/Principal Secretary (Health & Family Welfare)- All States/UTs



## 21. Dated: 13<sup>th</sup> July, 2019, Reviewing the Performance Indicators with the Programme Managers



**मनोज झालानी**  
Manoj Jhalani  
अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)  
Additional Secretary & Mission Director (NHM)



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GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011

D.O No. 10(36)/2018-NHM-I(Part 2)  
Dated 13<sup>th</sup> July, 2019

*Dear colleague,*

As you are aware that one of the strategies of National Health Mission (NHM) was to introduce Human Resource (HR) to manage different aspects of the programs. Over the years, about 57,000 program management HR have been approved; however, we have not been able to utilise their skills fully and hold them accountable.

2. As this is one of the key levers, which can improve our effectiveness and efficiency vastly, a suggestive set of the minimum performance indicators and benchmarks for 105 categories/posts of program managers was shared with you vide DO No. 10(36) 2018-NHM-I (Part 2) dated 15<sup>th</sup> April 2019.
3. During the NPCC meetings of 2019-20 and later, in the meeting of State Secretaries and Mission Directors, the Ministry has requested the States/UTs to:
  - i. Review the performance indicators in consultation with the program managers and suggest changes as per local context (if any) and share the changes with MoHFW
  - ii. Make the performance benchmarks a part of the contract of the Programme Management Staff engaged at different levels
  - iii. Disseminate these to each program management staff. Determine supervisor for each level/each PM staff who would review the performance indicators and attainment of minimum performance benchmark regularly.
  - iv. Share the names of those who could not meet the minimum standard of performance with MoHFW twice a year April to September in October, and October -March by 20<sup>th</sup> March. The flow of the non-compliant list would be from:
 

Facility → Block → District → State → MoHFW
- v. Review and discuss why the minimum benchmark could not be achieved in :
  - o Facility/block review meetings
  - o DHS review meeting
  - o SHS review meetings
- vi. Take corrective steps and support the incumbents who could not meet performance benchmarks in achieving them.

4. Please note that those who do not meet the benchmarks finalised by the State by end of the year would not be supported under NHM.

Page 1 of 2

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5. These basic steps would ensure that the people engaged in various managerial works remain productive and contribute towards making our health systems robust. I am sure you will monitor this personally every quarter.

We are organising a VC on 29<sup>th</sup> July 2019, 2 PM onwards where among other agenda items, minimum performance benchmarks too would be discussed. Please feel free to reach out to me or my team, in case you have any query.

Yours sincerely

-sd-


(Manoj Jhalani)

To  
Additional Chief Secretary (Health)/Principle Secretary (Health)/Secretary  
(Health) – All States and UTs

D.O No. 10(36)/2018-NHM-I(Part 2)

Copy to:

1. Mission Director, NHM – All States and UTs
2. ED, NHSRC.
3. PIP Process

  
(Manoj Jhalani)



## Learnings from Other States<sup>13</sup>

India is a highly diverse country and the nature and spectrum of challenges faced by different states can be extremely varied in terms of availability of HRH and their capacity building. However, there are certain commonalities that transcend state borders and thus cross learning among states can prove beneficial.

Good performing states have done well in the past to reach current level of achievement. Their success stories can help other states to understand, learn and leap forward as well. The process of innovation serves as a stepping ladder and should be shared among states as much as possible.

The State Training Consultant in coordination with the Mission Director should prepare a list of innovations and best practices across states under specific areas, which could then be replicated in other states. It is also equally possible that two states with similar challenges would adopt similar strategies resulting in greater success in one state, and relatively limited success in another. Therefore, the process of replication should be carried out with due understanding and contextualizing the innovation in the concerned state, preferably including a visit to witness the implementation of such innovation and effects in its place of origin.

These learning lessons could also be at intra state level, which should also be explored within the state.

<sup>13</sup> Please visit NHM Website to find more about Innovations: <https://nhm.gov.in/index1>

# Promoting Better Integration of Health Information Systems: Best Practices

## Introduction

India faces critical human resources shortages for most cadres such as doctors, specialists, nurses, and midwives. Lack of comprehensive, reliable, and up-to-date data along with an absence of commonly agreed definitions and analytical tools make the task of managing the health workforce difficult. Moreover, the available information received through manual recording systems is usually inadequate to plan activities.

The HRIMS is a centralized repository that stores, processes and manages employee-data such as skills, capabilities, hiring organization, engagement type (regular/ contractual), salary and additional information about dependents along with other functions like recruiting, application tracking, performance appraisals, e-pays slips and leave application relating to all personnel of the organization. The web-based software supports managerial functions such as master data management, organizational management- deputing positions and departments, employee and manager self- services, absence and leave management. The system overall benefits in the administration, work flow planning and monitoring, performance appraisal, recruiting and applicant tracking, compensation management, training tracking and basic analytics.

The state of Chhattisgarh funded an in-house Health Resource Information Management System with support and supervision from National Informatics Centre (NIC) in 2012

Similarly, in Assam the state had two separate information portals i.e., Health Management Information System (since 2008) and Mother and Child Tracking System (since 2011). There was discrepancy in similar data being captured through both the software and specific gaps of information collected for HR data, ASHA related activities, VHND monitoring, financial monitoring, health infrastructure development etc. To overcome these challenges, the state developed and implemented an Integrated MIS-GIS System called SwasthyaSewaDapoon in 2018. The system has been developed using in-house capacity of NHM-Assam and it is hosted in NHM server. The main goal of the software is to develop and integrate all health-related database within a single platform.

## Part 1: Human Resource Information Management System in Chhattisgarh

### Programme Implementation Methodology

A team of software developers under NHM/Chhattisgarh built the web-based HRIMS with supervision from NIC. NIC hosts the software in its secure servers and is responsible for server maintenance; the NHM personnel are responsible for software maintenance. The system covers all staff, both regular and contractual, across the entire state. It captures all official information, personal information, qualifications, current and past posting details, salary and bank details, and a monthly attendance sheet updated by the district account manager.

State, district, and block-level establishment data officers and district accounts managers were trained by the IT team to enter the data in the online web portal through an authorized user ID and password.

Data on regular staff is cross-checked with the official treasury records available with the Drawing and Disbursing Officer (DDO). The data of contractual staff is cross-checked with the NHM database. The CMHO views all the data in the built-in CMHO Dashboard to take informed decisions on recruitment, deputation and other activities.

### Advantages and Scalability

With the help of HRIMS, the managers can access the information they need to legally, ethically and effectively support the state employees. Key benefits include:

- **Improved HR Planning:** the availability of timely and accurate data about the HR helped in the PIP process, recruitment, rationalization of NHM staff and loyalty bonus distribution.
- **Transparency in the system:** Transfer and posting application registration.
- **Fast Data Retrieval:** Higher speed of retrieval and processing of data application registration.
- **Financial Management:** Salary preparation of NHM employee and pay slip generation.
- **Performance Management:** Annual appraisal of NHM employee through HRIMS.

Minimal cost has been incurred in setting up the HRIMS in Chhattisgarh. Expenses included the salaries of the software developers and time cost of NIC staff and employees in data entry and updating work. The major challenge, however, has been to retain the efficient programming staff. With in-house software programmers and technical assistance from NIC, the HRIMS in Chhattisgarh shows potential to be sustainable.

## Part 2: SwasthyaSewaDapoon: An Integrated MIS-GIS System in Assam

### Programme Implementation Methodology

The strategies adopted during implementation of the system are:

- **Single Database Structure:** The system was developed in single database structure. All modules shared the same master tables which makes it easier to integrate the system and share data among different modules.
- **Single entry:** In the entire system, one data point will be entered only once. If one data point is captured in one module, then the same would be shared with other systems avoiding duplication.
- **Open Source Technology:** The system has been developed using open source technology.
- **Use of in-house capacity:** The system has been developed using in-house capacity of NHM, Assam and the system is also hosted in the Server of NHM Office.
- **GIS-MIS Linkage:**
  - The GIS Layer: includes 100% GIS mapping, facilitating planning of infrastructure.
  - The Masters: includes the updated Human Resource Masters linked with the

Health Institution Masters with National Information Centre.

- The MIS Layer: includes the CHO monitoring, VHND, ASHA payment and performance monitoring, financial monitoring system, Inventory management system, Infant death, Maternal death, and Civil Work

### Advantages of the HR-MIS System

- Entire HR database of Health & Family Welfare Department is available on a click of the mouse.
- Centralized salary disbursement of 100% NHM employees within the last week of every month which has increased the motivational level of employees.
- Salary linked with grading of performance appraisal.
- Faster recruitment process by using online application module which also helps in sorting eligible candidates.
- Online transfer and posting for both employees under state health service and under NHM which helps in real time updation of information.
- Transparency of system by publication of HR database in public domain.
- Transparent posting on merit basis through counselling and on the spot issuance of appointment letter.

### Scalability

- Cost effective: No extra fund was required. The system was developed using in-house capacity.
- Customized Application: Regular customization as per need.
- Compatibility: Easy compatibility and integrated with NIN.
- Utilized services of PFMS for DBT payment.

### Programme Implementation Challenges

The Computerized information system offers various benefits but there are plausible challenges in scaling up:

- States where NIC is supporting the process will not incur any additional costs except for staff time and training but third party involvement may invite a one-time set-up cost for hardware (purchase of server, computer, antivirus and other equipment) and software (server license, server software, etc.) which will also add on the costs on maintenance capacity in future, as continuous external funding will be required.
- There is a need to assess the competency of staff for maintaining the software. If the personnel designing HRIMS are not competent enough, there can be a mismatch between data provided by the HRIMS and data required by the managers.

# Bringing Accountability in Health: The Madhya Pradesh Experience

## Introduction

Accountability in healthcare delivery system relates to three general categories i.e. financial, performance and political. Financial accountability encompasses tracking and reporting on allocation, disbursement, and utilization of financial resources by using the tools of auditing, budgeting, and accounting. Performance accountability refers to demonstrating and accounting for performance by setting minimum performance benchmarks focusing on services, outputs, and results. Political accountability is related to the public health institutions, procedures, and mechanisms that fulfill the public trust, represent citizens' interests and respond to societal needs and concerns.

Madhya Pradesh, in 2016-17, established the process of backtracking the cases of severe anaemia and eclampsia and intended to ensure accountability of the health service providers towards highly professional and outcome oriented practices. The Intervention was aimed at creating avenues to expect higher professional standards from the health service providers right from the level of the ANMs and to fix accountability for better outcomes.

## Methodology

### 1. Identification of Poor Performing ANM

Tracking of ANMs was done in case of late referral of severe anaemia (Hb) and eclampsia cases or maternal deaths reported due to these causes. District and block level teams investigated for any negligence on the part of ANM with respect to diagnosis and treatment during ANC for the particular cases.

### 2. Capacity Building of the ANMs

In case of negligence, ANM together with the RCH officer and MCH Consultant/DPHNO/DCM of district were called at the State office for two days on their own expenses. Day-1 was dedicated for review of all documents/case sheets by the state committee and day-2 for capacity building through intensive training on core skills at skills lab, Bhopal.

### 3. Regulatory Measure

Actions in the form of show cause notice and withholding of increments were recommended by the state and were ensured by district head quarter.



## 4. Follow-up Assessment

The post training assessment of ANMs was done by Clinton Health Access Initiative to assess the competency of the ANM.

### Programme Outcome:

The Back Tracking has taken roots into the system of setting professional standards and monitoring has started in the districts. The district authorities have taken cognizance of the cases and fixed responsibilities of the erring ANMs who have been found negligent. The practice standard across the state has significantly improved and the quality of care has shown advancement as revealed by patient satisfaction levels.

### Challenges

The major gaps identified during backtracking the ANMs were lack of data reporting, supervisions, treatment and ANC visits. A total of 84 show cause notices were issued in 2016-17 and 4 ANMs were terminated during that period.

### Scalability

- The project ensures accountability and responsibility of human resources towards the beneficiary as well as the system without any excessive financial burden to the system. Further the capacity building component allows for error corrections thereby strengthening the quality of service delivery.
- The continuum of learning is maintained by organizing trainings and courses which support continuous professional education, mentorship programmes, adherence to the protocols and guidelines developed by the state and establishing a good communication strategy with other professionals, settings and patients by using appropriate language and communication channels.
- It is important to be patient; successful accountability interventions call for long time periods and long-haul engagement. Those who promote increases in accountability must adjust their expectations of time horizons to match a strategic and dynamic reform process. Even effective accountability interventions that may yield relatively quick results seem to need a broader, sustained set of changes over a longer period to ensure that those gains are not lost.

# Strengthening Human Resource for Health in Remote and Difficult Areas

The urban rural disparity is stark when it comes to the availability of skilled HRH with availability doctors in urban areas four times more as compared to tribal areas. To overcome the shortage of health workers in rural and remote areas, various states such as Odisha and Chhattisgarh undertook a series of systematic and progressive reforms that seek to identify the existing bottlenecks and imbalances in the health systems that affect the human resources.

## Part 1- Odisha's Approach in Attracting and Retaining HR

### Programme Methodology:

#### 1. Robust HR Policy:

The state established a State Human Resource Management Unit (SHRMU). This led to the restructuring of the Odisha Medical Service Cadre and paved the way for career pathway for HRH and creation of new posts. The revamping of the public health service was done by creating a separate public health cadre. The formation of the directorate of Public Health was established to focus on public health improvements and the Directorate for Nursing, with Programme Management Units had been set up to enable, professional growth for nurses.

#### 2. Expansion of Scope for Production of Clinical HR:

To increase the intake capacity of Govt. Medical Colleges, the state government partnered up with private sector. The state government also strengthened the production of quality nurses by creating a scholarship scheme for ST/ SC students for GNM and BSC Nursing and comprehensive skill lab at selected nurse training schools with NHM support for skill enhancement. Laboratory technicians were preferentially selected from graduates of state government institutes. Retired doctors below 68 years of age are being utilized in the system on a contractual basis.

#### 3. Priority in Difficult Areas:

Financial incentives for medical officers in the periphery and district hospitals, such as geographical area allowance, specialist allowance, and post mortem allowance have been introduced. The state also has provision for in-service deputation for doctors to PG courses and additional marks in PG entrance exam for doctors working in specific institutions or areas.

#### 4. Transfer Policy

The state government has grouped districts into zones; norms for transfer and posting of doctors after a three-year tenure has been drawn up to ensure availability and retention of doctors in remote and rural areas of the state.

#### 5. E-Counselling

Institution wise list of vacancies and merit list of candidates are made available on the website. Counselling and choice locking is done as per the rank of the candidates in the merit list. Priority list is prepared based on weighted score as per years of services in type of districts / institutions.

#### Advantages

- In 2015-16, state witnessed a substantial decrease in vacancies of doctors in KBK+ districts from 45.51% to 32.75%
- Significant improvement in MCH indicators and an increase in outpatient and inpatient loads, institutional deliveries, and C-section rates.
- Financial implications corpus fund of Rs. 11 Crores was allocated for KBK and KBK plus districts @ Rs. 1 crore per district to be used for gap filling and to provide support to service providers for accommodation, mobility and communication related expenses - based on local context.

### Part 2- Recruiting and Retaining Specialists and other HRH—Bijapur Model, Chhattisgarh

Bijapur district in Chhattisgarh is a naxalism affected area. 74% of the population is tribal and the area did not have any private medical practitioner. Given the geographical limitations, no incentives to HRH were provided and lack of equipment, irregular medicine supplies and poor general facility upkeep made the scenario of service delivery even worse.

In 2015, the Directorate of Health Service (DHS) and National Health Mission collaborated with UNICEF to conceptualize a project to strengthen the health care delivery services in the districts of Bijapur and Sukma.

A planned approach of policy change, advancing technical support to the existing human resource and intensified strategies to attract specialist doctors was initiated in these regions. Consultative workshops were organized with various stakeholders at state and district level. The recommendations made through these workshops were contextualized to develop a lucrative incentive package for the region.

#### Programme Methodology:

1. Ensuring the availability of residential facilities for the health workers: Under the duration of 4 months, the state government was able to complete the construction of staff quarters.
2. Filling up the vacancies: The recruitment of support staff was completed during June-July, 2016.
3. Improving infrastructure: State prioritised the refurbishing of facility infrastructure, especially the blood bank, pathology lab, mortuary, OT, OPD and Wards.

4. Attracting HR: Formal advertisements, along with social media campaigns were planned by the state to attract the health workers.
5. Attracting Specialists: Differential salaries with additional incentives based on place of posting, policy reforms like preferred place of transfer after serving a fixed tenure, compulsory rural postings for new recruitments, benefits for family such as facilitation for education of children, accommodation for family in any city within the state, amenities like recreation facilities and transit hostel for specialist doctors, academic incentives etc were made available.

### Advantages

1. The state was able to fill positions for medical staff and specialists, reducing the vacancy by 10% and 15% respectively in one year. Infrastructural improvements and lucrative packages resulted in retention of staff which in turn improved quality and range of services being provided in these facilities.
2. The local available resources- NHM untied funds and other grants such as, Backward Region Grant Fund, District Mineral funds and Integrated Action Plan grants, CSR funds etc were utilized for strengthening infrastructure (medical as well as recreational) and HR incentives. Social Media platforms were used along with print media to achieve maximum coverage of advertisement in minimum costs.

### Scalability

Given the efficient usage of resources, the model shows potential and is being advocated for further scale up.

# Appraisals and Rationalization of Human Resources in NHM, Madhya Pradesh

## Introduction

In 2015, Madhya Pradesh undertook a systematic process of performance management of contractual NHM staff to overcome the challenges of unequal distribution of HR, irrational deployment and staff redundancy. These issues were hampering the HR management and planning, leading to duplication of work, lack of synergy and ad-hoc recruitment and postings of regular and contractual staff.

The main objective for implementing the Performance Management System in the state was to streamline the annual appraisal and to rationalize the human resource for health in the state. Through this process, the state aims for optimum utilization of existing cadres, elimination of redundant positions, retention of trained manpower from terminated cadres by way of redeployment, multi-tasking and integrated services approach for cadres such as lab technicians and counsellors, upgrading/downgrading of positions based on skill sets, contract renewal, termination of contracts of surplus and/or nonperforming staff, identifying gaps in existing staff performance, developing need specific training programmes and encouraging positive work environment.

## Methodology

The methodology of implementing performance management system involved various phases:

### 1. Planning:

Establishing Performance Management Criteria: At State-level, programme heads were authorised for monitoring and evaluation. The committees were formed to develop the criteria to judge adequate performance by the employees. These guidelines were then circulated in advance to enable preparedness of the appraisers and the contractual staff.

### 2. Developing

Communicating Performance Standards: Appraisal formats were prepared in Hindi and English and were designed to assess the knowledge and skills of the workforce. Self-Declaration formats with information regarding residence, disciplinary issues/court cases were also shared.

### 3. Performing

Measuring the actual Performance of Employees: The technical cadres were assessed for knowledge and competencies by appraisal teams from other districts at the district level.

As shown in Table 1, teams were formed for appraising each cadre (51 Teams for ANM, 51 teams for LTs, 51 teams for pharmacist comprising selected staffs from all the district). The teams were oriented on how to conduct the appraisal. The programme management unit was appraised at the state-level committee comprising representatives of their programme officers.

#### 4. Review:

Discussion of result with employees: To encourage transparency and reduce bias, a provision for appeal after declaration of results was also introduced so that staff could appeal to the next level of authority.

Making the correct decision: The contracts of those with a performance mark of 65% and above were renewed for a year, those obtaining between 55% and 64% were given a three-month notice to improve performance and those with less than 54% were given termination notices.

**Table 1: Appraisal teams**

Cadre	Team Members	Total Team
ANMs	DHO-1, DPHN, BMO, Nursing Tutor/Nursing sister/ staff nurse	51
Lab Technicians	Pathologist/ MO Lab In-Charge, BMO, Senior LT	51
Pharmacists	Store I/C MO/BMO, Pharmacist grade-1, Store I/C pharmacist/Senior pharmacist	51
DPMU	Director, NHM, Director, Finance, NHM, Dy. Director, NHM, SIO	1 Team
SPMU	Director, NHM, Executive Director, SHSRC, Dy. Directors – of various Programmes	1 team

#### Programme Outcomes

- **Goal-Based Approach:** The process of appraising and rationalization of HR helped in linking the NHM goals with individuals' performance goals.
- **Transparency in appraisal:** It provides the essential information to help managers in making informed decisions regarding contract renewals, redeployment and increments.
- **Optimum utilization of funds:** After implementing performance appraisal and rationalization in 2015-16, state was able to save around 140 crores from the HR budget, which is almost equivalent to 75% of its annual medicine procurement budget, without sabotaging service delivery.
- **Uniformity across the state and better contract management:** The HR cell had clear record of health workers posted in the facilities across the state.
- **Performance-based Incentives:** Overall 5% of staff were classified as poor performers and 5% as excellent, 70% as Good performers, 10% as average performers and 10% as very good performers.



## Challenges

The exercise was conducted in the state for the first time in 2015, within a time frame of less than 60 days. Initially, the state came across various challenges:

- Lack of communication and different level of understating across the appraisal team.
- Difficulty in developing TORs and appraisal formats.
- Slippage in schedules and timelines.

## Scalability

Once the process is institutionalized and the challenges addressed, this approach has significant scaling up and sustainability potential since it is conducted within the existing system by existing staff.

# Person-Centred Care through Shared Leadership- Banka Model of Bihar

## Introduction

The WHO Integrated People Centred Health Service framework advocates for strengthening governance and accountability through improving policy dialogue as well as policy formulation and evaluation together with citizens, communities, and other stakeholders. It is about promoting transparency in decision-making and generating robust systems for the collective accountability of policy-makers, managers, providers, and users through aligning governance, accountability, and incentives.

A person-centred care approach has been implemented in Banka district, Bihar in 2019 to overcome various health system challenges such as unavailability of assured services especially C-Section (Low C section rate 1.02%) due to lack of competent HR, low staff accountability, suboptimal utilization of HR and low patient satisfaction. The key objective of the programme was to enhance the quality of services by strengthening the leadership and governance.

## Programme Implementation Methodology

- **Quality Improvement:** Continuous quality improvement programme was initiated at the district hospital in collaboration with Bihar State Health Society. Hospital Leadership and frontline workers participated in Continuous Quality Improvement (CQI) from February 2018 to May 2019. The key strategies adopted in this programme focussed on behaviour change such as:
  - o Enhancing empathy and sensitivity of service providers to ensure person centric services.
  - o Improving ability to oversee quality and safety in hospital leadership in patient care specific to mothers and newborn.
  - o Developing and improving the understanding of quality improvement principles and tools.
  - o Lead data driven quality improvement activities.
  - o Effective coaching and engaging of all hospital staff towards delivering effective health services.
  - o Optimal utilization of available resources including HR, supplies, fund, etc. for person centered healthcare and to generate high client satisfaction.
- **Leadership and Strategic Management:**
  - o The leadership and coaching workshops were conducted to ensure commitment and accountability from civil surgeons, medical superintendents, District

- Programme Managers and hospital managers while orienting them about role of a coach.
- o The frontline staff and leadership were sensitized on system thinking and collaboration. Labour room nurses were encouraged by hospital leadership through shared leadership report complications, LAMA, referrals, near misses without fear so that further corrections and amendments could be made.
- o Hospital staff participated in learning sessions for clinical training, data analysis, progress review, cross learning, experience sharing, etc.
- Staff Motivation and Improving Working environment:
  - o Consistent engagement and regular interaction between the entire team encouraged the health workers.
  - o Storytelling of real experiences, felicitation of champions and engaging with all team members over tea on a weekly basis nurtured an informal relationship and strengthened team work.
  - o Information on patient rights was played on Audio Visual system.
  - o Key messages for mothers and families were displayed on TV in hospital's waiting area.
- Transparency: Results were shared with all the team members on both good and bad patient stories.
- Optimum Utilization of Human Resource:
  - o Duty rosters for all staff were prepared and publicly displayed for transparent and timely rotation of duties.
  - o To deal with shortage of skilled HR, specialists from district hospital in nearby CEmONC centres were deputed to peripheral facilities and vice versa.

## Programme Advantages

C-section rate improved from the baseline median of 1% and achieved the monthly target of 5% from January 2019 to May 2019. Patient satisfaction surveys scored an average 84 out of 100 marks in the month of July 2019. It was concluded that high impact leadership behaviours by hospital leadership and staff with support from District Health Society and Civil Surgeon were important key enablers for improvement in services.

## Programme Scalability

Positive results from this programme indicate a potential for scaling up the programme in other areas. Providing clear guidelines and standard measurement tools will help in improving accountability of facilities and supporting providers in understanding how to provide person-centred care. Furthermore, moving towards person centred care has no financial implications.

## Programme Challenges

- Defining the key stakeholders and identifying the goals of person-centred health care.
- Motivating the stakeholders for effective communication across the system.

- Developing common understanding and shared expectation of services and its outcomes.
- Improving the technology for accessing healthcare data and information.
- Developing sustainable and effective models of public health prevention and promotion.
- Developing strategies for community engagement.

# Public Health Cadre: Experience and Learning

## Introduction

Strengthening of the public health capacities is essential for Universal Health Coverage. The National Health Policy of India, 2017 has proposed for the creation of a separate public health cadre for development and functioning of the health system. The public health interventions are delivered by multidisciplinary functionaries from the community level to higher administrative levels. Except for a few states, these functionaries are not organized into a separate, systematically trained public health cadre. In addition, the absence of a comprehensive Public Health Act in most states means that public health officials lack the regulatory authority and powers to enforce public health legislation adequately. The lack of a separate public health directorate further compromises their independence, effectiveness, and efficiency.

Some states have demonstrated remarkable commitment in strengthening the healthcare delivery system by establishing public health cadres and are making concerted efforts in this direction. The learning and experience sharing will further help other states which are still contemplating issues such as its institutional framework, effectiveness, utility, and governance arrangements.

## Part 1: Public Health Cadre in Maharashtra

### Programme Design and Implementation

- Directorate of Health Services: Structure and Functioning
  - Selection and appointment of doctors as MOs who are posted based on their educational qualifications since 2011.
  - The career pathway for medical officers is defined in three cadres as per their qualification i.e., District Health Officer cadre, Civil Surgeon cadre, and Senior Clinician cadre
  - There is a common seniority of DHO/CS/Clinician cadres for being promoted to Deputy Director followed by Joint Director, Additional Director and Director of Health Services
- Benefits of Public Health Cadre:
  - Implementation of primary healthcare is responsibility of public health specialists, resulting into a strong primary care in the state.
  - Health Management Information System, Maternal Death Review, Child Death Review are integrated with the public health system which leads to smooth functioning and accountability in health sector.
  - Effective response in disease surveillance, epidemic control, control of emerging and re-emerging diseases.

- Public health professionals are posted in all bureaus facilitating systematic planning, monitoring and evaluation of all health programmes.

## Part 2: Public Health Cadre in Odisha

### Programme Design and Implementation

- Directorate of Health Services: Structure and Functioning:
  - Restructuring the Odisha Medical and Health Service Cadre and making provisions for medical officers to join public health stream.
  - Supporting capacity building of MOs in public health and ensuring that specialists are not posted in public health positions
  - Creating dedicated public health positions at block level and above.
  - Finalization of recruitment rules, including criteria and qualifications of those who wish to join public health cadre.
  - Development of clear rules for promotions, leave and posting for the cadre.
- Benefits
  - Effective planning, implementation and monitoring of public health activities including various National Health Programmes.
  - Improved provision of clinical care services and better utilization of public hospitals.
  - Increase in the number of medical professionals choosing to join government services due to creation of more promotional avenues for doctors at higher level.

## Part 3: Public Health Cadre in Tamil Nadu

### Programme Design and Implementation

- Directorate of Health Services: Structure and Functioning:
  - State has a separate Directorate of Public Health and Preventive Medicine functioning since 1923.
  - At all levels, Public Health qualified professionals head the department right from Municipal Health Officer to Deputy Director of Health Services at the district, programme officers at the state and the Director of Public Health and Preventive Medicine at the top.
  - Recruitment is through TNPSC or by transfer of service from PHC MOs with five years of service and public health qualification.
  - DPH or MD Community Medicine or MCI recognized MPH with basic MBBS qualification is compulsory, in case not, it is mandatory to acquire such qualification in four years of joining service.
  - There is a dedicated entomology cadre from junior entomologist to Chief entomologist at state HQ.
  - State Bureau of Health Intelligence is equipped with dedicated cadre of statisticians.



- Training and Capacity Building
  - Three months pre-service training is given to all the health workers.
  - Institute of Public Health, established in 1930s, provides all the required training.
- Benefits
  - The public health trained cadre adopts an annual cycle of anticipatory planning for responding to potential natural disasters such as floods and cyclones.
  - Vaccine Preventable Diseases have been controlled to a large extent.
  - Long years of service provide both knowledge stability and administrative stability to the employee.
  - Significant improvements in demographic indicators.

## Scalability

The experience of Maharashtra, Odisha and Tamil Nadu depict the advantages and feasibility of establishing their own public health cadre. The models are easily replicable across states and require minimum restructuring or disruption at block, district, and state level. Creation of public health cadre was affordable and only required an additional investment for training the professionals in the three states.

# AMANAT - Nurse Mobile Mentoring Programme - Bihar<sup>14</sup>

## Introduction

Reducing maternal and child mortality is among the most important goals of the National Health Mission. Public facilities for childbirth in Bihar must sustain minimum standards of quality of care to ensure safe birth outcomes. Most deliveries in public facilities are conducted by ANMs and GNMs. Maternity-benefit driven strategies have increased the utilization of public facilities for delivery and they currently conduct 65% of all deliveries.

There are serious obstetric skill deficits amongst nurses. Pre-service training and SBA training are insufficient in improving the quality of intra-partum care to desirable standards. It is unlikely that sufficient numbers of skilled nurses will be recruited in the conceivable future, and without in-service training of available nurses, intra-partum care is unlikely to result in reducing preventable perinatal deaths. Furthermore, the number of nurses in position is too small to permit prolonged offsite training.

Nurse mobile mentoring programme provides a platform for in-service, onsite mentoring of available nurses in public facilities by qualified mobile nurse mentors.

## Methodology

The nurse mentoring programme is embedded in the Quality Improvement process of the State. It is implemented by the Bihar Technical Support Programme (BTSP). The programme was implemented in a phase-wise manner. Initially, a pilot programme was run in 32 designated BEmONC level facilities in 8 districts during 2012-2013. This was then upscaled to 48 more facilities including 8 CEmONC level facilities in the same districts during 2013-2014. Finally, for the state-wide scale-up, 320 more BEmONC facilities and 56 more CEmONC level facilities were integrated in this programme during 2015-2017.

The pedagogy of learning comprised of iterative training and incremental learning systems delivered through teams of graduate and post-graduate nurses to the nurses working at different health institutions. Clusters of 6-8 staff nurses were made in each facility, including all available GNMs and additional ANMs selected by the concerned block/district hospital. They got exposure with a pair of mobile nurse mentors with experience in obstetric nursing for one week a month for a total of 6-8 months. The nurse mentors used a combination of bedside teaching (in the labour room on actual delivery cases), simulations (using inexpensive equipment for teaching complex skills such as managing maternal and neonatal emergencies), and theory to emphasize the rationale for each protocol and process. The process aimed to incrementally improve the quality of care until desired outcomes were achieved in the facility.

A carefully planned curriculum defined learning goals for each week. The programme course covered all basic practices in infection control, intra-partum, postpartum maternal and neonatal

<sup>14</sup> Since 2018, the programme has been remodeled as AMANAT Jyoti and has been expanded to test the model with doctors as well.

care services, as well as quality of family planning procedures provided at these facilities. To address the challenges and for supportive supervision, the mobile nurse mentors were overseen by master nurse mentors who hold an M.Sc. in obstetric nursing.

The progress of facilities and individual student nurses were monitored and evaluated regularly.

## Advantages and Scalability

- Programme data shows significant improvement in the quality of services:
  - o Oxytocin administration for Active Management of Third Stage of Labour (AMTSL) improved from 8.6% to 58.5%.
  - o Initiation of Kangaroo Mother Care increased from 30.9% to 62.5%.
  - o Use of sterile instruments increased from 13.0% to 43.5%.
- Besides the routine Government of Bihar finance allocation and PIP support from NHM for infrastructure and supplies, only the direct costs of recruiting, deploying and managing the nurse mentors have been borne by CARE/SRU budgets. It is estimated to cost Rs. 1300 per trainee per day assuming there are 8 trainees per faculty and 7 weeks training per trainee.
- This programme has already gone to full scale in Bihar in 5 years. The GOI has allocated a budget head in the State PIP for its funding.

## Challenges

Two potential barriers exist:

- First, although the rationale behind the recommended practices is discussed during the training, some nurses are not entirely convinced about the effectiveness of changed practices. These nurses probably feel more confident about following the prevailing practices or the practices that they learned in their training schools.
- Second, many nurses, because of their busy schedules, want to get over with conducting the childbirth process quickly. However, some of the recommended practices meant that a considerably longer time had to be invested per delivery, which was not acceptable to all participating nurses.

The model is effective in improving all aspects of quality of care but needs complete ownership by the leadership at the block and district level to sustain.

# Buddy-Buddy Model of EMOC-LSAS- Uttar Pradesh

## Introduction

It is imperative to acknowledge the gaps in existing infrastructure and specialist manpower at FRUs and undertake their re-organisation. It is also crucial to ensure the provision of quality Emergency Care Services at the district hospital and sub-district hospital followed by FRUs/CHCs. It is preferable to develop FRUs in a district by ensuring that they have the required number of specialists in position or the provision of services of specialists on call. The information on location of such emergency services/FRUs should be made available to all villages in the area so that the population knows where they should reach for getting appropriate emergency care. The provision of emergency care must be supported by appropriate referral services from sub-centres to PHCs and from PHCs to the functioning First Referral Units providing emergency services.

Though MMR and IMR in Uttar Pradesh has declined over the years, the state still accounts for second highest MMR and thirteenth highest IMR in the country. Majority of these deaths could be averted by ensuring comprehensive obstetric care services through FRUs. However, out of 305 designated FRUs in UP, only 98 are functional. Also 64% of Specialists posts are vacant. As per NFHS data, the proportion of C-section reported in public facilities has declined from 11.1% to 4.7% in past 10 years.

In view of the issue, the state is focusing on operationalization of 291 FRUs by 2020. In order to do so, a detailed gap assessment was conducted to identify non-functional FRUs (without a pair of Anaesthetist & Gynaecologist or those not performing adequate number of C-sections). To activate the non-functional FRUs, the government of Uttar Pradesh applied the strategy of task shifting through Buddy-Buddy Model of EMOC and LSAS trained doctors. The model has proven to be useful in training and orienting the doctors and improving their knowledge and skills in providing quality obstetric care.

## Programme Methodology

A “Buddy-Buddy Counselling Session” was conducted for LSAS and EMOC trained doctors. The doctors were given an option to choose their preferred FRUs. Priority was given based on seniority to doctors to choose from the list.

- **Identification of Buddy:** The counselling session helped in identifying the Buddy. The Buddy-Buddy group included a pair of LSAS and EMOC trained doctors (Buddy 1) clubbed with a pair of Anaesthesiologist and Gynaecologist (Buddy 2). During the first round of counselling, 47 buddy-doctors were identified, and transfer orders were released within 15 days.
- **Training and Capacity Building:** The LSAS and EMOC trained buddy-doctors were posted at DH for 6 months under mentorship of specialists (Anaesthetist-Gynaecologist). During this period, they assisted the specialists in C-section cases

and were expected to conduct minimum 5 C-sections independently per month under supervision.

- Performance Incentives: The performance of the buddy-doctors was also linked to incentives:
  - o Incentives during Mentoring Period: Rs 1000 per buddy-doctor and specialists (mentors) for maximum of 5 C-section per month.
  - o Team Incentives post-mentoring period at Inactive FRUs: Rs 1200 per doctor, Rs 600 for MBBS Doctor supporting in Post-op, Rs 600 per staff nurse and Rs 400 per OT Technician for all C-sections performed in the FRU.
  - o Incentives for visiting FRUs by Specialist Mentors after Mentoring Period: Rs 2500 per specialist per visit.

Required equipment was made available to provide suitable work environment to the doctors.

- Final Postings: At the end of 6 months, the doctors (Buddy 1) were posted back to their respective FRUs after receiving recommendation by the Anaesthesiologist and Gynaecologist (Buddy 2).
- Support from Government of India:
  - o Legal Indemnity by the state for all the C-sections being performed by the doctors.
  - o Preferred choice of postings in FRUs.
  - o Exemption from intra-inter district transfers for 5 years.

## Programme Outcomes

- 80 FRUs have been activated through two rounds of counselling for buddy-buddy model.
- Another 100 FRUs are aimed to make functional by 2020 which would potentially activate 130 out of 153 non-functional FRUs.

## Scalability

- Buddy-Buddy Model is a medium term, low-cost, replicable solution to meet the shortage of specialists in the states of our country.
- The model is scalable and can be implemented in other states, especially those not having specialist cadre.

# Paying for Performance- Odisha (P4P)

## Introduction

Contract management is the backbone of every relationship that an organization has with stakeholders including suppliers, partners, and beneficiaries and effective contract management can dramatically improve the performance of the organization.

In Odisha, all contractual manpower is engaged through Odisha State Health & Family Welfare Society for a contractual term of 11 months and their contract renewal is subject to satisfactory performance. Lack of defined hierarchical structures, uneven remuneration of staff, not commensurate with their qualifications, experience and level of posting and lack of standardised reporting pathways lead to dissatisfaction among the staff. In addition, lack of defined job responsibilities for different levels of staff also posed difficulty in objectively evaluating their performance for contract renewal.

In year 2009-10, the state devised new hierarchical structure and also developed an effective Performance Management System (PMS) for all positions under Programme Management Unit. PMS serves as a useful tool for contract renewal, determining staff compensation based on performance grades and training need identification. The objective of the programme is to develop hierarchical structure for contractual staff based on level of posting, experience, job responsibilities and qualifications and define structured reporting pathways for all staff categories as well as to standardize fixed base remuneration based on hierarchy level.

## Programme Methodology

The aim of the programme was to define terms of reference and to identify objectively verifiable deliverables for performance-linked appraisal and grading of incentives for different staff categories. Performance Management System has a unique built-in mechanism of two-way communication for providing constructive feedback from appraisers to appraisee. The Pay for Performance component (P4P) propels higher performance and is key strategy for improving capacity/productivity of HRH. It is applicable for both service delivery and programme management HR.

The P4P system comprise of:

- **HR Rationalisation:** Prior to 2014-15 there were more than 13 slabs of hierarchy with variations in remuneration. All the positions were brought under seven slabs with distinct levels of qualification, experience, responsibility and level of posting. All the newly created positions are also fitted in into this structure. State level HR committee is headed by MD-NHM.
- **Blended payment system:** The total compensation of the contractual staff is divided into three parts; 75% is the base remuneration, added with fixed 5% annual increment and 20% Performance Incentive which is a variable cost.



- **Performance Appraisal:** The performance is assessed using a PAR format of 100 marks with defined Core Performance Indicators (CPI). HMIS, FMR and other reporting platforms act as means of verification for each identified CPI. The PAR flows through 3 layers of reporting structure i.e., Reporting, Reviewing, and Accepting Authority. The State Contract Renewal Committee and District Contract Renewal Committee act as grievance redressal forums.
- **Career Progression:** The staff gets an opportunity for in house recruitment and state level committee decides on the positions to be opened up for the entry of existing employees through in house recruitment. There is the provision of sponsorship for courses for capacity building such as PGDHQM and MPH.
- **Welfare Measures:** NHM Employees Welfare Fund works on nominal contributions collected from all employees under NHM for augmenting corpus fund. The committee is constituted at SPMU to examine and recommend payment. The state has provision for difficult area allowance and also conducts annual health check-ups of employees over 40 years of age.

## Programme Outcome

No independent evaluation has been conducted so far. However, substantial improvement in fund absorption capacity under NHM has been observed with over two-fold increase to Rs. 1362.49 Crores FY 2017-18 from Rs 635 Crores in 2010-11. Significant reduction in staff turnover has also been observed after introduction of the process.

## Scalability

- No additional investment incurred for development of hierarchical structure and performance management system. However, annually, about Rs. 60 Crores are allocated towards performance incentives for about 4000 Programme Management Unit Staff and about 11,000 Clinical & Para-Medical staff working under NHM.
- With the staff positions under PMU largely similar across the states, the process may be replicated in other states based on their state specific context.

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