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Directory of Innovations Implemented in the Health Sector

December 2008

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Foreword

The National Rural Health Mission (NRHM) has come a long way since it was started in 2005. Wide-ranging changes have begun to be seen in the health scenario in the country. Acceptable, affordable and quality health care is now reaching households across the country.

One of the cornerstones of the NRHM is decentralised planning and implementation and flexibility to States and local Governments under the overall programmatic focus of the NRHM. This has resulted in an impressive range of innovations having taken place across States and Union Territories. These cover areas related to mother and child health, nutrition, better availability of drugs, improved programme management, incentive schemes for better staff performance, improved data systems, management information systems, etc. Many of these address locally identified gaps in health services.

In this context, this document being brought out by the Ministry of Health and Family Welfare will be useful for all the stakeholders and will be a big step in the process of cross-learning. I hope that promising innovations will be identified for full evaluation to assess their replicability and these may be adopted by other States and Union Territories.

I would like to recognise the good work done by the team led by Mr. G.C. Chaturvedi, Mission Director, Ms. Aradhana Johri, Joint Secretary and their team of officers. I would also like to thank our development partners; DFID, UNFPA, World Bank, USAID, GTZ and UNFPA, for their assistance in bringing out this extremely useful document.

Dr. Anbumani Ramadoss
Minister of Health and Family Welfare
Government of India

January 2009
New Delhi

Foreword

The main objective of the National Rural Health Mission launched by the Government of India in the year 2005 is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

With a view to improving the use of health care services by the poorest and the underserved populations, a number of innovations have been adopted by the States/Union Territories across various thematic areas. These innovations provide information on the process and the impact of many innovations on the key indicators and give an in-depth assessment of key innovations.

I hope that 'promising' innovations will be identified for a full evaluation to assess the potential for replication/adoption by other States/Union Territories.

I convey my appreciation to the development partners and the Government of India officers of the various divisions for their contribution in bringing out this useful document.

Mrs. Panabaka Lakshmi
Minister of State for Health and Family Welfare
Government of India

23 January 2009
New Delhi

Foreword

The National Rural Health Mission, a flagship programme of the Government of India, aims at bringing about dramatic improvements in the health system and the health status of the people, addresses the needs that have emerged over years of implementing the Family Welfare Programme and seeks to provide assured, equitable, responsive and quality health services to all citizens.

While implementing the programmes of the NRHM, an impressive range of innovative approaches have been adopted by the States to address local needs/gaps. In all such innovations, equity is a central consideration with a majority being targeted at Below Poverty Line families. More than 200 such innovations across nine themes have been documented.

I hope that the document will facilitate the development of an outline evaluation framework for innovations, commission cross-innovation reviews and impact the evaluation of key innovation categories. It will benefit all those involved in the implementation of the programme.

I take this opportunity to place on record my appreciation for Mr. Girish Chaturvedi, Mission Director, NRHM and Ms. Aradhana Johri, Joint Secretary to the Government of India and her team of officers as well as the development partners for their contribution in bringing out this document.

Mr. Naresh Dayal
Health and Family Welfare Secretary,
Ministry of Health and Family Welfare,
Government of India,

27 January 2009
New Delhi

Foreword

Recognising the importance of health in the process of economic and social development and improving the quality of the life of our citizens, the National Rural Health Mission was launched by the Government of India in April 2005. It seeks to carry out necessary architectural corrections in the basic health care delivery system.

In the above process, a large number of innovations being adopted by the States to enhance the reach and effectiveness of the programme, being adopted by the States/Union Territories, have been documented with considerable effort.

I am happy to note that the central theme in most of the innovations being adopted by the States in the programme relates to equity and gender issues, in consonance with the programme policy. The document on innovations will provide a wealth of information on various innovations adopted across the States and a further evaluation of the innovations documented for scaling-up will greatly improve the quality of health services all over the country.

I would like to place on record my appreciation to all the development partners, Ms. Aradhana Johri and Mr. Amarjeet Sinha, Joint Secretaries to the Government of India and their team of officers of the various divisions of the ministry for their efforts in bringing out this useful document. This is an evolving document and will be enriched in due course on further investigations and inputs from all stakeholders.

Mr. G.C. Chaturvedi
Additional Secretary and Managing Director, NRHM

27 January 2009

Ministry of Health and Family Welfare

Foreword

Under the umbrella of the National Rural Health Mission, there is a flexible programming approach with a view to moving away from prescriptive scheme-based micro-planning and, instead, encouraging States to develop need-based work plans, with the freedom to decide upon programme inputs. At the same time, pioneering work has been done through innovative approaches, which have led to appropriate solutions for local needs.

The flexibility provided under the NRHM has been well utilised by the States/Union Territories and they have introduced a number of innovations. These innovations cover several thematic areas such as safe motherhood and maternal mortality reduction, immunisation and neonatal and child health, adolescent and sexual reproductive health, behaviour change communication, gender mainstreaming, service delivery, programme management, school health and urban health. We have documented these innovations so as to:

(i) Provide robust assessment of the effectiveness of the schemes and how the benefits are impacting the poor and vulnerable groups

(ii) Promote cross-learning among the States to address challenges in the health sector

(iii) Enable the States to explore the possibility of replicating those innovations best suited to their local context and needs

More than 200 such innovations have been documented to capture the diversity of the initiatives across various themes.

I would like to place on record my appreciation to all the development partners, especially DFID and the team of officers of the various divisions of the Ministry of Health and Family Welfare, particularly the officers of the DC Division, for their dedicated efforts in bringing out this directory of innovations.

Ms. Aradhana Johri

23 January 2009 — Joint Secretary to the Government of India

New Delhi

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INTRODUCTION

Reproductive and Child Health, Phase II (RCH II), is a comprehensive sectorwide flagship programme, under the bigger umbrella of the Government of India's (GoI) National Rural Health Mission (NRHM), to deliver the RCH II/NRHM targets for the reduction of maternal and infant mortality and total fertility rates. RCH II aims to reduce social and geographical disparities in the access and utilisation of quality reproductive and child health services. Launched in April 2005 in partnership with the State Governments, it is consistent with the GoI's National Population Policy-2000, the National Health Policy-2002 and the Millennium Development Goals.

The design of RCH II builds on the lessons learnt from RCH I. The major points of departure in the second phase are:

- Ensuring a more explicit pro-poor focus
- Evolving a shared vision and a common programme covering the entire family welfare sector, the Sector Wide Approach (SWAp)
- Focussing on results (outcomes rather than inputs)
- Using evidence to prioritise interventions and shift resources to where the health outcomes are worst and the need is greatest
- Moving away from 'top down' to a 'bottom up' planning approach that gives flexibility for the States to evolve programmes based on their contextual needs
- Introducing concepts of performance-based funding
- Effective communications to bring about behaviour change
- Monitoring of the programme through triangulation of information (departmental reports, independent surveys and community monitoring) to track equitable access by and outreach to excluded groups
- Encouraging innovative approaches (including partnerships with private sector, social franchising, demand-side subsidy, etc.) to improve reproductive and child health outcomes among vulnerable populations

At the same time, the NRHM also encourages the States to appraise the need for innovation through decentralised planning. It provides for funds for local innovative approaches that emerge as priorities during the bottom up planning process.

Hence RCH II and the NRHM, by their very design, have fostered and provided flexibility to States to design and implement local and context-specific innovations, across a spectrum of

health services, spanning a range of service delivery projects and programmes. States have taken up the challenge and identified areas for strengthening the provision and quality of services. This has resulted in an impressive range and spread of innovative approaches and interventions being implemented across the country.

This document provides a directory of innovations under way in States; results of a desk review of select innovations; and a shortlist of innovations that provide sufficient 'promise' and need to be taken up for an in-depth evaluation to assess their scalability and replicability across States.

EXECUTIVE SUMMARY

Innovation: An intervention to address a specific problem through the creative use of resources, often through public partnerships, often introduced on a pilot basis at the periphery level, with scope of scaling up.

The design of RCH II/NRHM has fostered innovations across the country, resulting in an impressive range of innovative approaches being implemented by States to address identified needs/specific gaps in health services. Equity is a central consideration in all innovations with the majority being targeted to Below Poverty Line (BPL).

The term 'innovations' has been used in a flexible manner and covers new approaches as well as testing out known approaches in different contexts. The majority of the 227 innovations listed in this report are those that are being supported through central funds. Innovations that have been piloted by non-governmental organisations (NGOs), Development Partners (DPs) and State Governments have also been included. Some innovations spanned several States, while many were State-specific. The innovations are all being piloted in the context of substantial investments from national and State levels on improving the health infrastructure, strengthening health systems, promoting social mobilisation and community participation, enabling decentralised health planning and implementation, incentivising performance and quality to retain and attract human resources, and strengthening programme management and monitoring.

The innovations have been categorised into themes that roughly follow those laid out in the National Programme Implementation Plan of RCH II and also in the Implementation Framework of the NRHM. Nine major themes along with sub-categories for three themes have been identified that span the major thematic areas of RCH II/NRHM:

- Safe Motherhood/Maternal Mortality Reduction
    - Innovations to promote safe motherhood and institutional delivery
    - Ambulance services and helplines for transport of obstetric emergencies
    - Strengthening skills and capacity of providers
- Immunisation and Infant and Young Child Feeding
- Adolescent Reproductive and Sexual Health (ARSH)
- Behaviour Change Communication (BCC)
- Gender Mainstreaming
- Service Delivery for RCH
    - Mobile health units
    - Social franchising networks
    - Health financing
    - Contracting out management of public health services
- Programme Management
    - Incentives to improve mobility, availability and attendance of staff
    - Incentives to improve performance and range of services
    - Alternatives to In service training for improved performance

    - Community and Panchayat involvement in planning, monitoring and management of health services and facilities
    - Programme monitoring and management information systems
    - Improving procurement and finance systems
- School Health
- Urban Health

With reduction in maternal mortality being an important aim of RCH II/NRHM and one of the Millennium Development Goals (MDGs), the GoI is focussing on the provision of skilled care at birth and emergency obstetric care, strengthening of referral systems and transport, and demand-side financing. Forty-three innovations promoting safe motherhood are substantially related to the promotion of institutional delivery and the provision of emergency transport.

Janani Suraksha Yojana (JSY) is a flagship programme of the GoI to promote institutional deliveries among poor pregnant women. A 100% centrally sponsored scheme, JSY integrates cash assistance with delivery and post-delivery care. Other demand-side financing options, as in the use of vouchers, also appear to be popular with both the private and public sectors being involved. Chiranjeevi Yojana in Gujarat is the frontrunner in adapting the JSY model for involving the private sector in providing safe delivery services. Several other States have adopted the JSY/Chiranjeevi model to further provide services in areas not covered by JSY or to boost the gains from JSY, including Saubhagyawati Scheme (Uttar Pradesh), Janani Suvidha Yojana (Haryana), Janani Sahyogi Yojana (Madhya Pradesh), Ayushmati Scheme (West Bengal), Chiranjeevi Yojana (Assam) and Mamta Friendly Hospital Scheme (Delhi). In some States, additional facilities for institutional delivery have been created so as to enhance geographic access, for example, Delivery Huts in Haryana, and Maternity Waiting Homes in Andhra Pradesh, Uttarakhand and Manipur.

Establishing referral linkages between the community and First Referral Units (FRUs) is an essential component for the utilisation of services, particularly during emergencies. Flexibility has been given to the States for establishing such referral linkages. The States are coming up with their own innovative models to address the issue of delays in care, seeking for obstetric emergencies through the provision of transport in the form of various ambulance schemes. While originally envisaged as a readily available transport scheme for women with obstetric emergencies, ambulance services now cater to all emergencies. The Emergency Management and Referral Institute (EMRI) model has shown good results in Andhra Pradesh and is now being adopted by several States, including Chhattisgarh, Delhi, Gujarat, Jammu and Kashmir, Karnataka, Madhya Pradesh, Maharashtra, Orissa and Tamil Nadu. The Public Private Partnership (PPP) model is being used in Madhya Pradesh and Orissa (Janani Express Yojana) and in West Bengal (through NGOs). Several States are using central helplines/call centres for managing the referral transport (JSY helplines in Chhattisgarh, Jharkhand and Manipur; call centre in Madhya Pradesh; obstetric helpline in Rajasthan).

Availability of providers skilled in management of obstetric emergencies is a major gap across States. The GoI modified its policy to enable multi-skill training for selective interventions under specific emergency situations to save the life of the mothers. MBBS

doctors are being trained in life saving anaesthesia skill and emergency obstetric care. The GoI has awarded a grant to the Federation of Obstetrics and Gynaecology Societies of India (FOGSI) to build the capacity of selected State medical colleges as nodal training centres for training MBBS doctors in emergency obstetric care. The Enhancing Quality Care in Public Health Care (EQUIP) programme in Chhattisgarh is the forerunner of this initiative.

Twenty-eight innovations were listed in the area of child health and nutrition. The Monthly Village Health and Nutrition Day (VHND) is a major intervention of the GoI, rolled out nationwide, that provides comprehensive outreach services for pregnant women and children at their doorstep. Muskaan in Bihar is a variation of this. Assam, Bihar, Chhattisgarh, Madhya Pradesh and Uttar Pradesh are conducting bi-annual month-long campaigns for addressing child health and malnutrition through Vitamin A supplementation, provision of micronutrients, promotion of exclusive breastfeeding, de-worming, immunisation, etc. Nutrition rehabilitation centres have been established in Bihar, Chhattisgarh, Madhya Pradesh, Maharashtra and Rajasthan, for treating severe acute malnutrition in children. West Bengal is piloting a 'Positive Deviance Approach' to identify the families with healthy babies (that is, 'positively deviant') and share their knowledge and practices with others in the same community.

The maximum number of innovations was in the category of Programme Management (80). Interestingly, 30 innovations in this category are related to improving performance and range of services of staff through the provision of cash and other incentives. This category of innovations also aims at improving the availability of trained medical and paramedical staff, particularly in the 'difficult to reach' areas. The provision of untied funds appears to be an opportunity that all States have used. This also implies that adequate checks and balances need to be institutionalised. It appears that States have increasingly veered towards community ownership, a key strategy for ensuring accountability and ownership of the RCH II/NRHM programme. Towards this end, States have piloted 29 innovations to engage the community and Panchayati Raj Institutions (PRIs) in monitoring of health programmes and management of health facilities. The communitisation of health facilities by Nagaland, based on its traditionally inherent strength of traditional community-based groups (Village Health Committees, Village Education Committees and Women's Committees) is an excellent example of such endeavours. Similarly, community-based monitoring systems and community involvement in decentralised planning introduced in Rajasthan, Maharashtra, Chhattisgarh, Karnataka and Orissa have the potential to ensure the sustainability of the positive outcomes of the RCH II/NRHM programme beyond the planned period. The community-based interventions could be made more effective through the continuous support of the Government health system

Setting up effective monitoring systems also appears an area that States are concerned with. In the area of expanding the reach, quality and access of RCH services, 38 innovations were listed. Eight of these pertain to health financing schemes targeting mostly BPL families, and 15 to PPPs, involving the private for-profit sector and NGOs in almost equal numbers. There is considerable emphasis by the States on meeting the RCH II overarching goal of equity, where the focus is on ensuring quality services for the unserved and underserved population. Mobile health services have long been seen as an effective way of service

provision in inaccessible, rough terrain and in emergency measures, using various modes of transport, for example, vans, helicopters (Tripura) and boats (Assam, Kerala, West Bengal) to improve physical accessibility/reach of the health services for the unserved and underserved population. However, operational/logistics issues, community outreach and monitoring are some of the challenges in these innovations.

Several States have introduced innovations for improving programme monitoring, procurement and logistic systems. These range from the use of sophisticated systems, for example, Geographical Information System (GIS) mapping in Orissa, dashboard system in West Bengal, State Data Centre of Bihar to participatory investigations of maternal and infant deaths at the community level under way currently in several States, including Assam, Orissa, Madhya Pradesh, Uttarakhand, Jharkhand, West Bengal and Bihar. There has been an increasing focus on strengthening procurement systems and financial management systems as indicated by the establishment of the Tamil Nadu Medical Services Corporation, Kerala Medical Services Corporation, e-banking and introduction of debit cards for ASHAs (Accredited Social Health Activists) in Kerala. The procurement models of Kerala and Tamil Nadu have been met with success and are being replicated in other States of the country.

Contracting out the management of public health facilities by various States, for example, Uttar Pradesh, Orissa, Arunachal Pradesh and Karnataka, has been able to improve access to the services in hitherto unserved and underserved areas. Contracting out in the States ranges from complete facility management to contracting out particular services such as diagnostic services, housekeeping services and outreach services. Several States are contracting out to NGOs as well as to the private sector in order to expand services, which appears to have met with a fair amount of success indicated by the improved availability of health staff, equipments and infrastructure and increased staff efficiency that has subsequently led to increase utilisation of the facilities.

Areas where relatively few innovations have been listed are adolescent reproductive and sexual health with five innovations and gender with nine innovations. The School Health Programme is being launched soon and will address innovations for youth in school. Out of school youth need to be focussed, particularly unmarried youth.

Gender is considered to be a cross-cutting area in RCH II and mainstreaming gender in all aspects of the programme is vital for the success of the programme. States have attempted to integrate gender into programmatic aspects. Of the nine innovations in this area, gender budgeting has been implemented in Gujarat, Karnataka and Nagaland. Another multi-State intervention, family counselling centre (FCC), which seeks to address the issue of violence against women, challenges patriarchy, a fundamental issue of the society. These centres have enabled women to voice the injustices meted out to them in society. The increasing number of cases in these centres indicates an improvement in reporting cases of gender violence. Innovations by Punjab and Tamil Nadu aim at addressing sex selective abortions.

Population stabilisation is an important objective of RCH II. Most innovations in this category belong to the realm of Behaviour Change Communication (BCC) or social franchising and have been included therein. BCC is a major cross-cutting intervention in RCH II. Almost all

innovations have a component of BCC. The contribution of the three major multi-State social marketing campaigns targeting oral contraceptives (OCs), condoms and Oral Rehydration Salt (ORS) use in diarrhoea implemented with the support of Development Partners (DPs) and partnership with commercial private sector has been significant in terms of demonstrated positive impact on behaviour change among populations with high and middle Standard of Living Indices, increased utilisation of services by targeted groups and reduction of stigmatisation against condoms. Campaigns such as 'Saathi Bacchpan Ke' had resulted in policy modification. Such information, education and communication (IEC)/BCC innovations, with need-based modifications, and continued support when used in the right context, have tremendous potential in improving RCH outcomes

Detailed desk reviews (Annexures 3-10) were conducted for 55 innovations, which have been in place for over a year and for which sufficient documentation was available. The desk reviews were conducted using a tool that has seven major criteria: documentation, availability of evidence, reach and equity, environmental context, institutional fit, human resource requirements at scaled-up levels and cost analysis. Twenty of these are recommended for a more in-depth review. Eight of these are already undergoing review by DPs and other agencies.

The range and spread of innovations across the States is truly impressive. The trend of piloting new initiatives and State-led design of need and context-specific innovations is pathbreaking. The context for piloting innovations has, of course, been set by the flexible framework enabled by RCH II and the NRHM. As mentioned above, several innovations currently under way in the States are promising and have tremendous potential for scalability. For several innovations, it may be that although the entire innovation cannot be scaled up, crucial elements of the innovation can be scaled up. It is encouraging to note that several States have replicated some 'successful' models of innovations such as the PPP projects, EMRI, Chiranjeevi scheme, emergency helplines and emergency ambulance (Janani Express Yojana).

Varying performance by the States in overall health programme management, the limitations of inadequate human resources, governance issues, lack of attention to detailed process documentation and effective systems for monitoring and follow-up are some of the challenges in the scaling up of evidently successful innovations.

This directory of innovations touches the tip of the iceberg in terms of the list of innovations. Many of these innovations are yet in a fledgling state and need to be carefully nurtured and studied. This directory is meant to be updated and expanded upon. More details need to be analysed, especially in terms of outcomes, impact and cost data for the innovations. There is enormous potential for the list to be expanded given that States, NGOs and other private players are experimenting with newer approaches for health care services. The development of the innovations directory should be seen as a first step in developing a body of research in scaling up, particularly within the larger public sector system.

Way Forward

A review of innovations needs to be followed by training and support to the States for documentation, monitoring and evaluation, and advocacy. This will enable more rigorous assessments of scalability of innovations. Another potential area of training for States is introducing key principles of scalability at the design phase of the innovations in order to facilitate scaling up when the evidence becomes available.

I. BACKGROUND

1. Within the framework of RCH II/NRHM, several States have introduced pilot innovations across a spectrum of health services. These innovations span a range of service delivery projects and programmes. The main objective of the pilot innovations is to expand access to care and improve quality of services through testing a range of strategic approaches, such as: provision of incentives, facilitation of emergency transport, varying modes of health financing, enabling creative partnerships with the private sector, and piloting alternative means of service delivery. The Ministry of Health and Family Welfare, (MoHFW) commissioned a systematic review, supported by the Department for International Development (DFID), of these innovations to:

    - Provide a robust assessment of the effectiveness of the schemes, especially their impact on the poor and vulnerable groups
    - Promote cross-learning among the States to address challenges in the health sector
    - Enable the State to explore the possibility of replicating the innovations suited to their local context and needs
    - Inform the mid-term review of RCH II

2. Given the large number of 'innovations' proposed by the MoHFW, various States, and the DPs, over 200 in number, it was decided that the review would be undertaken in two stages. The first stage would involve a desk review of available documents and rapid field assessments in selected states, yielding a shortlist of innovations that could be undertaken for further detailed reviews in a subsequent second stage. This document is a directory of innovations proposed/under way in States, including reviews of select innovations.

II. SCOPE OF WORK AND METHODOLOGY

1. The objective of the innovations scan was to conduct a desk review of approximately 200 innovations implemented in the States and develop a directory of innovations according to the major thematic areas of RCH II and the NRHM. The outcome of the desk review was (1) to develop a directory of innovations under way in the States (2) provide a brief report on innovations in place for over a year, and for which sufficient documentation was provided, and (3) identify innovations to be studied for in-depth scalability assessments.

2. **Annexure 1** includes a list of the innovations classified by State. Some of the suggested innovations were excluded from the list because of the following reasons:
    - Element of a State or national programme and not a new intervention or innovation
    - An activity rather than an intervention or innovation
    - Micro research studies
    - Discontinued by the State

3. The categorisation of innovations into themes roughly follows those laid out in the National Programme Implementation Plan of RCH II and also in the Implementation Framework of the NRHM. The innovations have been classified into seven categories that span major thematic areas of RCH II/NRHM. (Box 1)

Box 1: Category of Innovations

Category of Innovation	**Nos.**
Safe Motherhood/Maternal Mortality Reduction	**43**
• Innovations to promote safe motherhood and institutional delivery	24
• Ambulance services and helplines for transport of obstetric emergencies	17
• Strengthening skills and capacity of providers	2
Immunisation and Infant and Young Child Feeding (IFCF)	**28**
Adolescent Reproductive and Sexual Health (ARSH)	**5**
Behaviour Change Communication	**19**
Gender Mainstreaming	**9**
Service Delivery for RCH	**38**
• Mobile health units	11
• Social franchising networks	4
• Health financing	8
• Contracting out management of public health services	15

Programme Management	**80**
• Incentives to improve mobility, availability and attendance of staff	22
• Incentives to improve performance and range of services	8
• Alternatives to In service training for improved performance	4
• Community and Panchayat involvement in planning, monitoring and management of health services and facilities	29
• Programme monitoring and management information systems	13
• Improving procurement and finance systems	4
School Health	5
TOTAL	**227**

4. Desk reviews were conducted for detailed scalability assessment for innovations that had been in place for over a year and for which sufficient documentation was available, which includes:

- Brief narratives extracted from State Project Implementation Plans (PIP) for fiscal years 2006-2007, 2007-2008 and 2008-2009
- Design documents for the innovation under consideration
- Power Point presentations made at conferences and meetings
- Mid-project reviews for selected innovations
- Detailed evaluation studies for a few selected innovations

The quality of documentation on the innovations was highly variable and posed challenges in conducting detailed analysis. There are several innovations for which budget details, date of initiation and data on outcomes are missing. Since most of the innovations of the pre-RCH and early RCH II phase were initiated as a pilot on a smaller scale at the State/district level, it is not surprising that there is insufficient documentation on the processes, outcomes and impact. It is likely that documentation on some of the innovations exists in some form or other, but has not been maintained by the relevant authorities. Some of the innovations that have been implanted for more than a year (for example, Chiranjeevi Yojana, Swasthya Panchayat Yojana, PPP with private hospitals in Assam, vouchers for institutional delivery in Uttar Pradesh and Uttarakhand) did have sufficient documentation, having been reviewed and evaluated by the DPs, State Governments and other external agencies.

In case of budgets, funding from multiple sources including DPs, State funds and non-RCH funds makes it difficult to cull out year-wise planned budget allocations and expenditures. However, budget allocations have been considerably streamlined in the last two years and currently most of the innovations are funded under the RCH II budget and Mission Flexipool budget.

Innovations with insufficient documentation/no documentation are also listed in the directory, so that the list can be updated as implementation proceeds. Wherever available, the nature and quality of monitoring and evaluation systems were reviewed with the potential to yield

credible evidence. The various levels of evidence that were reviewed included a basic logic model (a hypothetical assumption that a set of activities implemented well will achieve results) to the existence of internal performance monitoring systems to measure key outcomes and systematic external evaluations.

5. The methodology followed was the application of a scalability assessment protocol, developed by Management System International **(Annexure 2)**, to each of the innovations. The protocol was adapted to suit the special need of the review. The tool assessed the innovation on seven major criteria:

    1. Documentation: Did the documentation adequately cover processes, human resource and infrastructure needs, capacity building strategies, challenges, lessons?
    2. Availability of evidence: Did the innovation have in-built monitoring systems? Is it possible to identify key outcomes? Is there credible evidence of impact, or has impact evaluation being planned for?
    3. Reach and Equity: Is there adequate consideration of reach and equity in the design and implementation of the pilot?
    4. Environmental Context: Did the design of the innovation consider the environmental context (socio-political, governance, cultural and ethnic dimensions) in which the pilot was to be implemented?
    5. Institutional Fit: Degree to which the pilot innovation has been institutionalised or has the potential to be institutionalised within the system with minimal change in the current operating structures and systems
    6. Human resource requirements at scaled-up levels: Is there detailed information on the nature of external support provided during the pilot? Did the pilot envisage requirements for skill building of human resources for a scaled-up intervention?
    7. Cost Analysis: Is there information on the cost of the various components of the model? Is there sufficient data to allow the analysis of cost-effectiveness and cost benefit?

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6. Forty-eight innovations, for which detailed documentation on project design and data on outcomes and impact was available, were reviewed. Desk review reports for each of these are included in **Annexures 3 to 10.** The quality of documentation ranged from brief narrative descriptions to detailed project design and evaluation documents. Wherever possible, pertinent scalability issues have been highlighted.

7. Twenty innovations were recommended for an in-depth review, based on available documentation (**Annexure 11**). Eight of these innovations have already been studied in-depth or are undergoing in-depth reviews. It is likely that as more documents become available, this list will expand.

III. KEY FINDINGS

1. The NRHM's mandate is to bring about 'architectural correction' and make public health services 'equitable, affordable and effective'. The RCH II programme focusses on addressing the poorest and underserved populations within a framework of substantial degree of flexibility, decentralised management and enhanced accountability for results. These parameters have resulted in the States piloting innovations across the major RCH II and NRHM themes. The innovations listed in this report do not represent the entire universe of innovations in the country. Several State Governments are using State-level funds to pilot new innovations based on need and context. In addition, there is likely to be a plethora of innovations, many of them demonstrating a strong evidence base, that have been implemented by NGOs. The majority of the innovations in this report, however, are those that are being supported through central funds.

2. The term 'innovations' has been used very flexibly. Broadly, two sub-categories of innovations can be distinguished. One is a true 'pilot innovation' that has not been tried elsewhere, for example, Chiranjeevi Yojana of Gujarat or the boat clinic of Assam. The second is the use of particular components of an intervention or an entire intervention implemented in a new setting or different organisational context, for example, maternal or infant death audits. For the purposes of this document, the term innovations will be used, regardless of the sub-category.

3. Some innovations spanned several States (for example, mobile clinics), while many were State-specific (Chiranjeevi Yojana in Gujarat, boat clinics through PPP in Assam). The innovations are all being piloted in the context of substantial investments from national and State levels on improving the health infrastructure, strengthening health systems, promoting social mobilisation and community participation, enabling decentralised health planning and implementation, incentivising performance and quality to retain and attract human resources, and strengthening programme management and monitoring. The list of innovations also includes pilot initiatives (in a set of blocks or a particular district) for each of these areas.

4. Several pilot innovations introduced in the States are promising and have clearly demonstrated positive outcomes, For example, Chiranjeevi Yojana of Gujarat and the EMRI model of Andhra Pradesh have shown good results and are being adopted in various forms by several States. The EMRI has been replicated in Chhattisgarh, Delhi, Gujarat, Jammu and Kashmir, Karnataka, Madhya Pradesh, Maharashtra, Orissa and Tamil Nadu. Several States have adopted the JSY/Chiranjeevi model to further provide services in areas not covered by JSY or to boost the gains from JSY, including Saubhagyawati Scheme (Uttar Pradesh), Janani Suvidha Yojana (Haryana), Janani Sahyogi Yojana (Madhya Pradesh), Ayushmati Scheme (West Bengal), Chiranjeevi Yojana (Assam), and Mamta Friendly Hospital Scheme (Delhi).

5. One of the key requirements for scalability is institutionalisation of the innovation within the Government system. This necessitates credible evidence demonstrated in terms of clear outcomes. Cost-effectiveness of the model is another factor that needs to be examined.

6. Routine trend monitoring is a useful process measure and in many cases outcome data is provided, but in the absence of baseline data it is difficult to comment on the scalability of the intervention. States would need to establish effective monitoring systems with indicators for measuring outcomes against baseline data for the innovations; further quality of service delivery is another area that requires attention.

Innovations Supported by Development Partners

7. Some innovations are designed and initiated by the DPs. In cases of innovations supported by the DPs, while all are being implemented in some form of collaboration with the Government, the nature of collaboration varies. Two distinct patterns of collaboration emerge:

   (i) The pilot enjoys the support of the Government, is being largely implemented through the Government system but with significant technical support through an external mechanism primarily from an external donor, for example, USAID supported voucher schemes in Uttar Pradesh, UNICEF supported innovations in maternal audits in multiple States, and the UNFPA supported FCCs.
   (ii) The pilot is being implemented with tacit support from the Government but is entirely located in the private sector and is managed substantially by an external donor, for example, mass media campaigns for ORC, pills and condoms.

Category 1

Safe Motherhood/Maternal Mortality Reduction

Category 1: Safe Motherhood/Maternal Mortality Reduction

Under the NRHM (2005-2012) and the RCH Programme Phase II (2005-2010), the GoI aims to reduce maternal mortality by focussing on the following major strategies[1]:

Enhance availability of facilities for institutional deliveries and emergency obstetric care: This encompasses interventions that strengthen facilities and skill building of providers—non-specialists and auxiliary nurse midwives (ANMs) to provide emergency obstetric care

Improve access of poor women to institutional deliveries (Janani Suraksha Yojana) and other demand-side financing innovations

Increase access to care seeking through strengthening referral transport

Forty-three innovations in the area of safe motherhood that are listed in the document encompass three major areas. Of these, 12 were identified for desk review and are in Annexure 3.

- **Innovations to promote safe motherhood and institutional delivery**

  Promoting institutional delivery appears to be the area of focus for safe motherhood interventions. The Janani Suraksha Yojana is a flagship scheme that provides financial entitlements as incentives for women to deliver in institutions and is being implemented nationwide. In addition, individual States have piloted several schemes in this area.

- **Ambulance services and helplines for the transport of obstetric emergencies**

  Another innovation to address the issue of delays in the seeking of care for obstetric emergencies is the provision of transport in the form of various ambulance schemes. While originally envisaged as a readily available transport scheme for women with obstetric emergencies, ambulance services now cater to all emergencies. Thus all innovations under ambulance schemes are listed in this category.

- **Strengthening skills and capacity of providers**

  Innovations in this category test the feasibility of training non-specialists such as MBBS doctors in Emergency Obstetric Care (EmOC) and anaesthesia in order to overcome the acute shortage of specialists (Ob/Gyn and Anaesthetics) at the level of FRUs to manage obstetric complications.

[1] National PIP, RCH-Phase II

1.1 Innovations to Promote Safe Motherhood and Institutional Delivery

Of the 24 innovations listed in this section, a significant number of the innovations are based on some form of demand-side financing, mainly vouchers; some are a form of contracting out institutional delivery services for BPL women to the private sector. In some States, additional facilities for institutional delivery (maternity homes and birthing huts) have been created so as to enhance geographic access.

A large majority of the innovations were initiated in 2006 and have barely completed two years of implementation. Two innovations in this category have been recommended for an in-depth review. The Chiranjeevi Yojana, implemented in Gujarat at a statewide scale, is already undergoing an evaluation led by UNFPA. The delivery huts in Haryana, which is the only one of this category that is implemented by and through the public sector, has been recommended for an in-depth review to identify lessons that could be relevant in areas where even financial incentives are not attractive enough for the private sector to venture into the area of service provision, particularly in remote hamlets and tribal areas. Of these innovations so far only the Chiranjeevi Yojana has had systems in place to measure the key outcome, which is a significant increase in institutional delivery.

Table 1.1 Innovations for Safe Motherhood and Promoting Institutional Deliveries

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1999-2005/2006			
1.	Provision of Maternal Child Health (MCH) Services in Tribal Areas through Nurse Midwife Operated Clinics (1997-ongoing)	Rajasthan	This model has been implemented by an NGO, ARTH, in tribal Udaipur since 1999. The key feature is the management of a health centre that provides range of MCH services, including safe delivery in remote rural areas with the back-up support from a gynaecologist and strong referral linkages **Outcomes: from 1999-2005** • An increase in institutional delivery from 12% to 38% and among socially and economically marginalised from 3% to 13.8% • Nurse midwife conducted delivery increased from 1.6% to 20.7% • Stillbirth rate of 28.9 and NNMR of 37 per 1,000 live births, respectively ***(Desk Review Report in Annexure 3.1.1)***
2.	Chiranjeevi Yojana (2005-2006)	Gujarat	An innovative health financing scheme covered through PPP for emergency obstetric care and emergency transport services, for women in BPL

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			category. Private gynaecologists are contracted for services for normal and complicated deliveries at their health facilities. The financial package is worked out based on 100 deliveries and includes normal and complicated deliveries **Outcomes:** 852 of a total of 2,000 Ob/Gyns enrolled Total deliveries conducted under the scheme are 165,278 of which 143, 882 were normal deliveries with a C-section rate of 6.21% Complicated deliveries accounted for 6.72% of total deliveries ***(Desk Review Report in Annexure 3.1.2)***
3.	Birth Waiting Rooms (2005-2006)	Andhra Pradesh	A pilot intervention to ensure the provision of birth waiting rooms for pregnant women from distant tribal areas to reach the institutions a couple of days before the expected date of delivery in order to avoid complications. As a pilot it was proposed to construct three birth waiting rooms in each district each at a cost of Rs. 5 lakh
2006-2007			
4.	Janani Suvidha Yojana	Haryana	Increase access to safe delivery services and institutional delivery for urban BPL women through private health providers and referral arrangements with Government institutions, using vouchers ***(Desk Review Report in Annexure 3.1.3)***
5.	Delivery Huts	Haryana	Build and equip delivery huts to reduce home deliveries. An essential criterion for building the hut is that the ANM or nurse is resident in the village. There is also provision for transportation **Outcomes:** 476 delivery huts built About 30,000 deliveries conducted ***(Desk Review Report in Annexure 3.1.4)***
6.	Birth Companion Programme	Tamil Nadu	Ensuring the presence of a birth companion during delivery in all facilities. The package of service covers facilities such as screens between labour boards for privacy and seating arrangement for the companion

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
7.	Provision of Round-the-clock Delivery Services (since RCH I)	Tamil Nadu	Ensuring access to safe delivery services through the provision of three nurses on a shift system resulted in an increase in proportion of institutional deliveries in the public sector health facilities
8.	Providing Antenatal Care, Nutrition and Counselling through the Use of Indian Systems of Medicine (ISM)	Tamil Nadu	Administration of ISM drugs for antenatal care and counselling to pregnant women on nutrition and ISM drugs
9.	Traditional Birth Attendant (TBA) Incentives to Promote Institutional Delivery	Karnataka	Incentive to TBAs to escort pregnant women for institutional delivery
10.	Ensuring 100% Birth Registration	Manipur	Incentives to TBAs and others for ensuring 100% birth registration
11.	Enabling Round-the-clock Services for Institutional Delivery	Mizoram	Cash incentives for Medical Officers (MOs), staff nurses and Grade IV staff for conducting deliveries at night in primary health centres (PHCs)
12.	Vande Mataram Scheme	West Bengal	A scheme to involve the private sector in providing safe motherhood and family planning services. Gynaecologist members of FOGSI volunteers to provide free outpatient care services (antenatal and family planning services) to pregnant women on a fixed day each month. Enrolled Vande Mataram physicians are provided a kit of IFA tablets, condoms, OCs and intra-uterine devices (IUDs) for free distribution to patients.
2007-2008			
13.	Janani Sahayogi Yojana	Madhya Pradesh	Accreditation of private health facilities for MCH services and reimbursement on basis of fixed rates
14.	Voucher Schemes for Institutional Delivery	Uttar Pradesh (Agra, Kanpur, Bahraich)	Use of vouchers as a mechanism for demand-side financing where Reproductive and Child Health (RCH) services for BPL women and children are provided through private practitioners ***(Desk Review Report in Annexure 3.1.5)***
15.	Voucher Schemes for Institutional Delivery	Uttarakhand (Haridwar)	
16.	Ayushmati Scheme	West Bengal	A PPP initiative for enhancing access and improving institutional deliveries among BPL

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			families. The scheme is largely similar to the Chiranjeevi Yojana. The scheme has been launched on a pilot basis in 11 districts. Districts have been chosen on the basis of availability of public facilities functioning above the critical level. The State has estimated that around 20% of the estimated deliveries of pregnant women from BPL families will be covered ***(Desk Review Report in Annexure 3.1.6)***
17.	Mamta Friendly Hospital Initiative	Delhi	A PPP initiative for obstetric care services, covering BPL, SC/ST women in the State. Payment is made to private service provider on the basis of pre-decided fee per case
2008-2009			
18.	Transit Homes for Accompanying Relatives of Women for Institutional Delivery	Uttarakhand	Transit homes will be set up for providing accommodation to the attendants (relatives) of patients/pregnant women in order to facilitate the visit of the patients to the health facilities. The four to six-bedded transit homes will be set up near a Community Health Centre (CHC). The management of the homes will be handed over to Mother NGOS (MNGOs)/NGOs. User fee would be collected as maintenance fee for the homes. The initiative will be rolled out in four difficult districts
19.	Saubhagyawati Scheme: Private Sector Participation to Promote Access of BPL Women to Institutional Deliveries	Uttar Pradesh	A scheme to cater to the BPL population in the rural and urban areas. Under this scheme each private agency/provider will provide services in one or more blocks covering the entire package of safe motherhood services (from Ante Natal Care (ANC) to delivery to Post Natal Care (PNC), neonatal care and family planning. A panel of private agencies will be empanelled to perform more than 50 deliveries in a quarter. Identification and empanelment of the private gynaecologists/hospitals will be done by the medical officers In charge of the block PHCs
20.	Chiranjeevi Yojana: Contracting Out of Services to the Private Service Providers	Assam	A PPP initiative that intends to increase access to emergency obstetric care and institutional delivery for the unserved population. The scheme aims to contract out services to the private doctors/hospitals; provide insurance coverage to all BPL pregnant women and neonates and creating

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			awareness generation regarding the scheme. State plans to empanel the private doctors and hospitals. Cash reimbursement will also be provided for transport and for the patient's attendant wage loss. The scheme will be launched in four districts
21.	Insecticide-treated Bed Nets for Pregnant Women	Assam	Insecticide-treated bed nets will be provided to all the pregnant women accessing institutions for delivery. This will be combined with the Janani Suraksha Yojana incentive. Initiated in Sivasagar, Goalpara, Golaghat, Morigaon on pilot basis
22.	Maternity Waiting Centres	Manipur	Pilot initiative for two NGO-managed maternity waiting centres each with a capacity for 20 beds. Each of these centres will include 14 ANMs with two ANMs on service 24/7. The centres are exclusively for women belonging to the poor families, who will be required to provide a nominal admittance and daily fees. Pregnant women will be shifted to the referral centres for delivery and in cases of emergencies
23.	Maata Vikas Kendra (Mother's Development Centre)	Maharashtra	A mother's development centre for providing comprehensive care to pregnant women (and address the issue of malnourishment among mothers) and improving the quantum of institutional deliveries. The centres introduced in three tribal PHCs of Raigad district. The centres offer a range of services, for example, health check-up, immunisation, IFA tablets, and analysis on nutrition, identification of high-risk mothers and motivating them for institutional delivery
24.	Convergence Model, NRHM-NACO: ANC-PPTCT Programme (2008-2012)	Karnataka	A convergence model between the NRHM and National AIDS Control Organisation (NACO) under which pregnant women are covered by HIV counselling and testing through PHC outreach activities. Women who have touched the third trimester of pregnancy will be mobilised for undertaking pre-test counselling and HIV testing and registration with the Yeshaswini Scheme. The model also aims at providing free service to HIV positive women at the Yeshaswini Network Hospitals (YNH) for deliveries through the Yeshaswini Scheme. All hospitals both YNH and the public sector hospitals where the HIV positive women choose to deliver will ensure that NACO's PPTCT Protocols are followed and the ANMs

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			would ensure that the mother-baby pairs are followed up for 18 months postnatally when the baby's HIV status would be finally known ***(Desk Review Report in Annex 3.1.7)***

1.2 Ambulance Services and Helpline for Transport of Obstetric Emergencies

The three delays model of pregnancy-related mortality includes delay in reaching an appropriate facility, often due to a lack of readily available and affordable transport. innovations. The model has been devised to enable women, particularly poor women residing in hamlets and in areas where communication and modes of transport are poor and erratic.

Seventeen innovations were listed in this category. Almost all are a combination of a call centre and ambulance service. Two of these (EMRI in Andhra Pradesh and Ambulance in West Bengal) are already undergoing an in-depth review. The Madhya Pradesh-based Janani Express Yojana was documented in a fairly detailed manner as part of a recent evaluation. It is apparent even from the review of the limited material that the ambulance schemes have varying operational norms and standards. In West Bengal and Dholpur, the ambulance service is managed by NGOs, in Guna by the district health system, while in the rest of Madhya Pradesh the Janani Express Yojana works with private vehicle owners. EMRI is a highly efficient operation managed by a private foundation with world class communications and infrastructure facility at its disposal.

Over and above the additional management and contractual challenges that ambulance schemes pose to the District Health Society, key cross-cutting issues across the States include ensuring that communities of all sections become aware of the facility, enabling the really poor and marginalised to access the ambulance facility, and finally ensuring the state of preparedness of the health facility to which women are transported to assure them of safe and high quality delivery services. A comparative assessment of all ambulance schemes to draw lessons related to standard operating procedures, monitoring of the scheme and efforts to ensure reach and equity would support large-scale scaling up.

Table 1.2: Ambulance Services and Helpline for Transport of Obstetric Emergencies

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1.	**2005-2006** Free Bus Passes	Andhra Pradesh	Free bus passes to SC/ST and BPL pregnant women in rural areas to enable them to get at least one ANC check-up with a qualified

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			medical doctor. Eight lakh free bus passes have been issued
2006-2007			
2.	Janani Express Yojana	Madhya Pradesh	An ambulance service to enable BPL women overcome the problems from lack of access to suitable transport through district-level partnerships with private providers **Outcomes:** Implemented in 204 blocks 54, 202 women transported, of which half were for institutional delivery. Over 52% from BPL category Transported 68% multiparous women had not previously delivered in institutions ***(Desk Review Report in Annexure 3.2.1)***
3.	Call Centre with Network of Ambulances for Ob/Gyn/Newborn	Madhya Pradesh	The 24/7 emergency transport and call centre is an effort to enable women and sick children to reach health care facilities for institutional deliveries, through providing round-the-clock emergency transport, which the community can access through a call centre set up in the district hospital with a toll-free number **Outcomes:** • 5,026 women transported • Network of 24 vehicles at district level ***(Desk Review Report in Annexure 3.2.2)***
4.	Ambulance Scheme	West Bengal	Provision of round-the-clock emergency transport for obstetric and other medical emergencies, through a fleet of ambulances outsourced to NGOs with a communication network through fixed and mobile phones **Outcomes:** • Caseloads are increasing, given the widespread community awareness on the scheme. All ambulances are equipped with mobile phones. One-third of all cases were pregnancy and

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			delivery-related • Proportion of BPL cases transported (in three blocks) ranges from 35% to 57% • ***(Desk Review Report in Annexure 3.2.3)***
5.	Rural Emergency Health Transportation Scheme	Andhra Pradesh	An ambulance service for transporting emergency cases of pregnant women and children (and other emergencies) to the nearest facility. The scheme has the provision for a District Maternal and Child Health emergency control room in every district headquarter, with a toll-free telephone available for 24 hours **Outcomes:** • 732 ambulances, one ambulance makes around eight trips a day • Average reach time of the ambulance is 14 minutes in urban areas and 21 minutes in rural areas • MoU with 4,000 hospitals and nursing homes in different parts of Andhra Pradesh and 1,500 police stations linkages • Covers 147 million population and around 5,700 emergencies have been handled • Ambulance use by SC/ST/BC socioeconomic categories is 83% • Pregnant women using the ambulance for delivery—22% ***(Desk Review Report in Annexure 3.2.4)***
6.	Obstetric Helpline	Rajasthan	The focus of interventions is on addressing the second delay by mapping transport facilities, instituting a toll-free number, involving an NGO to engage local taxis and to escort women to the health facility (apparently the CHC), as well as negotiate the services and ensure timely payments of financial entitlements

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			Outcomes: • High utilisation of the service by women in the BPL category • Almost 100% correlation between calls and women delivering in institutions • Increase in numbers of caesarean sections at the CHC
7.	Emergency Medical Services	Bihar	Ambulance service and medical help/tele line. Control room operational 24 hours in the divisional headquarters of the State
8.	JSY Helpline	Mizoram	JSY helpline implemented by NGO
9.	District Maternal and Child Health Control Room	Andhra Pradesh	The public will be informed about this facility and will be encouraged to call this number in the case of any maternal, infant/child emergency. On receipt of the information, the NGOs responsible for the ambulance will transfer the patient to the nearest hospital
2007-2008			
10.	Janani Suraksha Vahini: Karnataka	Karnataka	Janani Suraksha Vahini is a part of JSY under which ambulances are placed in 176 *taluka* hospitals for transportation of emergency cases for pregnant women and children
2008-2009			
11.	Aarogya Kavacha Scheme	Karnataka	Scheme similar to EMRI of Andhra Pradesh
12.	JSY Helpline	Chhattisgarh	Tele helpline to promote institutional deliveries and reduce the three delays to be managed by a JSY cell within the directorate. The services will be contracted out to a private organisation, at a reimbursement of, on a call basis, at the rate of Rs. 5 per call. JSY cell to monitor quality through sample checks
13.	JSY Helpline	Jharkhand	A helpline in the district headquarters, functioning 24/7, connected to all CHCs and PHCs, and providing immediate medical care to mothers in case of emergencies, through

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			provision of ambulances for referral transport. A data bank will also be available for providing information on the status of ambulances
14.	Voucher Scheme for Referral Transport	Uttar Pradesh	A voucher scheme for providing transport to the BPL patients. The District Society/ Rogi Kalyan Samiti (RKS) at the block level will identify and accredit transport providers to facilitate transportation to BPL clients. The BPL families will be provided vouchers, which will be distributed through ASHAs. On reaching a health facility through an accredited private transporter, the driver/owner will be paid Rs. 250 at the health facility by the designated officer from the transport component of the JSY funds. In this case the transportation amount will not be paid to either the client or ASHA
15.	Emergency Management and Referral Institute	Assam	An EMRI with a toll-free number will be set up in Guwahati and will include emergency ambulance services in partnership with a non-profit organisation. The ambulances will be placed strategically in the districts and will function 24/7 to cater to any kind of emergency with three teams: Information team (call taking, call processing and call dispatch), Response team (ambulance) and Care team (pre-hospital medical care). A statewide toll-free emergency number will connect informants to the Emergency Response Centre in Guwahati. It will be launched statewide in November 2008 in a phased manner.
16.	Rural Ambulance to Transport Women with Obstetric Emergencies and Sick Newborns	Tripura	A scheme that provides ambulances for emergency referral transport for pregnant women and high-risk babies from sub-district hospitals to district hospitals. The scheme was launched in 2006-07 and will be extended to three PHCs in 2008-2009
17.	Ambulance Services and Helpline for Transport of Obstetric	Goa	An EMRI with an emergency transport placed in all *talukas* 24/7 for transportation of cases of obstetric emergencies. The EMRI has

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
	Emergencies		three teams: Information team, Response team and Care team. There has been positive response to the EMRI So far, 2,464 emergency calls received in a month, 1,253 medical emergencies responded and 35 lives saved (till September 2008)

1.3 Strengthening Skills and Capacity of Providers

This set of innovations intends to strengthen the skills and services of various service providers to manage selected obstetric emergencies through policy modification and training for selective interventions under specific emergency situations to save the life of the mothers. The innovations also focus on quality of care through accreditation of service providers. In addition, MBBS doctors are being trained in Life Saving Anaesthetics Skill and Emergency Obstetric Care. While the EQUIP programme is specific to Chhattisgarh, the GoI has awarded a grant to FOGSI to build the capacity of selected State medical colleges as nodal training centres for training MBBS doctors in Emergency Obstetric Care in the EAG States.

Table 1.3: Strengthening Skills and Capacity of Providers

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1	**2003-ongoing** Multi-skilling of medical staff—Enhancing Quality Care in Public Health Care	Chhattisgarh	EQUIP is an acronym for Enhancing Quality in Primary Health Care, an approach adopted by the State for addressing quality and adequacy of utilisation of services through block planning. The focus has been to address specialist gaps, through multiskilling doctors, particularly in Emergency Obstetric Care (EmOC) and anaesthesia **Outcomes:** • 27 doctors trained in Emergency Obstetric anaesthesia and 25 in Comprehensive Emergency Obstetric Care • 30 candidates undergoing training for Emergency Obstetric anaesthesia and 30 in Comprehensive Emergency Obstetric Care

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			(Desk Review Report in Annexure 3.3.1)
2	Certification of Facilities for Comprehensive Emergency Obstetric and Newborn Care (CEmONC)	Tamil Nadu	Certification of CEmONC based on a set of accreditation criteria with a focus on quality of care monitored by obstetric and paediatric specialists. The CEmONC would be evaluated on the basis of casualty services, EmOC procedures, emergency newborn care, laboratory services, post-operative care, adherence to standard emergency treatment protocol and quality of provider-patient interaction

Category 2

Immunisation and Infant and Young Child Feeding

Category 2: Immunisation and Infant and Young Child Feeding

The objectives of the newborn and child health strategy in RCH II are**:**

1. Increase coverage of skilled care at birth in conjunction with maternal care
2. Implement, by 2010, a newborn and child health package of preventive, promotive and curative interventions using the comprehensive Integrated Management of Neonatal and Childhood Illnesses (IMNCI) approach
3. Implement the medium term strategic plan for the Universal Immunisation Programme (UIP)
4. Strengthen and augment existing services in areas where IMNCI is yet to be implemented.
5. For infant and young child feeding, RCH II is working in close collaboration with the Department of Women and Child Development towards the attainment of the national goals in nutrition and promotion of early initiation of breastfeeding, focussing on exclusive breastfeeding until six months of age, promoting timely and adequate complementary feeding and including micronutrient supplementation in accordance with the national policy.

States have introduced a range of innovations under this category based on local context and need. Innovations such as home-based newborn care, alternative vaccine delivery models and a host of outreach mechanisms to improve immunisation coverage have been designed for micronutrient supplementation in conjunction with maternal health services. In order to overcome issues of poor immunisation coverage, States have piloted innovations that take the form of designated special fixed days, or a notified period of time during which services are provided through camps, outreach sessions as special events. During these days a broad range of services is provided, but since child health services (immunisation, Vitamin A and iron supplementation) are often the focus, this innovation has been classified under this head. VHNDs are the flagship innovation in this category that has been introduced nationwide.

A major thrust area in NRHM/RCH II has been on immunisation. Several innovations were proposed in this category. Some of these, including Muskaan in Bihar, are variants of the VHND. In the area of nutrition the Bal Shakti Yojana, Kano Parba Na (Positive Deviance Approach) and nutritional rehabilitation centres have been under way for some time. Of the 28 innovations in this category, seven were shortlisted for desk review (desk review reports in Annexure 4).

Table 2: Immunisation and Infant and Young Child Feeding

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
2001-2006			
1.	Dular Strategy (1999-2005)	Bihar	The main goal of this project was to put in place interventions that would empower the family and the community, within selected areas of the

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			Integrated Child Development Scheme (ICDS) purview, to make positive changes in health-related behaviours, as well as addressing the issue of malnutrition among women and children and reducing anaemia among adolescent girls. The interventions used consisted of behaviour change communication and interpersonal communication (IPC) strategies **Outcomes**: • Dular villages had a significantly higher rate of colostrum feeding, at 84%, than the non-Dular villages (64%) • A significant difference in the malnutrition rates (underweight) reported between the Dular and non-Dular villages (55.5% vs. 65.4%) and a significantly lower stunted population in the Dular villages (61.8%) as compared to the non-Dular villages (72.0%) ***(Desk Review Report in Annexure 4.1)***
2.	Ankur Project: Improving Neonatal Mortality through a Package of Home-Based Newborn Care (HBNC) (2001-2005)	Maharashtra	The main goal of this project was to expand the successful Gadchiroli model (reducing neonatal mortality through Home-based Newborn Care provided by a community health worker) in several sites across Maharashtra **Outcomes**: • In the third year of intervention, coverage of mothers and newborns, using a composite of seven indicators, was 85% • Neonatal mortality rate dropped from 46 (at baseline) to 24 and IMR from 62 (at baseline) to 36 by the third year of intervention • Home deliveries attended by the Community Health Worker (CHW): 63.8% • Newborns delivered at home examined by a CHW within 24 hours of birth: 77.4% ***(Desk Review Report, Annexure 4.2)***
3.	Kano Parba Na (2001-2005)	West Bengal	Implemented in four districts in West Bengal for reduction of low birth weight (LBW) and malnutrition through a positive deviance approach

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			Outcomes: • The proportion of normal ($p<0.05$) and Grade I ($p<0.01$) children increased significantly • Prevalence of Grade IV under-nutrition remained the same • ***(Desk Review Report in Annexure 4.3)***
4.	Reproductive and Child Health, Nutrition and HIV/AIDS Programme (RACHNA) (2001-2006)	Uttar Pradesh, Bihar, Rajasthan, Chhattisgarh, Jharkhand, Andhra Pradesh, West Bengal, Orissa and Madhya Pradesh	The aim of the RACHNA project was to augment the direct food distribution support to ICDS, with additional interventions to support improvements in maternal and child health and nutrition services, behaviours and outcomes. It is the largest intervention to demonstrate effective convergence between health and nutrition at community and block levels **Outcomes:** (comparison between baseline and endline surveys) • Per cent of children in 12-23 months old immunised with measles vaccine rose from 37% to 71% • Per cent of infants who received breast milk and solid-mushy food at six to nine months of age rose from 49% to 78% • Per cent of children under one year breastfed exclusively for six months post-partum rose from 34% to 44% • Per cent of children in 18-23 months, received at least two doses of Vitamin A went from 5% to 27% ***(Desk Review Report in Annexure 4.4)***
5.	Saksham: Community-based Intervention to Improve Newborn Care (2003-2006)	Uttar Pradesh	Implemented in one block in Rae Bareilly district, the overall goal of the Saksham Project was to develop community-based newborn care intervention models in resource poor settings ***(Desk Review Report in Annexure 4.5)***
2006-2007			
6.	Panchamrit Campaign	Rajasthan	A week-long intervention programme for MCHN during the first three months of the year, with elements added to the Immunisation service,

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			during the immunisation week, making a total of five services
7.	Shishu Samrakshak Maah	Chhattisgarh	Intensify coverage of MCH interventions through intensive bi-annual rounds in April and October of each year **Outcomes:** • Complete immunisation coverage for children rose from 28% in October 2005 (CES 2005) to 57% in October 2006 • Proportion of children receiving deworming treatment rose from 3% in October 2006 to 28% in October 2007 ***(Desk Review Report in Annexure 4.6)***
8.	Jacha Bacha Swasth Divas	Uttarakhand	A camp approach; fixed day visit schedule for providing ANC and child health services in all villages located in a sub-centre area on a rotational basis. ANMs to be provided Rs. 50 per camp for an assistant for handling equipments and supplies
9.	Mamta Abhiyan	Gujarat	Preventive and promotive RCH outreach services will be conducted on 'Mamta Divas' (Village Health and Nutrition Days), in convergence with ICDS will be continued. Link workers and NGOs will assist the ANMs in the identification of pregnant women and NGOs will undertake reorientation training of anganwadi workers (AWWs). Mobility support will be provided to the ANMs and Rs.100 be provided for organising each *diva*. The services of retired ANMs will be sought wherever they are available
10.	*Haat* Clinics	Gujarat	A camp will be started on the weekly market day (*haat*) visited by the communities in the tribal areas. A temporary camp including doctors and other staff will be deputed on a rotation basis to these weekly camps in the markets. The camps will provide services on minor ailments and vaccination. Awareness generating activities will also be undertaken during these camps
11.	Well Baby Campaigns	Andhra Pradesh	Well Baby shows will be organised in all the Gram Panchayats where children below one year will be assessed on the basis of their immunisation status, nutritional status and milestones for growth and development
12.	Annual De-worming	Andhra	A campaign for all Gram Panchayats where

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
	Campaign	Pradesh	anaemia in children (3-12 years) will be assessed based on clinical symptoms. Children identified with high level of anaemia will treated with de-worming tablets. Sensitisation workshops will be conducted in each habitation with the target groups to obtain the support and participation of all families in the campaign
13.	Vaccine Delivery through Mobile Vans	Bihar	Maximise the coverage of immunisation and Vitamin 'A' supplementation through the strategy of mobile van approach to cover inaccessible areas
14.	Annual Immunisation Census	Andhra Pradesh	Annual immunisation census to be conducted once a year to enable monitoring of 100% immunisation coverage of children. One week per year a dedicated tracking of all mothers and children for their immunisation status will be conducted in every habitation in the State. Quality control of the census process will be ensured by including sample checks by supervisors, done through house-to-house surveys. The women health volunteers, AWWs and ANMs will form teams and conduct the census, simultaneously giving mop-up immunisation for non-immunised children
15.	Young Infant Health Assurance Scheme	Andhra Pradesh	A voucher scheme, enabling infants of rural BPL families to access the services of the private sector hospitals, paediatricians and general medical practitioners in small towns and large Panchayats for health care services
16.	Public Private Partnerships for Critical Neonatal Care	Gujarat	In order to ensure availability of a paediatrician for critical neonatal care, financial support will be provided up to Rs. 72,000 per FRU for paediatrician on call basis (wherever the post of paediatrician is vacant)
17.	Bal Shakti Yojana, Including Nutritional Rehabilitation Centres	Madhya Pradesh	Under this scheme, Grade III and Grade IV malnourished children are identified jointly by ICDS functionaries under Bal Sanjivani Abhiyan and treated in nutritional rehabilitation centres. Mothers are provided information on nutrition for the preparation of low cost nutritious food for the children **Outcomes:** • 121 nutrition rehabilitation centres established • 7,182 children treated in 2006-2007

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			• 11,953 children treated in 2007-2008
2007-08			
18.	Child Development Centre (2007)	Maharashtra	A scheme for addressing malnourishment in children introduced by the State Government with the technical support of UNICEF. Under this scheme, Child Development Centres (CDCs) are established for treatment of malnourished children (Grade III/IV onwards). Children enrolled in the centres are treated based on a 10-step health management criteria. The scheme also provides nutritious diet to the children and mothers during the course of their stay in the centres. At district level the scheme is implemented by the Health and ICDS Department of the Zilla Parishad. The first CDC was started in the semi-tribal Gondiya district of Maharashtra in October 2007 and has been scaled up in 25 districts of the State. CDCs are being set up in the remaining district
19.	Muskaan	Bihar	A year-long initiative with a mix of BCC, convergence and increase in the number of immunisation sessions, including sessions at the *anganwadi* level **Outcomes:** • Immunisation coverage rose from 29.6% to 67.1%. Routine monitoring data demonstrate that 98% of ANMs succeed in visiting two to three session sites on Fridays. Newborn tracking register coverage is about 47% ***(Desk Review Report in Annexure 4.7)***
20.	Catch-up Rounds for Immunisation and Zero Diarrhoea Programme	Jharkhand	An activity for ensuring complete immunisation coverage; includes a package of services for vaccines, IFA, deworming, Vitamin A and surveillance for malaria and TB. The services in the catch-up round are being provided on a biannual basis to "the last person in the last household to the last village"
21.	Bal Swasthya Poshan Mah (BSPM) for Micronutrient Malnutrition	Uttar Pradesh	Fixed months (June and December) to be observed for promotion of child health activities in the State in coordination with ICDS. Biannual Vitamin A supplementation along with intensive promotion of exclusive breastfeeding,

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			complementary feeding, iodised salt consumption and referral of severely undernourished children are organised in the fixed months. The activities are linked to village-wise routine immunisation sessions organised as per the immunisation/ outreach session's micro plan of ANMs
22.	Nutrition Rehabilitation Centres	Rajasthan	Nutrition rehabilitation centres set up in district hospitals and CHCs for the treatment of severely malnourished children (Grades III and IV) identified by health workers, ICDS workers, ANMs and AWWs. Nutritional counselling to pregnant women is integral to these NRCs
2008-09			
23.	Mother and Child Health Month	Assam	Specific months in a year will be focussed (September and March) in all the districts for promoting awareness on child health and improving service delivery. During the MCH month, the emphasis will on the provision of the following services to be provided at the sub-centres, *anganwadi* centres (AWCs), during Village Health and Nutrition Days (VHNDs) and out-patient departments of all health institutions: Vitamin A prophylaxis up to children of three years, deworming of children between one to five years, treatment of anaemia in children between one to five years (IFA small tablets), treatment of ARI cases and cases of dehydration with ORS and zinc tablets
24.	Baby Friendly Hospital Initiative	Chhattisgarh	Health facilities will be accredited as Baby Friendly Health Facilities on fulfilment of 10 essential criteria. Mother and baby will be retained in the hospital for 72 hours after birth, with newborn assessment on Days 1 and 3 done by IMNCI worker. Facilities that fulfil these criteria (and the 10 essential criteria) will be accredited by the Breast Feeding Promotion Network of India (BPNI), RCH Department and UNICEF
25.	Addressing Undernutrition in Selected Districts	Uttar Pradesh	Children affected by undernutrition in 20 districts (with the lowest nutritional indicators) will be addressed through linkages with ICDS workers; ANMs and AWWs will be trained for counselling regarding quality nutrition; nutrition rehabilitation corners will be established at selected Community Health Centres for management of cases of

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			severely malnourished children. For proper management of malnourished cases, medicines and provision of supplementary nutrition will be made
26.	Hirkani Kaksha	Maharashtra	A scheme for promotion of exclusive breastfeeding of infants. The scheme provides the facility of a special room/kaksha where a working woman can breastfeed her child in privacy. There are facilities also for storing the breast milk of working women who are into exclusive breastfeeding to be used later. This scheme has been introduced under the IYCF programme, in Raigad district, on a pilot basis under the guidance of Breastfeeding Promotion Network of India. Currently these centres are functional in three tribal PHCs and are planned to be extended in the remaining 49 PHCs of the district. There is a plan to start such centres in district hospitals and Zilla Parishads

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
27.	Immunisation drive	Kerala	A campaign to strengthen immunisation coverage in the State through intensive IEC/BCC campaigns and intersectoral convergence of the Education and Health departments. A planning and review exercise will be undertaken through inter-sectoral co-ordination committees to be constituted at the district, education district, sub-district and school levels by involving officials from related departments such as Health, Education, Social Welfare and LSGIs and representatives of Parent Teachers Association, IMA, IAP, opinion leaders, religious leaders and NGOs. The campaign methodology includes various IEC activities: • Special talks in schools • Dissemination of the messages on immunisation during Immunisation Week in schools through brochures, posters, stickers, flip charts and pledges • Cultural folk media programme • Orientation training for teachers

28. Bal Poshan Mah Madhya Pradesh

A bi-annual drive to reduce child deaths from micronutrient malnutrition, especially anaemia. Package of services includes Vitamin A and iron supplementation, deworming, immunisation and breastfeeding promotion

Category 3

Adolescent Reproductive and Sexual Health (ARSH)

Category 3: Adolescent Reproductive and Sexual Health (ARSH)

RCH II includes two clear-cut strategies for ARSH. One strategy is to incorporate adolescent health issues in RCH II training and BCC material and activities and records to ensure that contraception and sexually transmitted diseases are addressed. The second strategy to be undertaken through pilots is to organise adolescent friendly health services at the PHC level. School-based interventions to promote ARSH are part of the school health programmes. Innovations to address the needs of out-of-school youth and the inclusion of adolescent friendly health services in existing facilities have been tried in two States. A desk review of the Married Adolescent Girls (MAG) intervention is in Annexure 5.

Table 3: Adolescent Reproductive and Sexual Health

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1.	2003-2006 Married Adolescent Girls Model	Maharashtra	The objective of the intervention was to address the needs of married adolescent girls in rural and urban settings through the design and delivery of a specific package of Reproductive and Child Health (RCH) **Outcomes:** • Median age at marriage increased by one year • Median age of conception increased by more than one year • Percentage of low birth weight babies declined from 35.8% at baseline to 25.3% at the end of the project in rural areas • Increase in percentage utilising treatment for Urinary Tract Infections (UTIs)/Reproductive Tract Infections (RTIs)/Sexually Transmitted Infections (STIs) • Contraceptive use increased from 11% (BL) to 23% (EL) in rural areas ***(Desk Review Report in Annexure 5.1)***
2.	**2006-2007** Improving Adolescent Health Services	West Bengal	Identified NGOs to provide adolescent health services at the community through Family Life Education in all blocks of four districts along with those where clinics are being set up as part of the adolescent programme. NGOs are also involved in providing facilities such as referral transport

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			and community mobilisation in hard-to-reach areas in tribal and forest pockets
2007-2008			
3.	Community-based Adolescent Programme	Haryana	This intervention involves: Peer group educators for increased demand generation, adolescent friendly health centres in sub-centre and PHC, capacity building and setting up adolescent groups as part of VHSC
4.	Saathiya Youth Friendly Project	Uttar Pradesh	Strengthen provider knowledge and skills on contraception and addressing youth needs, and promote youth friendly retail outlets and products for contraception
2008-09			
5.	Anti-Anaemia Drive for Adolescent Girls	Maharashtra	Prevalence of anaemia among adolescent girls in Maharashtra is 51.7% of which 3.2% suffer from server anaemia. In order to prevent and reduce the prevalence of anaemia among the adolescent girls, the Anti-Anaemia Drive has been planned. The drive includes strategies for service delivery and awareness generation, for example, the provision of IFA tablets for 52 weeks, deworming tablets, estimation of haemoglobin in all adolescent girls of 13 to 18 years old. In order to implement this drive, micro-planning will be carried out by the ANMs and MOs in the PHCs. A wide publicity campaign will disseminate information on the drive and community participation will be ensured. This campaign implemented in 11 districts in first phase through *anganwadi* centres and schools. Evaluation of this campaign will be carried out after a year by Health and Family Welfare Training centres of the State

Category 4

Behaviour Change Communication

Category 4: Behaviour Change Communication

Behaviour Change Communication (BCC) is a major cross-cutting intervention in RCH II. Almost all schemes have a component of BCC and thus it is difficult to delineate. However, the innovations listed below have been specifically highlighted as they have solely focussed on a set of interventions through the creative use of existing resources for changing behaviours related to specific services. Three of the popular BCC campaigns included in this category were implemented through the same partnership and have contributed to significant, well-documented outcomes. The BCC campaigns were complemented heavily by intensive interactions with providers and concurrent monitoring and validation of data. These appear to have been intensive in terms of implementation efforts and needed multi-skilled groups of partnerships for execution. The desk review reports of three interventions are available in Annexure 6.

Table 4: Behaviour Change Communication

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1.	**1998-2004** Goli Ki Hamjoli	Uttar Pradesh, Uttarakhand, Jharkhand, Rajasthan, Bihar, Madhya Pradesh, Chhattisgarh	Campaign to increase the use of low dose OCs **Outcomes:** • 28,360 ISM providers trained • 34,012 chemists trained • Free airtime on premier channels during prime time • Sales results for OCs increased • NFHS 3 shows a significant increase in pill use over NFHS 2 in Rajasthan, Madhya Pradesh and Uttar Pradesh ***(Desk Review Report in Annexure 6.1)***
2.	Family Health Day (in place since 2003)	Andhra Pradesh	A day in the week to be focussed on providing information to mothers/families on various issues pertaining to child health, adolescent health, etc.
3.	**2002-2007** Bindaas Bol Campaign	Uttar Pradesh, Uttarakhand, Jharkhand, Rajasthan, Bihar, Madhya Pradesh, Chhattisgarh,	Support sustainable growth in condom use by increasing the volume and value of the condom market in India **Outcomes:** • Current condom use with spouse among married men rose from 28% to

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
		Punjab, Haryana	60% • Consistent condom use by men with non regular partners rose from 7% to 80% ***(Desk Review Report in Annexure 6.2)***
4.	Saathi Bacchpan Ke	Uttar Pradesh, Uttarakhand, Jharkhand, Rajasthan, Bihar, Madhya Pradesh, Chhattisgarh	Use of ORS for diarrhoea, progressing to improved home care practices for diarrhoea management and zinc supplementation **Outcomes:** • Drug Controller approved shift to single low osmolarity formula • NRHM committed resources to support communication efforts related to diarrhoea management, including use of ORS • 60,000 providers trained • Leveraged media and marketing funds totalling about Rs. 6 crore over the life of the project • ORS sales rose by 10% during project period ***(Desk Review Report in Annexure 6.3)***
5.	Swasthya Chetna Yatra (2005-2006)	Rajasthan	A campaign for creation of awareness among the masses on the NRHM and RCH II through the use of folk and mass media
2006-2007			
6.	Health Mela	Bihar	Bi-annual health melas in all blocks by Field NGOs (FNGOs) to promote family planning services
7.	Yuva Mangal Mela	Uttar Pradesh	Youth festivals to be organised for creating awareness among the youth regarding RTI/Sexually Transmitted Disease (STD) and reproductive health in every district once in a year by NGOs. Rs. 2 lakh to be provided to each district for these melas
8.	Health Fair	Uttar Pradesh	Health Mela for the community for awareness on RCH II and NRHM activities in collaboration with the corporate sector
9.	Aadarsh Dampati Samman	Uttar Pradesh	Creating role models to induce behaviour change regarding male participation in family

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			planning: Awarding Rs. 500 to two men per sub-centre every year, which have followed the two-child norm and adopted male sterilisation methods
10.	Breastfeeding Promotion Campaign	Andhra Pradesh	Annual breastfeeding promotion campaign to be organised in the first week of August every year for sensitising the community on the importance of breastfeeding and colostrums. Planned activities include workshops, publicity through printed material, electronic media, cinema slides and sensitisation of the local leaders
11.	Mother and Mother-in-law Melawa	Maharashtra	A programme held at the village level for the orientation of mothers and mothers-in-law on various aspects of reproductive health. Some of the issues addressed: pre-menopause, post-menopause, age at marriage, pregnancy, mother's nutrition, gender bias regarding children and importance of spacing
12.	Dada-Dadi Orientation	Maharashtra	A programme intended for the orientation of grandparents on various maternal and child health issues
13.	Use of Satisfied Couples to Motivate Clients for FP	Manipur	Satisfied Acceptor Couples, special BCC utilising satisfied beneficiaries to generate demand
2007-2008			
14.	ASHA radio	Assam	Radio sets distributed to all the selected ASHAs and radio programme for ASHAs started from 8 October 2007 in All India Radio for two days in a week. Each programme in broadcasted for half-an-hour all over the State, produced in three languages. Provides health education information to the ASHAs through an episode per week. Pre-paid postcards have been distributed to the ASHAs for giving feedback. According to feedback, special programmes are organised to address the problem
15.	Health Mela	Kerala	Health fairs organised for awareness generation and creating demand for the health services Health melas held in all Legislative Assembly constituencies. Elected representatives also contribute funds for the

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			health fairs
16.	Sterilisation and IUD Campaign	Uttar Pradesh	Aao Batein Karein, Suvidha CuT and birth spacing campaigns developed and disseminated to cover messages at all levels
2008-09 17. Swasthya Mitra Yojna Rajasthan To empower the students to make positive changes in health-related behaviours, a Swasthya Mitra is selected from each middle school of selected blocks, through essay competitions/debates. A book is developed on health, sanitation, hygiene and drinking water and provided to the students. Swasthya Mitra makes a 10-minute presentation during the morning prayer session. A monthly honorarium is paid along with an incentive for wall slogans			
18.	Radio Health	Kerala	Radio Health is a community health education and communication model through the audio medium of radio that was launched on 28 September 2008. Through an FM radio programme, which is relayed four times every week, information is provided to a large audience on physical and mental health. The contents of the programme is prepared by a team of doctors and public health experts and executed by creative persons and Radio Health Club members. An approval committee has been constituted for approval of the programmes to be aired periodically. The radio programme focusses on Primary Health Care, AYUSH and alternative health practices and preventive aspects of health. The interactive programme also intends to solve health problems through interactive programme with specialists, ASHAs and other health workers. Under this programme health clubs will be established in schools and colleges
19.	Bodhana Nauka/ Information Boat	Kerala	An IEC campaign intended for people living in the coastal areas through the medium of a boat. A ‘Bodhana Nauka’ or Information Boat is used covered with posters and banners on various health messages for preventive health among the communities residing in the waterlogged Kuttanad region in Alappuzha. The programme focusses on creating health

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			awareness on waterborne diseases as well as vectorborne diseases such as chikungunya, leptospirosis and diarrhoea among the affected people by joining hands with health professionals, people's representatives, community leaders, educational Institutions, religious institutions, ASHA volunteers, etc. The programme includes street plays, awareness classes, quiz competitions for public and school children, special radio programmes, etc.

Category 5

Mainstreaming Gender Issues into RCH II and the NRHM

Category 5: Mainstreaming Gender Issues into RCH II and the NRHM

Gender in RCH II and the NRHM is meant to be cross-cutting and gender issues are expected to be integrated into the programme design, implementation and monitoring. In addition to this, a few specific innovations to address domestic violence and gender discrimination have been implemented. Gender-based budgeting, although mandated, appears as an innovation in a few States. Process evaluation documents were available for the Family Counselling Centres. Violence against women (VAW) is a fundamental abuse of women's rights. Gender-based violence is rooted in patriarchy and has a host of harmful health consequences. The Family Counselling Centres (FCC) were established in five UNFPA supported States, as part of a broader response including policy dialogue, advocacy, development of toolkits to sensitise health care providers and inter-sectoral approaches to strengthening a systemic response to VAW. The desk review report is in Annexure 7.

Table 5: Mainstreaming Gender Issues into RCH II and NRHM

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1.	**2002-ongoing** Family Counselling Centres	Madhya Pradesh, Rajasthan, Orissa, Maharashtra, Kerala	The Family Counselling Centres were established in five UNFPA supported States, as part of a broader response including policy dialogue, advocacy, development of toolkits to sensitise health care providers, and inter-sectoral approaches to strengthening a systemic response to VAW **Outcomes:** Increase in the number of cases of violence reported to the FCC ***(Desk Review Report in Annexure 7.1)***
2006-2007			
2.	Gender Responsive Budgeting	Gujarat	Analysis of the impact of actual Government expenditure and revenues on women compared to men. The State plans to focus on improving budgeting and planning processes to enhance gender equality and increasing resource allocation to support implementation of gender equality plans and policies
3.	Gender Budgeting	Nagaland	Gender budgeting integrating a gender perspective and ensuring that budgets respond to gender equality and requirements of women
4.	Gender Budgeting	Karnataka	Special provisions made in the budget to reflect gender issues. Budget focusses on allocations for adolescent girls, pregnant and lactating

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			mothers in the tribal districts
5.	Bhagyalakshmi Scheme	Karnataka	This scheme is for a secure future for the girl child of the BPL families. As per the provisions of this scheme, any girl child born in a BPL family after 31 March 2006 will be eligible to get Rs. 10,000 from the Government, which will be deposited in her name and the amount can be encashed after she attains 18 years of age
6.	Bal Rakshik Yojana: Improving Sex Ratio	Punjab	Balri Rakshak Yojana is a State-funded scheme, for promotion of the cause of the girl child. Incentive is paid for adopting terminal method of sterilisation after the birth of only one or two girl children at the rate of Rs. 500 and Rs. 700, respectively
7.	Savitribai Phule Kanya Kalyan Paritoshik Yojana (introduced in 1995, revised in 2007)	Maharashtra	An incentive-based scheme aimed at improving the social status of women/girl child. Under this scheme, BPL couples who have adopted sterilisation after one or two daughter(s) are entitled to receive Rs. 2,000 in cash and Rs. 8,000 worth National Savings Certificate in the name of the girl child and Rs. 2,000 in cash and Rs. 4,000 worth National Savings Certificates in the name of each girl child after accepting sterilisation after two girl children
8.	Scan Centre Audits	Tamil Nadu	Regular audits of ultrasound scan centres to monitor use of ultrasound to determine foetal sex
9.	Facilitating Gender Sensitive Services	Sikkim	Ensuring one lady MO and one male MO at PHC

Category 6

Service Delivery for RCH: Expanding Access, Reach and Quality

Category 6: Service Delivery for RCH: Expanding Access, Reach and Quality

Innovations in this section seek to improve access, reach and quality of RCH services through a variety of mechanisms. The four major categories include:

- Mobile health services
- Social franchising networks
- Health financing
- Contracting out of public health facilities

Of the 39 innovations in this category, nine underwent desk review. (Annexure 8)

6.1 Mobile Health Services

Mobile health services have long been seen as effective substitutes for service provision in situations of rough terrain and in emergency measures. In many cases mobile health units offer the only mechanism to provide services. Programming for mobile health clinics requires attention to service quality and technical competence of providers as well as attention to logistics, supply and outreach. Of the innovations listed here, one (boat services in riverine areas) has been recommended for an in-depth review. The following category of innovations utilises various modes of transport, for example, vans, helicopters, boats to improve physical accessibility/reach of the health services for the people residing in the unserved/underserved areas:

Table 6.1 Mobile Health Services

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1.	**1999-ongoing** Mobile Health Clinics	West Bengal	Use of a mix of road and river transport to provide mobile health services through NGOs to communities in underserved areas, not accessible for the better part of the year **Outcomes:** • Initiation of primary health care services to communities in remote areas • 75% of users rated the mobile health services better than locally available services • Community awareness of services is high ***(Desk Review Report in Annexure 8.1.1)***
2.	**2004-ongoing** Mobile Medical Units (MMUs)	Chhattisgarh	An MMU is a well-equipped vehicle designed to provide medical services along the path of weekly markets in 74 tribal blocks

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			Outcomes: • Every week, the MMUs cover 400 market areas catering to over 7,000 villages • About 10,000 people per month are covered by one MMU • Enables people to seek care without consequent wage loss ***(Desk Review Report in Annexure 8.1.2)***
2005-2006			
3.	Mobile Boat Clinics in Riverine Areas	Assam	Launched phase-wise in five districts of Assam (Tinsukia, Dhemaji, Dibrugarh, Morigaon and Dhubri). Will be launched in five more districts (Barpeta, Nalbari, Jorhat, Lakhimpur and Sonitpur) by 2008-2009.The boat clinic has provisions for providing routine primary health care services as well as emergency services. Health camps are held every month for providing ANC and RI services. During emergencies, that is, floods and other (natural or manmade) calamities, the boat clinic increase the frequency of visits **Outcomes**: • 385 camps held, covering 47,712 population • 1,588 antenatal cases seen • 3,828 children immunised • 1,297 FP beneficiaries ***(Desk Review Report in Annexure 8.1.3)***
4.	Mobile Health Units	Gujarat	Provision of basic health services and RCH services for marginalised communities living in remote areas through mobile health units
2006-2007			
5.	Mobile Helicopter Services	Tripura	Special services in 12 remote inaccessible areas through helicopter services
6.	Deen Dayal Chalit Aspatal Yojana	Madhya Pradesh	This mobile health clinic scheme aims to increase coverage of primary health services in remote areas. The clinic provides the following services free of cost: ANC, PNC, family planning and immunisation services, routine investigations and free distribution of

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			drugs to identified tribal blocks in pre-scheduled days. Each mobile unit includes a doctor, a nurse and an assistant. Private service providers are engaged in management of the mobile health clinics
2007-08			
7.	Mobile Health Clinics (MHCs)	Uttarakhand	The MHC is intended to provide basic RCH services in hard-to-reach areas such as a hilly village **Outcomes:** • Nearly 100% scheduled camps conducted • Over 30% of clients are BPL • Two-thirds of the clients are women ***(Desk Review Report in Annexure 8.1.4)***
8.	Doctor Tumachya Gaavi	Maharashtra	In order to improve coverage of service delivery in the State, a scheme has been introduced to ensure the presence of doctors at the village level. Under this scheme, preventive and curative services are provided in each village on a fixed day of every month through visits by doctors twice a month. The visit schedule of the doctors is provided to GP members and Self-Help Groups (SHGs) in advance. The scheme also has provisions for referral services
2008-2009			
9.	Emergency Response Services	Uttarakhand	This new initiative aims to provide immediate medical services to neonates, pregnant women and children suffering from accidents and serious illnesses. The emergency response services are operationalised in partnership with a non-profit organisation in three phases. In the first phase, ambulances will be operationalised in the plains areas, followed by ambulances in the rural areas with access to roads and hospitals. In the third phase, ambulances will be placed in the remote and hilly terrain without motorable roads. Currently, emergency ambulances are operating in the plains districts in the pilgrimage route. Ninety ambulances are planned to be operationalised by 2008-2009.

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			A toll-free phone number will be in provided for comprehensive emergency management (medical, fire and police), with services provided free of cost
10.	*Doli* Initiative	Tripura	Referral transport in the form of a *doli* or palanquin for ensuring access to services for the people in the remote areas of the State, piloted in one district. The *doli* will be used by the villagers/porters for transportation of sick mothers and children from the villages to the health facilities. The State expects to have 500 porter services in a year
11.	Floating Dispensaries	Maharashtra	Health services provided to the communities living in the Narmada basin through floating dispensaries. Forty villages from Akkalkuwa and Dhadgaon blocks are being covered through this scheme. Several activities are carried out by these dispensaries: diagnostic camps, health camps, public awareness camps, training of tubectomy surgeons and IEC/BCC activities using folk media and health fairs

6.2 Social Franchising Networks for RCH Services

Three innovations in this category are examples of efforts to create a sustainable model of health care services for the poor through developing a network of franchised providers/health facilities to offer high quality reproductive and child health services at fixed pre-negotiated prices. The three pilots for the DMPA strategy have shown successful outcomes. Since the fourth pilot is expected to culminate in end-term evaluation in 2009, the evaluation should include issues to plan a scaling-up strategy to promote the use of depo in the private sector as well as its possible introduction into the public sector. In Karnataka, community-based distribution of contraceptives is being implemented through extension workers.

Table 6.2 Social Franchising Networks

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1.	**2000-ongoing** Community-based Distribution of	Karnataka	Community-based distribution system for contraceptives strengthened by introducing and installing condom boxes at all public places (Panchayat Bhawan, market, dairy booth, etc.).

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
	Contraceptives		*anganwadi* worker, ASHA, pharmacist, male nurse, volunteers and NGOs will be made responsible for replenishment of condoms in the condom boxes
2.	**2002-ongoing** Fractional Franchising for Injectables through the Private Sector	Uttar Pradesh, Jharkhand, Uttarakhand	An innovation that combines BCC, skill building of providers and developing a network to promote injectables and expand use through the private sector **Outcomes:** • Programme expanded in Uttar Pradesh, Jharkhand and Uttarakhand (42 towns accounting for 24% of the population) • A total of 1,638 providers trained and 1,052 enrolled in the DIMPA network • Higher proportion of providers adhering to quality protocols • DIMPA members offer wider choice of contraceptives • Sales of 40,000 vials, DMPA use up • Cost of vial down substantially ***(Desk Review Report in Annexure 8.2.1)***
3.	**2006-2007** Social Marketing of Contraceptives through a Specialised Marketing Agency	Uttarakhand	A social marketing agency to promote the brand of contraceptive, create demand for the brand and also distribute contraceptives to remote rural outlets, both conventional and non-conventional outlets, and increasing village-level participation. The social marketing agency would also conduct meetings with allopathic doctors, ISM providers, RMPs, organise stakeholders workshops and carry out IEC campaigns to promote the SM brands
4.	**2007-2008** Merrygold Scheme for Provision of Quality RCH Services for Low-income Working Class and the Poor	Uttar Pradesh	Sustainable PPP model in health care for the low-income working class and poor by developing a sustainable network of 770 franchised health facilities offering quality RCH services at pre-fixed prices at different levels. Services included are emergency obstetric care at levels 0 and 1; basic obstetric care at levels 0, 1 and 2; IUD insertions at levels 0,1 and 2; sterilisation operations at levels 0,1 and 2; laboratory facilities at levels 0 and 1 and pharmacy facilities at levels 0 and 1

6.3 Health Financing

Given the high out-of-pocket expenses in the face of burgeoning health care costs, it is invariably the poor who suffer. Health financing mechanisms particularly for the poor are being implemented in several States. Several of the schemes have undergone evaluations and studies. Many schemes are mature in terms of operationalisation and could serve as models for scaling up to other States where the programmes are just nascent. Networking with private providers and development standard operation protocols, checklists and guidelines also appear to be in place. However, even successful schemes with efficient operational systems still rely heavily on Government subsidies.

It would be appropriate to obtain information and conduct a comparative analysis of all insurance schemes so that the newer schemes are able to garner the benefit of lessons learned by those that have been in operation for a longer period of time.

Table 6.3 Health Financing

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1.	**1989-ongoing** Mediclaim Scheme	Goa	Financial assistance up to Rs. 1.50 lakh for availing super specialties not available under State Government hospitals, and up to Rs. 3 lakh for treatment such as kidney transplantation, open-heart surgery, cancer and neurosurgery. Eligible for households with annual income less than Rs. 1.50 lakh per annum. Goa State Illness Assistance Society formed to provide financial assistance to BPL families
2.	**2004-ongoing** Deen Dayal Antyodaya Upachar Yojana	Madhya Pradesh	The scheme provides free diagnostic and treatment facilities to the poorer sections of the community for any disease in public health facilities and accredited private health facilities on referral and includes a maximum benefit of Rs. 20,000
2006-2007			
3.	State Illness Fund/District Illness Fund	Madhya Pradesh	Provides financial aid to one ailing member of the BPL families who suffers from one of the specified serious diseases in the accredited health institutions of the State

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
4.	Yeshasvini Health Insurance Scheme	Karnataka	A scheme run through farmer co-operatives. The members are provided with a Yashaswini card and may undergo free surgical operations in selected hospitals. There is also a special provision for women of SC/ST communities under this scheme
2007-2008			
5.	Community Health Insurance for BPL	Uttarakhand	This scheme aims at providing an incentive for the family to make health care more accessible to women of BPL families, where each family is required to pay Rs. 150 per head per year or Rs. 365 for individuals. These funds would form a village health corpus, managed by the village Panchayat. The scheme is supervised and supported technically by a national insurance firm
6.	Community Health Insurance Scheme for BPL	Jharkhand	Assistance programme for BPL families (up to Rs. 1.5 lakh) in cases of major illnesses
7.	Aarogyashri Insurance Scheme	Andhra Pradesh	Intended to increase access of BPL families to medical care. Pilot implemented in three districts
2008-2009			
8.	Health Insurance for BPL	Mizoram	A family health insurance in partnership with a private insurance company and private sector hospitals. The State Government/nodal agency will assist the insurance company in establishing the network of hospitals, finalising treatment protocols and costs and treatment authorisation and claims scrutiny. Private hospitals fulfilling the minimum criteria for standards will be empanelled. Pre-existing diseases will be covered and actual travel expenses as well as wage loss. The scheme will be subsidised for the BPL families

6.4 Contracting Out the Management of Public Health Facilities

This category of interventions deal with a range of PPPs where the public sector enters into a contract with a private sector entity in the for-profit or not-for-profit sector in order to improve the quality of service. Fourteen innovations were included in this category. Contracting out the management of public health facilities ranges from complete facility management to contracting out particular services. Several of the States are contracting out to NGOs, as well as to the for-profit private sector, in order to expand services. NGO-related

contracting seems to be focussed on the more peripheral facilities such as a sub-centre and primary health centre. In Orissa, Arunachal Pradesh and Karnataka, NGOs are given charge of managing the PHCs. The approach towards contracting out appears uniform with respect to the private as well as the NGO sector notwithstanding the significant differences in strengths and competencies.

Table 6.4 Contracting Out the Management of Public Health Facilities

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1.	**2003-2004** Management of Sub-centres by NGOs in Health Systems Development Project	Uttar Pradesh	Launched in 2003, the scheme has now handed over the management of 290 sub-centres to NGOs in Uttar Pradesh. Results of an evaluation in 2006 appear mixed **Outcomes:** • All health centres have been established in remote areas • 70% of the beneficiaries of the scheme are primarily members of BPL households • 45% of women have been registered for ANC • Institutional deliveries have risen to 23% • Childhood immunisation is 60% • 20% of people participated in the NGO-led awareness programmes • 37% responded positively with regard to availability of medicines at the sub-centre ***(Desk Review Report in Annexure 8.3.1)***
2005-2006			
2.	Sub-contracting: (i) Diagnostic Services In Rural Areas (ii) Security, Scavenging and Waste Management Functions and (iii) Mechanised Laundry (2005-ongoing)	West Bengal	Although there is increased efficiency when contracting out services of large Government facilities, delays in work orders, lack of regulation and supervision by the Government and quality gaps need to be addressed **Outcomes:** • Average monthly caseloads for the diagnostic services range from 820 to 1,300. Caseloads have increased by 20% in the last two years • Survey of hospital users (over half of whom belonged to SC/ST) indicated that half felt that the quality of laundered linen was satisfactory ***(Desk Review Report in Annexure 8.3.2)***

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
3.	Contracting Services Through Private Hospital in Urban Areas	Assam	A partnership was established with the Marwari Maternity Hospital (MMH), an accredited 100-bedded hospital to provide RCH services. The Government is responsible for providing free supply of vaccine, contraceptives, RCH kits, capital investment for hospital equipment, furniture, vehicle, expenditures on mobility of staff for sessions, contingencies, regular fund flow to the trust against achievements and supportive supervision. The MMH provides first tier health services in the slums. Simultaneously, it also functions as a second tier health facility. In the hospital, sterilisation, spacing and abortion services are provided free of cost to patients, while deliveries, operations and diagnostic tests are charged at concessionary rates. BPL families are provided free services **Outcomes:** • Improvement in service access for urban poor and migrants • Increase in institutional delivery, immunisation coverage and basic curative service provisioning ***(Desk Review Report in Annexure 8.3.3)***
2006-2007			
4.	Management of PHCs through Voluntary Organisations	Orissa	Two NGOs each in Bhadrak, Dhenkanal and Jajpur districts are responsible for the management of primary health care centres and provision of comprehensive primary health care package of services. As a result of this partnership, PHCs lying defunct have become vibrant centres of primary health care delivery services
5.	Contracting Outreach Services to NGOs	Nagaland	Partnership with Mission hospitals, women's organisations, Hohos and Red Cross Society for outreach services
6.	Contracting Out the Management of PHCs to NGOs	Arunachal Pradesh	Management of 16 PHCs in 16 districts have been handed over to NGOs: Karuna Trust, Voluntary Health Association of India (VHAI), FGA and Prayas. MoUs have been signed with the NGOs by the Government under which the NGOs provide manpower, equipment and administrative support and the range of outreach services. Sub-centres under the respective PHCs are also managed by the NGOs who

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			provide outreach services in the villages covered by the PHCs. The Government provides 90% of the funds with a 10% contribution from the NGOs **Outcomes:** Manpower position has increased from 130 (all cadres) to 352. NGOs are delivering all PHC services, round-the-clock. Increase in community awareness and in availability and use of services ***(Desk Review Report in Annexure 8.3.4)***
7.	Contracting Out Support Functions such as Gardening and Cleaning, as Part of Uttar Pradesh Health Systems Development Project (2006-ongoing)	Uttar Pradesh,	The scheme was launched in 2006 to enable a clean environment within the district hospitals in the pilot districts. The contract was to maintain the OPD, indoor wards, operation theatres, emergency wards, and outer premises. The tasks are to be supervised by the section heads and reported to the Superintendent. Payment is made through DPMU **Outcomes:** Hospitals now remain clean internally and externally as cleaning work runs continuously. No waterlogging as drainage system is functional. Toilet blocks are clean and functional. Bathroom fittings are intact, with no theft or damage of fittings in toilet blocks as the cleaning personnel is always there. Patients and their attendants are comfortable while availing the hospital services. Gardens outside the hospitals are well maintained
2007-2008			
8.	PPP with Private Hospitals/Tea Garden Hospitals	Assam	Partnership formed with private sector/ trust hospitals/ tea garden hospitals, refinery hospitals, army hospitals and other non-profit earning hospitals to deliver quality RCH services in urban and uncovered remote areas. The private hospitals will provide a range of services for promoting JSY, CmOC, safe abortion facilities, newborn care services, sterilisation programmes and counselling on adolescent health. The hospitals rendering RCH services under PPP will be given annual grant of Rs. 15 lakh each and will be supported in terms of honorarium for manpower, drugs, mobility support, JSY funds and social mobilisation and orientation. The State has established partnership with seven trust hospitals and

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			22 tea garden hospitals
2008-2009			
9.	Outsourcing of CHCs to NGOs	Assam	Management and operation of one CHC/block in four districts will be outsourced to private agencies, that is, charitable/army hospitals. The private partner will use the existing Government infrastructure including the equipment. The State will also provide drugs and consumables to the partner and will be responsible for monitoring. The private agency/partner will provide manpower and will be responsible for the service delivery in the CHCs. Outsourcing will be done in Jonai, Majuli, Sadiya and Mankachar districts
10.	Contracting Out PHC to Faith-based Organisations	Mizoram	One PHC (Marpara PHC) located in a very remote area in a district covering two SCs and six villages will be managed by a church-based-organisation, Presbyterian Durtlang Hospital. A project implementation plan has been prepared and the State is in the process of signing the MoU with the organisation. The State Health Society (SHS) would provide the funds for the staff salaries, maintenance of the infrastructure, all equipments to the Mission hospital. The Mission hospital will be responsible for service delivery, recruitment of staff, managing the PHC in accordance with the norms provided by the SHS
11.	Rural Outreach and Community Services through NGO	Uttar Pradesh	The outreach services of the Ramakrishna Mission, Varanasi, started under the EU's SIP programme, will be extended to more than 80,000 villages across 13 blocks of Mirzapur district in various village clusters. The services will be provided through 60 trained Community Health Facilitators and 40 TBAs who provide services once a month
12.	Contracting Out of PHCs	Uttar Pradesh	Primary Health Centres will be handed over to reputed private agencies (Trust/NGOs/business houses/other institutions) that will be responsible for the management of the facilities. In the initial period, three to four facilities in different districts would be selected for piloting the contracting-out arrangement. The agencies will be selected on the basis of indicators, for example, the qualification of five key personnel, registration under income tax, financial capacities, past experiences in the health sector, ability to manage Government facilities (including prior experience of managing 30-bedded Government

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			facilities)
13.	Management of CHC through PPP (ongoing)	Rajasthan	The maintenance of the hospital/CHC is given on contract to a private donor who provides support for cleanliness of the premises. A hospital management committee has been formed by the donor and funds are contributed by several donors for the management of the hospital/CHC. The hospital management committee has carried out construction and repair/renovation work in the hospital/CHC and also provided various inputs, for example, beds and equipment
14.	Improving Sanitation Facilities in CHCs through PPP	Rajasthan	The State has established partnership with a social service organisation for improving the sanitation facilities in 100 high performing CHCs in 33 districts. A budget of Rs. 25,000 has been allocated for each CHC on a monthly basis. The expected outcomes are cleaner and hygienic environment in the CHCs; reduction in the incidences of patients with hospital-related infection and improved utilisation of clinical services in the CHCs

15. PPP for Primary Health Care in Urban Slums Delhi

A primary urban health facility covering the underserved population of approximately 1.5 lakh in slums in the northeast district of Delhi in partnership with HOPE Foundation under an MoU. Drugs and consumables provided by the Government while other costs are provided by the NGO. The facility is providing primary health care to 50,000 people living around the facility and covers an additional one lakh people through its outreach activities

Category 7

Programme Management

Category 7: Programme Management

Both RCH II and the NRHM have focussed on improving programme management and strengthening health sector reforms; several innovations were identified as part of this category. The key challenge in the NRHM/RCH II is to find a solution to the gap in human resources and to a lesser extent ensuring availability and attendance. Building the capacity of human resources is another major strategy. Monitoring of health programmes at all levels is emerging as an area of concern. The overall process of communitisation appears to have taken root with several innovations being attempted with communities and the Panchayats.

Innovations in this category are sub-divided as follows:

7.1 Incentives to improve mobility, availability and attendance of staff
7.2 Incentives to improve performance and range of services
7.3 Alternatives to in-service training for improved performance
7.4 Community and Panchayat involvement in planning, monitoring and management of health services and facilities
7.5 Programme monitoring and Management Information Systems
7.6 Improving procurement and finance systems

Of the 80 innovations in this category, desk reviews were conducted for 18 innovations. (Annexure 9)

7.1 Incentives to Improve Mobility, Availability and Attendance of Staff

Improvement in health outcomes is directly related to the availability of trained providers, particularly in rural areas. RCH II and the NRHM provide support for a range of innovations to improve the availability of medical and paramedical staff in health facilities. These innovations include a mix of provision of financial incentives for 'difficult area' postings, and expanding the pool of providers particularly in the nursing and ANM cadres to ensure availability of skilled human resources, and creating new cadres as alternative resources for clinical services.

Most States have introduced incentives for staff in all cadres, based on attendance, performance and service quality. The incentives include cash incentives, mobility support, communication support, nomination to professional development courses, including prioritisation for postgraduate medical courses, and recognition in the form of awards.

Table 7.1 Incentives to Improve Mobility, Availability and Attendance of Staff

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1.	**2005-ongoing** Incentive Scheme for Health Functionaries	Madhya Pradesh	A monthly cash incentive scheme and recognition of the best performing worker, based on recommendations of BMO

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
2.	State Health Award (no date)	Madhya Pradesh	State-level performance awards to staff at different levels as motivation
2006-2007			
3.	Incentive for Specialists for Remote Areas	Andhra Pradesh	Special incentive for specialist doctors in tribal and remote areas at the rate of Rs. 3,000 per month
4.	Incentives to Retain Human Resources in Difficult Pockets/Hard-to-reach and Tribal and Coastal Areas	Gujarat	In order to expand service reach and to reduce the health disparities in tribal, coastal and difficult pockets, additional resources have been deployed in the areas. Key incentives include: A flexi-time approach for service providers and health facilities, top priority for providers in these areas for professional development programmes
5.	Special Provisions for Backward Districts	Karnataka	Provision of contractual doctors and staff nurses at the PHCs for the 24/7 services, honorarium for night deliveries in the PHCs in backward districts and remote area allowance to doctors and nurses in 100 PHCs
6.	Award for Best Performing ANM	Karnataka	An award of Rs. 5,000 to the best performing ANM in every district
7.	Cash Incentives for Staff in Underserved Areas	Arunachal Pradesh	Additional HRA and cash incentives for encouraging staff postings in under-developed districts
8.	Incentives to Increase Mobility of Health Workers	Mizoram	Vehicle loan for health worker, health supervisor and community health worker
9.	Cash Incentives for Working in Remote Areas	Mizoram	Provision of cash incentives for doctors serving in remote rural areas
10.	Cash Incentives for ANMs	Nagaland	Incentive for ANMs posted in sub-centres of remote districts
11.	Annual Award Scheme	Sikkim	Annual award scheme for the best performance by sub-centre, PHC and CHC on important RCH indicators
12.	Ensuring that Human Resource Gaps are Filled	Sikkim	Posting ANMs on deputation to sub-centres compensate for leave of absence
2007-2008			
13.	Providing Mobile Phones to ANMs to	Uttarakhand	Under an earlier initiative the State provided mobile phones to ANMs in selected districts. In

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
	Improve Reach		2008-2009, a minimum recharging amount (Rs. 230 per month) will be paid to the ANMs with mobiles. A directory containing the names, addresses and mobile numbers of all the ANMs will be published
2008-2009			
14.	Performance Incentives for Government Facilities to Improve Institutional Delivery	Assam	Performance-based incentives to hospitals for institutional delivery (monthly targets: FRUs—200; CHCs—150; BPHCs—100). Incentives will include normal and caesarean deliveries. Only FRUs with staff staying within two km of the hospital will be eligible for the incentives. The cash incentives will be paid to the institution and 50% of the incentives will be deposited in the Hospital Management Committees/RKS and the other 50% will be paid to the team conducting the deliveries
15.	Incentives to Retain Staff at Centres During the Night	Uttar Pradesh	A special incentive scheme for provision of incentives for MOs, staff nurses, ANMs and Grade IV staff for attending night deliveries. In 2008-2009, the cash incentives will be payable against the fulfilment of a minimum criteria, that is, the total number of deliveries should be more than 20 per month of which at least 10 deliveries are night deliveries. In CHCs the number of deliveries should be at least 60 (30 night deliveries)
16.	Cash Incentives for Staff Staying in Difficult Areas	Assam	Difficult areas allowance will be paid to 40 specialists and 60 MOs posted in difficult areas. The MO's salary will be at par with the Associate Professor of the medical colleges and Specialists with the Professor. Rs. 5,000 given to Specialist serving in rural area as HRA> Difficult area allowance for all doctors serving in Karbianglong, NC Hills and five sub-divisions—Jonai, South Salmara, Sadiya, Majuli and Dhakuakhana. (MO— MBBS at the rate of Rs. 28,000 per month and Specialist at the rate of Rs. 38,000 per month)
17.	Incentives to Sub-centre Second ANM	Manipur	Performance-based incentives will be provided to additional ANMs posted at sub-centres
18.	Incentives for Provision of EmoC	Manipur	Performance-based incentives for MBBS doctors trained in CemOC and life-saving anaesthesia skills (Rs. 1,000 per case)

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
19.	Performance Incentives for Medical Officers in PHC, CHC and SDH	Tripura	Cash incentives to be paid to the MOs in PHCs, CHCs and SDHs posted in the remote areas in all the four districts of the State. The amount payable per month is Rs. 3,000 for the MOs, Rs. 1,000 to the SNs and Rs. 1,000 to the LTs in the PHCs; Rs. 2,000, Rs. 800 and Rs. 800 to the MOs, SNs and LTs in the CHCs and Rs. 1,000, Rs. 600 and Rs. 600 to the similar category of staff based in the SDHs. The bed occupancy rate of these facilities will be regularly monitored along with the performance of the staff chosen for the incentives
20.	Incentive Grant Scheme to Enhance Institutional Deliveries	Maharashtra	An incentive scheme intended for improving institutional deliveries. The scheme provides a grant at the PHC level in 99 *talukas* of 21 districts for staff involved in institutional deliveries at the rate of Rs. 150 for each delivery (Rs. 100 to the nurse or Medical Officer and Rs. 50 will be given to the sweeper). The scheme also promoted a two-day stay in the institution post-delivery for the mothers
21.	Best Gram Panchayat Scheme	Maharashtra (Amravati district)	A scheme for improving performance in significant health indicators at the Gram Panchayat. Cash prizes would be awarded to the GP that has managed to achieve the following: - No infant/maternal death takes place - 100% registration of births and deaths - Every delivery takes place in an institution - Special efforts to improve the status of Grade III and Grade IV children
22.	Malnutrition Improvement Scheme	Maharashtra (Amravati district)	Cash prizes to be awarded to Gram Panchayats for improving the status of current Grade III and Grade IV malnourished children to healthy children by 26 January 2009

7.2 Incentives to Improve Performance and Range of Services

A key issue afflicting public health services is the lack (and inappropriate distribution) of human resources, inadequate skills and consequent poor performance. Under the NRHM,

States have attempted several efforts to overcome this constraint, including multiskilling of existing workers, skill upgradation, experimenting with changing job descriptions and expanding scope of work. In addition, new cadres are being created. In order to overcome human resource shortages and to address the issue of equity, special courses for sponsored candidates in SC/ST communities is being commissioned.

Table 7.2 Incentives to Improve Performance and Range of Services

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1.	**2004** Revising Health Worker Training	Kerala	In 2004, the curriculum for junior public health nurses, which had not been designed for 20 years, was revamped to include competency-based training, community needs assessment and sub-centre planning. The six-month course includes an examination and is mandatory for promotion as a female health supervisor ***(Desk Review Report in Annexure 9.1.1)***
2.	Tribal Auxiliary Nurse Midwives for Tribal Areas	Karnataka	This was a model created to fill a critical gap in grassroots health functionaries—the ANM. Tribal girls were trained in the ANM curriculum and posted in local sub-centres. This had the effect of empowering girls from tribal communities to serve their people, and improving service delivery arising out of the problem of vacant posts at sub-centres in tribal areas **Outcomes:** Increased coverage of difficult-to-reach tribal areas, especially those that are inaccessible to regular sub-centres and PHCs ***(Desk Review Report in Annexure 9.1.2)***
3.	**2005-2006** Building Skills of MPHW (Male)	Sikkim	Skill development training for MPHW (male) for assuming joint responsibility of implementation of RCH II at the sub-centre
2006-2007			
4.	Swavlambhan Yojana for Sponsoring SC/ST Women	Madhya Pradesh	A scheme to strengthen and expand the nursing cadre by sponsoring SC/ST candidates for post-basic nursing certificate course, BSc and MSc nursing courses in private institutions **Outcomes:** Agreements have been signed with 28 private

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			nursing colleges to accommodate 500 students that the Government will sponsor each year to the course. Over the past two years, 943 students have been admitted to the four-year BSc course; 57 to the yearly post-basic BSc course and four in the two-year MSc course ***(Desk Review Report in Annexure 9.1.3)***
5.	District Public Health Nursing Officer	Rajasthan	A new cadre of District Public Health Nursing Officer (PHNO) reserved for women to supervise and support ANMs and LHVs of the district
2007-2008			
6.	ASHA plus	Uttarakhand	An operations research project in six blocks spread over three districts. Reported differences (obtained from the design document) between the ASHA plus and ASHA scheme include more structured training with use of job aids for communication, a reporting and information system, and inclusion of eligible couples mapping in micro planning
2008-2009			
7.	Rural Medical Corps	Chhattisgarh	Creation of a rural medical corps with attractive packages for ensuring availability of health services in the remote areas of the State. Incentives will be provided to MOs and paramedical staff after every five years of posting in the most inaccessible areas identified as difficult/tribal blocks. This will be done in four FRUs of four blocks on a pilot basis; 60 doctors will be covered. Transportation facilities will be provided and child and spouse allowance would be provided. Doctors completing five years of service in such difficult area PHCs will be prioritised for selection and admission in post-graduate courses. Assurance of non-transferable posting for five years in CHCs/FRUs against special vacancy after completion of PG course for doctors
8.	Nurse Practitioners: Alternative Clinical Human Resources Development through	Chhattisgarh	This innovation is to enable the provision of nurse practitioners in rural and tribal areas in order to solve the problem of non-availability of clinicians to work in remote rural/tribal areas.

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
	Nurse Practitioner Programme		State plans to map the areas/facilities that lack manpower and notify these areas on a district basis. Applications will be invited from existing ANMs/LHVs with more than 15 years of service and private nurses with degree/diploma with minimum 15 years of nursing experience. The nurses selected will sign a bond for 10-15 years and will be enrolled for the Nurse Practitioner Certificate Course to be implemented through medical institutes, or any other competent institutions for training, evaluation and certification. The trained nurses will set up their clinic in the existing PHCs and in case the facility is not available they will be provided additional grants for setting up clinics In lieu of these facilities, the nurses will provide free treatment to patients (service coupons may be provided to the patients by the State/ district administration). A minimum number of patients will be decided as part of her service bond and in case the nurse/s are not able to meet this, the bond will also carry clauses regarding budget provision to be fixed for coverage of package of services. Jeevan Deep committees will be set up to support the nurses in managing and maintaining the facilities. The pilot programme will be coordinated by the PMU/SHRC

7.3 Alternatives to Service Training for Improved Performance

Table 7.3 Alternatives to Service Training for Improved Performance

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcome
1.	**2005-2006** Post-training Supervision of IMNCI Trained Personnel by NGOs	Orissa	In Mayurbhanj, NGOs are engaged for training as well as supervision of IMNCI trained workers
2.	Involvement of Medical Colleges in Monitoring and	Gujarat	The Director, SIHFW, coordinates with the existing medical colleges in the State to monitor the quality of all technical trainings.

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcome
	Improving the Quality of the Training		Further consultants for MH trainings are hired from the gynaecology department of medical colleges
3.	**2007-2008** Decentralising Clinical Training	Uttar Pradesh	Establishing state-of-the-art district-level Divisional Clinical Training Centres (DCTC) for clinical family planning trainings. One DCTC in each division will cater to the training requirements of the neighbouring three to four districts
4.	Rapid Diffusion of IUCD Training Programme using Alternative Training Methodology in 12 States	12 States	The objective is to develop a competency-based clinical training approach that is rapidly scalable and easily adoptable within Government systems and to support the GOI's efforts to substantially increase use of IUCD as a FP method **Outcomes:** • A total of 653 trainers were trained across the States • Standard training protocols and checklists for monitoring training quality as well as trainee performance are in place ***(Desk Review Report in Annexure 9.2.1)***

7.4 Community and Panchayat Involvement in Planning, Monitoring and Management of Health Services and Facilities

Decentralised planning, active engagement of the PRI and enabling public participation in health services (in contrast to contracting out facilities to the private sector) are hallmarks of RCH II and NRHM. Given the limited experience of the health sector in this area, nearly all interventions have been classified as innovations. Under this category a range of innovations are under way. Engagement of the health system with PRI is an important area; as is public participation in the management of health facilities.

The Community Health Care Management Initiative in West Bengal is the only innovation that has been initiated by the Panchayat department, while the rest of the innovations in this category are initiated primarily by the health system. The Swasthya Panchayat Yojana is perhaps the only example of a statewide programme of enabling Panchayats to collate village and hamlet planning into Panchayat plans. Systems and software for data entry are in place. The scheme has a system for ranking and awards. It has been recommended for an in-depth review. The Jeevan Deep Samiti is similar to the RKS. Since RKSs are an integral

part of the NRHM, an in-depth review of this experience and that of RKSs elsewhere may provide lessons on what elements can be scaled up into other States and which are purely locale- or context-specific.

Table 7.4 Community and Panchayat Involvement in Planning, Monitoring and Management of Health Services and Facilities

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1.	**1999-ongoing** Aarogya Iyakkam-Community Volunteer Initiative	Tamil Nadu	Volunteer health activist at village level to promote health services supported by a mentor and Village Health Committee **Outcomes:** • In 2001, UNICEF recognised Aarogya Iyakkam as one of its 10 best programmes the world over, and recommended it for replication. • The number of children with normal weight increased from 34.5% to 45.8%, an increase of 11.3% and the number of Grade II, Grade III and Grade IV children decreased by a corresponding 12.6% • The percentage of children with a 'normal' weight increased from 36.3% to 46.7%, an overall increase of 10.5%. In villages where there was effective intervention the improvement was 15% ***(Desk Review Report in Annexure 9.3.1)***
2.	**2000-2002** Improving Community Participation in Decentralised Planning of RCH Services	Karnataka	Developing a sub-centre-level advisory committee with community involvement to facilitate decentralised planning **Outcomes**: • 64 committees were formed (one per rural sub-centre) of which 57 were active at the time of evaluation • 85% committees were active in organising health programmes. • About half the people in the community reported knowing or participating in those programmes • Over two-thirds of health staff provided high to moderate level of support to these programmes

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			• Over 90% committees also enjoyed support from Panchayats and received donations and Panchayat funds ***(Desk Review Report in Annexure 9.3.2)***
2002-2009			
3.	Integrated Village Planning Project (2002-2004)	Uttar Pradesh	This model was implemented in Lalitpur district to demonstrate the efficacy of village-based planning through Village Health Committees (VHCs) and by involving service providers and elected representatives at village and block levels **Outcomes:** • Full immunisation coverage rose from 39% to 49.3% • Feeding of colostrum went from 39.05 to 86.2% • Institutional deliveries rose from 19.9% to 28.7% • Child marriages declined by one percentage point • Birth registration increased from 91.7% to 98.2% ***(Desk Review Report in Annexure 9.3.3)***
4.	Jeevan Deep Samiti (2005-2006)	Chhattisgarh	A substantially modified version of RKSs, which included PHCs in its ambit. The revamped Samitis now have greater nongovernmental and civil society participation, have powers of appointing short-term staff, awarding performance incentives, and given the increased infusion of funds from the NRHM are no longer pressured to collect user fees **Outcomes:** • 580 out of 679 facilities concerned have completed the registration procedure of Jeevan Deep Samiti. Funds have been received from the NRHM and the State Government has also made budgetary provision • The process of annual planning has begun

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			(Desk Review Report in Annexure 9.3.4)
5.	Improving Quality of Care in the Health Facility by Deploying Voluntary Health Worker—Yashoda (2005-2006)	Rajasthan	A scheme to provide quality services to the mothers and neonates at the hospitals and effective health education to the new mothers and their companion at institutional level through the provision of voluntary health workers called 'Yashoda' who provide 24/7 services on maternal and child health issues
6.	Community-led Initiatives for Child Survival (CLICS) (2003-2008)	Maharashtra	CLICS was an effort in selected areas of Wardha district to build the capacity of the target communities to develop, manage and ultimately achieve 'ownership' of village-based child survival and health services. This was accomplished by forming CBOs and Village Coordination Committees (VCCs) and by applying the principals of 'social franchising' **Outcomes:** • LBW deliveries reduced from 29.4% to 23.4% • 23.6% mothers (with children aged 0-11 months) had received complete ANC package in last pregnancy compared to 11.6% during the baseline • Institutional deliveries went up by 20 percentage points between baseline and midterm (BL—64.4% to MT—84.4%) • Around 80% children (0-5 months) were breastfed within one hour of birth at the time of mid-term as compared to only 0.9% at the time of baseline • Complete vaccination of children aged 12-23 months went up to 92.6% at the time of mid-term as compared to 75.6% during the baseline ***(Desk Review Report in Annexure 9.3.5)***
7.	Community Mobilisation for Improving Mother and Child Health through the Lifecycle Approach	Jharkhand	The model demonstrated community participation for health through the formation of VHCs **Outcomes:** • Institutional deliveries increased from 10% at baseline to 16% at mid-term

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
	(2003-2008)		• Breastfeeding within one hour of birth went from 11% at baseline to 13% at mid-term ***(Desk Review Report in Annexure 9.3.6)***
8.	Alternate Health Delivery System (2005-ongoing)	Punjab	Health services in subsidiary health centres/rural dispensaries to be provided through Zilla Parishads (PRIs) by engaging doctors on service contract basis **Outcomes**: Routine monitoring of the scheme shows that outpatient attendance in the dispensaries increased substantially from the baseline in 2005. Performance in selected programmes such as TB, blindness control and school health also show increases ***(Desk Review Report in Annexure 9.3.7)*** 9. Indira Kanthi Patham (IKP) (formerly Velugu Project) (2005-ongoing) Nutrition Programme for Pregnant Women and Mothers in Convergence with Rural Development Department Andhra Pradesh Implemented in 54 'pilot' *mandals* and eight tribal *mandals*, IKP has specific strategies to address issues of health and nutrition services that are essential for the rural poor through empowering the communities and creating and enabling environment, demystifying the concept of health so that it is not only understood in a simplified manner by the rural poor but also perceived as a social issue as against the traditional medical and clinical models. The core interventions initiated in pilot *mandals* are: continuous capacity building of health activists and health sub-committees; fixed Nutrition and Health Days (NHDs); screening

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			camps for women; case managers positioning at district/area/PHC hospitals; health savings—Health Risk Fund; comprehensive food security; nutrition-cum-day care centre; need-based intervention such as community kitchen gardens, weaning foods and drug depots; contracting out for health services with private medical colleges and network hospitals; involvement of Panchayat and youth for safe drinking water supply and environmental sanitation; special initiatives for social accountability using health scorecards and an intensive approach for behaviour change through health community resource persons ***(Desk Review Report in Annexure 9.3.8)***
10.	Swasthya Panchayat (2006-2007)	Chhattisgarh	A scheme to ensure health as a key agenda of the Panchayats. Under this scheme, a hamlet-level health indicator-based human development index has been developed so that assessment of health status as well as identification of gaps in a Panchayat is possible. Key features include ranking of Panchayats, creating competition among the Panchayats with a system of rewards, and participatory Panchayat planning **Outcomes**: • The first set of awards was distributed on 26 January 2007 • Panchayat-level health data collected, analysed and feedback provided to 133 block Panchayats (9,041 of a total of 9,800 Panchayats) • Panchayat-level planning is ongoing in these blocks • Data from remaining 66 blocks is being analysed ***(Desk Review Report in Annexure 9.3.9)***
11.	Mitanin (2006-2007, ongoing since 2002)	Chhattisgarh	Community health worker programme with a health rights approach, to enable community health awareness and enable community to take action for health triggered by training and support

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			of woman community health volunteer **Outcomes:** • 55,865 Mitanins cover the entire State • Over three-quarters of Mitanins regularly attend immunisation camps, visit the newborn on the first day of birth, provide counselling on essential newborn care, visit mothers in the last trimester of pregnancy and are the first point of referral for curative care • Sample Registration Survey (SRS) estimates for Infant Mortality Rate (IMR) indicated a reduction from 79 in 2000 to 60 in 2004 • Breastfeed initiation within 24 hours of birth increased from 27% (1998-1999 NFHS) to 88% (2005-2006 NFHS) Proportion of children with complete immunisation increased from 30% in 1998-1999 to 42% in 2005-2006 ***(Desk Review Report in Annexure 9.3.10)***
12.	Adarsh PHC Yojana (2006-2007)	Maharashtra	An incentive scheme under which three PHCs with high performance will be rewarded in three categories on a yearly basis. The cash award is to be utilised for improvement of the PHC
13.	Adarsh RH Yojana (2006-2007)	Maharashtra	An award scheme for rural hospitals at the district level, ranked on the basis of their performance (bed turnover rate, bed occupancy rate, preferred in and out services, several FW/ RCH indicators), and community-related parameters based on customer satisfaction surveys
14.	Arogya Gram Sabha (2006-2007)	Maharashtra	Organising a special Gram Sabha in the villages intended to enhance participation of men in women and child health activities such as increasing age of marriage, early ANC registration, early breastfeeding, Grade III and Grade IV. The Gram Sabhas will be conducted in the evening by the male health animators and male health workers
15.	Mahila Arogya Gram Sabha—Jal Swarajya (not known)	Maharashtra	Under the drinking water and sanitation project Jal Swarajya, implemented in selected districts of the State, Mahila Gram Sabhas and Mahila Vikas

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			Samitis have been introduced to engage women in the implementation of RCH activities. Gram Sabhas for women to be held in every village and at the district level in coordination with the Water and Sanitation department
16.	Adarsh Gram Yojana (2006-2007)	Maharashtra	A scheme for increasing the community participation in RCH II activities. Under this scheme it is envisaged that RCH issues will be discussed in Gram Panchayats, Panchayat Samitis and Zilla Parishads to ensure the publicity of the activities under the scheme. After a year, village-wise review of the health indicators will be conducted. Subsequently, three best performing villages will be rewarded with a cash incentive
17.	Community Health Care Management Initiative (2006-2007)	West Bengal	An initiative to install sustainable systems and processes for community action for health care management. The initiative aims to develop the attitude and knowledge on public health issues for all Government functionaries, PRI members, civil society groups so that they could act upon as change agents and improve the access of the communities to basic health services
18.	Village Councils for Planning Health Services (2006-2007)	Meghalaya	Orientation of village councils and village durbars for programme planning and monitoring
19.	Communitarian Private Public Partnership for the Management of Health Centres (2006-2007)	Nagaland	This is an ongoing initiative in engaging community participation in management of health centre services from the sub-centre upwards to encourage ownership. So far 397 sub-centres, 63 PHCs and 31 CHCs have been notified under the scheme and have the appropriate levels of health committees **Outcomes:** • There has been a significant increase of more than 50% in children accessing the health centres across all villages • 75-90% villages reported improvement in health staff attendance. Attendance improved to over 90% in the sampled villages, with unauthorised absence down to zero per cent • Back-up referral support is poor, with

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			limited numbers of medical professionals • At least 83 sub-centres, which had no staff earlier, were given one ANM through redeployment ***(Desk Review Report in Annexure 9.3.11)***
20.	Community Monitoring, Rayagada (2006-2007)	Orissa	The essence of the innovation appears to be support to a District Level Advisory Committee to enable the data collected in respect of IMR to be subject to a closer 'epidemiological' scrutiny, running a concurrent validation study in a set of 22 villages to cross-check the data and involving the Gram Panchayats in the Health Management Information System for data triangulation. This involved capacity building of the PRI representatives, SHG members, community leaders and frontline Government staff for tracking births and deaths. Outcomes of the study appear to be that the IMR rose from 50 to 100, which appeared to be more credible, and underreporting decreased from 61% to 26%. (***Desk Review Report in Annexure 9.3.12***)
21.	District Level Complaint Committees (2006-2007)	Rajasthan	A committee formed at the district level headed by women as a redressal mechanisms for complaints related to workplace harassment issues
22.	Communitisation of Health Services (2007-2008)	Gujarat	Involving local communities in planning and implementing programmes with a monitoring framework that allows them to assess progress against agreed benchmarks. Systems and processes will be developed to provide communities and community-based organisations opportunities to monitor demand/need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care, negligence, etc. The health functionaries will be oriented on the communitisation processes, roles of different health committees and responsibilities of the system in responding to the emergency needs based on the findings

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			shared by the VHCs in the monthly interface meetings. Endline assessments would be done on the communitisation initiative
23.	Health Village Awards to Autonomous Development Councils (2008-2009)	Tripura	In order to generate the interest of the community regarding the RCH programme, the Healthy Village award scheme will be given to the top three GPs on Autonomous District Councils (ADCs) in the district every year, chosen by the District Selection Committee. All villages under the GPs and ADCs will be involved in the process. The State will provide a select list of indicators and the Gram Pradhans and health committees will monitor the implementation of the various activities related to the indicators. The cash prizes for the top three villages are Rs. 3 lakh for the best village, Rs. 2 lakh for the second village and Rs.1 lakh for the third best performing village, to be used for development activities in their respective areas
24.	Community Monitoring (2008-2009)	Chhattisgarh	Community monitoring by NGOs has been initiated in three districts on a pilot basis and will be scaled up in the remaining 15 districts in 2008-2009. Community monitoring is aimed at providing regular and systematic feedback about community needs. Feedback will be provided through this monitoring on the status of entitlements, functioning of various levels of the public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability. This system will also be used for validating the data collected by the ANMs, AWWs and other functionaries. Community participation will be ensured through this mechanism. Mentoring groups have been formed in three districts. The initiative will be implemented by the NHSRC in consultation with the State Health Resource Centre
25.	Community Participation in Hospital Management (ongoing)	Rajasthan	A community-led initiative in which a district hospital in Beawar, in Ajmer district of Rajasthan, has been rejuvenated through donations from villagers, Rajasthan Medical Relief Society and grants from the Government of Rajasthan.

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			Infrastructure development and upgradation of equipments have been undertaken. The contributions have improved the working conditions and physical attributes of the hospital and transformed it into a functional hospital. There has been a reportedly marked increase in OPD, IPD and the number of deliveries
26.	Community-based Monitoring of Health Services	Maharashtra	In order to promote accountability and community-led action in the field of health, community monitoring systems have been established as a pilot in five districts with the objective of providing regular and systematic information about community needs, provide feedback on the status of fulfilment of entitlements, functioning of various levels of the public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability. The monitoring systems are being set up in 15 blocks, 45 PHCs, 225 villages in the five identified districts. The representatives of health officials, PRIs, CBOs/NGOs/people's movements and villagers are part of the monitoring and planning committees at the village, PHC, block, district and State levels **Outcomes:** • Improved accountability of health functionaries as a result of Public Dialogue (Jan Samvad) or Public Hearing (Jan Sunwai) process held once/twice in the year • Illegal practices such as charging fees for injection or medicine, or sending patients to a medical shop to buy medicines, have stopped • Some officials who were involved in corrupt practices were suspended in one block • People's awareness of health care has improved

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			• Functionaries (especially ANMs) have started approaching the block and the district coordinators, with institutional and personal difficulties
27.	Developing and Strategising Community Ownership of Village Plan through Micro-planning and Community Monitoring	Maharashtra	An innovation for involving the community in the planning process to improve ownership of the programme. Within the broad framework of the intervention there would be three vital components, namely programme communication, community dialogue and social mobilisations. Each of these components would be driven by a set of unique and mutually reinforcing strategies and action taken. The project involves preparation of village plans through participatory process (micro-planning) and follow-up activities, preparation of a block response plan through a participatory process, participatory implementation of the response plan and participatory monitoring and evaluation
28.	Improving Efficiency of Hospitals through Decentralisation (2008)	Kerala	The programme aims to increase people's participation (through suggestions and opinions from the people's representatives, NGOs and the general public) for improving the functioning of the hospitals and to chart out a concrete plan of action based on the suggestions. A public contact programme called Janasamparkaparipadi was implemented in three districts (Wayanad, Kannur and Kasaragode) where grievances were received from the people on the implementation of the programme. During the programmes, the programme activities were published through ASHAs, NRHM kiosks, leaflets and several IEC/BCC activities **Outcomes:** The suggestions and grievances from the people were sorted out, discussed and solutions suggested with a definite action plan for implementation
29.	ASHA Workers Owing More Responsibilities	Kerala	The burden of NCDs is on the rise in the State. Considering this scenario, the State has decided to make a paradigm shift in the role of ASHAs, whereby their role will be extended beyond the realm of preventive and promotive aspects to

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			include the management of communicable and non-communicable diseases. ASHAs would manage the specific areas of prevention and control of communicable diseases, identification and control of NCDs, palliative care and community-based mental health programme. The specific responsibilities of ASHAs would be: • Reporting of outbreaks/cases to the sub-centre/PHC/CHC • House-to-house campaigns and other IEC activities • House visits with teams for source reduction activities and chlorination • Lead source reduction activities by house visits

7.5 Programme Monitoring and Management Information Systems

Eleven innovations are listed in this category. They range from the use of sophisticated systems such as GIS mapping in Orissa and the dashboard system in West Bengal to participatory investigations of maternal and infant death at the community level. It is clear that programme monitoring is an area where States are attempting innovations. Six of the innovations pertain to either infant or maternal death audit. Although details are not available on any of these schemes, the issue of training in investigation and reporting are key to death audits. Information is required on the duration of training of 'investigators' in verbal autopsy qualitative techniques, costs of technical assistance, logistics and outcomes of audit on functioning of the system and community feedback and action. These are important when considering scaling up of a new method of investigation such as death audits.

Table 7.5 Programme Monitoring and Management Information Systems

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
2006-2007			
1.	Maternal Death Audits (since RCH 1)	Tamil Nadu	Maternal death audit conducted in all districts of the State. The District Collectors monitor the audit processes stringently
2.	Maternal and Perinatal Death Inquiry and Response	Rajasthan, Orissa, Jharkhand, West Bengal,	In order to understand the underlying causes of maternal death in remote and inaccessible villages, MAPEDIR is a process of confidential enquiry into maternal deaths, also intended to

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
	(MAPEDIR) (2005-2007, ongoing)	Bihar	generate local evidence, sensitise communities and health officials and galvanise them into taking action to reduce such deaths. MAPEDIR was introduced as a pilot in Purulia district in 2005 and scaled up in six States (including Madhya Pradesh) ***(Desk Review Report in Annexure 9.4.1)***
3.	State Data Centre	Bihar	A State data centre formed under the SHS is a modernised centre for collecting data on the various programmes under the NRHM. It is based on data collected on a daily basis from health personnel
4.	Application of GIS Technology	Orissa	Geographical mapping of existing health care facilities, spatial mapping of incidence of diseases, mapping of service coverage of sub-centre and identifying the unserved areas
5.	Matre Sishu Suraksha Cards and Registers	Uttar Pradesh	Development and distribution of birth preparedness cards to be filled by the family of pregnant women as a checklist
6.	Verbal Autopsy for Newborn Deaths	Manipur	Verbal autopsy for deaths of newborns
2007-2008			
7.	Dashboard System for MIS	West Bengal	The dashboard is a simple visual representation tool that uses a colour band ranging from dark red (poor performance) to dark green (excellent performance) to identify performance of various indicators, grouped into broad sections such as Maternal and Child Health, Public Health
8.	Maternal Death Audit	Madhya Pradesh	A maternal death review committee is constituted at the district level to review the cause of maternal death in a facility. Social audit supported by UNICEF. Training of investigators completed in three blocks of Gwalior district and two blocks of Bhopal district
9.	Infant Mortality Death Audit	Uttarakhand	At the community level, grassroots workers, such as CARE change agents, AWWs, other community volunteers, school teachers and opinion leaders, will help identify cases of infant and maternal deaths during the last three years

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			and advise on actions to follow-up the audit
2008-2009			
10.	MAPDA: Maternal and Perinatal Death Autopsy (08-09)	Assam	MAPDA is an initiative to track maternal and perinatal death through verbal autopsies carried out by ASHAs and ANMs. All maternal deaths in a district/block will be reported directly to the DPM by the ANMs, ASHAs and the community within 24 hours of the death. This is followed by a detailed investigation of the case within 15 days of the occurrence of the death by an investigation team, which will include a Block MO, BPM, SN and obstetrician. The team would provide their feedback to the JDHS and the DPM, DC and ADC in conjunction with the family members, invited to present the accounts of the events related to the death. A State-level committee has been formed for assessing the quality of the maternal death investigation and providing feedback to the district on a quarterly basis. Master training for district level completed. MAPDA is being started in Dibrugarh and Barpeta
11.	Increasing Mobility to Enable the Monitoring of Sub-centres	Tripura	A two-wheeler will be provided to each SDH/ CHC and all PHCs in a phased manner in Dhalai district for improving the supervision of the sub-centres. Visit report of the two-wheelers will be submitted to the district office and registers will be maintained for their movement
12.	Telemedicine (2001)	Kerala	A web-based telemedicine system started as 'Cancernet' in 2001 and renamed in 2002 as 'Onconet', which provides information related to medical treatment, sharing of resources and an integrated health care delivery system using various media, for example, telephone calls, video conferencing, remote monitoring and consultation using tele-otoscope, tele-stethoscope, teleradiology and remote microscope. The system of telemedicine, which connects *takul* and specialist hospitals, provides improved patient care and thereby better access to health. The State also has a mobile telemedicine initiative, which includes the development of a low cost mobile

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			telemedicine facility. It deploys the prototype in another district for extending specialist care to the rural areas for early detection of diseases such as tuberculosis, diabetes, hypertension, etc. It also includes a follow-up of patients with chronic diseases, early detection of cancers, comprehensive care for the cancer patients, follow-up consultation and provision of maternal and child health services
13.	Telemedicine Project	Maharashtra (Beed District)	In order to improve accessibility of specialty health care to under-served rural and urban populations the State has introduced a telemedicine project in a number of undeveloped districts and rural *taluka* places such as BEED, Sindhudurg, Nandurbar, Latur and Ambajogai. These centres are connected with a specialty hospital in Mumbai and provide easy and quick access to specialists, reduce cost of travelling and associated cost for patients. There is also provision for continuous education and training for rural health care professionals

Table 7.6 Improving Procurement and Finance Systems

S. No	Title of Innovation/ Year of Innovation	Location	Brief Description/Outcomes
1	Tamil Nadu Medical Services Corporation	Tamil Nadu	The Tamil Nadu Medical Services Corporation, (TNMSC) is a statewide drug management system whose key objective is to ensure a regular supply of drugs and prevent stockouts. The model is currently undergoing an in-depth review to study procurement processes, commissioned by the World Bank ***(Desk Review Report in Annexure 9.4.2)***
2	**2007** Kerala Medical Services Corporation Ltd. (KMSCL) Initiative: Ensuring Quality Supply of	Kerala	In order to make quality drugs, supplies, equipment and diagnostic services accessible to the poor population in the State, the State Government has constituted Kerala Medical Services Corporation Ltd. The Corporation procures and stocks quality drugs and supplies,

S. No	Title of Innovation/ Year of Innovation	Location	Brief Description/Outcomes
	Medicines in a Transparent and Efficient Way		ensures ready availability of all essential drugs and supplies throughout the State and also ensures quality of the supplies. The Corporation plans to establish district drug warehouses in all 14 districts in the State to cater to the needs of 1,316 health care institutions under the State Health Services Department and 16 institutions under the six Government medical colleges in the State
3	**2007-2008** E-banking for Fund Management	Kerala	Kerala introduced e-banking in 2007-2008 in order to improve financial management. Under the e-banking system, using customised software, the transaction of NRHM funds at the State and 14 districts are done online. Information on sanction orders are posted in the State's NRHM website **Outcomes:** The online system of fund transaction has been found to be user friendly and has helped the State to capture updated data on fund transfer, expenditure and utilisation. Tracking and monitoring of funds has become feasible and delays in fund transfer have reduced considerably
4	Debit Card for ASHAs	Kerala	In order to ward off delays in payment of incentive to ASHAs, the State has introduced the system of paying incentives using debit cards. Under this system, the incentives for ASHAs are credited to the respective accounts of ASHAs from the district NRHM office. The performance report of ASHAs verified by the PHC medical officer are sent to the districts, based on which payments are made by way of crediting the amount to the respective ICICI bank account of ASHA from the district headquarters. This system also generates SOEs. The card-owning ASHAs can check all transactions online and also receive SMS alerts on mobile phones on every transaction made. A tele helpline started by the bank for this initiative provides 24/7 information against various enquiries made by ASHAs

Category 8

School Health

The school health programme is a vehicle to impact the health of school going children and youth in India and address issues of population stabilisation, gender and demographic balance. States are offered the flexibility to adapt the key elements of the school health programme to their needs. The essential elements of school health programming include: school health policies to encourage healthy lifestyles, provision of safe and supportive environments, health, hygiene and nutrition education, and school-based health and nutrition services. The State programme implementation plans for 2008-2009 include a range of interventions to ensure that these policies are operationalised in schools.

Of the five innovations in this category, desk reviews were conducted for four innovations. (Annexure 10).

Table 8.1 School Health

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
1.	School Health Programme	Tamil Nadu	To improve the overall health status of school children studying from the 1st to 12th standards in Government and Government-aided schools by early detection, diagnosis and timely treatment of health problems and by providing referral services to the needy students **Outcomes (June 2008 till January 2009):** o Total number of school children screened—9,986 o Total school children recommended for surgery by the specialist team—2,395 o Number of students found fit for surgery by the hospital—1,772 o Beneficiaries (surgery done)—1,104 o All students screened biannually o PHC staff systematically involved in school health programme o Drugs, registers and cards made available at the school level o Integration with programmes such as rehabilitation, blindness control, adolescent reproductive health education (implemented by TANSACS), etc.
2.	School Health Programme	Gujarat	All school going children in the State are covered for screening and provision of services for:

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			common skin diseases; heart defects; disabilities; and learning disorders/problem behaviours/stress/anxiety. Additionally, an adolescent anaemia control programme is in place since 2002 ***(Desk Review in Annexure 10.1)***
3.	**2007-2008** School Health Programme	Kerala	The objectives of the school health programme are: • Clinical examination of children for primary, preventive and clinical minor problems • Counselling through the services of a clinical psychologist/MSW present at regular intervals in a month for general and specific counselling • Health education through various media • Participation of the parents and teachers • Creating a comprehensive health database of children The first school health clinic has been launched in a girls' school in 2007 and the programme will cover all districts covering one school per Panchayat/municipality/corporation. In this pilot phase, 1,100 schools will be covered. The local Self-Government shall have the option of funding the programme in another school in the same Panchayat ***(Desk Review in Annexure 10.2)***
4.	School Health Programme	West Bengal	To improve the health of school going children through: o Promotion of health education including adolescent health arising out of physical, emotional and different stresses and strains prevailing in the present social psyche o Prevention of diseases and promotion of immunisation o Early detection, diagnosis and treatment of diseases o Provisions for referral services to higher health centre o Building health awareness in the community o Development of habits on personal hygiene and cleanliness

S. No.	Title of Innovation/ Year of Initiation	Location	Brief Description/Outcomes
			(Desk Review in Annexure 10.3)
5.	School Health Programme	Dadra and Nagar Haveli	**Objectives:** • Promotion of positive health and healthy environment • Prevention of disease • Early diagnosis/treatment/follow-up/referrals • To enlighten the district level, block level officials and school heads on health issues • Awakening of health consciousness • To provide platform for practising healthy habits **Outcomes:** • Well maintained records with elaborated reporting leading to good follow-up action Tracking of child done regularly • Improved quality of nutrition by training of parents and teachers by dietician ***(Desk Review in Annexure 10.4)***

9. **Urban Health Programme:** Urban health programming under RCH II/NRHM is expected to be guided through the National Urban Health Mission (NUHM), which is currently being finalised. The NUHM proposes the following interventions to add on to the ongoing urban health initiatives:

- City-level need-based planning, including spatial mapping of slums and health facilities
- Service delivery guarantee at the primary health care and referral level by strengthening, revamping and rationalising the existing set-up and filling up the gaps through partnerships
- Ensuring quality of service delivery through norms/standards
- Communitisation efforts will be encouraged in planning and management of health care services through promotion of an Urban Social Health Activist (USHA) in urban poor settlement (covering 200-500 households); organising slums into Mahila Arogya Samitis
- USHA will receive performance-based incentive
- Filling the gaps through PPPs
- It is also proposed to provide for community risk pooling and insurance mechanism under the Mission for protecting the poor from the impoverishing effect of out-of-pocket expenditure

- Effective targeting of the resources to the most vulnerable

Existing innovations in urban areas are primarily restricted to maternal and child health and have been included in the respective categories outlined above.

Annexures

Annexure 1

State-wise Matrix of Innovations

Annex 1: State-wise Matrix of Innovations in RCH II and the NRHM

State	**Innovation**
Andhra Pradesh	1. Rural Emergency Health Transportation Scheme/EMRI
	2. Aarogyashri Insurance Scheme
	3. Young Infant Health Assurance Scheme
	4. District MCH Control Room
	5. Free Bus Passes for Pregnant Women to Obtain ANC
	6. Incentives for Specialists for Remote Areas
	7. Family Health Day
	8. Breastfeeding Promotion Campaign
	9. Annual Immunisation Census
	10. Well Baby Campaigns
	11. Annual Deworming Campaign
	12. Birth Waiting Rooms 13. Health and Nutrition Initiative: Indira Kanthi Patham (formerly Velugu Project)
Arunachal Pradesh	14. Contracting Out Management of PHC by NGOs
	15. Cash Incentives for Staff in Remote Areas
Assam	16. Mobile Boat Clinics in Riverine Areas
	17. Contracting Out Services through Private Hospital in Urban Areas
	18. Insecticide Treated Bed Nets for Pregnant Mothers
	19. Mother and Child Health Month
	20. Chiranjeevi Yojana
	21. EMRI
	22. Outsourcing of CHCs to NGOs
	23. Cash Incentives for Staff Staying in Difficult Areas
	24. ASHA Radio
	25. Performance Incentives for Government Facilities for Institutional Delivery
	26. PPP with Private Hospitals/Tea Garden Hospitals
	27. MAPDA—Maternal and Perinatal Death Autopsy
Bihar	28. Vaccine Delivery through Mobile Vans
	29. Health Melas
	30. State Data Centre
	31. Emergency Medical Services for Referral
	32. Muskaan Ek Abhiyaan—Intensifying Outreach Efforts For Immunisation
	33. Dular Strategy to Address Malnutrition
Chhattisgarh	34. Shishu Samrakshak Maah
	35. Mitanin Programme
	36. Swasthya Panchayat
	37. Jeevan Deep Samiti
	38. Mobile Medical Units

State	Innovation
	39. EQUIP Initiative—Multi-skilling of Medical Staff
	40. JSY Helpline
	41. Baby Friendly Health Facility Accreditation
	42. Creating a Nurse Practitioner Cadre
	43. Rural Medical Corps
	44. Community Monitoring 45. School Health
Delhi	46. Mamta Friendly Hospital Scheme 47. PPP for Primary Health Care in Urban Slums
Goa	48. Ambulance Services and Helpline for Transport of Obstetric Emergencies
	49. Goa Mediclaim Scheme
Gujarat	50. Chiranjeevi Yojana
	51. Mobile Health Units
	52. Involvement of Medical Colleges in Monitoring and Improving Quality of the Training
	53. Incentives for Staff to Serve in Remote Areas
	54. Mamta Abhiyan—Special Day for Outreach Services
	55. PPP for Critical Neonatal Care
	56. Gender Budgeting
	57. Communitisation of Health Services
	58. *Haat* Clinics 59. School Health
Haryana	60. Delivery Huts
	61. Janani Suvidha Yojana
	62. Community-based Programming for Adolescent Health
Jharkhand	63. Catch-up Rounds for Immunisation and Zero Diarrhoea
	64. Janani Suraksha Yojana Helpline
	65. Community Health Insurance Scheme for BPL
	66. Community Mobilisation for Improving MCH through a Lifecycle Approach
Karnataka	67. Janani Suraksha Vahini
	68. Yeshaswini Health insurance Scheme
	69. Special Provisions for Backward Districts
	70. Award for Best Performing ANM
	71. Bhagyalakshmi Scheme
	72. Improving Community Participation in Decentralised Planning of Services
	73. Tribal ANMs for Tribal Areas
	74. Incentive to TBAs to Escort Women for Institutional Delivery
	75. Gender Budgeting
	76. Community-based Distribution of Contraceptives
	77. Arogya Kavacha Scheme

State	Innovation
	78. Convergence Model: NRHM-KSAPS ANC-PPTCT Programme
Kerala	79. Revising Health Worker training
	80. Radio Health
	81. Health Mela
	82. Bodhana Nauka
	83. E-banking for Fund Management
	84. Debit Card for ASHA
	85. Improving Efficiency of Hospitals through Decentralisation
	86. Telemedicine
	87. Kerala Medical Services Corporation Ltd.
	88. ASHA Workers Owning More Responsibilities
	89. Immunisation Drive
	90. School Health
Madhya Pradesh	91. Janani Express Yojana
	92. Call Centre with Network of Ambulances for Ob/Gyn/Newborn, Guna
	93. Janani Sahayogi Yojana
	94. Deen Dayal Antyodaya Upachar Yojana
	95. State Illness Fund
	96. Deen Dayal Chalit Aaspatal
	97. Incentive Scheme for Health Functionaries
	98. Swabhlambhan Yojana
	99. State Health Award
	100. Bal Shakti Yojana (and Nutritional Rehabilitation Centres) 101. Bal Poshan Mah
	102. Maternal Death Audit
Maharashtra	103. Ankur—Improving Neonatal Mortality through Home-based Newborn Care (HBNC)
	104. Adarsh PHC Yojana
	105. Married Adolescent Girls Intervention
	106. Adarsh RH Yojana
	107. Adarsh Gram Yojana
	108. Arogya Gram Sabha
	109. Mahila Arogya Gram Sabha—Jal Swarajya
	110. Community-led Initiatives for Child Survival
	111. Mother and Mother-in-law Melawa
	112. Dada-Dadi Orientation
	113. Mata Vikas Kendra
	114. Child Development Centre
	115. Hirkani Kaksha
	116. Anti-anaemia Drive for Adolescent Girls
	117. Savitribai Phule Kanya Kalyan Paritoshik Yojana
	118. Doctor Tumachya Gaavi

State	**Innovation**
	119. Floating Dispensaries
	120. Incentive Grant Scheme to Enhance the Institutional Deliveries
	121. Best Gram Panchayat Scheme
	122. Malnutrition Improvement Scheme
	123. Community-based Monitoring of Health Services
	124. Developing and Strategising Community Ownership of Village Plan through Micro-planning and Community Monitoring
	125. Telemedicine Project
Manipur	126. Verbal Autopsy for Newborn Death
	127. Incentives to TBAs to Ensure Birth Registration
	128. Use of Satisfied Couples to Motivate Clients for FP
	129. Incentives to Sub-centre Second ANM
	130. Performance Incentives for Doctors Providing EmOC and Anaesthesia
	131. Maternity Waiting Centres
Mizoram	132. Incentives for Doctors Serving in Remote Rural Areas
	133. Vehicle Loan for Health Worker, Health Supervisor and CHW
	134. Cash Incentives to PHC Staff to Conduct Night Deliveries
	135. Contracting Out PHC to Faith-based Organisations
	136. JSY Helpline by NGO
	137. Health Insurance for BPL
Nagaland	138. Communitarian Private Public Partnerships for Management of Health Centres
	139. Partnership with Mission Hospitals for Outreach Services
	140. Incentives for ANM Posted in Sub-centres of Remote Districts
	141. Gender Budgeting
Orissa	142. Management of PHC by NGOs
	143. Post-training Supervision and Monitoring of IMNCI-trained Personnel by NGO
	144. Community Monitoring
	145. Application of GIS Technology
Punjab	146. Alternate Health Delivery System
	147. Balri Rakshak Yojana
Rajasthan	148. Obstetric Helpline
	149. Panchamrit Campaign
	150. Provision of MCH in Tribal Areas through Nurse Midwife-operated Clinics
	151. Swasthya Chetna Yatra
	152. District-level Complaint Committees
	153. District Public Health Nursing Officer
	154. Nutrition Rehabilitation Centres
	155. Improving Sanitation Facilities in CHCs through PPP

State	Innovation
	156. YASHODA—Improving Quality of Care in Health Facilities by Deploying Voluntary Health Worker
	157. Management of CHCs through PPP
	158. Community Participation in Hospital Management 159. Swasthya Mitra Yojana
Sikkim	160. Annual Award to the Best Performing Facilities
	161. Facilitating Women's Access to Services by Ensuring One Female MO and One Male MO
	162. Posting of Extra ANM at PHC to Substitute for ANMs on Leave
	163. Skill Development for Male Health Worker
Tamil Nadu	164. Round-the-clock Delivery Services with Three Staff Nurses
	165. Community Volunteer Scheme, Aarogya Iyakkam
	166. Use of Indian Systems of Medicine in ANC, Nutrition and Counselling
	167. CEmONC Certification
	168. Birth Companion Programme
	169. Maternal Death Audit
	170. Scan Centre Audit
	171. Tamil Nadu Medical Services Corporation 172. School Health
Tripura	173. Helicopter Ambulance Services
	174. *Doli* Initiative
	175. Mobility to Improve Monitoring and Supervision
	176. Rural Ambulance Service
	177. Cash Incentives for Doctors of PHC, CHC and SDH
	178. Healthy Village Awards to Autonomous District Councils
Uttar Pradesh	179. Voucher Scheme to Increase Institutional Delivery in Agra, Kanpur and Bharaich
	180. Incentives for Night Deliveries
	181. Voucher Scheme for Referral Transport
	182. Contracting Out Support Functions such as Gardening and Cleaning, as part of UPHSDP
	183. Merrygold Scheme
	184. Saathiya Project
	185. Yuva Mangal Mela
	186. Health Fairs
	187. Adarsh Dampati Samman
	188. Matra Shishu Cards and Registers
	189. Bal Swasthya Poshan Maah
	190. Addressing Malnutrition in Selected Districts
	191. Saubhagyawati Scheme: Private Sector Participation to Promote Access of BPL Women to Institutional Deliveries
	192. Contracting Out PHCs to NGOs

State	**Innovation**
	193. Management of Sub-centres by NGOs
	194. Saksham: A Community-based Intervention for Health of Newborn
	195. Integrated Village-level Planning
	196. Rural Mobile Medical Outreach Services through NGOs
	197. Sterilisation and IUD Campaigns
	198. Decentralising Clinical Training
Uttarakhand	199. Voucher Scheme for Institutional Delivery, Haridwar
	200. Mobile Health Clinics
	201. Community Health Insurance for BPL
	202. ASHA Plus Scheme
	203. Jacha Bachha Swasth Divas
	204. Social Marketing of Contraceptives through a Specialised Marketing Agency
	205. Improving Communication with ANM through Mobile Phone Facility
	206. Transit Maternity Homes
	207. Emergency Response Services
	208. Infant Mortality Death Audit
West Bengal	209. Ayushmati Scheme
	210. Ambulance Scheme
	211. Partnerships with NGOs for Adolescent-friendly Services
	212. Vande Mataram Scheme
	213. Mobile Health Clinics
	214. Subcontracting Out: (i) Diagnostic Services in Rural Areas (ii) Security, Scavenging and Waste Management Functions (iii) Mechanised Laundry
	215. Dashboard Health Management Information System
	216. Community Health Care Management Initiative (CHCMI)
	217. Kano Parba Na/Positive Deviance Approach 218. School Health
Multiple States	219. Rapid Diffusion of IUCD Training Programme Using Alternative Training Methodology in 12 States
	220. RACHNA: Reproductive and Child Health, Nutrition and HIV/AIDS Programme
	221. Goli Ki Hamjoli
	222. Bindaas Bol
	223. Saathi Bacchpan Ke
	224. Fractional Franchising to Promote Use of Injectables
	225. Family Counselling Centres
	226. Maternal and Perinatal Death Enquiry-Response (MAPEDI-R)

Annexure 2

Scalability Checklist

Annex 2: Scalability Checklist

Model Characteristic		A ☺ ✓	Scaling Up is Easier	B 😐 ✓	Scaling Up is Harder	C ☹ ✓
Is the model credible?	**1**		Based on sound evidence		Little or no solid evidence	
	2		Independent external evaluation		No independent external evaluation	
	3		There is evidence that the model works in diverse social contexts		There is no evidence that the model works in diverse social contexts	
	4		The model is supported by eminent individuals and institutions		The model is not supported by eminent individuals and institutions	
How observable are the model's results?	**5**		The impact is very visible to casual observation; tangible		Impact not very visible; not easily communicated to public	
	6		Clearly associated with the intervention		Not clearly associated with the intervention	
	7		Evidence and documentation exists with clear emotional appeal		Currently little or no evidence with clear emotional appeal	
How relevant is the model?	**8**		Addresses an objectively significant, persistent problem		Addresses a problem that affects few people or has limited impact	
	9		Addresses an issue that is currently high on the policy agenda		Addresses an issue that is low or invisible on the policy agenda	
	10		Addresses a need that is sharply felt by potential beneficiaries		Addresses a need that is not sharply felt by potential beneficiaries	
Does the model have relative advantage over existing practices?	**11**		Current solutions for this issue are considered inadequate		Current solutions are considered adequate	
	12		Superior effectiveness to current solutions is clearly established		Little or no objective evidence of superiority to current solutions	
	13		Superior effectiveness to other innovative models established		Superior effectiveness to other innovative models not established	
How easy is the model to adopt and transfer?	**14**		Implementable within existing systems, infrastructure and human resources		Requires new or additional systems, infrastructure, or human resources	
	15		Contains a few components easily added onto existing systems		Is a complete or comprehensive package of multiple components	
	16		Small departure from current practices and behaviours of target population		Large departure from current practices and behaviours for target population	
	17		Small departure from current practices and culture of adopting organisation(s)		Large departure from current practices and culture of adopting organisation(s)	
	18		Few decision-makers are involved in agreeing to the adoption of the model		Many decision-makers are involved in agreeing to adoption	
	19		The model has limited number or layers of monitoring and supervision		The model has multiple numbers or layers of monitoring and supervision	

	20		Demonstrated effectiveness in diverse organisational settings		Demonstrated effectiveness in only one organisational setting	
# of Checks						

		A		B		C
Model Characteristic		☺ ✓	**Scaling Up is Easier**	😐 ✓	**Scaling Up is Harder**	☺ ✓
How easy is the model to adopt and transfer?	**21**		The model is not particularly valuable or process intensive		Process and/or values are an important component of the model	
	22		Low technical sophistication of the components and activities of the model		High technical sophistication of the components and activities of the model	
	23		Key innovation is a clear and easily replicated technology, for example, vaccine		Focus of the model is not a technology, or one that is not easily replicated	
	24		Low complexity; simple with few components; easily added on to existing systems		High complexity with many components; integrated package	
How testable is the model?	**25**		Able to be tested by users on a limited scale		Unable to be tested without complete adoption at a large scale	
Is funding likely to be available or resources saved?	**26**		Superior cost-effectiveness to existing or other solutions clearly established; cost savings likely		Little evidence of superiority in terms of **cost-effectiveness;** no potential savings and likely additional expenditure	
	27		The model itself has its own internal funding (for example, user fees), corpus or endowment		No internal funding; the model is dependent on external funding source	
	28		Overall funding for this sector is a priority and growing, even to the extent of unspent funds		Overall funding for this sector is already severely stretched with many unmet competing demands	
Total Number of Checks p.3						
Total Number of Checks p.2						
Total Number of Checks p.1						
Total						

Annexure 3

Innovations for Safe Motherhood

ANNEXURE 3.1.1

Provision of Essential Maternal and Child Health Services in Tribal Areas

Title **State**	Provision of Essential Maternal and Child Health Services in Tribal Areas Rajasthan
Geographic Area of Coverage	Kumbhalgarh block in Rajasmand district, Gogunda and Badgoan blocks in Udaipur district
Target Population	Women of reproductive age group and adolescent girls; children below five years of age
Project Life	1997-2008 (ongoing)
Budget	Rs.1 lakh per clinic for set-up (including equipment, furniture, drug fund, etc.); Rs. 5 lakh per clinic as operating cost
Implementing Partners	Funded by Sir Ratan Tata Trust and MacArthur Foundation and is implemented by Action Research and Training for Health (ARTH)
Existing Evaluations	Not available
Documents Reviewed	Action Research and Training for Health. Nurse Midwives for Maternal Health: Experience in Southern Rajasthan. Udaipur: ARTH. 2005 Action Research and Training for Health. Clinic Performance Data. Udaipur: ARTH unpublished, 2005-2006) Action Research and Training for Health. Documents pertaining to Materials, Technology, and Financial Efficiency. Udaipur: ARTH (unpublished, 2006-2007) Roy N. Provision of Essential Maternal and Child Health Services, Rajasthan. PROD Reference No. 176. Policy Reform Options Database. 2006

Objectives:

1. To improve maternal-neonatal health and survival of communities living in remote areas where health facilities are not available.
2. To increase access to safe deliveries by locating midwives trained in safe motherhood and neonatal health interventions in a rural community.

Strategies: Five nurse-midwives manage two health centres and provide 24-hour delivery and obstetric first aid services. The key strategies include:

1. Practical hands-on clinical and counselling training in a range of RCH issues including first aid for obstetric emergencies, reversible contraception and neonatal and child care.
2. Use of standard guidelines and protocols adapted to Rajasthan setting.

3. Pairing of nurse midwives at a health centre, guaranteeing 24/7 services and reducing the feeling of isolation.
4. Providing mobility to nurse midwives by placing a health worker-cum-driver with motorcycle in the health centre.
5. Subsidies to poor women and children who need referral to a district hospital.
6. Arrangement for assisted referral.
7. Mobilisation of men and Panchayats to take greater responsibility for maternal health care through community volunteers.
8. Support from doctors who visit NM clinics one to two times every week.
9. Regular supply of drugs and consumables.
10. An escort to accompany nurse midwives for home visits and for referrals in the night.

Outcomes: ARTH has a very competent MIS system that monitors performance data from its clinics every month. The data is then evaluated and published by ARTH annually. The comparison of data from 1998-1999 and 2004-2005 shows:

- An increase in uptake of institutional delivery in the area (from 12% in 1999 to 38% in 2005), especially among socially and economically marginalised (from 3% in 1999 to 13.8% in 2005) communities
- Nurse/midwife-conducted delivery increased from 1.6% in 1999 to 20.7% in 2005
- Stillbirth rate of 28.9 and NNMR of 37 per 1,000 live births, respectively, way below the established averages of 30.9 to 32 stillbirths and 49 per 1,000 live births (for Rajasthan)
- Increase in health services uptake among tribals:
    - ANC: 18% in 1999 to 73.9% in 2005
    - TT: 45% in 1999 to 70% in 2005
    - IFA : 40% in 1999 to 71% in 2005

Lessons learnt: The ARTH intervention demonstrates the effectiveness of enabling nurse midwives in managing community-based MCH centres. Factors that appear to contribute to the outcomes include mechanisms to enhance community mobilisation; mobility support to nurse midwives; well functioning clinics; attending home deliveries where preferred, but maintaining quality of care; high levels of competency-based training and, most important, the strong back-up and referral mechanisms including transport. ARTH employed spouses of nurse midwives as co-workers, thus incentivising them to stay in the vicinity of the clinics. Encouraging nurse midwives to participate in management decisions and operational issues enabled increased ownership and retention in the organisation.

Conclusions: The model demonstrates that well trained nurse midwives can provide a broad range of MCH services to populations living in remote areas. The ARTH model appears to have a two-fold potential: enable existing Government sub-centres to incorporate some of the features and identify areas where NGOs can be contracted to run similar centres. However, the profile of the organisation should be similar to ARTH and the nature of

training, participatory decision-making and strong back-up support should be essential features. The overall operating cost needs to be differentiated as set-up and running costs.

Title	Chiranjeevi Yojana
State	Gujarat
Geographic Area of Coverage	Pilot implemented in five districts of Gujarat—Kutch, Banaskanta, Sabarkanta, Godhra and Dahod—now in all 25 districts
Target Population	Pregnant women from BPL families
Project Life	Pilot: December 2005 to January 2007, scaled up in all 25 districts of the State from January 2007
Budget	Rs. 110 million for Year One in five districts Rs. 506 million for the entire State/year
Implementing Agency/Partners	Commissionarate of Health, Medical Services, Medical Education and Research, Health and Family Welfare, Government of Gujarat
Existing Evaluations	Independent rapid qualitative assessment of Chiranjeevi Yojana by UNFPA, 2006, after six months of operation
Documents Reviewed	Rapid assessment of Chiranjeevi Yojana, UNFPA, 2006 Maternal Health Financing—Issues and Options, A study of Chiranjeevi Yojana, IIM-A, Working Paper series, March 2007 Government of Gujarat, Department of Health website, accessed 11 July 2008

Objectives: The Chiranjeevi Yojana is a PPP scheme to enable access to women for institutional delivery. The key objectives of the scheme are to:

1. Increase access of BPL women to institutional deliveries.
2. Negotiate partnerships with the private sector in order to increase the proportion of institutional deliveries.

Strategies: The scheme was originally designed for implementation in five poorly performing districts and was subsequently scaled up statewide. The strategies include:

1. The Chiranjeevi Yojana is targeted towards BPL women. The initial pilot was restricted to districts where there were sufficient numbers of private health facilities.
2. Community and Panchayat involvement in raising awareness and provider identification.
3. The scheme provides financial incentives to providers in the private sector to offer obstetric services. Under the Chiranjeevi Yojana, private providers (who meet a set of pre-identified criteria) are contracted at the district level (health system and Zilla Parishad) through a fixed pricing mechanism for the provision of obstetric services, including comprehensive obstetric care. At present the Chiranjeevi Yojana does not provide services for newborn care or post-partum follow-up or family planning services.

4. The contract with each provider is for a maximum of 100 deliveries at a cost of Rs. 179,500. This includes the estimated cost of both normal and complicated deliveries. In case the private provider opts to provide services at a public sector facility, the cost works out to Rs. 169,500 for 100 deliveries. The scheme also covers the costs of transport (Rs. 200) and an incentive of Rs. 50 for the person accompanying the woman.
5. The district health officer's role has moved from being a service provider to that of facilitator and organiser.

Outcomes: The data from the Government of Gujarat's Department of Health website (February 2008) indicates the following:

- 852 of a total of 2,000 obstetricians/gynaecologists enrolled in the scheme
- Total deliveries conducted under the scheme in the five districts: 165,278, of which 143, 882 were normal deliveries with a C-section rate of 6.21%
- Complicated deliveries accounted for 6.72% of total deliveries

The role of the district officials is that of enrolling private providers in the scheme, coordinating and monitoring all components of the scheme. The coordination and monitoring of the scheme is complex but has been clearly defined for all levels of the public health system from village to district. The providers appear to be technically competent although there has been no training of empanelled providers in standard treatment guidelines. The scheme has now been scaled up to all 25 districts of Gujarat.

Lessons learnt: Evaluations conducted in the pilot districts demonstrate that engaging private providers to provide obstetric care has resulted in increasing institutional delivery. Commitment and competency in managing the schemes appears to be highest at the State level and appears to gradually diminish at the block levels and below. District Medical Officers (DMOs) now include facilitation and organisation of obstetric services through the Chiranjeevi Yojana in their work. The effect of the Chiranjeevi Yojana has also been that the number of deliveries in the public sector has declined. However, the scheme needs to also focus on providing the other components of the Safe Motherhood package, for example, antenatal and postnatal care, family planning to women, in addition to institutional delivery. Although technical competency among providers has not been found wanting, they would benefit from being sensitised to standard protocols in accordance with national guidelines.

Conclusions: The Chiranjeevi Yojana appears to have substantially increased institutional deliveries in the five pilot districts, with relatively low C-section rates. Where private providers are available and willing to be involved in this form of demand-side financing, the Chiranjeevi Yojana holds potential for scaling up. Given that the Chiranjeevi Yojana provides incentives to the private sector only for the single event of institutional delivery, more data is required on how this impacts care seeking among the same target population for other reproductive conditions such as RTIs, other gynaecological morbidities, medical termination of pregnancy, or even family planning services.

ANNEXURE 3.1.3

Janani Suvidha Yojana

Title	Janani Suvidha Yojana
State	Haryana
Geographic Area of Coverage	Urban slums in eight districts
Target Population	Women and children in BPL category living in urban slums
Project Life	2005-2006 and ongoing in 2008
Budget	Rs. 50 lakh (2005-2006); Rs. 2 crore each proposed in 2006-2007 and 2007-2008 (Source: State PIPs for respective years)
Implementing Partners	Government of Haryana, MNGOs and FNGOs
Existing Evaluations	None. External evaluation planned in 2008-2009
Documents Reviewed	Concept note—Excerpts from PIP Status report of Delivery Hut and JSY, up to August 2007

Objectives: Janani Suvidha Yojana is a voucher scheme for maternal and child health services in private health facilities for the urban poor in Haryana. The key objectives are:

1. To make quality mother and child health services accessible to the needy.
2. To provide high maternal and child health services including drugs, supplies and diagnostic facilities to the urban poor.
3. To optimally utilise the existing resources in health.

Strategies: The scheme involves the private sector as well as the network of NGOs created under the MNGO scheme**.** The strategies include:

1. The scheme is being implemented through a network of MNGOs and FNGOs who are responsible for community sensitisation, voucher distribution and ensuring redemption of vouchers to the private health providers.
2. The NGOs are expected to engage a worker called Sakhi who is responsible for the identifying and escorting of women and children in need of services to the private health facility.
3. The District Health Service (DHS) provides drugs and vaccines free of cost to the private health providers.
4. A package of maternal and child health services are provided through the private health providers who are identified, based on a set of criteria.
5. Referral linkages are established and referral cards are provided to the patients.

Outcomes (as in January 2008):

- NGOs and private health providers identified
- 666 Sakhis for community mobilisation
- 28,507 pregnancies registered

- 6,445 instututional deliveries, of which 5,796 are normal deliveries and 649 were C-section deliveries
- 118 private providers empanelled under the scheme

Lessons learnt: There are no evaluation or implementation programme documents so far that allow for assessment of lessons learnt. The State has planned an external evaluation of the scheme in 2008-2009 (as stated in State PIP, 2008-2009). However, the outcomes over the 18-month period show that FNGOs are registering pregnant women and private facilities are being increasingly used by women. It appears that the MNGOs and FNGOs are critical to the functioning of the scheme. More information is required to assess the issues of service quality, compliance with standards protocols, streamlining of voucher distribution and redemption.

ANNEXURE 3.1.4

Delivery Huts in Haryana

Title	Delivery Huts to Increase Geographic Access
State	Haryana
Geographic Area of Coverage	Delivery huts in 476 villages across the States
Target population	Pregnant women
Project Life	Since 2005-2006 and ongoing in 2008
Budget	Rs. 300 lakh in Year One
Implementing Partners	Government of Haryana
Existing Evaluations	None; external evaluation planned in 2008-2009 (Source: State PIP)
Documents Reviewed	Excerpt from PIP for the year 2005-2006 Status Report of Delivery Hut and JSY, up to August 2007

Objectives: Institutional delivery in Haryana at the time of the design of the scheme was about 28% (2005-2006). The rationale for building delivery huts is that sub-centres and other institutions that provide safe delivery are too far for women to access. The key objective is to ensure functioning facilities for delivery close to women's houses to promote the number of institutional deliveries.

Strategies: The strategic choice of the village in which to establish a delivery hut is that an ANM or staff nurse is resident in the village and it is the headquarter of either the sub-centre or PHC. The cost of one delivery hut is estimated at Rs. 1 lakh and includes both capital and recurring costs for one year.

Outcomes: The key outcomes based on data from the Status Report (August 2007) and State PIP (2008-2009):

- 476 delivery huts available in the State as in January 2008
- Institutional deliveries in Haryana (in both the Government and private sector) has increased sharply—from 28% in 2005-2006 to 53.18% (until August 2007)
- Total of 44,019 deliveries conducted and 6,633 cases referred (up to January 2008)
- The delivery huts also provide birth certificates, BCG and zero dose polio; 41,957 birth certificates issued and 41,492 newborns administered zero dose polio (till January 2008)

Lessons learnt: Although there is no descriptive narrative available on the design or of the actual implementation details, it appears from the outcome data that overall there has been an increase in the number of deliveries and the delivery huts account for about 44,000 deliveries. Thus it would appear that the huts have addressed the barrier of geographical access responsible for high home deliveries. The quality of care provided at the huts, the

extent to which the facility reached the poor and marginalised and the nature of referral linkages, including transport for obstetric emergencies, need to be assessed.

Conclusions: This description is based on very little documentation. However, the scheme is recommended for in-depth review because of the opportunity to test out a second stage pilot in other parts of the country, which have limited access to institutional delivery.

ANNEXURE 3.1.5

Vouchers to Increase Institutional Delivery—Uttar Pradesh, Uttarakhand

Title	Vouchers to Increase Institutional Delivery
State	Uttar Pradesh, Uttarakhand
Geographic Area of Coverage	Seven rural blocks in Agra, 360 urban slums in Kanpur, two rural blocks in Haridwar—supported by USAID Two rural blocks in Bahraich—supported by the World Bank
Target Population	Pregnant women, infants
Project Life	Agra: March 2007, ongoing Kanpur: March 2007, ongoing Hardwar: May 2007, ongoing Bahraich: July 2007, ongoing
Budget	Bahraich: Rs. 8,796,100, co-funded through Janani Suraksha Yojana, Kanpur Nagar, for two years: Rs. 40,992,275
Implementing Partners	Futures Group (overall design, technical support and substantial management support), NGOs, private sector hospitals, Bahraich: Uttar Pradesh Health Systems Development Project
Existing Evaluations	No evaluations; however, the scheme was reviewed in-depth during a broader evaluation of IFPS II in September 2007
Documents Reviewed	• Proposal for implementation of the voucher scheme in Kanpur • IFPS 2 evaluation report • Power Point presentation on voucher scheme, dated • Power Point on voucher scheme in Agra, 20 June 2008, USAID partner meeting

Objectives: The premise of the scheme is that the provision of vouchers to BPL women would entitle them to a maternal health package of high quality and at no cost to them, and significantly increase the motivation of the private sector providers to serve women in this category. The design of the model varies in different areas. While the USAID supported intervention is primarily through the private sector, the World Bank supported scheme is through the public sector. The key objectives are:

1. Improve demand and service coverage for a predetermined RCH service package (ANC, PNC, delivery, family planning, child immunisation and RTI/STI management).
2. Accredit private health facilities to provide services to BPL families.
3. Create and manage a voucher system through a network of stakeholders, including NGOs, the district health system and the private providers.

Strategies: The key strategies include:

1. The voucher scheme covers three antenatal visits, (check-up, TT injection, IFA tablets and nutritional counselling), institutional deliveries (normal and

caesarean), two postnatal visits, family planning services (sterilisation, IUD, condoms and pills), child immunisation, RTI/STI check-up and treatment, partner counselling and diagnostic tests. The cost of each one of these services is clearly laid out in the project document.

2. ASHAs—the key functionaries in the voucher scheme—are expected to: disseminate information on the voucher scheme in the community; identify and register pregnant women from BPL families; plan for appropriate health services needed for pregnant women; distribute the vouchers; accompany the women (and the children) to the service point with the voucher; arrange for transport on the day of delivery; carry out beneficiary feedback; maintain beneficiary records; liaison with the ANMs, AWWs and other community-based functionaries and provide counselling to the beneficiary.

3. NGOs have been appointed as independent agencies to co-ordinate between the public and the private sector and to supervise and monitor the quality of care. These NGOs are responsible for the appointment, training and supervision of ASHAs in the scheme.

4. The vouchers (serially numbered, with holographic stickers to prevent counterfeiting) are provided to pregnant women through a chain involving NGOs and ASHAs.

5. The private hospitals receive supplies (contraceptives, IFA and vaccines) from the Government.

6. In case of delivery complications, the patient is transported to the district hospital.

7. A Voucher Management Agency (VMA), which functions under the Project Advisory Committee (PAC), chaired by the District Magistrate (DM) or Chief Medical Officer (CMO), controls the overall management of the scheme including: identification of the beneficiaries; identification and accreditation of private nursing homes interested in participating in the voucher scheme; conducting training programmes for staff of accredited institutes on quality standards; developing a financial disbursement system for advancing and/or reimbursement of funds to private hospitals; managing project MIS; conducting periodic quality audits and carrying out beneficiary feedback.

8. In Agra, the State-run medical college (SN Medical College) has been entrusted with the task of accrediting, training and monitoring the quality of services in private nursing homes.

9. The system of management of the voucher scheme is similar in both Agra and Haridwar. However, in Agra, SIFPSA (through its district project management unit or DIFPSA) assists the CMO in the management of the scheme. The entire voucher scheme is implemented through SIFPSA with substantial technical support from ITAP (Futures Constella).

Outcomes: More than 1,500 ASHAs have been identified and trained under the voucher scheme in Agra. Under the voucher scheme in Uttarakhand, July-September 2008:

- 3,720 pregnant women registered
- Institutional deliveries increased from 81% (January-March 2008) to 87.5% (July-September 2008)
- Number of children receiving complete vaccination: January-March 2008—1,080; April-June 2008—1,150; July-September 2008—1,113

Lessons learnt: The scheme in Uttarakhand and Uttar Pradesh has been under way for about one year. In Agra, there is a need to pay immediate attention to many of the operational problems in the voucher scheme. These relate to the high proportion of caesarean deliveries, long waiting period, segregation of the BPL patients, low inventory of vouchers in stock, and implementing a uniform quality measurement tool for all the private hospitals. The project management unit or VMA needs to spare more efforts in supervising and monitoring of private health facilities, patient feedback and in redressing grievances from the beneficiaries. Newborn care is a critical service that needs to be included in the voucher scheme.

Conclusions: It is likely that some of these challenges are teething troubles but other issues need consideration and perhaps refinement of the model. Although the State intends to scale up the model, information on appropriate private sector facilities is necessary and the presence of committed NGOs essential. Accreditation and regulation of the private sector in India and Uttar Pradesh is nascent at best, and needs to be a key consideration in any PPP. Information on the individual cost of the numerous components of the model would help obtain a true assessment of costs. Several pilots using vouchers as an alternate financing mechanism are under way. However, more time is needed for implementation before a rigorous assessment of the model is undertaken.

ANNEXURE 3.1.6

Ayushmati Scheme

Title	Ayushmati Scheme
State	West Bengal
Geographic Area of Coverage	Pilot project in 11 districts
Target Population	Pregnant BPL, SC/ST women
Project Life	Started January 2007-2008, ongoing
Budget	Rs. 481 lakh in 2007-2008; Rs. 400 lakh (2008-2009)
Implementing Partners	Government of West Bengal
Existing Evaluations	None
Documents Reviewed	Design document

Objectives: The Ayushmati scheme is substantially similar to the Chiranjeevi Yojana of Gujarat. The goal of the scheme is to reduce the incidence of maternal mortality and morbidity. The overall objective of this PPP is to increase the number of institutional deliveries by partnering with private sector service providers/facilities empanelled against certain pre-determined criteria and ensure quality of service delivery in the empanelled private sector facilities through stringent monitoring and supervision. The key objectives are:

1. Enable free institutional delivery services to all BPL women and women in SC/ST categories.
2. Increase the number of institutional deliveries by partnering with private sector facilities empanelled for the purpose.
3. Ensure quality of service delivery in the private sector facilities by stringent monitoring and supervision.

Strategies: The scheme recognises the potential of the private sector to provide services. The roles and responsibilities of the private partners are clearly defined. The key strategies include:

1. The nature of the PPP will be governed by a contractual agreement between the District Health and Family Welfare Samiti and the private partner.
2. The agreement would be valid for one year, with the responsibility of provision of space, infrastructure, appropriate human resources and equipment being the responsibility of the private provider.
3. Establishing a set of clearly defined standards and protocols.
4. Facilities to be graded, empanelled and reviewed periodically by external reviewers.
5. Reimbursement will be made to private facilities on a capitation fee basis, according to which they get a fixed rate for a package of 100 deliveries and diagnostic tests.

Outcomes: (Source: State PIP, 2008-2009)

- Launched in 11 districts and under way in 15 districts; 25 maternity homes have been selected for provision of services under the Ayushmati scheme
- 24 nursing homes in the 11 selected districts have already signed contract under PPP and have started implementing the scheme
- 1,225 deliveries have already been reportedly conducted during 2007-2008. In 2008-2009, the State plans to opertaionalise the scheme through 180 nursing homes, targeting 20,000 deliveries for the year (Rs. 2,000 per delivery)
- 2,896 deliveries have been conducted as of September 2008

Lessons learnt: Although no formal evaluation of the scheme has been undertaken so far, it appears that the partnership with the private sector has led to increased accessibility to maternal health services in the underserved remote districts. The increasing trend of institutional deliveries in the State also substantiates the contribution of the scheme towards the improved outcomes.

Conclusions: The scaling up of the Ayushmati scheme from 11 to 15 districts indicates that the scheme has met with a fair amount of success. It will be useful to focus on the quality of service delivery in the case of the private service providers. A monitoring mechanism needs to be established for capturing data on outcome indicators of the scheme.

ANNEXURE 3.1.7

Convergence Model: NRHM-KSAPS ANC-PPTCT Programme in Karnataka

Title	Convergence Model, NRHM-NACO: ANC-PPTCT Programme
State	Karnataka
Geographic Area of Coverage	All the 29 districts in Karnataka right up to PHC level
Target Population	All the ANCs from second trimester of pregnancy
Project Life	2008-2012
Budget	Annual budget of Rs. 6.5 crore
Implementing Partners	NRHM, Karnataka and Karnataka State AIDS Prevention Society, NACO
Existing Evaluations	Mid-term evaluation of GFATM Round-II Project by NACO through Development and Research Services Pvt. Ltd., New Delhi
Documents Reviewed	Mid-term evaluation report of GFATM Round-II Project by NACO through Development and Research Services Pvt. Ltd.

Objectives: The key objective of the model is to ensure full ANC coverage of all pregnant women; identification of HIV positive women and infants and provision of services through coordination with NACO.

Strategies:

1. Testing 100% of the ANCs in the second trimester of pregnancy at PHCs after seeking their consent was worked out. The strategy employed to cover 100% of all ANCs was through the ANMs who would be registering all ANCs in their jurisdiction and then mobilising all second trimester and above ANCs to the PHCs on the stipulated date based on the weekly roster. The testing at the PHCs would be undertaken on Thursdays, the regular ANC check-up day, through a rotational weekly roster basis by the ICTC Counsellor and Lab Technician from the jurisdictional ICTC.
2. The MOs of the PHCs would be responsible for ensuring the efficient management of their services and the resources (of the NRHM and KSAPS) at their disposal and ensuring that the ANC seeking women are provided a meal during their visit.
3. Fee service to be provided to HIV positive women at the YNH for deliveries through the Yeshaswini scheme. All hospitals, both YNH and the public sector hospitals, where HIV positive women choose to deliver, will ensure that NACO's PPTCT protocols are followed and the ANMs will ensure that the mother-baby pairs are followed-up for 18 months postnatally when the baby's HIV status would be finally known.
4. Special camps to be held for covering the backlog of ANCs. This campaign approach to cover the urgent backlog of ANCs commenced from August 2008

and till date 46,231 ANCs were counselled and tested at the PHC level, out of which 199 ANCs were found positive.

Outcomes:

The convergence of NRHM-KSAPS activities for the ANC PPTCT programme in Karnataka has had a tremendous impact on the number of ANC cases registered in health facilities, for pre-test counselling, HIV testing and for those who were detected positive and for providing them the complete package of services available under the PPTCT programme by NACO. This will have a positive impact on the mother, child and ultimately on the family and the State. It will help greatly in achieving the NACP-III goals and reduce the burden of HIV/AIDS on the State and will contribute significantly in achieving the objectives of NACO as well as those of the NRHM in Karnataka.

The outcomes of the the NRHM /KSAPS convergence activities since April 2008:

January-March 2008

Number of pregnant women who registered for ANC in the health facilities—2,1372
Number of pregnant women who attended the pre-testing counselling—18,335
Number of pregnant women who accepted the HIV test—1,7735

April-August 2008

- Number of pregnant women who registered for ANC in the health facilities—200,197
- Number of pregnant women who attended the pre-testing counselling—209,760
- Number of pregnant women who accepted the HIV test—183,644
- Number of ANC registered women who were found positive—1,902,178

Till date, 562 ANCs have registered under the Yeshaswini scheme whose third party managers are Family Health Plan Limited (FHPL). Out of 562 registered ANCs, 22 have already delivered in YNHs: eight normal deliveries and 14 caesarean sections

There are plans to upscale PPTCT activities at 300 24/7 PHCs by training the three staff nurses and the laboratory technicians in HIV counselling and testing by November 2008. This, in addition to the activities mentioned through outreach activities at other PHCs, would ensure 100% coverage of all ANCs for HIV counselling and testing and thus reduce the burden of disease in women and children. It will contribute significantly to the goals and objectives under NACP-III. Over the next few years there are plans for the establishment of ICTCs in all the 24/7 PHCs in Karnataka.

Lessons learnt

The strategy of convergence by KSAPS with the NRHM has proved that the combined efforts by all concerned stakeholders in the Government yield far more concrete, far -reaching and superior results, than the sole efforts of the total workforce involved within

individual programmes and departments. It inculcates a sense of collective responsibility by concerned stakeholders in the public sector, decreasing the burden of the workload and responsibilities on only a few officials.
The synergistic co-ordinated efforts facilitate effective programme implementation and stimulate inter-departmental and inter-sectoral interaction. This builds a good working relationship and a healthy environment for improved and sustained progress.

Conclusions: The convergence model has demonstrated that collaborative work is much more cost-effective than fresh investments. The desired results can be achieved through the readily available workforce and resources of different programmes within the concerned departments. However, in order to scale up the programme, availability of manpower, logistics, periodic training to all relevant staff, supportive supervision and mentoring of the concerned staff will be necessary. Periodic evaluation by external agencies will be useful. Integration of ICTC activities with mobile health clinics to ensure coverage in inaccessible areas, intensifying IEC activities on PPTCT programmes (through mass media) and the establishment of ICTCs in all 24/4 PHCs, will yield benefits in the coming years.

ANNEXURE 3.2.1

Janani Express Yojana

Title	Janani Express Yojana
State	Madhya Pradesh
Geographic Coverage	Phase 1: Piloted in August 2006 in two blocks in 10 districts Phase 2: June 2007—covers 204 of the total 313 blocks in the entire State
Target Population	All pregnant women and any medical emergency needing transport, free services for BPL, charge for others
Project Life	August 2006-ongoing
Budget	Funds made available from Janani Suraksha Yojana and Rogi Kalyan Samiti
Implementing Partners	Government of Madhya Pradesh, UNFPA
Existing Evaluations	Evaluation commissioned by UNFPA, June 2007
Documents Reviewed	Evaluation report

Objectives: The Janani Express Yojana is a model of PPP with the district health authority contracting out transport to private vehicle owners in the district. The key objectives are:

1. Provision of transportation services for obstetric services and other medical emergencies.
2. To increase access to institutional delivery.

Strategies:

1. The DHS contracts with a vehicle owner, to provide at a pre- specified cost, transport services for women in case of delivery, pregnancy related complications, MTP and to other individuals with any form of medical emergency that necessitates treatment in a health institution.
2. The vehicle is expected to be stationed at a block level facility and available round-the-clock. The responsibility of maintenance and meeting operating costs is that of the driver/owner. The owner of the vehicle is expected to deposit Rs. 10,000 with the Rogi Kalyan Samiti, ensure 24/7 availability and make alternative arrangements in cases of breakdown.
3. The costs are fixed at Rs. 150 for a distance up to 25 km and Rs. 250 beyond that. Beyond travel of 1,200 km/month the vehicle owners are entitled to an incentive categorised into slabs.
4. Janani Express Yojana services are free of cost for BPL patients. APL patients are expected to pay at the rates mentioned above.

Outcomes: The evaluation report states that 54,202 women have used the scheme. A significant proportion of Scheduled Tribes (36.4%), Scheduled Castes (18.6%) and Backward Castes (32.9%) availed of the scheme. Roughly half the clients using the scheme were for delivery. Over 50% of the clients belonged to the BPL category. The scheme has enabled multiparas to access institutional delivery for the first time. 61% of women, delivering their second baby, accessed institutional delivery for the first time and 72% of women, delivering their third baby, accessed institutional delivery for the first time. Overall the scheme seems to enjoy high political and popular support.

Lessons learnt: The scheme fills a critical gap in meeting the delays on account of lack of transport for obstetric emergencies, recognised as a key contributor to maternal mortality. Political commitment for the scheme is very high and there has been intensive involvement of senior officials. Protocols and guidelines are fairly well developed. High levels of publicity to the scheme prompted community awareness and resultant high usage. The scheme has not yet been instrumental in enabling women to access services for emergency obstetric care. Only 3.2% of cases were those requiring emergency obstetric services. Given that this is a first-time initiative, there have been long delays between the selection of vehicles and actual operationalisation of the scheme. Vehicle owners have been slow to customise/modify vehicles for ambulance specifications. The financial procedures appear to be complex and reporting requirements onerous. One of the issues is that although the vehicle is supposed to cover the return of the woman to her residence, only 10% of women were transported because of insufficient funding. The private owners have not provided the vehicle drivers with mobile phones, resulting in frequent changes in phone numbers and confusion in the community.

Conclusions: The scheme appears to have fulfilled a critical need for reduction of maternal mortality, improving safe motherhood and also for transport of other medical emergencies. In order to scale up, management, pricing, contractual and monitoring processes would need to be streamlined to ensure continuing equity and access at the scaled-up level.

ANNEXURE 3.2.2

Call Centre and Ambulance Network

Title	24/7 Emergency Transport and Call Centre
State	Madhya Pradesh
Geographic Area of Coverage	Guna district
Target Population	Pregnant women to enable institutional deliveries (20,000 pregnant women in 2008)
Project Life	September 2007, ongoing in 2008
Budget	Rs. 5.4 lakh in 2008-2009, co-founded through Janani Suraksha Yojana's transport component
Implementing Partners	District Health Society, UNICEF
Existing Evaluations	None
Documents Reviewed	Power Point presentation

Objective: The objective of the 24/7 emergency transport and call centre is to provide rapid and readily available transport for women and sick children to reach health care facilities for institutional deliveries and health care.

Strategies:

1. Round-the-clock emergency transport, which the community can access through a call centre set up in the district hospital, with a toll-free number—102.
2. Vehicles pooled from various sources at the district level. Each is equipped with a mobile phone and connected to the call centre.
3. The intervention also includes IEC throughout the district to communicate the toll-free number to all villages.
4. The fuel cost of the transport is taken from Janani Suraksha Yojana and hence this service is made available free of cost.

Outcomes:

- A total of 5,026 women have been transported free of charge
- Twenty-four vehicles have been pooled from various sources

Lessons learnt: Intensive management support, a well run call centre readily accessible to the community, a committed pool of ambulance vehicles, ready availability of ambulances and a commitment to ensure emergency services at the facility have resulted in positive outcomes.

Conclusions: The call centre and ambulance scheme is in many respects similar to the EMRI, the Dholpur model of Rajasthan and several others being tried out in other areas. Scaling up the scheme to the State-level requires a scaling-up strategy with clear-cut

guidelines for the call centres, ambulances, capacity building of grassroots functionaries and facility preparedness.

ANNEXURE 3.2.3

Ambulance Services

Title	Ambulance Services
State	West Bengal
Geographic area of Coverage	Statewide
Target Population	All pregnant women and any medical emergency needing transport
Project Life	March 2005: PHCs, Block PHCs and Rural Hospitals in eight districts,133 sites November 2006: cover all blocks in the State
Budget	Not known
Implementing Partners	District Health Societies and NGOs
Existing Evaluations	Public Private Partnership Review, May 2008
Documents Reviewed	Public Private Partnership Review Report, May 2008

Objectives: The key objectives of the ambulance services are:

1. To develop cost-effective ambulance services for transporting accidents, emergency and other patients to appropriate referral medical centres in the districts of West Bengal
2. To establish a sustainable system of emergency transportation, operated professionally and cost-effectively by NGOs/CBOs/Trusts

Strategies:

1. The District Health Societies have entered into five-year agreements with local NGOs to manage the ambulance services.
2. Ownership of the vehicles is with the public sector that purchases, refurbishes and then hands over the vehicles to the NGOs.
3. The vehicles are expected to be stationed at the Block PHCs or Rural Hospitals and to be available round-the-clock.
4. Drivers are provided with handsets
5. Awareness-raising in the community is through notices in the Panchayat office, in the marketplace, medicine shops and clinics of medical practitioners.
6. All ambulances are expected to post one attendant trained in first aid in addition to the driver.
7. Fees for the ambulance service are fixed by the District Health and Family Welfare Samitis between Rs. 5 and Rs. 6 per km. Minimum charges of Rs. 100 for 15 km and waiting charges are also fixed.
8. The choice of referral to a public or private sector facility is up to the patient.

9. Monitoring is through the maintenance of the logbook, request for ambulance form, money receipts and monthly reports. They are to be submitted to the DMO.

Outcomes: The usage of vehicles varies across the districts. Key outcomes include:

- Increased caseloads indicating improved community awareness on the scheme
- One-third of all cases were pregnancy- and delivery-related
- Proportion of BPL cases transported (in three blocks) ranges from 35% to 57%
- 133 ambulances operating under the Basic Health Project and 201 ambulances under HSDI for emergency transport under management of NGOs/CBOs at the level of BPHCs
- All ambulances are equipped with mobile phones

Lessons learnt: Since all vehicles have been purchased and outfitted appropriately by the Government, ownership rests with the Government. The time to function after the signing of the contract appears to have been impressively short. The Government has insured all vehicles for a five-year period. The NGOs are responsible for maintenance and operational costs. In general, ambulances are well maintained. There is no mention of an exit or penal clause. None of the vehicles have annual maintenance contracts. The contracts stipulate that the NGOs hire an attendant trained in first aid; however, none of the NGOs have appointed attendants. The rates compare favourably with those in the commercial private sector. Private vehicle owners also provide credit facilities and the choice of payment is lump sum rather than a per kilometre-based rate with additional waiting charges. Ambulance caseload varies widely from district to district and there is a correlation between caseloads and off-days, with districts having low caseloads with a high number of off-days. In some cases the ambulance is used for various purposes other than emergency transport. Not all NGOs maintain data on the use of the ambulance by economic category. Where they do, it appears that between one-third and half the cases belong to the BPL category. Despite being on par with the market rate, the ambulance is still too expensive for some categories of the population. They tend to use rickshaw vans that are much cheaper. Apart from a few exceptions, the monitoring system appears to be working well.

Conclusions: Overall the review that was conducted in four districts, with its focus on standard operating procedures, provides some information on the functioning of the ambulance service. However, it is difficult to assess how the scheme is being implemented at scale and whether the monitoring and evaluation processes enable measurement of impact or outcomes. For instance, the underlying reason for differential caseloads or for off-days is not clear from the review. Both these are important in considerations of viability. Data on reach and equity are also missing. Perspectives of DMOs on scheme management need to be considered, particularly their assessments of the strengths and challenges.

ANNEXURE 3.2.4

Rural Emergency Health Transportation Scheme/Emergency Medical and Relief Initiative

Title	Rural Emergency Health Transportation Scheme/EMRI (108)
State	Andhra Pradesh
Geographic Area of Coverage	Pilot implemented in five major cities of Andhra Pradesh—Hyderabad, Secunderabad, Vishakapatnam, Vijayawada and Tirupati—now scaled up to the entire State
Target Population	General population, however, with an objective to include families in the remote areas and BPL; approximately eight crore population covered
Project Life	Pilot: August 2005, scaled up and ongoing
Budget	Rs. 50 million seed funding by Satyam Foundation Rs. 10 million for entire State/year, including Rs. 2 million for procurement of new ambulances by the State
Implementing Agency/Partners	Satyam Foundation with funding from the Government of Andhra Pradesh
Existing Evaluations	No external evaluations done. Most data presently available are from in-house monitoring and analysis
Documents Reviewed	Observations based on field visit to EMRI by MSI/PFI team

Objectives: The EMRI is an emergency response management service programme in Andhra Pradesh implemented by the Satyam Foundation. The objectives of the service are:

1. Provide optimum pre-hospital care to the patients in need of emergency care.
2. Design nodal emergency service programmes.
3. Improve emergency care in hospitals triggered by increased referral of patients by EMRI.
4. Link the rural population to tertiary health care systems.
5. Work on sense-reach-care approach, which includes coordination between the emergency response centres, ambulance transport of the patient and pre-hospital treatment in the ambulance that aims at prevention of an emergency and stabilising the patient before handing over to a hospital.

The Satyam group supported the implementation with around 200 software engineers to develop the call centre systems and software for GPRS, tracking and aligning with the medical information systems and the legal system. The Satyam Foundation started work with 70 ambulances in five towns. The Government of Andhra Pradesh transferred 122 ambulances to the EMRI after the MoU with the Government in 2005.

Strategies:

1. The ambulance has been modified for the Indian scenario with the addition of cutters, ropes and other hardware material; anti-snake venom, a cold box for

carrying certain drugs; suctioning instruments that are used in poisoning cases; increased space for transporting multiple patients in case of road traffic accidents, training of the ambulance driver (pilots) in safe moving and lifting of the patients.

2. Presently all the drugs are procured through the State.
3. In case of road traffic jams and traffic snarls, a PRIME response has been instituted, where a paramedic in a two-wheeler with a resuscitation kit reaches the emergency site to provide first aid even before the ambulance reaches.
4. A team of two people for two morning and two night shifts per ambulance. The driver is in-charge of the ambulances.
5. Maintenance is centralised and is done by the ambulance executives who help in keeping the ambulance in 'load and go' mode.
6. In-house research is ongoing in the area of monitoring results, introducing operational methodologies of other systems such as GPRS and software, into emergency response management and incorporating new systems. Monthly reporting is to the Government of Andhra Pradesh.
7. The geographic coverage of each ambulance is fixed. Most awareness programmes are through advertising campaigns. Some planned demonstration and promotional activities are carried out by the ambulance staff.
8. The EMRI is working with the local bodies on institutional capacity building and with the Government to train paramedics and doctors in Government hospitals in accident and emergency care; orienting police personnel and conducting a six-week training course for the staff of local hospitals and ambulances.

Outcomes:

- The EMRI has enrolled 6,010 staff including call centre associates, doctors, paramedics, drivers and 732 ambulances. One ambulance makes around eight trips a day
- An ambulance is mobilised in less than three minutes after receiving a help call. The average reach time of the ambulance is 14 minutes in urban areas and 21 minutes in rural areas. The emergency toll-free number is made available to approximately eight crore people
- Emergency cases attended during 2007-2008: 5.93 lakh
- Total lives saved: 20,165
- MoU with 4,000 hospitals and nursing homes in different parts of Andhra Pradesh and 1,500 police stations linkages
- Presently cover 147 million people and around 5,700 emergencies have been handled. Pregnancy-related, labour: 22% (about 130 deliveries in the ambulance)
- Andhra Pradesh has an MMR of 197 and the EMRI reportedly has reduced the MMR by 23%
- Ambulance use by SC/ST/BC socioeconomic categories is 83%

Lessons learnt: The EMRI model with its tol- free number and ambulance service has been proposed for expansion into several States. The operation is extremely efficiently managed and the back-up support of Satyam Foundation, with its software expertise, management systems capacity, financial and human resources, has played a considerable part in crafting the EMRI's success story. Apart from the rapid reach, effective training and orientation, the linkage with the police and health facilities has been critical in making the EMRI a successful ambulance service.

Conclusions: The EMRI model is no longer a pilot, since it has been scaled up across Andhra Pradesh and is now gearing up for roll-out in several of the northern States. Both the costing and monitoring data needs to be evaluated by an independent agency.

ANNEXURE 3.2.6

EQUIP: Enhancing Quality Care in Public Health Care

Title	EQUIP: Enhancing Quality Care in Public Health Care
State	Chhattisgarh
Geographic Area of Coverage	64 selected blocks across all districts
Target Population	Focus on pregnant mothers
Project Life	2003, ongoing
Budget	Not applicable
Implementing Partners	Department of Health and Family Welfare, Chhattisgarh, with the technical assistance of State Health Resource Centre (SHRC)
Existing Evaluations	Not applicable
Documents Reviewed	Giving Public Health a Chance: Some Success Stories from Chhattisgarh on Community Basing of Health Sector Reforms, Department of Health and Family Welfare, Government of Chhattisgarh

Objectives: The key objective was to address the issues of service delivery with reference to the provision of safe motherhood services at various levels:

1. Making the CHC/FRU capable of comprehensive emergency obstetric care.
2. Every PHC should be open 24 hours to conduct institutional deliveries.
3. Every Sub-Health Centre (SHC) should provide high quality antenatal care.

Strategies: The key strategic approaches followed by EQUIP were:

1. Process of micro-planning in select blocks where all critical gaps in infrastructure, equipment and supplies were identified and closed.

2. A second plan to develop the workforce required to operationalise the facilities, with a mix of supplementing with new skills (multi-skilling) and new appointments if necessary.

Outcomes: Key outcomes so far:

- 52 candidates trained: 27 in emergency obstetric anaesthesia and 25 in comprehensive emergency obstetric care
- 30 candidates undergoing training for emergency obstetric anaesthesia and 30 in comprehensive emergency obstetric care

Lessons learnt: Multi-skilling of all staff as well as doctors is necessary in order to operationalise facilities such as the CHCs/FRUs, PHCs and SHCs to provide services beyond safe motherhood. In addition to multi-skilling, various efforts are necessary to expand the pool of medical professionals available to work in public sector health facilities: mandatory rural area service, contractual walk-in appointments, increasing recruitment of medical professionals by the State health system, appointment of AYUSH (doctors from non-allopathic systems of medicine) doctors in PHCs, setting up additional medical colleges. Constant supportive supervision of newly-trained doctors in anaesthesia and EmoC enables improved performance.

Conclusions: The EQUIP initiative is a unique management innovation that focusses on block-level planning, systematically closes gaps and addresses larger policy issues by filling lacunae in human resources. This scheme needs to be scaled up in the States and also needs to be preceded by capacity building of participants in the micro-planning exercise.

Annexure 4

Immunisation
and
Infant and Young Child Feeding

ANNEXURE 4.1

Dular Project

Title	Dular Project
State	Jharkhand and Bihar
Geographic Area of Coverage	Jharkhand districts—Jamshedpur, Ranchi, West Singhbhum and Saraikela Kharsawa Bihar— Not applicable
Target Population	Children under three years of age; adolescent girls; pregnant and lactating women
Project Life	1999-2005
Budget	Not applicable
Implementing Partners	ICDS Jharkhand, ICDS Bihar
Existing Evaluations	External evaluation by Tufts University
Documents Reviewed	The case of Dular: Success and Growth Despite the Odds. Evaluation report, 2005 ICDS Programme in Bihar by Dr. N.C. Saxena

Objectives: The main goal of this project was to put in place interventions that would empower the family and the community, within selected areas of the ICDS purview, to make positive changes in health-related behaviour, as well as address the issue of malnutrition among women and children and reduce anaemia among adolescent girls. The key objectives were:

1. To create a 'working together environment' for ICDS and health teams through innovative capacity building strategies at the district level.
2. To establish a State-level monitoring system for care behaviour, malnutrition and micronutrient deficiencies within ICDS and health departments.
3. To prevent and reduce malnutrition and micronutrient deficiencies among children and women.
4. To reduce or eliminate entrenched cultural and behaviour practices.
5. To create learning opportunities for pre-school children between three and six years of age.
6. To reduce nutritional anaemia for adolescent girls through IFA supplementation.
7. To monitor and improve health and nutrition-related indicators for women and children.

Strategies:

1. A life course approach to the care of children under three.

2. Ensuring that girls and women of reproductive age have access to adequate nutrition, health care, and information about child care throughout their lives—especially while they are pregnant and nursing their young children.
3. Initiating a community mobilisation effort and trained community members to disseminate information and encourage healthy behaviour and practices in the places where they live.
4. Initiating a two-day Village Contact Drive (VCD) in which the whole community participates and use of participatory methods and demonstrations to enhance awareness and participation by the community.
5. Introducing a new cadre of volunteers named Local Resource Persons (LRPs) to assist the AWW.
6. Household counselling on various issues related to health and nutrition.
7. Regular weighing of children was instituted.
8. Setting up a District Mobile Monitoring Training Team (DMMTT) to monitor progress and provide on-thejob guidance to village teams.
9. Instituting a District Support Team (DST) to improve coordination between sectors, review overall progress and ensure effective implementation across the district.
10. Setting up a taskforce at the State level to assess and develop communication and training needs.
11. Monitoring progress of the Dular project and linking it to overall quality improvement of ICDS.

Outcomes: The 2005 evaluation of the project indicates that:

- Dular villages had a significantly higher rate of colostrum feeding at 84% than the non-Dular villages (64%). However the median age of introduction of complementary feedings for six- to 12-month-olds did not show any significant difference between the two groups and remained high at eight months
- For ages six to nine months: Dular 48.3% and non-Dular 52.7% have received solid food in the previous 24 hours and 48.9% and 51.3%, respectively, had milk other than breast milk
- For ages 9 to 12 months: 73.8% of Dular and 72.5% of non-Dular had received complementary solid food in the previous 24 hours, and 42% and 48%, respectively, had milk other than breast milk
- A significant difference in the malnutrition rates (underweight) reported between the Dular and non-Dular villages (55.5% vs. 65.4%) and a significantly lower stunted population in the Dular villages (61.8%) as compared to the non-Dular villages (72.0%)
- Wasting was not found to be statistically significant and seen to be lower in the Dular villages (9.3%) than the non-Dular villages (14.2%)
- There is an increasingly widening gap between malnutrition rates in Dular villages as compared to non-Dular villages indicating that over time the interventions become effective

Lessons learnt: The decentralised Local Resource Group (LRG) was perhaps the strongest element of the Dular project. The monitoring was very intensive. It needed rigorous and regular monitoring not only of LRGs but also of programme activities in general. Given appropriate guidance and support, the AWWs were effective in bringing about behaviour change in the mother and family members.

Conclusions: The Dular programme demonstrates that intensive support and extensive use of IPC played an important role in obtaining positive outcomes. Village Health and Sanitation Committees (VHSCs) or local community-based groups could play the role that local support groups did in Dular and thus hold the potential for scaling up in the NRHM context.

ANNEXURE 4.2

Ankur: A Model to Reduce Neonatal Mortality through the Provision of Home-based Newborn Care

Title	Ankur Project: Replicating/Home-based Newborn Care (HBNC) model developed by SEARCH
State	Maharashtra
Geographic Area of Coverage	Seven sites, in six districts: Nasik (rural), Sangli (rural), Osmanabad (rural), Nagpur (rural), Nagpur city (urban slums), Yavatmal (tribal) and Gadchiroli (tribal)
Target Population	Newborn infants and their families
Project Life	2001-2005
Budget	Not available
Implementing Partners	Lead Agency: SEARCH, Gadchiroli; ISSUE, Nagpur; NIWCYD, Nagpur; Sahayog Nirmiti, Osmanabad; Rugna Seva Prakalpa, Sangli; Aamhi Aamchya Aarogyasathi, Srujan, Yeotmal; VACHAN, Nasik
Existing Evaluations	Review by peer group at the end of the project
Documents Reviewed	• Publications in the Journal of Perinatology, 2005 (supplement) • Replicating the Home-based Newborn Care in India. New evidence from 12 sites and implications for national policy. Report of the convention. New Delhi, 10 August 2006. ICMR, SEARCH, PFI • Ankur project. A Case Study of Replication of Home-based Newborn Care: prepared by Dr. Dileep V. Mavalankar, Ms. Parvathy Raman (Centre for Management of Health Services, IIM Ahmedabad [pre-publication results])

Objectives: The Ankur project was an expansion type scaling up of the HBNC model pioneered by SEARCH in a 40-village pilot intervention in Gadchirloi district in Maharashtra. SEARCH coordinated the entire interventions through NGOs in three types of population (tribal, rural and urban slums). The intervention focussed almost exclusively on providing newborn care with the related issues of skilled attendants at birth. The primary target groups were pregnant women and newborns and their mothers. The Ankur project was independent of the Government health services with the exception of referring high risk mothers/newborns to the district hospital. The key objectives of the Ankur project were:

1. Primary prevention of morbidities.
2. Diagnosis and management of birth asphyxia; breastfeeding problems; pre-term and LBW babies, including supportive care; hypothermia and sepsis.
3. Referral of sick newborns.

Strategies:

1. The model involved home-based care of newborns, using child and newborn survival techniques, all provided through a community-based female health worker, selected through community participation.
2. Skill-based training in the HBNC package that focussed on 'learning by doing'. The training was modular with a gap of four to six weeks to enable the CHW to practice and hone the new skill learnt, supported by qualified supervisors.
3. The intervention empowered not only the mothers of newborns, but also their families and the community to take responsibility for ensuring better care for newborns, including their prenatal care by caring for the health of the pregnant women.
4. The technical components for the Ankur project were identical to the original HBNC model with a few modifications as per the requirement of the local condition at the individual site.
5. Seven selected NGOs in Maharashtra were entrusted with testing out the methodology of HBNC in their project sites, with the flexibility to make the necessary modifications at the different sites as necessitated by local conditions.

Outcomes:

- In the third year of intervention, coverage of mothers and newborns, using a composite of seven indicators, was 85%
- Neonatal mortality rate dropped from 46 (at baseline) to 24 and IMR from 62 (at baseline) to 36 by the third year of intervention
- Home deliveries attended by the CHW were 63.8%
- Newborns delivered at home examined by a CHW within 24 hours of birth were 77.4%
- Newborns who received exclusive breastfeeding within 24 hours after delivery were 90.2%
- Newborns who received at least four visits by a CHW during the neonatal period were 90.2%
- Newborns who received at least one supervisory visit during the neonatal period were 98.9%
- Sepsis diagnosed babies who received treatment by a CHW or got referrals from CHWs were 91.1%

Lessons learnt: CHWs can provide HBNC. However, coverage difficulties arose in tribal areas with small, dispersed hamlets. Community acceptance of HBNC services provided by the CHW was high. The intervention does not depend on a well functioning health system. It has been proven to be effective in resource poor settings. Intensive supervision seems to play a key role in the success of this model. The model created a separate cadre of supervisors who provided intensive supervision to the community-based workers. The interventions not only addressed key contributors to neonatal mortality conditions such as hypothermia, asphyxia and sepsis, but also addressed care of newborn, initiation of breastfeeding at birth and exclusive breastfeeding.

Conclusions: The Ankur project demonstrates that a well-trained community health worker, supported by effective supervision and on-the-job mentoring is capable of providing newborn

care services in the home and community setting. Despite rising institutional deliveries, most mothers return home within 24 hours, unless there are maternal or newborn complications necessitating longer hospital stay. Thus there is a continuing role for HBNC even in cases where high institutional delivery is the norm. The presence of ASHAs at every village and hamlet level makes the introduction of HBNC a very real possibility. The current ASHA training is modular and thus the HBNC training can be included as appropriate after the introductory training is complete. The introduction of a cadre of facilitators to support ASHAs also could provide the requisite supportive supervision in the field.

ANNEXURE 4.3

Reproductive and Child Health, Nutrition and HIV/AIDS Programme (RACHNA)

Title **State**	Reproductive and Child Health, Nutrition and HIV/AIDS Programme (RACHNA) Nine States of India—Uttar Pradesh, Bihar, Rajasthan, Chhattisgarh, Jharkhand, Andhra Pradesh, West Bengal, Orissa and Madhya Pradesh
Geographic Area of Coverage	95,000 *anganwadi* centres located in 78 districts across nine States
Target Population **Project Life**	All rural population under the Scheme coverage. Special emphasis on women of reproductive age group and adolescent girls; children below five years of age 1996-2006, ongoing
Budget	Total budget: US$ 116 million. Cost per AWC per year: Rs. 4785.00
Implementing Partners	Implemented by CARE India in partnership with Ministry of Health and Family Welfare (RCH and NRHM), Ministry of Women and Child Development ICDS, Panchayati Raj Institutions and several NGOs. Supported by USAID India
Existing Evaluations	RACHNA Programme 2001-2006: Summary of Approaches and Results, 2007 A cost analysis of CARE/India's RACHNA Programme, 2006 Andersen M.A. et al, RACHNA final evaluation, May 2006, CARE India
Documents Reviewed	CARE India. Reflections on a Journey—RACHNA Midway. New Delhi: CARE India. 2004 CARE India. RACHNA Programme Final Review Report. New Delhi: CARE India. 2006 CARE India. Reproductive and Child Health Nutrition and HIV/AIDS (RACHNA) Programme: End of Programme Documentation–National Document. New Delhi: CARE India. 2006 CARE India. RACHNA Programme 2001-2006—Summary of Approaches and Results. New Delhi: CARE India. January 2007 A Cost Analysis of CARE/India's RACHNA Programme, 2006 Andersen M.A. et al, RACHNA Final Evaluation, May 2006, CARE India

Objectives: The aim of the RACHNA project was to augment the direct food distribution support to ICDS, with additional interventions to support improvements in maternal and child health and nutrition services, behaviours and outcomes. The key objectives were to:

1. Strengthen systems and communities to sustain reductions in infant mortality and child malnutrition.
2. Support a set of technical interventions covering antenatal care, neonatal care, nutrition and immunisation that are integral to the national programmes of ICDS and RCH.

Strategies: The main approaches of the RACHNA programme included capacity building, as joint learning for functionaries from ICDS and health along with community members; support to channels of BCC including IPC and support for information systems, supplies and training. All these attempted to maximise the reach of health and nutrition interventions to the underprivileged and to find ways to meaningfully enhance equity including gender equity. The main strategies included:

1. Innovation and demonstration for behaviour change with NGO partnerships.
2. Replication of best practices (change agents, nutrition and heath days, community-based monitoring systems) through Government partnership and capacity building.
3. Strategic alliances for organisational learning and advocacy.
4. Promotion of gender equity.
5. Provision of a package of services that needed convergence between the departments of health and nutrition.
6. Antenatal interventions: Check-ups, TT vaccination, IFA supplementation, supplementary nutrition, increased dietary intake, reduced workload, rest and preparations for safe delivery.
7. Neonatal interventions: Clean childbirth, adequate warmth, early and exclusive breastfeeding, clean handling including cord care, recognition and extra care for weak newborns (LBW or premature)
8. Nutrition interventions: Exclusive breastfeeding, appropriate complementary feeding with emphasis on feeding during and after illness, Vitamin A supplementation and supplementary nutrition.
9. Immunisation interventions: Complete and timely vaccination of all children with BCG, DPT, OPV and measles by the completion of one year.

Outcomes:

- Proportion of children 12-23 months whose weight for age is more than two standard deviations below the median weight achieved by children of that age showed a reduction from 61% to 53% between baseline and endline surveys
- Receipt of 2+ doses of TT immunisation by pregnant women was high at 78% at baseline and increased to 85% in the endline survey (B-E)
- Proportion of women, delivered in past year, who received 90+ iron folic acid tablets during pregnancy increased from 39% at baseline to 50% in the endline survey (B-E)

- The practice of delayed bathing of the newborn increased from 4% to 42% in the intervention area while showing a small change from 2% to 3% in the comparison area
- Drying and wrapping the baby increased from 18% at baseline to 44% at endline in the intervention area in Uttar Pradesh while comparison area decreased from 9% to 4%
- Improvements in early initiation of breastfeeding in the first hour. In Uttar Pradesh it increased from 3% to 37% at endline while in the comparison area it increased from 2% to 6% at endline
- Prelacteal feeding, almost universal at baseline, declined in the Uttar Pradesh intervention district (from 92% to 44%) while no significant change was noticed in the comparison area (ER)
- Proportion of children in 12-23 months of age immunised with measles vaccine (37% at BL to 71% at EL)
- Proportion of infants who received breast milk and solid, mushy food at six to nine months of age (49% at BL to 78% at EL)
- Proportion of children under one year breastfed exclusively for six months postpartum (34% at BL to 44% at EL)
- Proportion of children in 18-23 months of age received at least two doses of Vitamin A (5% at BL to 27% at EL)

Lessons learnt: The programme had built explicit focus to reach the left-outs and dropouts. Analysis of RAPS data, disaggregated by lower and higher socioeconomic groups, indicates that the RACHNA programme is benefiting the lower socioeconomic groups more. The analysis indicated equal or greater progress on most indicators among the low socioeconomic groups in most States (RACHNA, Final Evaluation Report 2006). Most of the improvements have been significant among the low and high socioeconomic groups across most surveys, in some cases being more marked among the poorer half. The evaluation research data on newborns confirms that service provider visits to women were equitable by standard of living index categories (low, medium and high). Results from other surveys showed a significant improvement in newborn care practices by endline. Districts with large changes in reported behaviours also had large changes in reported home visits by service providers (AWWs and ANMs), indicating an association between home visits by service providers and positive outcomes. In States and districts that demonstrated high levels of desirable practices (households practising good newborn care practices), these practices were significantly more common among those who reported home visits and advice by service providers (ANMs and AWWs) pointing to a strong contribution of system effort to positive outcomes.

Conclusions: RACHNA is one of the few programmes that demonstrated convergence between health and nutrition at scale and in multi-State contexts. RACHNA developed several tools for improving ICDS programme efficiency. Mechanisms used by RACHNA to improve effectiveness of AWWs through supportive supervision and mentoring will be valuable in ICDS. RACHNA was a well documented effort and some of the 'best practices' offer the potential for scalability within the context of RCH II and the NRHM. For example, the RACHNA change agents, whose profile is similar to ASHA, were the key to improving

household behaviour regarding child care and safe motherhood, as well as linking with the formal health and nutrition systems.

ANNEXURE 4.4

Kano Parbo Na: Model to Reduce Low Birth Weight and Malnutrition Using a Positive Deviance (PD) Approach

Title	Reduction of LBW and Malnutrition Using a Lifecycle and Community-based Approach: Positive Deviance
State	West Bengal
Geographic Area of Coverage	Selected blocks in four districts of West Bengal: Murshidabad, South-24 Parganas, Purulia and Dakshin Dinajpur. Since 2005-2006, being implemented in Birbhum and Uttar Dinajpur districts
Target Population	Children below three years who are healthy with normal growth, termed positive deviants
Project Life	2001-2005 (ongoing, supported through GOI funds under RCH II)
Budget	Budget: Rs. 101.28 lakh each in 2007-2008 and 2008-2009 Expenditure: Rs. 17.23 lakh in 2007-2008
Implementing Partners	ICDS and UNICEF
Existing Evaluations	Impact evaluation of the project done by the National Institute of Nutrition, Hyderabad
Documents Reviewed	Bringing Up Tasmina: a human interest story Addressing Malnutrition through Surveillance and Innovative Community-based Strategies—a KCCI publication of UNICEF

Objectives: The project was geared towards reducing the prevalence of undernutrition among children less than three years of age. The key objectives were:

1. Community-based management of malnutrition emphasising positive behavioural changes in childcare practices (12 days of spot feeding and 18 days of take-home rations for Grades II, III and IV children).
2. Community mobilisation around nutrition issues through the use of participatory processes.

Strategies:

1. Use a PD approach to identify feeding practices of mothers in the community with healthy children, and transmit them to other mothers through a community-based approach.
2. Formation of village committees, pro-active dialogues between social groups and institutions and using culturally appealing activities such as village picnics, fairs, etc.
3. Hands-on training on infant feeding, health care, hygiene and psycho-social care practices was provided to mothers or caregivers over a 12-day period, which was

followed by practice sessions at home for another 18 days. The cycle extended over six to nine months.

4. Convergence and partnership between the service providers, the civil administration and the NGOs involved in implementation.
5. Capacity building of child care functionaries in weighing all children under three years and identifying their nutritional status and identifying pockets of high malnutrition.
6. Motivating families to adopt these practices through participatory learning during Nutritional Counselling and Childcare Sessions (NCCS).
7. Focusing on related health issues such as immunisation, Vitamin A supplementation hand washing practices, diarrhoea management, prevention of LBW, early registration of pregnancy, antenatal care, etc.

Outcomes: The National Institute of Nutrition (NIN), Indian Council of Medical Research, Hyderabad, carried out a study to evaluate the impact of the PD programme.

- During the period of implementation of the programme in PD areas, the proportion of normal and Grade I children increased significantly and, consequently, the proportion of children in Grade II and III undernutrition decreased significantly
- However, the prevalence of Grade IV undernutrition remained the same
- Among six-month-old children: 37% in the PD area and 19% in the control area started receiving complementary food at six months. Among 7-11-month-old children, about 13% and 12% in the PD and control areas, respectively, started receiving complementary food at ≤ three months of age
- Among children aged 12-23 months, 44% of children in the PD area compared to 27% in the control area (29%), were started on complementary feeding at six months of age
- The proportion of children receiving formula milk was lower in the PD area (5%-9%) compared to the control area (6%-13%). At six months of age, a relatively higher proportion of infants received homemade semi-solid or solid foods (33%) in the PD area compared to the control area (21%). Among children aged 7-11 months, 44% in PD and 34% in control areas were receiving homemade solid foods
- Among six-month-old children currently receiving complementary feeding, 58% of children in the PD area were receiving complementary feeding ≥four times a day, compared to 29% in the control area

Lessons learnt: Political commitment was important to programme implementation**.** Systematic planning and implementation of project processes, including community participation, enabled positive outcomes. The demonstration of positive outcomes in child nutrition was made possible by the relatively long duration of project implementation. The involvement of NGOs also contributed to the success of the programme. Training of the child development programme officers and medical officers of the PHCs, in the concept of the PD, enabled active participation. It was observed that the impact of the programme was much better wherever there was greater involvement and participation of the PRIs and the VHCs. The PD approach had positive outcomes on stunting, but not on underweight and wasting, which requires longer periods of this type of programme implementation. Although PD

proved to be a low cost model of malnutrition reduction, the development of the model was cost intensive.

Conclusions: This model was tested later in Bihar, Andhra Pradesh and Orissa by ICDS. In the present scenario, VHSCs, VHNDs and the proposed convergence between ASHAs and the AWWs, provide a conducive environment to implement this approach. It would be done by adaptation to local needs and cultures in other parts of the country.

ANNEXURE 4.5

Saksham: Improving Neonatal Health through Community-based Newborn Care

Title **State**	Saksham—Community-based Newborn Care Uttar Pradesh
Geographic Area of Coverage	Shivgrah block, district Rae Bareli
Target Population	Families with pregnant mothers including decision-makers such as husbands, in-laws and neighbours
Project Life	2003-2007
Budget	NA
Implementing Partners	Community of Shivgarh; Johns Hopkins University; KGMU/KGMC-ICE
Existing Evaluations	Evaluation by Johns Hopkins University (report not available for review)
Documents Reviewed	Darmstadt G. L., Kumar V., Yadav R., Singh V., Singh P., Mohanty S., Bharti N., Gupta S., Gupta A., Baqui A. H., Santosham M. Introduction of Community-based Skin-to-Skin Care in Rural Uttar Pradesh, India. J. Perinatol 2006; 26:597-604 Darmstadt G.L., Kumar V. Community-based Skin-to-Skin Care: Letter in response to Sloan [editorial]. J. Perinatol. 2007 April; 27(4): 255; author reply 255-6 Kumar V., Gupta S., Singh V., Gupta A., Yadav R., Awasthi S., Singh J.V., Baqui A.H., Winch P., Santosham M., Darmstadt G.L. Community Mobilisation and Behaviour Change Communications Reduce Neonatal Mortality in Uttar Pradesh, India. Global Forum for Health Research, Mumbai, India, September 2005

Objectives: The overall goal of the project was to develop community-based newborn care intervention models in resource poor settings. The key objectives were:

1. To determine domiciliary newborn care practices and identify determinants of neonatal mortality.
2. To evaluate the impact of a basic newborn care communication package on neonatal mortality, key practices and abilities, morbidity and care-seeking.
3. To design and evaluate BCC interventions based on community mobilisation and empowerment and inform the development of community-based health programmes in resource-poor settings.
4. To evaluate acceptability, compliance, safety and the process of introduction of skin-to-skin care to inform the development of future strategies for community-based kangaroo mother care.

5. To describe the association of the use of skin-to-skin care with improved essential newborn care practices, including breastfeeding, prevention and management of hypothermia and reduced risk for mortality and infections.
6. To evaluate cost-effectiveness of the intervention and assess household expenditure on newborn care.
7. To evaluate the feasibility of community audit of neonatal death.

Strategies: Identification of key practices that potentially influence neonatal mortality through formative research and social mapping of the entire study area and baseline survey of knowledge, attitude, practices and constraints.

1. Development of the intervention package.
2. Trials of improved practices in a sub-set of the proposed area.
3. Randomisation of the study clusters into three arms.
4. Training of CHWs.
5. Development of village-level voluntary network for lateral transfer of knowledge, social support and attendance at the time of delivery. (The intervention is provided through a combination of home visitation twice during the antenatal period and immediately after birth and at day three, besides being followed-up by community volunteers.)

One of the more important activities of the project was the randomised controlled trial on community newborn care conducted in three separate cells*:*

1. Family package of intervention.
2. Family package of intervention and thermoSpot.
3. Control standard existing Government intervention.

This was carried out as a rigorous research study and yielded valuable data on a number of indicators.

Outcomes: The controlled randomised trial showed that for all the indicators, the test interventions 1 and 2 yielded far improved results than in the control group. The indicators covered were:

- TT doses administered during the last pregnancy
- Percentage of mothers who received prenatal care two or more times by a trained provider
- Percentage of mothers whose birth was attended by a trained provider; percentage of mothers whose newborn was delivered in hand
- Percentage of newborns whose umbilical cord was tied within half-an-hour of delivery
- Percentage of newborns whose umbilical cord was cut within half-an-hour of delivery
- Percentage of newborns whose whole body was wiped (instead of face, mouth and nostril only)
- Percentage of mothers whose newborn were given pre-lacteal feed
- Percentage of newborns who were breastfed by their mother in less than one hour of delivery

- Percentage of newborns who were given kangaroo mother care; percentage of newborns bathed within 24 hours of delivery
- Percentage of mothers who accepted Thermospot for assessing the thermal condition of the newborn

Lessons learnt: The model demonstrates that pilots designed around local behavioural and epidemiological profile have the potential to positively impact health indicators. Understanding community and family practices and their rationale is pre-requisite and so is their participation in the development and implementation process. BCC strategies need to follow an individual-to-social continuum. Traditional care providers need to be included and their roles enriched through on-site orientation and their relationship fostered with providers from the formal health care providers. Day 0/1 visit by a health care worker is effective in reducing neonatal mortality. Antenatal visit is a useful opportunity to build rapport and trust with the targeted beneficiaries. Skin-to-skin care is an effective and easily adapted strategy in improving newborn health.

Conclusions: The pilot holds the potential to impact neonatal health through use of community-based interventions. This design should be tested in diverse settings through multi-centric interventions. Feasible interventions related to IPC and timely postnatal visits can be explored for integration within the service delivery package provided by field functionaries.

ANNEXURE 4.6

Shishu Samrakshak Maah

Title	Shishu Samrashak Maah (SSM)/Child Protection Month
State	Chhattisgarh
Geographic Area of Coverage	All districts of Chhattisgarh
Target Population	Children 0-5 years and pregnant women
Project Life	October 2006, ongoing. Four rounds conducted so far
Budget	Approximately Rs. 7,500,000 per round
Implementing Partners	Directorate of Health and Family Welfare, Government of Chhattisgarh, UNICEF and Micronutrient Initiative (MI). State Government and UNICEF
Existing Evaluations	Joint monitoring conducted by MI-UNICEF, through coverage evaluation surveys—2005, 2006, 2007
Documents Reviewed	Note provided by UNICEF Note provided by SHRC, Chhattisgarh

Objectives: The SSM was conceived in 2006 as a strategy to enable expanded coverage of services for mothers and children. The key objectives were to:

1. Synergistically improve coverage of RCH indicators.
2. Deliver a selected package of services: Administration of Vitamin A, deworming of children, immunisation of children and pregnant women, iron supplementation for children and mothers and impregnation of bed nets (in nine high malaria prevalence districts).

Strategies: The SSM envisages an integrated approach through intensifying activities rather than introducing a campaign mode of functioning. The key strategies were:

1. Improve coverage of key child health interventions through intensive bi-annual rounds focussing on children and pregnant mothers during the months of April and October each year. This service delivery innovation leverages the existing fixed day approach in the immunisation micro plan (vaccination on Tuesdays and Fridays, covering all habitations in the State).
2. Utilise and build on the infrastructure and human resources already existent and not create parallel systems.

Outcomes: Clearly the model has had positive outcomes although not all may be attributable to the SSM alone. Joint monitoring is being conducted by UNICEF and the MI. The key outcomes include:

- Complete immunisation coverage for children increased from 28% in October 2005 (CES 2005) to 57% in October 2006. It is estimated that each round of the SSM

contributes to an average of 10.5% vaccinations compared to 7.4% in non-SSM months

- Vitamin A administration coverage increased in October 2007 to cover 1,554,338 children (nine months to five years) compared to 554,285 (nine months to three years) in October 2006
- Proportion of children receiving deworming treatment improved from 3% in October 2006 to 28% in October 2007
- The document reports that the coverage of IFA for pregnant women doubled between SSM and non-SSM, but no data is provided. IFA for children is provided only during the SSM
- Proportion of session cancelled reduced from 3% in October 2006 to 9% in October 2007. However, in April 2008,18% of the sessions were cancelled
- Proportion of sessions where time of reconstitution of BCG and measles vaccine is recorded increased from 27% in October 2007 to 83% in April 2008

Lessons learnt: The strength of the model is that it is being implemented within the institutional context of the existing service delivery system. One of the articulated benefits of the SSM is that it did not disrupt the existing work of health staff. It appears to have been implemented at scale and covered all districts in Chhattisgarh. It is not clear from the existing document whether this was done in phases or simultaneously implemented in all districts. The model addresses a felt need, but is selective in its approach, in that despite relying on a feature of the system that purports to deliver integrated services, the 'integration' in this case applies to child health interventions and does not include nutrition. Although the document indicates that the model conforms to the NRHM guidelines for conducting VHNDs, it also reports that 'experiences of including nutritional assessment and referral of children was dropped after the first two rounds, because it failed to have desired results as it is not yet a part of the core activity of the health staff'. The existing documentation of the model portrays it as a service delivery innovation primarily with a focus on child-centred interventions. There is no reference to the role of the Mitanin or to the part that community mobilisation plays. Since the SSM added on an additional set of interventions there were likely implications for the service providers. Monitoring results indicate that implementation of the SSM resulted in improvement of service quality. It is reported that these improvements appear to span non-SSM as well.

Conclusions: Based on the increase in coverage for the indictors as described above, the State Government has included this in the State project implementation plan for the year 2008-2009. Jharkhand has also adopted the approach beginning February 2008. The SSM is a local innovation but holds promise to be implemented at scale and several issues on capacity building, monitoring, logistics and training need to be studied in-depth. While UNICEF and MI provided close oversight particularly in the monitoring, effective planning is required to enable the State system to include this into routine monitoring and management systems.

ANNEXURE 4.7

Muskaan Project: Augmentation of Routine Immunisation Coverage

Title	Muskaan
State	Bihar
Geographic Area of Coverage	Entire State
Target Population	Children from zero to two years and pregnant women
Project Life	October 2007, ongoing.
Budget	No data
Implementing Partners	State Health Society, Government of Bihar, UNICEF and its child survival network and NPSP
Existing Evaluations	Coverage evaluation survey—early 2008 in 10 districts, shows rise in immunisation coverage to 67%
Documents Reviewed	Note provided by UNICEF

Objectives: In October 2007, UNICEF supported the Bihar Government in launching a year-long immunisation campaign whose objective is to achieve 100% immunisation coverage. Operational strategies span both demand generation and supply-side management, and involve convergence between ICDS and the Department of Health (DOH).

Strategies:

1. Identification of all beneficiaries (pregnant women and children under two years of age) and tracking to ensure complete immunisation coverage.
2. Intersectoral coordination between ICDS and the DOH to ensure community mobilisation and service delivery.
3. Increasing the number of sessions so that immunisation services are provided in all health sub-centres on Wednesdays and in two to three *anganwadi* centres on Fridays.
4. Introduction of performance-based incentives and penalties to community mobilisers as well as to providers at all levels of the service system.
5. Village-level mahila *mandals* served as fora to sensitise mothers to the benefits of immunisation.

UNICEF provides technical support to the initiative through its child survival network. The network along with other partners is responsible for orientation and training of all workers, developing new micro plans for the campaign in all PHCs, and monitoring of programme activities. 500 field staff of the National Polio Support Programme (NPSP) and UNICEF's Polio Social Mobilisation Network monitor the interventions regularly.

Outcomes: Routine monitoring and a coverage evaluation survey (in 10 districts) by an external agency have shown evidence of positive outcomes. The 10-district survey has shown that immunisation coverage rose from 29.6% to 67.1%. Routine monitoring data demonstrate that 98% of ANMs succeed in visiting two to three session sites on Friday

(when sessions are held at *anganwadis*) and that only about 4% of planned sessions were cancelled. Newborn tracking register coverage is about 47%. However, the payment of incentives that appears to be a distinctive innovation within this approach lags behind—about 12% to ASHA, 15% to ICDS workers and 11% to ANM.

Lessons learnt: A key strength of the model appears to be that the interventions were directed through existing public health system frontline providers. The introduction of tracking to ensure complete coverage is also an interesting aspect that could potentially be integrated into the programme. Delinking implementation from routine monitoring by the system may have the advantage of reducing bias in reporting. Although the implementing agency appears to be the Government, the technical assistance input by UNCEF is considerable. More documentation on the specific nature of this technical assistance and, more importantly, what was done to build technical capacity to manage and monitor such programmes is required.

Conclusions: Although it is too early to draw conclusions from the implementation of the Muskaan model, areas that could benefit from an internal review in preparing for scale up include:

- Identification of mechanisms to enable grafting onto the system
- Documentation of the incentive and penalty system and the resultant consequences on the programme and outcomes
- Sustainability of the partnership involved in the interventions in the long-term and possibilities of the linkages to the health system on an ongoing basis
- Potential of the Muskaan intervention to integrate other child health interventions, sustain the immunisation outcomes and action to be taken in these areas

Annexure 5

Adolescent Reproductive and Sexual Health

ANNEXURE 5.1

Delay Age at First Conception and Avert the Adverse Consequences of Early Motherhood in Married Adolescent Girls

Title	Delay Age at First Conception and Avert the Adverse Consequences of Early Motherhood in Married Adolescent Girls
State	Maharashtra
Geographic Area of Coverage	50 villages in Aurangabad district; 17 urban slums in Pune district
Target Population	All adolescent girls, with special emphasis on married adolescents and their spouses and families
Project Life	2003-2006
Budget	Not applicable
Implementing Partners	Implemented by the Institute of Health Management, Pachod. Financially supported by John D. and Catherine T. MacArthur Foundation
Existing Evaluations	Not applicable
Documents Reviewed	Institute of Health Management. Documents pertaining to the project for addressing the needs of MAGs. Pachod, Maharashtra: Institute of Health Management (unpublished)

Objectives: The objective of the intervention was to address the needs MAGs in rural and urban settings through the design and delivery of a specific package of RCH.

Strategies: The project was implemented by an NGO, Institute for Health Management, in Paithan Block of Aurangabad district and in selected slum areas in Pune. The strategies included a mix of technical components, community engagement processes and skill development among married adolescent women and men to plan their families and in parenting.

1. The intervention design incorporated the key RCH needs of MAGs: anaemia, delay in age at first conception, use of contraception for spacing, RTIs/STIs, early treatment of UTIs, post-abortion complications, prevention of LBW among newborns and spousal participation of men in family planning and child rearing.
2. Residential camps for newly-married couples for knowledge and skill building on RCH issues were organised by the Institute for Health Management. The camp also served to reinforce spousal communication, interaction with peers and exposure to a wider perspective. It culminated in a pledge by the couples who committed to planning their families and good parenting.
3. The Institute for Health Management established a cadre of community workers called Community Organisers (COs), who undertook daily home visits, detected pregnancies, assessed the need for RTI/STI services, post-abortion care and contraceptive use and provided primary-level care in these three areas. They also counselled women on Rural Health (RH) issues and provided referral to secondary and tertiary referral centres.

4. The COs were supported by ANMs, who undertook field visits to each of the project villages, organised village-level clinics at spaces provided by the community and did home visits to any MAG who had delivered within the last six weeks.
5. The Institute for Health Management also set up VHCs composed of community members with influence, elected representatives and grassroots Government functionaries. This was to enable ownership, overcome resistance of parents and other adults to the RCH programme and to supervise the process.
6. The VHCs facilitated creating demand for Government health services, monitoring service providers and also making service providers accountable in order to address women's health needs through a right's-based approach. The VHCs also mobilised community resources, monitored monthly surveillance for identifying needs of the married adolescents done by the COs and paid the COs honorarium on performance.
7. Community-based surveillance system by the COs facilitated early detection of pregnancy, treatment and referral, and the tracking of key reproductive health behaviours.

Outcomes:

- Median age of marriage increased by one year
- Median age of conception increased by more than one year
- Significant increase in percentage for those who received complete ANC and percentage of institutional deliveries
- Significant increase in percentage of women receiving PNC services
- Percentage of LBW babies dropped from 35.8% (BL) to 25.3% (EL) in rural areas
- Increase in percentage utilising treatment for UTIs/ RTIs/STIs
- Contraceptive use increased from 11% (BL) to 23% (EL) in rural areas

Lessons learnt: The MAG's model pioneered working with MAGs, hitherto a group not addressed by mainstream health services. The technical package was effective in addressing the specific RH needs of this category. Several programmatic innovations contributed to the success of the interventions. Holding supervisors responsible and accountable for supporting the work of frontline health functionaries improve results. Frontline workers need effective linkages to the rest of the health system. Monthly review meetings focussed on well-defined output indicators can be an important part of an effective monitoring and supportive supervision system for community workers. Performance improves if community-level workers have contextually relevant, good quality job aides.

Conclusions: The MAG's model demonstrated significant results but required intensive community processes, technical competence and the ability to provide community base interventions with service delivery. The CO and the VHC are identical to ASHA and village health committee components of the NRHM. Thus the inclusion of MAGs-related interventions within the NRHM offers an opportunity to address the needs of this priority group.

Annexure 6

Behaviour Change Communication

ANNEXURE 6.1

Campaign to Promote Behaviour Change for Use of Oral Contraceptive Pills

Title	**Goli Ki Hamjoli**
States	Delhi, Rajasthan, Uttarakhand, Uttar Pradesh, Jharkhand, Bihar, Madhya Pradesh and Chhattisgarh
Geographic Area of Coverage	Urban areas—33 towns
Target Population	Young (18-29 years) married middle class women in urban North India, wishing to space pregnancies
Project Life	1998-2004
Budget	Total budget not known Advertising—Rs. 16.90 crore
Implementing Partners	Ogilvy and Mather (communications agency) and three OC manufacturers—Wyeth, Organon, German Remedies
Existing Evaluations	Not applicable
Documents Reviewed	Project Report—USAID, ICICI Bank and PSP-One

Objectives: The goal of the Goli Ki Hamjoli campaign was to increase use of low dose OCs. The key objectives were:

1. Change consumer and provider attitudes about OCs.
2. Increase OC sales by 12% to 15%.
3. Increase industry and investment in OCs.

Strategies: The campaign was implemented in the urban areas of Delhi, Rajasthan, Uttarakhand, Uttar Pradesh, Jharkhand, Bihar, Madhya Pradesh and Chhattisgarh and was funded by USAID through its PACT-CRH (Advancement of Commercial Technology—Child and Reproductive Health) project, and implemented by the ICICI Bank. Technical support was provided to the campaign through successive USAID technical assistance mechanisms, namely commercial marketing strategies, SOMARC and Partnerships for SP-One.

1. Key campaign elements focused on demand and supply and included:
    - Creating public demand for products and services through marketing and behaviour change interventions.
    - Enabling the private sector to develop the capabilities to supply relevant quality products and services.
2. The campaigns involved the participation of a large and diverse range of stakeholders—115 people based in 25 towns to support and follow-up on mass media campaigns, train providers, conduct validations studies.
3. Advertising (radio and television) accounted for the largest component of campaign, consumer research through periodic tracking surveys, outreach activities, provider and retailer training.

4. Husbands, health care providers, (formal and informal) chemists, media, local civic groups—beauticians, social marketing firms, limited success with traditional NGOs were secondary target groups.

Outcomes:

- NRHM is using two of the advertisements promoted by the campaign
- 28,360 Indian Systems of Medicine Providers trained
- 34,012 chemists trained
- Advertising visibility to spends ratio: (Rs. 41 crores to Rs. 16 crores: 2.5)
- Free airtime on premier channels during prime time
- Sales results for OCs increased
- Post-marketing survey shows continued interest by private sector
- NFHS 3 shows a significant increase in pill use over NFHS 2 in Rajasthan, Madhya Pradesh and Uttar Pradesh

Lessons Learnt: The outcomes of the Goli Ki Hamjoli campaign are significant. However, the interventions involved substantial technical assistance, particularly in the area of intensive ground work with the secondary target audience and with rigorous concurrent monitoring. Changes were more significant in populations with high and middle standard of living indices. Social marketing campaigns such as this need to target poorer groups who in fact are in need of these services. The multitude of partners involved suggests that the management of such a campaign is complex and challenging and could limit expansion/ replication. The role and nature of involvement of the commercial private sector raises several issues, which are well documented in the reports.

Conclusion: Some components of the communication strategy, particularly advertisements on television, continue to be implemented through NRHM. Such campaigns need constant consumer surveys to enable modification in communication strategies.

ANNEXURE 6.2

Campaign to Promote Behaviour Change for the Use of Condoms

Title	**Yehi Hai Sahi/ Bindaas Bol**
States	Delhi, Rajasthan, Uttrakhand, Uttar Pradesh, Jharkhand, Bihar, Madhya Pradesh, Chhattisgarh, Punjab, and Haryana
Geographic Area of Coverage	Urban areas—34 priority towns with one to ten lakh population
Target Population	Sexually active men (married and unmarried, in the age group 20-45 years, across the economic spectrum
Project Life	2002-2007
Budget	Total budget not known
Implementing Partners	Lowe (communication strategy), three condom manufacturers: JK Ansell, TTK-LIG, Hindustan Latex limited
Existing Evaluations	Not applicable
Documents Reviewed	Project Report—USAID, ICICI Bank and PSP-One

Objectives: The goal was to support sustainable growth in condom use by increasing the volume and value of the condom market in India. The key objectives include:

1. Increase condom use among men.
2. Increase knowledge and improve attitudes influencing trial and consistent use of condoms.
3. Increase access and environment to facilitate purchase and use of condoms.

Strategies:

1. The campaign was funded by USAID through its PACT-CRH (Advancement of Commercial Technology—Child and Reproductive Health) project and implemented by the ICICI Bank. Technical support was provided to the campaign through successive USAID technical assistance mechanisms, namely Commercial Marketing Strategies (CMS), SOMARC and Partnerships for SP-One.

2. The campaign used an integrated communications and marketing approach, involving mass media campaigns, celebrity involvement, innovations to reach retailers, partnerships with condom manufacturers, marketers and health providers and ongoing research. The secondary target audience was retailers (including them as agents of change) and health care providers. The campaign used the field force set up ‘Goli Ki Hamjoli’ (a similar campaign to promote use of oral contraceptives was implemented from 1999-2004).

3. The campaign used mass media to create a positive image of the condom, active endorsement of the product by celebrities, partnering with condom retailers and ongoing consumer research.

Outcomes:

- Media campaigns won several awards
- 40,000 providers involved
- Leveraged Rs. 4.1 crore (US$ 942,281)
- Current condom use with spouse among married men rose from 28% to 60%
- Consistent condom use by men with non-regular partners rose from 7% to 80%
- Volume of commercial condom brands increased by 6.4%
- Value of commercial condom brands sold through the retail sector increased by 10.3%

Lessons learnt: The Yehi Hai Sahi/Bindaas Bol campaign was targeted at men from all segments. The project has demonstrated clear results in terms of volume and value of condom off-take. There has been a significant change in behaviour and use related to condom use. The campaign demonstrated a reduction of stigmatisation against condom purchases. The multitude of partners involved suggests that the management of such a campaign is complex and challenging and could limit scaling up. The role and nature of involvement of the commercial private sector raises several issues, which are well documented in the report.

Conclusions: The campaign has had a positive impact on behaviour related to condom use. However the complexity of partnerships, intensity of technical assistance and cost of reaching out to manufactures as well as the mass media campaigns need to be considered while scaling up.

ANNEXURE 6.3

Campaigns to Promote Behaviour Change for the Use of Oral Rehydration Salts

Title	**Saathi Bacchpan Ke**
States	Delhi, Rajasthan, Uttarakhand, Uttar Pradesh, Jharkhand, Bihar, Madhya Pradesh and Chhattisgarh
Geographic Area of Coverage	Urban Areas—33 towns
Target Population	Care givers—mothers and fathers, in middle and upper income households
Project Life	2002-2007
Budget	Total budget not known. Media component— 60% of annual campaign budget
Implementing Partners	McCann (media planners) and pharmaceutical companies—CFL, FDC, Merck, ShreyaLife Sciences, TTK Health Care, Wallace Pharmaceuticals, Dr. Reddy's lab, PharmaSynth Formulations, and Population Services International
Existing Evaluations	
Documents Reviewed	Project Report—USAID, ICICI Bank and PSP-One

Objectives: The goal of the campaign was to promote the use of ORS for diarrhoea, progressing to improved homecare practices for diarrhoea management and zinc supplementation. The key objectives were:

1. Increase use of ORS for diarrhoea management, including correct mix, use and as first line treatment of diarrhoea.
2. Increase sales of ORS brands using World Health Organisation (WHO) formula.
3. Conduct policy advocacy to shift to single WHO approved formula.
4. Increase industry and health care support for ORS.

Strategies: The campaign was implemented in urban areas of Delhi, Rajasthan, Uttarakhand, Uttar Pradesh, Jharkhand, Bihar, Madhya Pradesh and Chhattisgarh. The campaign was funded by USAID through its PACT-CRH (Advancement of Commercial Technology—Child and Reproductive Health) project and implemented by the ICICI Bank. Technical support was provided to the campaigns through successive USAID technical assistance mechanisms, namely Commercial Marketing Strategies, SOMARC and Partnerships for SP-One. Activities include advertising (radio and television), consumer research through periodic tracking surveys, outreach activities—street theatre, provider and retailer training. The secondary target audience included health care providers (formal and informal) and chemists. The campaign used the field force set up in Goli Ki Hamjoli, a similar initiative implemented from 1999-2004 to increase use of oral contraceptives. Street and folk theatre was a medium used to expand direct contact with care givers. National ORS day was established on 29 July 2001 as a day to motivate doctors to commit to prescribing ORS.

Key campaign elements focused on demand and supply and included strategies for:

1. Creating public demand for products and services through marketing and behaviours change interventions
2. Enabling the private sector to develop the capabilities to supply relevant quality products and services

Outcomes:

- Drug controller approved shift to single low osmolarity formula
- The NRHM committed resources to support communication efforts related to diarrhoea management, including use of ORS
- 60,000 providers trained
- Leveraged media and marketing funds totalling about Rs. 6 crore (US$ 1.4 million) over the life of the project
- ORS sales increased by 10% during the project period

Lessons learnt: The campaign involved the participation of a large and diverse range of stakeholders, including: the commercial sector, media companies and providers of all hues, chemists, community networks and target groups (specified in the matrix above). The Saathi Bacchpan Ke campaign resulted in policy modification. However, NFHS 3 data on ORS usage show no increase over NFHS 2 possibly because NFHS data are from a wider cross section of the population than the sections that the campaigns focused on. Overall some targets of achievement were met but not others, especially those on recognition of critical danger signs and improving feeding practices. The multitude of partners involved suggests that the management of such a campaign is complex and challenging and may not lend itself to expansion or replication. The role and nature of involvement of the commercial private sector raises several issues, which are well documented in the reports. Several of the manufacturers used the opportunity provided by the campaigns to promote their own brands, notwithstanding the spirit of generic marketing that the campaigns espoused.

Conclusions: Some components of the communication strategy, particularly advertisements on television, continue to be implemented through the NRHM. Such campaigns need constant consumer surveys to enable modification in communication strategies.

Annexure 7

Gender Mainstreaming

ANNEXURE 7.1

Family Counselling Centres

Title	Family Counselling Centres
State	Madhya Pradesh, Rajasthan, Kerala, Orissa, Maharashtra
Geographic Area of Coverage	Entire State in some cases, selected districts in others
Target Population	Women who suffer domestic violence and their families
Project Life	2002, ongoing
Budget	Not available
Implementing Partners	Departments of Health and Family Welfare, Police Department, Department of Women and Children and UNFPA
Existing Evaluations	Family Counselling Centres in Madhya Pradesh: An Assessment, UNFPA, October 2004 Coordinated Responses to Violence Against Women, UNFPA, April 2006 Family Counselling Centres in Chhatarpur, Panna, Satna, Rewa and Siddhi, UNFPA, May 2008.
Documents Reviewed	Evaluation reports

Objectives: FCCs were established as pilots in five States of India—Madhya Pradesh, Orissa, Rajasthan, Maharashtra and Kerala. The FCCs appear to have been established between 2001 and 2004. In Rajasthan six FCCs have been set up and all are located within the district hospital. In Madhya Pradesh, all five FCC are located in police stations and in Maharashtra a combination is to be found—one FCC is based in a hospital, one in a police station and three, including a legal guidance cell, are part of a community development initiative. The hospital-based FCC worked in collaboration with community-based NGOs.

The key objectives were:

- Sensitise service providers in various departments to the issues of violence against women
- Establish counselling centres for women and families who are affected by violence

Strategies: The strategy was to develop a broad response including policy dialogue, advocacy and development of tool kits to sensitise health care providers and inter-sectoral approaches to strengthen a systemic response to VAW. This has involved collaboration with the health system and with the National Commission for Women (NCW). A common objective is to provide a coordinated and systemic response to VAW. The location of FCCs in different States varies—hospitals, police stations and the general community. The rationale for location in police stations and hospitals was to build capacity in these formal institutions to enable identification of cases of violence, provision of appropriate responses and to enable follow-up.

Outcomes: Since the establishment of the FCC, it is clear that there is an increase in the number of cases reported to the FCC.

Lessons learnt: The components of the model are clear in all three States. The evaluation reports demonstrate that a specialised cell with a team of sensitive counsellors and support staff for follow-up, with community outreach, is a critical strategy in addressing VAW. While linkages to the police and the hospital are essential, co-location can be a deterrent. Community-based efforts to address VAW seek to influence a larger section of the determinants of violence and are highly dependent on the credibility and skills of the organisation. Appropriate selection of counsellors and extensive capacity of all key staff are also integral to the model. Both these factors could prove to be an impediment to scaling up, as they require processes that are somewhat alien to the current systems. While the evaluations are all clear, that maintaining case records and documentation are important requisites, it is not clear from the documentation whether specific and common monitoring frameworks for all FCCs were set up. In fact, the UNFPA evaluation conducted in 2008 shows that the quality and periodicity of reporting in Madhya Pradesh needs substantial changes. Although the reports discuss qualitative changes such as increased referrals for GBV or that the outcome in the FCC located within the police stations is counselling of the woman and the family has reduced the formal lodging of complaints, this does not provide information on what were the processes or outcomes expected, what was actually achieved and most important what were the determinants that either supported or hampered the achievements.

Conclusions: The work of the FCC challenges a fundamental societal issue of patriarchy. Thus, advocacy should be an inbuilt feature of the model. Although the evaluation states that the FCC was part of a broader policy response, it is important to understand how the policy dialogue and advocacy at the national level is related to the State and district levels. The key components of FCCs are much more in the realm of process and values, both of which are difficult to achieve in scaling up. The evaluation in non-UNFPA-supported counselling centres in Madhya Pradesh suggests several lacunae in the FCC, indicating that the FCC needs substantial and sustained technical support.

Annexure 8

Service Delivery for Reproductive And Child Health

ANNEXURE 8.1.1

Mobile Health Clinics in West Bengal

Title	Mobile Health Clinics
State	West Bengal
Geographic Area of Coverage	382 remote villages in the riverine belt of the Sunderbans
Target Population	General population with a focus on well baby clinics, immunisation and family planning
Project Life	1999, ongoing
Budget	Rs. 300 lakh in 2007-2008; Rs.150 lakh in 2008-2009
Implementing Partners	Government of West Bengal and NGOs
Existing Evaluations	Review of Public Private Partnerships, commissioned by the Technical Assistance Support Team (West Bengal)
Documents Reviewed	Report of the review of PPPs

Objective: As part of increasing access to health services, the Government of West Bengal has introduced mobile health clinics through mechanised boats and ambulances and outsourced through NGOs under PPPs. The scheme is being implemented in the remote areas of the Sunderbans through five NGOs and has been operational since 1999.

Strategies: The clinics cover a population of roughly 400,000. The key strategies include:

1. Use of a mix of ambulances, launches and mechanised boats that have medical equipment and supplies as well as wireless facility.
2. The clinics are expected to provide diagnostic services, routine PHC services and organise community awareness programmes.
3. NGOs provide monthly plans to the local Panchayats, health facilities and communities, detailing the site and day of the mobile clinic.
4. Organisations are expected to employ local staff.

Outcomes: (data from two of the five organisations)

- 75% of the users rated the mobile health services better than locally available services
- Community awareness of services is high

Lessons learnt: While the mobile health units were intended to fulfill the lack of fixed facilities in the area and the difficulty encountered by communities living in remote areas, the assessment shows that there are several lacunae that hamper effective provisioning of services. NGOs find it difficult to recruit doctors to work in mobile health clinics. Training of staff is reportedly inadequate. The nature of reporting formats that are primarily quantitative makes performance assessment difficult. (There are no details on this observation, which probably impacts the monitoring data). There are no mechanisms in place for feedback. The

report indicates that there is a shortfall in the case of both NGOs on the number of general clinics, immunisation clinics and specialist clinics.

Conclusions: The review report concludes that the services are much needed and makes some generic recommendations to fill the gaps identified. Instituting sound monitoring systems and ensuring that NGOs fill in the gaps identified, may be the first steps in developing this model before planning for scale up.

ANNEXURE 8.1.2

Mobile Medical Units—Reaching the Unreached

Title	Mobile Medical Units
State	Chhattisgarh
Geographic area of Coverage	74 of 81 tribal blocks covered
Target Population	Community in need of medical services
Project Life	2004, ongoing
Budget	Not applicable
Implementing Partners	Department of Health and Family Welfare, Chhattisgarh, with the technical assistance of the State Health Resource Centre (SHRC)
Existing Evaluations	Not applicable
Documents Reviewed	Giving Public Health a Chance: Some Success Stories from Chhattisgarh on Community Basing of Health Sector Reforms, Department of Health and Family Welfare, Government of Chhattisgarh

Objectives: The objective of the scheme is to enable communities in remote and difficult-to-reach areas to get the benefits of medical treatment near their place of residence when there is no fixed facility operational.

Strategies: Seventy four MMUs have been commissioned, 64 in tribal areas and 10 in non-tribal areas. The key strategic approaches are:

1. Enabling the MMU to charter a route where weekly *haats* (village marketplaces) are held in order to provide services to a large number of people in an area regularly accessed by them.
2. Each unit is equipped with drugs and supplies, medical officers, support staff and clinical examination facilities.
3. The MMU also conducts social mobilisation and BCC activities.
4. The MMU can double up as an ambulance when required.
5. The MMU will be phased out as and when fixed facilities in these areas become operational.

Outcomes:

- Every week, the MMUs cover 400 market areas catering to over 7,000 villages
- About 10,000 people per month are covered by one MMU
- Enables people to seek care without consequent wage loss

Lessons learnt: The MMUs appear to serve an important need although logistics, ambulance design and optimum staffing need to be worked out more carefully. An in-depth review of the scheme is being planned to assess functioning.

Conclusions: The MMU serves a useful purpose where geographical barriers and difficult terrain are a major constraint in accessing services. However, MMUs should not be seen as a substitute for fixed facility services, except under extreme conditions.

Improving Access to Basic Services by Excluded Communities Mobile Boat Clinics in Riverine Areas of Assam

Title	Mobile Boat Clinics in riverine (*char*) areas
State	Assam
Geographic Area of Coverage	Five districts—Dhubri, Dhemaji, Dibrugarh, Morigaon and Tinsukia
Target Population	Women and children living in the riverine areas; services provided to tribes and migrant communities
Project Life	Pilot 2005, five district models—February 2008,
Budget	Rs. 214.90 lakh in 2007-2008 (7 boat clinics at the rate of Rs. 30.70 lakh); Rs.260.00 lakh for 10 boat clinics (including the cost for 5 new boat clinics from 2007-2008) in 2008-2009
Implementing Partners	Centre for North East Studies and Policy Research (NGO) and the National Rural Health Mission
Existing Evaluations	None
Documents Reviewed	Boat clinic report, April 2008, North East Resource Centre Memorandum of Understanding between C-NEs and the National Rural Health Mission UNICEF note on AKHA—Ship of Hope

Objectives:

1. The challenge of routine service delivery to sparsely populated, difficult-to-reach areas exists in almost all parts of the country and necessitates local and context-specific responses. Several areas of selected districts in Assam have riverine islands—referred to as 'char' areas. During the rainy season, the habitations are cut off from the mainland by floods in the Brahmaputra River. Even during the dry season, service provision to these areas is inadequate. There are 2,251 villages in these *char* areas, with 52 PHCs and 132 sub- centres. Due to the recurring floods, it is difficult to construct permanent infrastructure in these areas.

2. In 2005, the Centre for North East Studies (C-NES) and Policy Research, as part of an emergency response, launched a ship to provide a package of primary health care service to the community in these areas. The key objective of the boat service is to function as a service- delivery facility providing preventive and curative services through round-the-year visits.

3. Through the boat clinics the State plans to reach out to 1 lakh people in 2008 and 2.5 lakhs in 2009.

Strategies: The initiative was originally implemented in partnership with the Assam Medical College, District Health Society and UNICEF. Recently the initiative has been scaled up into five districts retaining C-NES as the implementing agency.

1. The five-district implementation model is based on a detailed MoU laying out clear roles and responsibilities.
2. There is a distinct role for ASHAs and incentives for performance.
3. Clear monitoring mechanisms and management information systems have been developed.
4. A package of preventive and curative services is provided including health education.
5. The boat clinics also provide emergency services and basic health care during disasters/epidemics/public health emergencies/ accidents.
6. Each boat clinic is staffed by a district community organiser, two medical officers, one GNM, two ANMs, one pharmacist, one laboratory technician and four community workers.
7. C-NES is responsible for advocacy with potential partners for scaling up and expansion to other districts, maintenance and operations of the boat and co-ordination and management of logistics for health camps.

Outcomes:

- 95 riverine islands covered in 114 villages in the five districts
- 385 camps held, covering 47,712 population
- 1,588 antenatal cases seen
- 3,828 children immunised
- 1,297 beneficiaries provided FP services

Lessons learnt: Each of the partners appears to have clear and distinct roles that are complementary. The model is one of PPP and appears to be addressing a great need. Key challenges include: tracking the drop-out of children and providing antenatal and postnatal check up of women, given that the population in the *char* area is mostly migrants; difficulties in reaching these islands during floods; transportation of the referred cases to nearby institutions; dedicated manpower for boat clinics and follow up of the progress made by the patients.

Conclusions: The boat clinics seek to provide services to an area of significant need. However, there are challenges to provide a package of promotive, preventive and curative services. It is necessary to develop other mechanisms such as empowering ASHAs to increase community health awareness and enable provision of first level curative services. Systems also need to be developed to enable improved tracking and follow-up.

ANNEXURE 8.1.4

Mobile Health Clinics—Uttarakhand

Title	Mobile Health Clinics
State	Uttarakhand
Geographic Area of Coverage	Nainital district
Target Population	Pregnant women
Project Life	Expected start date: March 2007
Budget	Rs. 40 lakh for 2008-2009
Implementing Partners	GoUP, through IFPS II
Existing Evaluations	None
Documents Reviewed	IFPS evaluation, September 2007

Objective: The MHC is intended to provide basic RCH services in hard-to-reach areas such as the hilly villages in Ramnagar, Nainital. The Birla Institute of Scientific Research (BISR) has a partnership arrangement with the IFPS II project to implement this scheme. The BISR has past experience in providing diagnostic services through this model. The objective is to increase accessibility of preventive, diagnostic and curative services with emphasis on RCH services by using a mobile medical van to supplement health services in remote rural areas.

Strategies:

1. The funds for purchase and equipment of the mobile van are provided by the Government.
2. The clinic provides diagnostic, RCH and referral services including the provision of spacing methods for family planning, ANC, PNC and immunisations.
3. The MHC will establish linkages with the public and private sector static facilities so that clients can be referred for sterilisations and other clinical services requiring more intensive follow-up.
4. Services for patients in the BPL category are free with user fees for those APL.
5. A fixed date approach ensures bi-monthly visits to each of the eight camp sites.
6. Monitoring and review is by the Project Advisory Group.

Outcomes:

- Nearly 100% of scheduled camps are being conducted
- Over 30% of clients are from the BPL category
- Two-thirds of the clients are women
- 157 camps organised as on August 2008

Lessons learnt: This model has the potential for reaching geographically isolated populations and is supported by the GoI and the Government of Uttarakhand. The State's service statistics report improved coverage of services in the eight sites selected for the clinics. Some of the key concerns are: delays in launch due to faulty equipment (the scheme had not yet been operationalised as of September 2007). There seems to have been no communication between the BISR and the district officials, so planning was not coordinated. Mechanisms for referrals between the mobile clinic and static facilities have not yet been established. No plans have been made for outreach to communities to be affiliated with the mobile clinic, an essential element for increasing utilisation of its services. While there are reporting forms, the BISR does not yet have an MIS system to track and report service use. Reporting forms at present apply only to diagnostic services, not RCH or FP services. The plan for use of the revenue from user fees is unclear.

Conclusions: Although it is too early to comment, the MHC does have the potential to reach difficult areas, given the terrain in Uttarakhand. Issues with operations, particularly logistics and community outreach, need to be studied and streamlined. Referral linkages and transport facilities should also be established.

ANNEXURE 8.2.1

Expanding Access and Demand for Depot Medroxy Progesterone Acetate (Depo-Provera) in Uttar Pradesh, Uttarakhand and Jharkhand

Title	DMPA Programme
State	Uttar Pradesh, Uttarakhand and Jharkhand
Geographic Area of Coverage	42 cities in Uttar Pradesh, Uttarakhand and Jharkhand
Target Population	Women in the higher economic groups needing to use a spacing method for family planning
Project Life	Four phases starting from 2002, currently in fourth phase, progressive expansion of provider network
Budget	Not available
Implementing Agency/Partners	Overall technical assistance PSP-One through USAID, FOGSI, (to promote DMPA among its membership) Pfizer, DKT, PHS, (to supply DMPA to the network clinics) IPAN (public relations and advocacy) Lowe (mass media activities)
Existing Evaluations	None, project report on activities and coverage
Documents Reviewed	Project report

Objectives: This innovation uses a multi-pronged approach to expand access to DMPA—a three-monthly indictable contraceptive, currently available only through the commercial sector. The key objectives are to:

1. Train and sensitise private providers in the provision of DMPA as a spacing method.
2. Generate demand through a range of communication channels.

Strategies: The strategy was to implement the innovation as one-year pilots over three successive phases. It is now nearing the end of the fourth phase. The key strategic approaches include:

1. Increasing demand for DMPA through mass media, outreach and interpersonal communication.
2. Creating a network of providers and clinics (branded as DMPA clinics) trained in provision of family planning services including all elements of quality of care.
3. Negotiation with commercial manufacturers to provide DMPA at subsidised rates.
4. Advocacy to create support for the initiative.
5. Ongoing research, monitoring and evaluation to modify, adapt and strengthen the programme.

The fourth phase of the pilot is expected to be completed in 2009. The operations research nature of the pilots in the first three phases enabled identification of problems and mid-course corrections.

Outcomes (as of March 2008):

- Programme expanded in Uttar Pradesh, Jharkhand, and Uttarakhand. (42 towns accounting for 24% of the population)
- A total of 1,638 providers trained and 1,052 enrolled in the DMPA network
- Higher proportion of providers adhering to quality protocols
- DMPA members offer wider choice of contraceptives
- Expand base of commercial sources for DMPA
- Sales of 40,000 vials, DMPA use-up
- Cost of vial down substantially

Lessons learnt: Based on the outcomes, it would appear as though the strategy of involving private providers enables increase in use of DMPA. DMPA is not available in the public sector programme partly because of opposition by activists. The advocacy effort in the innovation has not been able to address this issue. The promotion of DMPA is primarily in cities and large towns through networks of private providers. Thus it is perhaps out of the reach of poor rural women. In order to expand women's choices to family planning, DMPA is a potential candidate. However, given the data it is difficult to draw conclusions on scaling up the approaches used in the DMPA pilots in a large scale programme.

Conclusions: The fourth pilot concludes in 2009. The focus of the evaluation needs to be on identifying factors that would enable the development of an advocacy strategy for promoting DMPA through the public sector, especially identifying champions and building up a support base among providers and women; identifying key capacity building needs; DMPA should become available in the public sector; planning a communication strategy to suit the needs of the rural poor and finally to integrate DMPA as another method in the basket of choices.

Annexure 8.3.1

Rashtriya Swasthya Bima Yojana

Title	Rashtriya Swasthya Bima Yojana
State	Pan India scheme
Geographical Area of Coverage	Below poverty line workers and their families in the unorganised sector across the country
Budget	Approximately Rs. 2,000 crore for five-year period (2008-2013)
Project Life	Rashtriya Swasthya Bima Yojana (RSBY) was launched on 1 October 2007 and implemented from 1 April 2008 in a phased manner
Implementing Agency/Partners	The Ministry of Labour, GoI and State Government through insurance companies
Existing Evaluation	Nil
Documents Reviewed	Nil

Objectives:

The main objective of this scheme is to provide health Insurance cover to the BPL workers and their families in the unorganised sector and to improve access of BPL families to quality medical care for treatment of diseases, involving hospitalisation and surgery through an identified network of health care providers and was rolled out from 1 April 2008.

Strategies:

This scheme will be operational in all the 600 districts of the country in a phased manner by 2012. However, the Government has allowed different State Governments to take up all the districts in 2009-2010. Till now approximately 16 States have launched this scheme and are at different stages of implementation. Many other States including the North Eastern States and Jammu and Kashmir also are planning to launch this scheme in 2009-2010.

For effective operation of the scheme, partnership is envisaged between the insurance company, public and the private sector hospitals, smart card providers, NGOs and the State agencies. Few unique features of this scheme are as follows:

1. **Empowerment:** Beneficiaries have option to access both public and private providers.
2. **IT:** Technology intensive with first time use of smart card technology at this scale in India. Smart cards at this scale are being issued for the first time and printed in the field.
3. **Safe and foolproof:** All the transactions are very transparent and biometric technology is used, thereby reducing the chance of fraud to a large extent. Each smart card has fingerprints and photographs of all the beneficiaries of the family and the card is only used after authentication, which is done by providing fingerprints.
4. **Less moral hazard:** Package rates have been developed for all common surgical procedures by fixing treatment and other related cost for each intervention. Therefore, hospitals cannot charge arbitrary rates for the treatment, which reduces the chances of moral hazard from the hospital side.
5. **Portability:** A BPL family can get benefits across India and the same smart card can be used in any network hospital across India. Even when one member of the family is going out to work as migrant labour, the family has the option to get another smart card by paying extra money and the total benefit can be divided in these two cards.

6. **Cashless and paperless** scheme for all stakeholders: The beneficiaries need not pay anything in the hospital. For hospitals, they need not submit any paper claims to the insurer.
7. **Business model in the social sector:** This scheme works on the principle that all stakeholders involved in this process shall have benefits for themselves.
8. **Heavily subsidised**: Less financial burden on BPL as the State and Central Government share 100% of the subsidy. People have to pay only Rs. 30 as the registration fee.
9. The main benefit within this scheme is a hospitalisation cover for Rs. 30,000 per family.
10. All pre-existing conditions/diseases are covered from Day One and there is no age restriction also.
11. Provision for transport allowance (actual with limit of Rs. 100 per visit) up to a maximum of Rs.1,000 per year.
12. From 2009 even maternity-related expenses are also covered, which are incurred at the time of delivery. The newborn child gets automatically covered, for that policy period, from the moment the child is born.
13. Costs incurred one day prior to hospitalisation and five-day post-hospitalisation are also covered in this scheme.
14. Unit of enrolment for this scheme is a family up to a unit of five. This would comprise the household head, spouse, and up to three dependents. The dependents would include such children and/or parents of the head of the family as are listed as part of the family in the BPL data base. However, newborn children will be covered for that policy period in which the child is born even if the child is the sixth member.
15. Contribution of the Government of India is 75% of the estimated annual premium of Rs.750 subject to a maximum of Rs.565 (90% of the premium for States in the North East and Jammu and Kashmir Rs. 675) per family per annum.
16. Contribution by the respective State Governments is 25% of the annual premium (except for the North East and Jammu and Kashmir where States will contribute 10%).
17. The scheme has 725 identified common surgical packages apart from medical procedures. In addition to the package list other procedures are also covered.

Outcomes:

- As on 20 February 2009, the scheme has been rolled out in 15 States on various dates
- States such as Kerala, Haryana, Gujarat, Maharashtra and Uttar Pradesh have already launched the scheme in all districts
- A total of 28 lakh family smart cards have been issued, covering 1 crore 30 lakh members
- Seven insurance companies registered with IRDA are providing the health insurance cover under Rashtriya Swasthya Bima Yojana to BPL families

Innovations in RSBY:

- **Extensive use of information technology** has been done in this scheme. All the data is collected real time at both State and Central levels, which can be generated into reports daily

- **Cleaning of BPL list:** This scheme has brought forward very clearly the need to prepare a better BPL list. The enrolment process is helping in identifying the deficiencies in the existing BPL list.

- **Use of biometric-enabled smart card** is a very unique feather of this scheme. For the first time in the world this has been done at this large scale for poor people

- The scheme has also started a **partnership between different departments** at the State level, which needs to work together to successfully launch this scheme. Departments such as Rural Development, Health and Family Welfare, Labour, etc., are working together in the implementation.

- **Incentive for public providers:** The money from the insurer will come directly to public hospitals when they treat a beneficiary of RSBY. The money received can be used by these hospitals not only to improve the quality of these hospitals but also to provide cash incentive to the staff of the hospital.

Conclusions:

The initial response of hospitalisation in four States is quite positive. However, it is very early and the scheme has completed only one year.

Annexure 8.3.2

Rajeev Aarogyasri Health Insurance Scheme, Andhra Pradesh

Title	Rajeev Aarogyasri Health Insurance Scheme
State	Andhra Pradesh
Geographical Area of Coverage	BPL population of the State identified as per State parameters
Budget	Rs 66 crore
Project Life	Introduced a health Insurance scheme in three districts with effect from 1 April 2007. It covers 25.27 lakh BPL families on a pilot basis in **Phase I** for heart, cancer, neuro surgery, renal diseases, burns and poly trauma (not covered by the MV Act) and covers 163 surgical interventions through standalone health insurance companies with PPP. Scaled up in the entire State in a phased manner
Implementing Agency/ Partners	Rajeev Aarogyasri Trust, a body constituted by the State. The scheme is implemented through Star health Insurance Company
Existing Evaluation	Nil
Documents Reviewed	Nil

Objectives:

Like in other States, many people approached the Government for financial assistance to meet the medical/surgical expenses. During the period from 14 May 2005 to 26 June 2007, financial assistance to the tune of Rs 168.52 crore was provided from the Chief Minister's Relief Fund for 55,361 cases to meet hospitalisation expenses for such people. However, the system to provide these benefits is quite ad hoc. Therefore, the State Government felt a need to introduce health insurance, to provide medical assistance to BPL families for treatment of critical illnesses such as cancer, kidney failure, heart and neuro, etc.—all those requiring hospitalisation.

Strategies:

1. The Government of Andhra Pradesh introduced a health Insurance scheme in three districts with effect from 1 April 2007 covering 25.27 lakh BPL families on a pilot basis in **Phase I** for heart, cancer, neuro surgery, renal diseases, burns and poly trauma (not covered by MV Act) and covering 163 surgical interventions. An insurance company was selected through open bidding and the premium was Rs 330 per family, that is, Rs 66 crore. The sum insured is Rs. 1.50 lakh with a buffer of Rs 50,000 per family.

2. Consequently, the State has introduced this scheme in **Phase II** by increasing the interventions to 213 by open tender process in five districts with effect from 5 December 2007, covering 48.23 lakh BPL families. By an open bidding process the same insurer was selected with a premium of Rs 220 per family.

3. Encouraged with the responses, the State replicated the scheme in a phased manner, that is, **Phase III**, 34.86 lakh BPL families in five districts from 5 April 2008; **Phase IV**, 35.46 lakh BPL families in five districts from 7 May 2008, **Phase V,** 40.92

lakh BPL families in the remaining five districts from 5 October 2008. Thereby the State would be covering a total of 1.85 crore BPL families, that is, 6.55 crore BPL population.

4. To have a better monitoring scheme it is being implemented through a trust called the 'Aarogyasri Health Care Trust'.

5. The BPL population is identified by biometric ration cards issued by the Civil Supplies department.

6. The Trust is also issuing a health card to all BPL families based on the above data.

7. Both public and private health facilities are allowed to be a part of the provider network.

8. Health Melas, being the major areas of thrust under this scheme, are being organised by the networked hospitals for the identification of patients.

Outcomes:

- The scheme was able to provide the BPL people of the State with health insurance benefits and more than 10,000 surgeries were done in the first year of the first phase. The website of the scheme provides all the details about the surgeries, which are done under the scheme.
- After implementing the scheme in all the districts of the State, the Government of Andhra Pradesh has been able to successfully provide health insurance coverage to approximately 80% of the total population across the State.

Lessons learnt:

- An insurance scheme cannot be successfully implemented in the State if the Government will not work very closely with the insurance company
- The State Government needs to work in partnership mode with the insurer
- An independent body such as the Arogyasri Trust is needed to work full time on the implementation and, at the same time, closely monitor the scheme
- Information technology can be used for close and real-time monitoring of the scheme
- Data should be analysed and the report should be used to improve the performance and efficiency of the scheme
- A fool-proof identification system ensures that benefits reache the right person and are not misused
- A scheme such as Aarogyasri, which provides critical illness cover can only be successful in a State if the State has a sufficient number of public and private providers who can provide critical care and, at the same time, have unused capacity available with them
- Inclusion of public provider means that Government hospitals can also earn an income, which they can use to improve their service delivery

Conclusions:

If the existing infrastructure of the State is good enough to provide secondary health care to poor people free of cost then a health insurance scheme such as Aarogyasri, which provides critical illness cover, can be very beneficial for poor people.

However, before other States plan to start similar schemes in their States, they should first analyse whether they have enabling factors in their State, which are responsible for its success.

Annexure 8.3.3

Yeshasvani Co-Operative Farmers Health Care Scheme[*]

Title	Yeshasvani Co-operative Farmers Health Care Scheme
State	Karnataka
Geographical Area of Coverage	Any farmer who is a member of a co-operative society in Karnataka
Budget	Contributory: Beneficiary and State Government
Project Title	Any farmer who is a member of a co-operative society in Karnataka can get the necessary treatment and have access to expensive medical procedures by becoming a member of a scheme
Implementing Agency/ Partners	Yeshasvani Trust and implemented through FHPL (TPA)
Existing Evaluation	Nil
Documents Reviewed	Nil

Objectives:

To provide cost-effective quality health care facilities to any farmer who is a member of a co-operative society in Karnataka.

Strategies:

1. Initiated by Dr. Devi Shetty of Narayana Hrudayalaya, Bangalore and State Government of Karnataka through Yeshasvani Co-operative Farmers Health Care Scheme (YCFHCS) is a great boon to the co-operative farmers of Karnataka.

2. Family Health Plan Ltd. is the implementing agency and operates under the aegis of the Karnataka State Co-operative Department.

3. The scheme aims to provide cost-effective quality health care facilities to the co-operative farmers spread across the State of Karnataka.

4. Being a self-funded scheme, the governing body for implementation, policy decision and financial control lies with the special purpose trust named the Yeshasvani Trust and the Principal Secretary of the co-operative department.

5. The scheme has a wide surgical cover (900 procedures) for the farmers and their family members.

6. Beneficiaries are offered cashless treatment at the network of over 135 hospitals spread across the State of Karnataka.

7. Coverage is limited to Rs 2 lakh per annum per individual and a sub-limit of Rs 1 lakh per surgery per individual with category limit.

8. All procedures are limited to one incidence per year. 1,600 surgical procedures are covered, subject to some exclusions, at a tariff pre-negotiated with the participating hospitals.

[*] *Though technically Yeshaswani is not a health insurance scheme as there is no insurance company involved, yet it is included here as it hasa lot of characteristics of a health insurance scheme such as premium payment by the beneficiaries*

9. This excludes prosthesis, implants, joint replacement surgeries, transplants, chemotherapy, cosmetic surgeries, burn cases, dental surgeries and several other events and items.

10. Coverage for stabilisation of defined medical emergencies are also available in cases of dog bite, snake bite, bull run injury, drowning, accidental poisoning, electric shock, accident while working with agriculture implements, road traffic accidents and burns. These would be limited to two days of hospitalisation and up to a maximum of Rs. 1,500 per member per incidence.

11. Coverage for maternity care is also available to a woman member who should be above 18 years. Hospital charges for normal delivery are limited to Rs. 600 per birth. In addition, neonatal is also covered.

12. In addition, free OPD consultation at participating hospitals, discounts on investigation charges and on the tariff for non-covered hospitalisation is also available.

13. Each individual co-operative farmer has to contribute Rs. 10 per month per life for adults and children (Rs. 120 per annum).

14. 15% rebate on contribution for family of five or more members is provided as an incentive to members. Members should have minimum six months membership in co-operatives societies.

15. The plan is open to all members on a voluntary basis. The State Government also provides financial support to the scheme.

Outcomes:

- This is one of the few health insurance schemes in India, which is working successfully for many years and has such a large number of beneficiaries
- This is not a Government-funded scheme in the strictest sense as people pay a premium to get the benefits
- The role of Government is to provide financial assistance whenever the expenses of the scheme go higher than the revenues collected from beneficiaries. Since there is no insurance company involved, the role of the Government becomes critical for the survival of the scheme

Lessons learnt:

- If the unorganised sector workers can be targeted through some mechanism where they can be grouped together, then it is simpler to enroll a higher number of people
- Since beneficiaries were not enrolled individually but through cooperatives, the collection of premium is much simpler.
- One of the main reasons of the success of the scheme is the presence of a large number of private providers in the State with underutilised bed capacity

- Another important factor for success is the leadership and vision provided to the scheme by people suc as Dr. Devi Shetty
- The support provided by the Yeshasvani Trust is another reason for the successful implementation of the scheme.

ANNEXURE 8.4.1

Management of Sub-centres in the Uttar Pradesh Health Systems Development Project

Title	Management of Sub-centres in the Uttar Pradesh Health Systems Development Project (UPHSDP)
State	Uttar Pradesh
Geographic Area of Coverage	28 districts
Target Population	Pregnant and lactating mothers, and children under five years
Project Life	Launched in 2003, ongoing
Budget	Total budget not known, one sub-contract is Rs. 300,000 per annum
Implementing Partners	Government of Uttar Pradesh
Existing Evaluations	Evaluation Study, Indian Institute of Management, Lucknow, 2006
Documents Reviewed	Evaluation report

Objectives: The 'Innovative Scheme' was initiated in 2003 with 119 NGOs. In 2007, 290 NGOs were contracted by the project to manage the preventive, promotive and limited curative interventions in the geographic area of coverage of a sub-centre. The objective of the programme was to enable NGOs to deliver limited and curative and preventive health services in remote, inaccessible and unserved areas with a focus on poor and disadvantaged groups, especially women.

Strategies:

1. Enable NGOs to establish a health care unit with a doctor, a paramedic and an ANM to provide a package of RCH services and PHC.
2. NGO to use a participatory approach to work with the community and other stakeholders.
3. Scheme to be monitored by the PMU and District Programme Manager (DPM).

Outcomes:

The evaluation results are mixed. There is no baseline data for comparison.

- All health centres have been established in remote areas
- 70% of the beneficiaries of the scheme are primarily members of BPL households
- 45% of women have been registered for antenatal care
- Institutional deliveries are about 23% (although this may have changed recently on account of Janani Suraksha Yojana)

- Childhood immunisation is reportedly around 60%
- 20% of people ever participated in the NGO-led awareness programmes
- 37% responded positively with regard to availability of medicines at the sub-centre

Lessons learnt: Supporting NGOs to provide services in remote underserved areas has been part of many Government health schemes. In one respect the scheme demonstrates that setting up of health centres in remote areas, enables access by the poor and marginalised. The evaluation comments that the monitoring systems set by the UPHSDP were not adequate and that monitoring mechanisms were very weak. The evaluation also recommends substantial changes in the organisation structure for managing the scheme and a more systematic compilation of implementation and monitoring guidelines. It also appears that funding was inadequate. There are also issues of poor service quality and limited participation of NGOs in Government training programmes. The impact of the scheme appears limited. However given that there is no baseline data it is likely that the scheme may have had a significant impact.

Conclusions: The review reports findings indicate that substantial modification of the scheme is required before being scaled up, particularly from the view of the management and institutional structures.

ANNEXURE 8.4.2

Contracting out Services in West Bengal under Public Private Partnership

Title	Contracting out Diagnostic Functions, Mechanised Laundry, Security and Scavenging, Bio-medical waste management,
State	West Bengal
Geographic Area of Coverage	Selected Institutions in West Bengal
Target Population	General population: Users of public sector health facilities
Project Life	2005, ongoing
Budget	NA
Implementing Partners	Government of West Bengal
Existing Evaluations	Review of Public Private Partnerships commissioned by the Technical Assistance Support Team (West Bengal)
Documents Reviewed	Report of review of PPPs

Background: The Department of Health and Family Welfare, West Bengal, has, since 2005, involved the private sector through outsourcing for key services in public sector institutions. The PPPs policy seeks to actively engage in such partnerships to realise its mission of providing equitable access to health services for all; especially the poor. This report briefly reviews the key findings of an assessment of the scavenging services, diagnostic services and mechanised laundry services.

Mechanised Laundry

Objectives:

- To improve efficiency along with the quality of washing and disinfection of hospital linen according to standard operating protocols

- Minimise the potential risk of infection transmission through reused lines when washed by conventional manual methods

Strategies: Thirty-two hospitals in Kolkata are covered under the scheme. The key strategies include:

1. Setting up five year agreements with mechanised laundry units.
2. Laundry units to engage requisite human resources procure and install laundry equipment with the stipulated capacity.
3. Compling with collection, washing and delivery regulations defined in the contract.
4. Establishing a monitoring and management information system.

Outcomes:

- Survey of hospital users (over half of whom belonged to SC/ST) indicated that half felt that the quality of laundered linen was satisfactory, but over 50% said that in a hospital stay of five days the bed linen had not been changed at all
- Private partners have complied with the establishment of laundry units for equipment and staff
- Payments to the private organisations are regular

Lessons learnt: While outsourcing to the private sector has been an important step in ensuring mechanised washing, some issues such as quality of services and management information system need to be streamlined.

Conclusions: Outsourcing and use of mechanised laundry services represent an important step in improving quality of care as well as infection prevention. However, several issues need to be streamlined including MIS, quality of services and proper collection schedules.

Specialised Diagnostics

Objectives: The objective of the scheme is to ensure availability of specialised diagnostic services, specifically Computerised Tomographic (CT) Scan and Magnetic Resonance Imaging (MRI) through installation and operation by the private sector.

Strategies:

1. Installation of CT scan units in six medical colleges and outsourcing the management to the private sector.
2. Installation of MRI units follows tow strategies: one is within the public health facility and the other to install them in private sector institutions.
3. Setting up an audio vestibular laboratory in a public health facility.

Outcomes:

- The Government has been able to provide the requisite space for the functioning of these units
- The private groups have set up the equipment and hired the requisite staff to manage the diagnostic units
- Average monthly caseloads for the diagnostic services range from 820 to 1,300. Case loads have increased by 20% in the last two years
- Private partners have adhered to the fixed rate schedule
- Proportion of private cases seen in public health facilities is about 2%

Lessons learnt: Most units reported starting on time; staff appeared competent and followed all norms and standards, including compliance with the highly subsidised rates, patient consent forms and patient satisfaction cards. Overall there appears to be an increase in caseload for diagnostics by 23% in the last two years. However, the financial package needs to be reviewed and inadequate visibility of the rate charts could affect targets.

Conclusions: The outsourcing of diagnostic services appears to be a valuable service being provided and caseloads have increased. However, several factors continue to hamper effective functioning and need to be addressed in order to recommend scaling up to other centres. These include strengthening the monitoring and management information systems, ensuring that the poor have access to these facilities and review the financial package for the diagnostics.

Scavenging

Objectives: The objective was to improve the cleanliness and efficiency of the hospital's external environment as well as the internal units and wards to keep off infection and maintain environmental sanitation.

Strategies: The Government of West Bengal initiated the scheme in three sub-divisional hospitals through private partners selected through a tendering process.

Lessons learnt: Several issues have been specified in the assessment report. There is considerable patient dissatisfaction with the levels of cleanliness. The private partners tend to minimise the use of detergents, soap and other consumables. Work shifts are not adhered to. Privacy for female patients is compromised with male cleaners working in the female wards. Preventive cleaning measures are not undertaken as stipulated in the contract. As in the laundry case, quality appears to be an issue, with the contractors not adhering to quality norms or to specification on who to hire (for example, ex-servicemen for security). It is clear that there needs to be a significant improvement in regulating and monitoring the contractors.

Conclusions: While outsourcing of cleanliness may remove an onerous burden from the public sector facility management, the lessons from the West Bengal experiences are that privatisation may not necessarily help unless there is stringent monitoring and ensuing adherence and compliance with contractual obligations.

ANNEXURE 8.4.3

Contracting out Services through Private Hospitals in Urban Areas of Assam

Title	PPP to Promote Institutional Delivery
State	Assam
Geographic Area of Coverage	14 urban slums of eight low income municipal wards in Guwahati, Assam
Target Population	Low income population for RCH services
Project Life	February 2002-2003
Budget	Rs. 2.25 lakh in 2005-06; Rs. 88.4 lakh at the rate of Rs. 44.2 lakh every year) in 2007-2008 and 2008-2009
Implementing Partners	Directorate of Health Services, Government of Assam, in partnership with the MMH (through ECTA support); Extended to another private city-based hospital
Existing Evaluations	None
Documents Reviewed	Project update note prepared by North East Regional Resource Centre (NE-RRC); PPP: Operational Framework used in Andhra Pradesh and Assam: A documentation (August/September 2002); ECTA working paper 2002/61 **http://cbhi-hsprod.nic.in/files**

Objectives: The key objective is to improve access to facility-based integrated primary health care services for the urban poor living in slums.

Strategies: In February 2002, the Government of Assam contracted with a local Trust Hospital, the MMH, to provide a package of RCH services in eight low-income municipal wards of the city, with a population coverage of 200,000 to 250,000. The key strategies include:

1. The State Government contracts with the MMH for providing outreach and referral services and provides vaccines and contraceptives to MMH. MMH covers 14 outreach sites in these areas.
2. The MMH provides a mix of facility and outreach services. Services for sterilisation, child spacing and abortion services are provided free of cost to patients, while deliveries, surgical procedures and diagnostic tests are charged at concessionary rates.
3. The Government supports strengthening of MMT's hospital with 'marginal investment'.

Outcomes: Although no quantitative data are available, the documentation indicates that there is:

- Improvement in access to services, particularly for the urban poor, floating population and women and children who were previously unserved.

- Increases in institutional deliveries, immunisation coverage levels, improved management of obstetric emergencies and provision of basic curative care

Lessons learnt: The State Government perceives that this form of PPP is successful because it has enabled RCH services to a floating population of women and children and 'is not very costly'. The model has also attracted community and political support and has sparked interest among other private hospitals. Significantly, lessons from the model have been applied to the State Government's own urban municipal dispensaries where staff and infrastructure were largely under-utilised. The PPP model has been extended to another city-based hospital for increasing the coverage in the urban slums.

Conclusions: Substantial additional information is required to complete the documentation of the model and to identify the potential for scaling up. Some areas that need to be addressed are: costing issues, quality of care, adherence to national guidelines, experiences with procurement of logistics and other issues in collaboration between MMH and the Government and mechanisms to enhance community participation.

ANNEXURE 8.3.4

Management of Primary Health Centres by NGOs in Arunachal Pradesh

Title	PHC Management through PPP
States	Arunachal Pradesh
Geographic Area of Coverage	All 16 districts of the State
Target Population	Community in area of coverage
Project Life	2007-08 ongoing
Budget	Rs. 9.86 crore (Rs. 4.93 crore in 2007-08 and 2008-09 respectively);10% contribution by implementing NGOs
Implementing Partners	Government of Arunachal Pradesh and four NGOs: Karuna Trust (Karnataka), Voluntary Health Association of India (VHAI), New Delhi; Prayas Juvenile Aid Centre (JAC) Society (New Delhi) and Future Generation Arunachal (Arunachal Pradesh).
Existing Evaluations	None
Documents Reviewed	North East Resource Centre, Arunachal Pradesh.

Objectives: Management of 16 PHCs in 16 districts has been handed over to NGOs—Karuna Trust, VHAI, FGA and Prayas. MoUs have been signed with the NGOs by the State Government under the NRHM programme. As a part of the partnership, the NGOs provide manpower, equipment, administrative support and a range of outreach services. Sub-centres under the respective PHCs are also managed by the NGOs who provide outreach services in the villages covered by the PHCs. The objective of the PPP is to provide quality clinical and preventive health services to the people residing in the area of PHCs.

Strategies:

1. Community mobilisation.
2. Filling in infrastructure and equipment gaps at PHC and sub-centres in the area of operation.
3. Providing comprehensive PHC in keeping with the state and national guidelines.
4. Ensure round-the-clock attendance of providers.
5. Autonomy to NGO in staff selection and recruitment in engaging human resources (medical officers to Group IV employees) in keeping with need, availability and context.
6. Monitoring and supportive supervision for all the staff.
7. Setting up PHC committees under the oversight of the State steering committee.

Outcomes (based on a State report Involving National NGOs in Health Service Delivery in Arunachal Pradesh):

- Manpower position (for example, MOs, SNs, ANMs and Grade IV staff) in the PHCs has improved from 130 (prior to the PPP) to 352 after the PPP has been operationalised
- Immunisation coverage, have reportedly increased
- ANC and PNC services and birth registrations improved
- 24/7 services available in the facilities
- Increase in patient load indicated by OPD, IPD attendance
- Increase in community awareness and in availability and use of services
- Improved infrastructure in the facilities (due to renovations carried by the NGOs)including availability of referral transport
- Improvement in services in the hamlets and villages under the PHC areas through outreach services by the NGOs

Lessons learnt: In Arunachal Pradesh, NGO management has made a substantial difference in the functioning of the PHCs. Regular service availability has improved utilisation of the services by the communities. The NGOs are working with ASHAs who are becoming critical for immunisation and motivating women for institutional delivery. Challenges to the PPP include the very low population density in the districts and difficult geographical terrain. Communication and transport of patients, supplies and equipment is a difficult issue to overcome.

Conclusions: It appears that handing over PHCs to NGOs where public sector facilities do not function is an effective interim strategy until such time as Government infrastructure is established. NGO management of PHCs could also serve as a model for effective PHC functioning even in areas where there is Government infrastructure but service utilisation is low. Establishing one model PHC in a district needs to be co-terminus with strategies to share experiences and lessons with other PHCs.

Annexure 9

Programme Management

ANNEXURE 9.1.1

Revising Female Health Worker Training Course

Title	Revising Female Health Worker Training Course
State	Kerala
Geographic Area of Coverage	Entire State of Kerala
Target Population	All ANMs
Project Life	One year
Budget	The cost of module preparation was Rs. 165,000.00. Training cost is not available
Implementing Partners	Implemented by Public Health Training School. Supported by the Department of Health and Family Welfare, Government of Kerala, Kerala Nurses and Midwives Council and the European Commission's Sectoral Investment Programme
Existing Evaluations	Not applicable
Documents Reviewed	Directorate of Health Services, Government of Kerala. Curriculum for the Female Health Supervisory In Service Training Thiruvananthapuram, Kerala: Directorate of Health Services. 2005 Sandeep K. Updating the Training Syllabus of Female Health Workers, Kerala. PROD Reference No. 149. Policy Reform Options Database. 2006

Objectives: The curriculum for training Junior Public Health Nurses (JPHNs) in Kerala had not been updated for 20 years. The aim of the innovation was to review the job descriptions of its female health workers, redefine their roles and responsibilities and then redesign the training curriculum to ensure they had the appropriate skills.

Strategies: Key strategies include:

1. Participation of key stakeholders at all steps of the process. They include: Additional Secretary, Health and Family Welfare, the Director of Health Services (DHS), Additional DHS, Sector Reform Cell, Additional DHS, Planning and experts from the PHTS, representatives from associations, unions and the JPHNs.
2. The key tasks were: Job analysis, redefining the objectives of the curriculum, listing and prioritising subjects, which must be taught, selecting method of instruction, timing and duration of sessions and protocols for evaluations and assessment of trainers and trainees.
3. The module spans a six-month period and includes an examination. Those who pass are promoted to the supervisory posts of Female Health Supervisors. This training is mandatory for promotion.

4. The newer module clearly defined an ANM's role during field visits, maintenance of records and registers and RCH services, which also segregated her roles at sub-centre and at community levels
5. The training focuses on expanding knowledge base and on building skills and competencies. The training is spread over six months and includes classroom training, with demonstration and practice. The training includes: client communication, management principles (motivation, workforce management,), including supervision, community needs assessment sub-centre planning and updates on maternal and child health as well as areas of emerging concern such as HIV/AIDS, adolescent health, mental health and substance use.

Outcomes: No data available on the progress of the scheme.

Lessons learnt: Overall it appears that a revamping of the ANM curriculum in the current context is essential. In addition to curriculum revision, a pool of trainers needs to be created, and appropriate training aids and material need to be developed. Follow-up, mentoring and support in the field are essential.

Conclusions: The revision of the ANM curriculum in Kerala is the first step towards enabling ANMs to fulfill the manifold tasks that are currently their responsibility. Providing them with the skills and knowledge to address management and technical issues is a critical need across the country. Finally using assessments and measuring competency by way of an examination and creating career avenues could be key to higher motivational and performance levels. More information on implementation of the scheme would be helpful in conducting further analysis.

ANNEXURE 9.1.2

Tribal Auxiliary Nurse Midwives for Tribal Areas

Title	Tribal ANMs for Tribal Areas
State	Karnataka
Geographic Area of Coverage	BR Hills area of Karnataka
Target Population	All tribal population of BR Hills area. Special emphasis on women of reproductive age group and adolescent girls; Children below five years of age
Project Life	Ongoing
Budget	Not applicable
Implementing Partners	Implemented by Karuna Trust and Vivekananda Girijana Kalyan Kendra. Financially supported by the Government of Karnataka, the Association for India's Development (AID) and the Population Foundation of India
Existing Evaluations	Not applicable
Documents Reviewed	Bhat D. Role of Midwives in Promoting Rural Health: A Case Study and Lessons from South India. African Journal of Food, Agriculture, Nutrition and Development. 2003 Communication for Development and Learning. Vivekananda Girijana Kalyana Kendra: Anubhav Series. Bangalore, Karnataka Sudarshan H. Mainstreaming Traditional Medicine in Primary Health Care. Competition Entries for Disruptive Innovations in Health and Health Care: Solutions People Want. Changemakers and Robert Wood Johnson Foundation, 2007

Objectives: Tribal hamlets in several parts of the country are relatively underserved by the public health system because service providers, generally non-tribal, are unwilling to stay in these areas. Health care service for tribal communities living in these areas remains inaccessible. Under a pilot programme granted to an NGO, Vivekananda Girijana Kalyana Kendra (VGKK) under the India Population Project IX, a batch of 16 ANMs belonging to the tribal community, were trained and assigned to tribal sub-centres in three *talukas*. The objective is to train tribal girls in a comprehensive tribal RCH approach to function as ANMs, recognising their role as a vital link between the community and improving access to high quality primary health care.

Strategies: Key strategies include:

1. The tribal ANMs are especially trained to work in tribal areas through a year-long training programme that broadly follows a national programme that has been modified to suit the particular local context.
2. The ANMs are based in sub-centres and provide services to the Soliga tribe, numbering around 20,000.
3. These specially designated sub-centres cater to a population of 500-1,000, against designated tribal sub-centres that 3,000 people.
4. This has led to more effective implementation of national programmes and community level initiatives.
5. The ANMs report to the local PHC, but also interact and work closely with VGKK.

Outcomes

- Increased coverage of difficult-to-reach tribal areas, especially. those that are inaccessible to regular sub-centres and PHCs

Lessons learnt: The challenges of lack of human resources in the public health system in India are partly due to: (a) absenteeism of health staff, (b) lack of motivation to perform and (c) limited accountability. The model highlights the experience that 'localising staffing' and supportive supervision has the potential to reduce absenteeism and staff turn-over. There is a sense of empowerment in the tribal community. The tribal ANM is also empowered for livelihood and as a service provider. Engaging tribal healers as facilitators helped reduce the resistance of the community to tribal ANMs. The local presence of the VGKK, which was also the lead training agency, facilitated training and post-training mentoring and ongoing support.

Conclusions: A critical need of the public health system is a rapid expansion of skilled human resources. Two barriers to this are the limited availability of training organisations/ training centres and the need to ensure local recruitment, selection and training to ensure continuous presence. The VGKK model demonstrates that this is possible. Additional information on the costs, accreditation processes, maintenance of standardised performance guidelines and acceptance within the public health system would need to be considered in preparation for scaling up.

ANNEXURE 9.1.3

Swavlamban Yojana for Sponsoring SC/ST Women Candidates for Nursing Courses in Private Institutions

Title	Swavlamban Yojana
State	Madhya Pradesh
Geographic Area of Coverage	All districts of Madhya Pradesh
Target Population	Sponsoring Class12-pass students to study nursing courses in private nursing colleges in the State. 500 students to be sponsored every year
Project Life	Since 2006, ongoing
Budget	• MSc Nursing; 2 years course; Rs.90,000/annum/student • BSc Nursing; 4 years course; Rs.40,000/annum/student • Post basic nursing course; Rs.25,000/annum/student
Implementing Agency/Partners	Department of Public Health and Family Welfare, Government of Madhya Pradesh
Existing Evaluations	Not available
Documents Reviewed	Power Point presentation

Objectives: Lack of trained human resources is a significant challenge to the provision of high quality, affordable and equitable services. The objective of the Swavlambhan Yojana in Madhya Pradesh is to bridge the gap in availability of trained nurses and to address the issue of equity by enabling girls and women from SC/ST communities to be trained through graduate and post graduate nursing courses.

Strategies:

Although there is only one nursing college in Madhya Pradesh that offers a Bachelor's degree in nursing, 47 private nursing colleges in the State exist. The Government has entered into Memorandum of Agreement with 28 of these. The course is open to residents of Madhya Pradesh (SC/ST candidates) between the ages of 17-25, who have passed Class 12, with a minimum of 50% in the science stream. Students are expected to sign a bond of seven year service in the rural areas, with the degree certificates being awarded at the end of seven years. Students are also expected to execute a bond for Rs. 2 lakh.

Outcomes:

- Agreements have been signed with 28 private nursing colleges to accommodate 500 students that the Government will sponsor each year to the course.
- Over the past two years, 943 students have been admitted to the four year BSc, 57 to the yearly post-basic BSc, and four in the two year MSc course.

Lessons learnt: Ensuring that women students from SC/ST categories are enabled to pursue graduate and post-graduate nursing careers contributes to personal empowerment and to community empowerment. These are important from a gender and equity perspective.

Conclusions: As an innovation, the scheme appears to have significant potential. More information would be required on the nature of agreement between the Government and the private nursing colleges and whether they include use of up-to-date protocols, standardised curricula, availability of appropriate caseload, monitoring of quality of teaching/training. It would be helpful to understand what avenues are available to private nursing colleges to ensure that they are in sync with current trends in public health nursing and mainstream public health programmes. The scheme appears scalable but needs substantial additional information to draw definitive conclusions.

ANNEXURE 9.2.1

Rapid Diffusion of IUCD Training Programme Using Alternative Training Methodology in 12 States

Title	Rapid Diffusion of IUCD Training Programme Using Alternative Training Methodology in 12 States
State	12 States
Geographic Area of Coverage	State level and one district-training inputs
Target Population	Women of reproductive age, needing a temporary family planning method
Project Life	November 2007, ongoing
Budget	Not known
Implementing Partners	MoHFW, Government of India, State Governments, with technical support from JHPIEGO through USAID
Existing Evaluations	None
Documents Reviewed	Note provided by USAID—update as of February 2008

Objectives: Despite the introduction of the IUCD in 1993 as part of the national FPP, it accounts for 2% of the method mix at the national level (NFHS 3- 2004-2005). The objectives of the training are to:

1. Develop a competency-based clinical training approach that is rapidly scalable and easily adaptable within the Government systems.
2. To support the Government of India's efforts to substantially increase use of the IUCD as a family planning method.

Strategies: Key strategic approaches include:

1. The MoHFW, with technical support from a USAID technical partner—JHPIEGO, developed a six-day training course in IUCD insertion (CuT 380A) using a mix of clinical and pedagogic approaches. Clinical competencies were to be built through repeated practice of IUCD insertion using the Zoe model.
2. Standard training guidelines and performance checklists have been developed.
3. The first step was to train teams of State-level master trainers in 12 states.[2] Sixty master trainers were trained.
4. These master trainers were then expected to train district teams in one district of their parent State. JHPIEGO provided TA for the State-level training. Subsequently the initiative has been that of the central and State Governments.
5. Follow-up was structured using standardised checklists and trainers were coached on clinical competency as well as training skills.

[*] *Gujarat, Maharashtra, Assam, Uttar Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Orissa, Chhattisgarh, West Bengal, Karnataka and Kerala*

Outcomes:

- Replication of training programme was achieved by nine out of the 12 States in four months and in all States within six months
- Between November 2007 and February 2008 a total of 653 trainers were trained across the States. The highest numbers were trained in Kerala (105), Karnataka (101), Gujarat (85), Maharashtra (95) and Assam (95)
- Standard training protocols and checklists for monitoring training quality as well as trainee performance are in place. It is expected that IUD services will be provided at static facilities

Lessons learnt: Immediate, intensive and supportive follow-up by the training coordinator of the MoHFW was key to the successful diffusion. Presentation of outcome data at a national workshop stimulated more rapid action and diffusion and motivated lagging States. Well designed and structured training initiatives that are competency-based and skill focussed can be more easily implemented. Ownership by the GoI promotes institutionalisation of the programme.

Conclusions: The IUCD training has been designed to improve competency and skills among ANMs to enable increased use of IUCD among women desiring to space their families. The programme has currently set in place training systems and trained trainers. The rapidity of institutionalising the basic training processes and creating a pool of master trainers are positive features. The programme is already being viewed to achieve scale. Implementation and should be monitored and mechanisms for demand creation set in place.

ANNEXURE 9.3.1

Community Volunteer Initiative

Title	Community Volunteer Initiative/Arogya Iyakkam
State	Tamil Nadu
Geographic Area of Coverage	One million people in over 1,000 villages in 23 blocks of Tamil Nadu. This methodology has now been taken up by ICDS and by the Tamil Nadu H&FWD. The model has also been replicated in Chhattisgarh. It has since been extended and is being continued in 17 districts by the Tamil Nadu State Government
Target Population	All rural population under the scheme coverage. Special emphasis on women of reproductive age group, adolescent girls and children below five years of age
Project Life	1999-2008, ongoing
Budget	In the first phase the programme cost was Rs. 3 lakh/block per annum, then reduced as the programme was scaled up, to about Rs. 100,000 per block
Implementing Partners	Implemented by Tamil Nadu Science Forum. Financially supported by Association for India's Development and UNICEF
Existing Evaluations	Not applicable
Documents Reviewed	Kitchen C. Community Volunteer Initiative, Tamil Nadu. PROD Reference No. 85. Policy Reform Options Database. 2004 Sampath B. Arogya Iyakkam—Tamil Nadu: February 2002-March 2003. Presented at the Tamil Nadu Science Forum, 2003; Chennai, India

Objectives: The Tamil Nadu Science Forum initiated Aarogya Iyakkam in 1999. The key objective of the initiative was to place people's health in people's hands through community organisation and equipping local health activists with the knowledge and skills to facilitate local attention to key health issues.

Strategies: Key strategies include:

1. Organising VHCs with women's participation. Elected Panchayat leaders to manage and monitor the project.
2. Linkage of programme with women's savings and SHGs.
3. Equipping local health activist volunteers with knowledge and skills to address health issues at community levels including the ability to reason and provide rationale for public health interventions in the face of community resistance.
4. Training voluntary health activists in classroom and field settings and providing intensive field support in the ratio of one supervisor for ten volunteers.

5. Each volunteer looked after 125 families, with children under five years of age. They followed them from pregnancy through to pre-school period in the hope of bringing about behavioural change.
6. A four-step information collection process was developed and used for family counselling.

Outcomes

- In 2001, UNICEF recognised Aarogya Iyakkam as one of its 10 best programmes world over, and recommended it for replication
- The number of children with normal weight increased from 34.45% to 45.77%—an increase of 11.33% and the number of Grade II, Grade III and Grade IV children decreased by a corresponding 12.56%
- The percentage of children with a 'normal' weight increased from 36.25% to 46.69% —an overall increase of 10.5%. In villages where there was effective intervention the percentage improvement was 15%

Lessons learnt: In addition to giving packaged messages, the frontline workers must also possess the requisite knowledge and skills to counter arguments that are an integral component of the training. In Aarogya Iyakam, a group of trainers visited the health activist regularly, which affect acceptance of services. This provided legitimisation, encouragement and an opportunity for retraining. Holding supervisors and those above them responsible and accountable for supporting the work of frontline health and nutrition functionaries can improve health results. To ensure that the focus of the activist is on actually meeting mothers and pregnant women, writing reports and maintaining records was kept to a minimum. Health workers require a supporting environment to deliver results. Support and guidance not only from the health systems but also from the community she serves played a critical role in the success of Aarogya Iyakkam.

Conclusions: The initiative was a 'first' to organise Village Health Committees and use voluntary health activists at scale. Since then the Mitanin programme, and now the ASHA programme have been implemented. The Aarogya Iyakkam effort emphasises that local health activism, and attention to people's health perceptions play a key role in improving access and use of health services.

ANNEXURE 9.3.2

Improving Community Participation in Decentralised Planning of RCH Services

Title	Improving Community Participation in Decentralised Planning of RCH Services
State	Karnataka
Geographic Area of Coverage	216 villages in Hunsur Taluk of Mysore district in Karnataka
Target Population	Community representatives comprising the health advisory committee
Project Life	2000-2002
Budget	Of the initial grant of Rs. 92,500 received as seed money from FRHS, expenditure of Rs.21,000 was incurred; Rs.48,000 in kind was mobilised, thus saving about Rs. 71,500 for future activities
Implementing Partners	Implemented by Foundation for Research in Health Systems, (FRSH) Bangalore. Supported by Department of Health and Family Welfare, Karnataka and Population Council
Existing Evaluations	Not applicable
Documents Reviewed	Murthy, Nirmala. Village Health Committees, Karnataka. PROD Reference Number 39. Policy Reform Options Database. August 2004 Community involvement in reproductive health: Findings from research in Karnataka, India. Foundation for Research in Health Systems. September 2004

Objectives: The key objectives of the project were:

1. To develop and field-test a new model of health advisory committee-based on community suggestions.
2. To identify successful processes and strategies that facilitate community involvement in decentralised planning.

Strategies:

1. Forming sub-centre level health advisory committees ensuring gender and caste representation.
2. Building capacity of health committees to play a 'collaborative' role with the local health providers.
3. Providing seed money for their initial activities
4. Priming them to participate in a Community Needs Assessment planning exercise at the sub-centre level.

Outcomes:

- Total of 64 committees formed (one per rural sub-centre), 57 were active (at the time of evaluation)
- 85% committees were active in organising health programmes
- About half the people in community reported knowing or participating in those programmes
- Over two-thirds of health staff provided high to moderate level of support to these programmes
- Over 90% committees also enjoyed support from Panchayats and received donations and Panchayat funds
- Survey data from 'before and after' the experiment, recorded significant increases in the awareness and access to certain RCH services such as treatment of RTI/STI, safe delivery, and weighing of babies at birth. The control block, where another NGO was active in providing health care, also showed gains on most RCH indicators during this period. But the experimental block showed larger gains on many indicators, which helped bridge the initial gaps between the two blocks
- Participation of health providers: Initially only 20% health staff was positive about committees. By the end of the project, 80% of them had a positive opinion on the contribution of the committees

Lessons learnt: The VHC appears to work better when it supports and serves as an ally with the health system (for example, supporting the community-level health and nutrition workers such as the AWW and ANM), rather than acting mainly as a critic or activist group. It seems advisable for the VHC to start with a simple, feasible Village Health Plan (VHP) that has clear objectives and targets. The community should consider a monitoring mechanism, with a few simple indicators, to monitor progress on the plan. Gathering the needed information and preparing a VHP requires considerable, sustained effort.

Conclusions: The intervention was an early effort at enabling village planning by Panchayat committees and has contributed along with several other initiatives to the VHSCs and the processes of village-level planning envisaged in the NRHM.

ANNEXURE 9.3.3

Integrated Village Planning Project

Title State	Integrated Village Planning Project Uttar Pradesh
Geographic Area of Coverage	376 revenue villages, 179 Gram Sabhas of Birdha, Jakhaura and Talbehat blocks of Lalitpur district in Uttar Pradesh
Target Population	All rural population
Project Life	Two years
Budget	Rs. 3,64 lakh; Rs. 9,452 per village
Implementing Partners	Implemented by Sarthi Foundation. Supported by ICDS, Health Department, PRI, Government of Uttar Pradesh
Existing Evaluations **Documents Reviewed**	Not applicable Fukuda, Wakana, Mizumoto Ann and Tyagi, Kunal. Of the People, For the People, By the People. Water and Sanitation Service Delivery: Gram Panchayat Environment Plan, Lalitpur, Uttar Pradesh. Knowledge Community on Children in India: Turning Knowledge into Action. Case Studies. 10 November 2006 UNICEF. Unpublished Presentation. Integrated Village Planning: A Joint Initiative of UNICEF and Government of Uttar Pradesh; Implemented by Sarathi Development Foundation. New Delhi/Uttar Pradesh: UNICEF UNICEF and Sarathi Development Foundation. Unpublished Concept Note: Integrated District Approach and Village Planning. Lalitpur, Uttar Pradesh: UNICEF and Sarathi Development Foundation

Objectives: The objectives of the project were:

1. To enhance the ownership of the Government in the behaviour change process.
2. To bring the community and service providers together for planning and implementation.
3. To facilitate actions on unaddressed issues of interest to the community.
4. To apprise the community of the progress made and identify gaps.

Strategies: Key strategies included**:**

1. Increased involvement of the community by enhancing a sense of responsibility.
2. Improving role clarity among PRIs.
3. Promoting BCC through local champions and role models.
4. Strengthening the sense of community and togetherness in the community.
5. Bridging the gap between frontline service providers and the community and making the providers accountable to the community.

Teams spent five days and nights in each Gram Sabha interfacing with village-level functionaries. The team comprised NGOs and community volunteers. In the post-planning phase they developed change maps, cluster, block and district-level reviews with a taskforce created by the district authority. The post-planning phase is a part of ongoing activities during the project period. The pre-planning phase and planning phase were completed in these five days. Finally, an integrated village planning document was prepared and was given to the Gram Sabha and posted on a wall in a common place. The entire integrated planning process is very enabling and provides ample opportunity to the community to plan most appropriately for itself. It also helps in interfacing with the service provider and the community/PRIs.

Outcomes: All changes based on baseline and end-term evaluations surveys.

- Full immunisation coverage increased from 39.% to 49.3%
- Feeding of colostrum increased from 39.05% to 86.2%
- Institutional deliveries rose from 19.9% to 28.7%
- Child marriages declined by one percentage point
- Birth registration increased from 91.7% to 98.2%

Lessons learnt: Outcomes have improved where the VHC has linked with the Government to support service providers and where the VHC has linked with block-level officials. The VHCs could consider using the citizen's charter mechanisms to establish linkages with the Government system (including the PRIs), as well as with Government health services (for transport, referrals). It takes time and skill facilitation to lead to village understanding and ownership of the VHCs and the VHPs. The support of civil societal agencies, such as NGOs, CBOs and Self-Help Groups, can be very helpful in setting up of the VHCs and meeting NRHM-related objectives. Involving NGOs in facilitating village-level planning is likely to yield more positive planning outcomes The VHCs should have wide representation from different sections of the village population, including women, different castes and classes, and adolescents to ensure responsiveness to the various health demands in the village.

Conclusions: This model appears to have achieved positive outcomes in the short span of two years although it is unclear when exactly this was implemented. The model itself is an example of the effect of local planning by VHCs for health and nutrition and demonstrates the effectiveness of local need-based planning.

ANNEXURE 9.3.4

Jeevan Deep Samiti

Title	Jeevan Deep Samiti
State	Chhattisgarh
Geographic Area of Coverage	Entire State
Target Population	Population accessing public health facilities—PHCs, CHCs, District Hospitals
Project Life	Since 2005, ongoing
Budget	Districts and CHCs: Rs. 200,000 for maintenance, PHCs: Rs. 100,000 Jeevan Deep Samitis at CHCs receive seed fund of Rs. 5 lakh for infrastructure improvements
Implementing Partners	Department of Health and Family Welfare, Chhattisgarh, with the technical assistance of the State Health Resource Centre (SHRC)
Existing Evaluations	None
Documents Reviewed	Giving Public Health a Chance: Some Success Stories from Chhattisgarh on Community Basing of Health Sector Reforms, Department of Health and Family Welfare, Government of Chhattisgarh

Objectives: The Jeevan Deep Scheme, which is a transformation of the erstwhile Rogi Kalyan Samitis, seeks to improve hospital/health facility management through public participation. The objectives of the scheme, which has been functioning since 2005, are to improve the functioning and, therefore, utilisation of the public health system through:

1. Establishment of hospital management committees with public participation, responsive to the needs of the patient and accountable to the community.
2. Leveraging existing infrastructure by instituting key management practices, motivational techniques and engaging public participation.
3. Ensuring compliance with hospital accreditation standards.

Strategies: The Rogi Kalyan Samitis, functional in district and CHCs before the introduction of Jeevan Deep Samitis, had several limitations that included: indiscriminatory collection of user fees, which deterred the poor from seeking services, funds not used for hospital improvements and lack of capacity to identify and implement modifications required in the institutions. The scheme did not take off in many of the backward areas where people's ability to pay was limited. Subsequently, the Rogi Kalyan Samitis were renamed as Jeevan Deep Samitis and several structural adjustments were made to enable their functioning. The key strategies of the Jeevan Deep Samitis are:

1. Jeevan Deep Samitis extended to PHCs.
2. In addition to elected representatives, the committees also include participation from NGOs, respected individuals and organisations.

3. The samitis are given powers to manage the land, local purchase of medicines, appointments of doctors and instituting incentives and awards for staff.
4. Each Jeevan Deep Samiti is expected to draw up an annual plan for infrastructure development, equipment-related needs, human resource requirements—medical and non-medical, availability of medicines information and catering services.
5. Capacity building for development of the plan was entrusted to the SHRC and State Institute of Health and Family Welfare (SIHFW).
6. Resources for Jeevan Deep Samitis are now available from the NRHM, reducing dependency on user fee collection, and improving prospects for the provision of equitable health services.
7. Performance rating of Jeevan Deep Samitis: Every facility is assessed twice annually, once by an external agency, and given a performance rating score. Achievement levels would be publicised through the award of stars. Gold stars for facilities that score over 95%, silver stars for those that score between 75% and 94% and bronze stars for achievements in the 61% to 74% category.

Outcomes:

- 580 out of 679 identified facilities have completed the registration procedure of Jeevan Deep Samiti
- Funds have been received from the NRHM and the State Government has also made budgetary provision
- The process of annual planning initiated
- A Hospital Improvement Index has been developed for facility assessment
- Assessment of district hospital performance completed for all 15 district hospitals
- Under the Jeevandeep Scheme star grading of all districts hospitals done—three silver star hospitals and one bronze star hospital identified

Lessons learnt: The programme is still at an initial stage and thus it is too early to identify lessons. However, the new mandate of the Jeevan Deep Samitis involves a significant change in processes and management structures within the system. The implementation needs to be monitored carefully to see how the opportunity is utilised.

Conclusions: Clearly expanding the powers and streamlining the functioning of Jeevan Deep Samiti represents an innovation over the Rogi Kalyan Samitis, involving public participation in facility management. It is likely that the proposed modifications including performance incentives will have positive ramifications on the functioning of the institutions. The performance of the scheme from the point of view of equity considerations also needs to be assessed.

ANNEXURE 9.3.5

Community-Led Initiatives for Child Survival

Title **State**	Community-Led Initiatives for Child Survival (CLICS) Maharashtra
Geographic Area of Coverage	Wardha district
Target Population	Children under three years of age, women of reproductive age group and adolescent girls
Project Life	2003-2008, ongoing
Budget	Not applicable
Implementing Partners	Funded by USAID—managed through the Aga Khan Foundation (AKF). Implemented by Mahatma Gandhi Institute of Medical Sciences, Sevagram
Existing Evaluations	Not applicable
Documents Reviewed	Aga Khan Foundation. Mid-term Evaluation: Community-led Initiatives in Child Survival, Wardha District, Maharashtra. Child Survival 19—India. 2006 Aga Khan Foundation (USA) and Department of Community Medicine (DCM), MGIMS, CLICS Annual Report. 1 October 2005 to 30 September 2006 Department of Community Medicine. Logical Framework for Institutional Development for VCCs Under CLICS**.** (Unpublished project document.) Mahatma Gandhi Institute of Medical Sciences, Wardha, India Department of Community Medicine. Social Franchise Model of CLICS**.** (Unpublished project document.) Mahatma Gandhi Institute of Medical Sciences, Wardha, India CLICS Annual Report, 1 October 2005 to 30 September 2006. Submitted on 15 October 2006 to USAID. Prepared by Department of Community Medicine (DCM), Mahatma Gandhi Institute of Medical Sciences CLICS *Doot* (Village Health Worker), DCM, Mahatma Gandhi Institute of Medical Sciences

Objectives: The overall goal of the project was to bring about sustainable improvement in the health status and well-being of children under the age of three and women of reproductive age group (15-44 years). The key objectives were to:

1. Provide affordable, high quality health care through effective partnerships at the village level.
2. Deliver a package of interventions that included: safe motherhood and newborn care, home-based management of neonates, including management of sick neonates using IMNCI; awareness on breastfeeding, nutrition, ARI and diarrhoea.
3. Build the capacity of coalitions of local partners to sustain child survival activities and health gains.
4. Refine and test a social franchising model for the delivery of child health interventions.
5. Document, disseminate and share key programme lessons and results to facilitate adaptation and replication.

Strategies: The strategy of CLICS was to build the capacity of the target communities to develop, manage and ultimately achieve 'ownership' of village-based child survival and health services. This was accomplished by forming CBOs and VCCs and by applying the principals of 'social franchising'. The key approaches include:

1. Building a cadre of CLICS *doots*—a cadre of community workers—similar to ASHAs under the NRHM. However, there are differences in the selection procedure, as well as in the payment mechanism. The selection procedure itself involved a three-day 'selection camp and a 'scoring' system to select the best candidate.
2. Training CLICS *doots* in community mobilisation and AWWs in early childhood development. TBAs were also trained in promotion of ANC and institutional delivery.
3. Mobilising communities to form VCCs to function as the nodal agency responsible for decentralised health care delivery at the village level.
4. Developing with each VCC a 'social franchise agreement', a document that outlines a clear set of health priorities and the means to address them.
5. Implementing the franchise agreement through the VCC.
6. Achieving 'community ownership' with the VCC to independently manage key health activities and sustain health gains on their own

Outcomes: The intervention has undergone midterm evaluation in 2006, and the results are encouraging. It showed that:

- LBW deliveries have reduced from 29.4% (baseline) to 23.4% at the time of mid-term evaluation
- 23.6% mothers (with children aged 0-11 months) had received a complete ANC package in the last pregnancy at the time of the mid-term, compared to 11.6% during the baseline
- Institutional deliveries went up by 20 percentage points between baseline and mid-term (BL—64.4% to MT—84.4%)
- Around 80% children (0-5 months) were breastfed within one hour of birth at the time of mid-term as compared to only 0.9% at the time of baseline
- Complete vaccination of children aged 12-23 months went up to 92.6% at the time of mid-term as compared to 75.6% during the baseline

Lessons learnt: The concept of 'community ownership' is a key strategy, which requires participation of several stakeholders. The formation of SHGs, notably women's groups, and partnerships with private practitioners played a significant role in achieving results.

The CLICS *doot* is a multi-tasking worker and is responsible for a range of interventions including home visits and maintaining records and needs intensive training. Too many interventions by a single worker dilute focus and so his/her work should be limited to key areas. Sustainability of change (actual transformation to 'community ownership') after cessation of funding remains a challenge.

Conclusions: Several similarities are evident between the CLICS model and the NRHM comunitisation strategy. However, the CLICS model seemed to have been implemented completely in isolation of the system. More needs to be studied on how referral beyond community-evel interventions was managed. A second stage pilot that incorporates the community structures piloted in CLICS with institutional linkages is needed to posit the CLICS model for scale up within RCH II and the NRHM.

ANNEXURE 9.3.6

Community Mobilisation for Improving Mother and Child Health through the Life Cycle Approach

Title	Community Mobilisation for Improving Mother and Child Health through the Life Cycle Approach
State	Jharkhand
Geographic Area of Coverage	Silli and Angara blocks of Ranchi district; Churchu block of Hazaribagh District; Sadar block of Gumla district
Target Population	Women of reproductive age, newborns, infants and children
Project Life	2003-2008, ongoing
Budget	Not applicable
Implementing Partners	Implemented by Child in Need Institute. Supported by the Krishi Gram Vikas Kendra, Nav Bharat Jagriti Kendra, LGSS (an NGO) and Department of Health and Family Welfare, Government of Jharkhand, ICICI Bank Social Initiative Group, Population Foundation of India and Sir Dorabji Tata Trust
Existing Evaluations	Not applicable
Documents Reviewed	Child in Need Institute. Strengthening NGOs Capacity to Improve Maternal and Child Health. Unpublished Presentations for Dissemination of Mid-term Assessment Report of Churchu Block, Sardar Block-Gumla, Hazirabagh district block. Ranchi, Jharkhand: Child in Need Institute Child in Need Institute. Gumla Baseline Report. Ranchi, Jharkhand: Child in Need Institute Child in Need Institute. Hazaribagh Baseline Report. Ranchi, Jharkhand: Child in Need Institute Davey, Anuradha. Pictorial Tools for Behaviour Change Communication for Tribal Population, Jharkhand. PROD Reference No. 204. Policy Reform Options Database. October 2006 Krishi Gram Vikas Kendra, Child in Need Institute and Social Initiatives Group-ICICI Bank. Ranchi Low Birth Weight Project: Baseline Survey Summary Report. Ranchi, Jharkhand: Krishi Gram Vikas Kendra, Daulatpur, West Bengal: Child in Need Institute, Mumbai, Maharashtra: Social Initiative Group -ICICI Bank. October 2006 Krishi Gram Vikas Kendra, Child In Need Institute and Social Initiative Group-ICICI Bank. Ranchi Low Birth Weight: Reducing Incidence of Low Birth Weight using a Community-Based Lifecycle Strategy. Study Protocol. Ranchi, Jharkhand: KGVK, Daulatpur, West Bengal: Child in

	Need Institute, Mumbai, Maharashtra: Social Initiative Group -ICICI Bank. October 2006 Purvita Chatterjee. ICICI Bank Bid to Build Brand through Social Work. *The Hindu Business Line*. 5 July 2003

Objectives: The objectives of the project were to:

1. Empower the community to participate in health planning and oversee its implementation.
2. To facilitate access to and delivery of effective health care.
3. To ensure availability and access to preventive curative services.
4. To identify health needs of the community.
5. To generate awareness on health issues.

Strategies:

1. Formation of the VHCs through facilitators, that is, NGO staff, who interacted with the community and built a rapport with them. These facilitators were trained for this work and mobilised the community to form the VHC.
2. Selection of health worker, *sahaiya,* to be done by and from the community by the VHCs. The *sahaiyas* were responsible to the VHCs and were expected to attend the VHC meetings. The ANMs and other health functionaries along with representatives from the *tolas* (hamlets) were also invited to attend the meetings.
3. VHCs identify local health problems at community level and also monitor progress of the plans and *sahaiya* performance.
4. A number of VHCs formed a federation to mobilise additional resources and build a stronger pressure group for better implementation of public health schemes.
5. The VHCs raise funds from voluntary contributions in cash or in kind from households in the village, which are used for emergency health needs or collective community initiatives.

Outcomes:

- Institutional deliveries increased from 10% at baseline to 16% at mid-term
- Breastfeeding within one hour of birth improved from 11% at baseline to 13% at mid-term

Lessons learnt: Successfully establishing the VHCs is a long and formal process. It takes time to gain acceptance and generate community participation and ownership and there are complex local and political issues that may need to be addressed. The evidence shows that it is important to have gender sensitive leadership in the VHCs to enhance outcomes. There are challenges, but the VHCs can improve the functioning of the Government service delivery at PHCs and CHCs. There is a gap in outcome-level data on the functioning of the VHSCs, which will need further examination. There is a need to study the working relationship between the VHSCs and the PRIs.

Conclusions: The Jharkhand initiative builds on the *sahaiya* (now part of the NRHM ASHA scheme) and the NRHM VHSC formation. The strategies of federation of the VHSC and local fund raising by the VHCs need to be studied in-depth as they have the potential of identifying lessons for the process in other States.

ANNEXURE 9.3.7

Alternate Health Delivery System in Punjab

Title	Alternate Health Delivery System in Punjab
State	Punjab
Geographic Area of Coverage	Entire State
Target Population	General population
Project Life	Launched in 2005, planned till 2009
Budget	Year One: Rs. 112.09 crore, Year Two onwards: Rs. 58.95 crore/per year
Implementing Partners	Directorate of Health and Family Welfare, Punjab
Existing Evaluations	None, report based on routine monitoring data provided by Government of Punjab.
Documents Reviewed	Website of the Department of Health and Family Welfare, Government of Punjab

Objectives: Punjab has a network of 1,310 rural dispensaries (SHCs), in addition to PHCs, CHCs and district hospitals. The alternate health delivery system in Punjab envisages provision of health care services through the Zilla Panchayats. The key objectives include:

1. Bringing services closer to rural communities.
2. Resolving disruptions in health care provision at this level caused by frequent transfer of doctors in the regular health system.
3. Enabling active involvement of the Zilla Parishads in health.
4. Enabling MOs of the regular State health system to be posted in PHCs, CHCs and district hospitals.

Strategies: The Zilla Parishads engage a team of doctors and paramedics, to provide outpatient services and elements of national programmes in rural dispensaries, building maintenance, provision of basic infrastructure and drugs worth Rs. 7,500/month (to be provided by the Zilla Parishad). Doctors will be paid a lump sum of Rs. 360,000/annum. Out of this they are expected to meet the salary of the paramedics and recurring expenses, such as utilities and day-to-day maintenance. Doctors will be engaged under a service contract, renewable after a three-year period, based on performance against established benchmarks. Doctors engaged under this scheme will be non-transferable.

Outcomes: Routine monitoring of the scheme shows that out-patient attendance in the dispensaries increased substantially from the baseline in 2005. Performance in selected programmes such as TB, blindness control and school health programmes also show improvement.

Lessons learnt: The model demonstrates that the presence of a provider closer to communities and the uninterrupted availability of drugs increase service use. The scheme has demonstrated improved OPD service utilisation. Although data is insufficient to draw on

more concrete lessons, it is evident that Panchayat-managed service provision has the potential to improve service utilisation. However, more information is required before an in-depth review is recommended.

Conclusions: The model has created an alternative to the mainstream health system and an in-depth understanding of the consequences of the scheme on existing public health facilities would enable evaluation of benefits. The innovation here is the Panchayat-managed service provision. Decentralised service deilvery and management by institutions of local governance are attractive propositions, when the management and capacity building strategies are clearly thought out.

ANNEXURE 9.3.8

Health and Nutrition Initiative: Indra Kanthi Patham (formerly Velugu Project)

Title	Indra Kanthi Pratham (Velugu) Project
State	Andhra Pradesh
Geographical Area of Coverage	62 *mandals*
Target Population	Rural poor
Project Life	2005, ongoing
Budget	Proposed for 2009-2010: Rs. 8,370 lakh (expected GoI share is 30% of the total budget)
Implementing Partners	NRHM, Andhra Pradesh, Department of Rural Development with support of MPLAD and DFID
Existing Evaluations	Mid-term assessment studies of the IKP project
Documents Reviewed	State PIP of Andhra Pradesh, 2009-2010

Objectives: The Indra Kanthi Patham (formerly known as the Velugu project) aims to demystify the concept of health so that it is understood in a simplified manner by the rural poor and perceived as a social issue as against the traditional medical and clinical models. The innovation aims to address issues of health and nutrition services that are essential for the rural poor through empowering the communities and creating an enabling environment in project *mandals* of Andhra Pradesh. The pilot is going on in 54 *mandals* and is being replicated in eight tribal *mandals* under the Giripragathi programme. The State proposes to continue and replicate the interventions in 100 *mandals* during 2009-2010 (in 62 existing pilot *mandals* under IKP and to replicate the same in 38 additional tribal, Chenchu and rural *mandals*) by the Department of Rural Development under the NRHM.

Strategies:

The State proposes to continue and replicate the following interventions:

1. Continuous capacity building of health activists (that is, ASHA) and health sub-committees: appointment of a health activist from the community for promoting better health-seeking behaviour.
2. Capacity building of the health activist and the health sub-committees at VO, MMS and ZS level will be trained regularly with fixed training schedule and topics prepared during the calendar year based on the seasonality of the diseases.
3. Fixed Nutrition and Health Day: Institutionalisation of fixed NHD wherein the health sub-committees would take a role in social mobilisation and also involve the Panchayat for necessary arrangements. To be held once in every fortnight in the village.
4. On-site case manager at PHC/network hospitals: Placement of case managers at the disposal of patients who are members of the health plan (that is, is their on-site representative) is a complementary resource. In case of partnership with network hospitals, the case managers will play a vital role

in encouraging the members to avail the facilities initially at the PHC and the network hospitals for secondary/tertiary care.

5. Nutrition-cum-day care centres as VHRCs for social change: Establishment of community-managed nutrition-cum-day care centres to provide nutritious diet for pregnant and lactating mothers and children up to five years of age by dovetailing the SNP funds from ICDS and JSY funds from the health department. In addition, the package also includes community kitchen, practice of using weaning foods for children in the age group of 6-12 months and prevent the incidence of malnutrition during infancy and leveraging the public funding of women and child health care with special focus on neonatal and infant care.
6. Intensive approach for behaviour change through HCR persons: In order to influence the household behaviours for preventive and promotive health care measures for maternal and child health, the team of best practitioners identified from the pilot *mandals* to come and share the experiences in other *mandals* and districts and help the communities to sustain their activities on their own. The focus is on development of internal resource persons to realise and adopt measures for evaluation and baseline survey: To evaluate the effectiveness of the interventions proposed, a mid-term evaluation will be conducted in the existing 53 pilot *mandals* of IKP with the selected indicators and work towards reaching the MDGs in the State of Andhra Pradesh.

Outcomes:

Some of the outcomes of the project based on the implementation in the last 20 months are:

- Development of social capital: 2,000 health activists positioned at Village Organisation (VO) level were trained on preventive and promotive health care measures; health sub-committees were constituted at VO, MMS and ZS levels; 700 best practitioners were identified as health Community Resource Persons to share their experiences with the members of SHGs in 100 VOs in other districts in a period of eight months and motivated them to adopt the measures for comprehensive health care and come out of the problems of malnutrition
- Institutionalisation of activities in convergence with line departments: plans for improved coverage of immunisation in coordination with the SHGs under IKP;1,200 VOs against 1,400 VOs have institutionalised the fixed Nutrition and Health days (NHD) with focus on propoor. The Department of WD and CW issued orders for monitoring of activities at AWC and the functionaries are accountable to VO
- Establishment of health risk fund: 87% of VOs have opened accounts for monthly health savings (at the rate of Rs10-30/member/month); the project had supported Rs. 1 lakh per VO towards health risk fund and improve access in case of any health emergencies
- Community-managed nutrition interventions: Establishment of 400 nutrition-cum-day care centres to provide a balanced diet to pregnant and lactating mothers and also extended with facilities for children and to reduce the prevalence of malnutrition among women and children. As a result of these centres, 98% institutional deliveries have been reported. Practice of using weaning foods for their children in the age group of 6-12 months was

observed among 74% of mothers who prepared collectively at nutrition centres. Further 64 community kitchen gardens have been established to provide green leafy vegetables to the nutrition centres and also promote the practice of regular use of leafy vegetables as measures to overcome the problems of anaemia especially among the adolescents, the SHG members and thereby the entire community

- Specific impact of best practitioners as external health Community Resource Persons (CRP) in 22 districts (that is, in 400 VOs): Formation of 161 adolescent girls groups to bring awareness about health and encouraged them to continue their education with necessary support from the VO;10% of the cases referred in screening camps had treatment by accessing the health risk fund available at VO formation of 131 youth groups for safe water supply and environmental sanitation in the village with the support of Panchayat and VOs; the youth groups were motivated for promotion of clean village concept with safe drinking water and environmental sanitation
- Social accountability approaches (community health score card and village health action plans) to make public health systems more responsive for improved utilisation of health facility for institutional deliveries, regularity in conducting fixed NHDs, support in organising screening camps, participation of field staff at all levels in implementation of intensive health CRP strategy, participation of ANMs in VO meetings, regular health check-ups and health education sessions at nutrition-cum-day care centres established by the VOs

Lessons learnt: The mid-term assessment studies taken up for the IKP revealed that interventions, which are not possible through the public health system, are best accepted by the rural poor through community-based intervention processes. It further establishes that community/village ownership is the key to sustaining health interventions and ensuring that they continue to have an impact in the long term. The experiences from the villages covered by the Health Community Resource Persons (Health CRPs) demonstrated the ability of the VOs to do necessary follow-up and continue the activities beyond the visit of the CRP teams to the respective villages. It has also shown that at the end of the project, the VOs will have acorpus towards meeting any health emergencies, nutritional support and a social capital to provide preventive and promotive health care.

Conclusions: The IKP-Health and Nutrition Model is complementary to the NRHM goals. The model operates in a convergent mode with the Department of Rural Development and ICDS has reportedly had some positive outcomes in the short span of time. The project needs to be monitored through community monitoring mechanisms for ensuring that the envisaged outcomes are achieved. Orientation of the community on monitoring and ensuring quality will be crucial to ensure the success of the project.

ANNEXURE 9.3.9

Swasth Panchayat Yojana

Title	Swasth Panchayat Yojana
State	Chhattisgarh
Geographic Area of Coverage	All districts
Target Population	General population
Project Life	Begun 2006, ongoing
Budget	Rs. 159 lakh
Implementing Partners	Department of Health and Family Welfare, Chhattisgarh, with the technical assistance of the SHRC
Existing Evaluations	None
Documents Reviewed	Giving Public Health a Chance: Some Success Stories from Chhattisgarh on Community Basing of Health Sector Reforms, Department of Health and Family Welfare, Government of Chhattisgarh

Objectives: The Swasth Panchayat Yojana, initiated in 2006, aims to support village and Panchayat health planning through data collection on health and health-related information at hamlet and Panchayat levels.

Strategies: An annual exercise, the scheme is being implemented in 9,820 Panchayats and 20,639 villages in all the 18 districts of the State. It covers the entire rural population of the State. Key strategies include:

1. A set of 12 indicators developed to measure the health status and the delivery of health and health-related services at the village level.
2. Mobilisation and orientation of Panchayat leaders and members, women's groups, youth groups and other village-level organisations.
3. Data on these indicators collected by the Mitanins, health staff and staff of the ICDS with active participation of Panchayats and communities. The data is consolidated at GP and block levels and is computerised using especially developed software.
4. All hamlets within a Panchayat and all Panchayats within the block are ranked and scored, with awards being given to the highest ranking Panchayats. This exercise brings into focus several health issues hitherto ignored and also identifies pockets of poor performance and vulnerability.
5. Enable every Panchayat to draw up village plans so as to improve its ranking. The plans are to be reviewed annually and updated.
6. Capacity building of Panchayats to conduct this exercise is a key element of the Swasth Panchayat Yojana.
7. Poorly performing Panchayats are monitored closely and supported to improve performance.

Outcomes: The first set of awards was distributed on 26 January 2007.

- Panchayat-level health data collected, analysed and feedback provided to 133 block Panchayats (9,041 of a total of 9,800 Panchayats)
- Panchayat-level planning is ongoing in these blocks
- Data from remaining 66 blocks is being analysed

Lessons learnt: Hamlet-level data is crucial in understanding and addressing poor performance and vulnerability. Active participation of the Panchayat members is important for their continuing interest and commitment to the programme. Data collection and village-level planning need considerable skills. The planning phase needs to take the time required for capacity building and building interest and motivation into account. Comparison of performance needs to be restricted to a homogenous area, such as a block, given the commonality of geographical, cultural and socioeconomic profiles. Close monitoring of poorly performing Panchayats and addressing special needs in terms of human and financial resources is necessary for improved functioning,

Conclusions: Village health plans and Panchayat involvement are important elements of the NRHM. Given the paucity of models in this area, and the fact that it has been operationalised in Chhattisgarh at scale, the Swasth Panchayat Yojana merits a detailed review. Dissemination of key lessons learned, including challenges and opportunities from the Swasth Panchayat Yojana, can support village and Panchayat-level planning in other States.

ANNEXURE 9.3.10

The Mitanin Programme

Title	The Mitanin Programme
State	Chhattisgarh
Geographic Area of Coverage	Pilot: 14 blocks (May 2002), Phase-1: 66 blocks; Phase-2: 80 blocks; scaled up in the entire State in 2004
Target Population	All rural population. Special emphasis on women of reproductive age group and adolescent girls; children below five years of age
Project Life	2002-2008, ongoing
Budget	Annual programme cost per Mitanin (over 60,000 Mitanins) is Rs. 3,750. Annual drug cost per Mitanin (over 60,000 Mitanins) is Rs. 2,300
Implementing Partners	Implemented by the SHRC. Financially supported by the Government of Chhattisgarh and ActionAid India
Existing Evaluations	Society for Community Health Awareness, Research and Action. An External Evaluative Study of the State Health Resource Centre and the Mitanin Programme: Final report. Bangalore, Karnataka: SOCHARA, 2005 State Health Resource Centre, Government of Chhattisgarh. Outcome Evaluation of the Mitanin Programme: A Critical Assessment of the Nation's Largest Ongoing Community Health Activist Programme. Chhattisgarh, India: SHRC. 2004
Documents Reviewed	State Health Resource Centre, Government of Chhattisgarh. Outcome Evaluation of the Mitanin Programme: A Critical Assessment of the Nation's Largest Ongoing Community Health Activist Programme. Chhattisgarh, India: SHRC. 2004 Sundaraman T. Community Health Workers: Scaling Up Programmes. *Lancet*. 369. 2007: 2058-59 Sundaraman T. Prasad V. Ed. Community Participation and Community Health Workers: With Special Reference to ASHA. Public Health Resource Network, Book No. 4. Chhattisgarh, India: PHRN, 2007

Objectives: The Mitanin programme was initiated in November 2001. Mitanin, a community health volunteer, is identified by the Panchayat and selected through a process of community consultation. She is generally a married woman with a bent for social work and may or may not have received a formal education. The programme was launched in 14 pilot blocks in May 2002 and was expanded to 80 blocks in 2003. In early 2004, the programme was scaled up to cover the entire State. Presently there are over 55,865 trained Mitanins in the State. The key objectives of the Mitanin programme are:

1. Community health education and improved community health awareness.

2. Improved utilisation of existing public health care services.
3. Initiating collective community-level action for health and related development sectors.
4. Provision of immediate relief for health problems.
5. Organising women for health action and enabling women's empowerment.

Strategies: The programme is run by a State-civil society partnership at the State, district and block levels. The State established a SHRC, an innovative and autonomous institution outside the Government that guides and supports this programme. Key strategies of the Mitanin programme include:

1 Spreading the theme of social mobilisation for health based on a rights and ownership concept and communicated through song, drama and folk drama, enabling a health programme to be converted into a people's campaign.
2 Intensive training process, involving 20 days of camp-based training, 30 days of on-the-job training and support. The on-the-job training support was provided by the trainers who had a regular programme schedule of observing and assisting the Mitanin to perform her tasks.
3 Well developed monitoring and support system at block, district and State levels, involving local NGOs and the public health system.
4 Attempting to strengthen the public health system through the increased demands placed on health facilities as community demand for quality health services increased.

Outcomes: In addition to the empowerment of the Mitanin and building a people's health movement, the Mitanin programme demonstrated significant changes in health care indicators that relied on household behaviours, such as initiation of breastfeeding.

- 55,865 Mitanins cover the entire State
- Over three-quarters of Mitanins regularly attend immunisation camps, visit the newborn on the first day of birth, provide counselling on essential newborn care, visit mothers in the last trimester of pregnancy and are the first point of referral for curative care
- SRS estimates for IMR indicated a reduction from 79 in 2000 to 60 in 2004
- Breastfeed initiation within 24 hours of birth increased from 27% (1998-1999 NFHS) to 88% (2005-2006 NFHS)
- Proportion of children with complete immunisation increased from 30% in 1998-1999 to 42% in 2005-2006

Lessons learnt: The Mitanin programme created a middle-level management workforce that provided continuous support and guidance to the Mitanin. Increased community demand for services has been triggered by the work of the Mitanin and this, in turn, has pressurised the public health system to deliver. The Mitanin programme was the inspiration for the nationwide ASHA programme and in effect represents a scaled-up version of the programme. However, a programme of this scale requires sustained political support if

substantial changes are to be achieved. Where the classroom training was not effectively supported by on-the-job training, the Mitanin could not perform well.

Conclusions: The Mitanin programme represents a unique innovation using women as health volunteers and training them to transform a health programme into a people's movement and empowerment process. The situation of the Mitanin programme within a health sector reform indicates the need to strengthen public health systems in order to build strong and effective community processes to change health behaviours and meet the demands generated by people's action and ownership.

ANNEXURE 9.3.11

Communitisation of Health Centres

Title	Communitisation of Health Services
State	Nagaland
Geographic Area of Coverage	Across the State, 350 of 394 sub-centres, 10% of PHCs and one of 21 CHCs were transferred to community
Target Population	General population
Project Life	Launched in 2002, ongoing
Budget	Total estimated cost: Rs. 190,388,000
Implementing Partners	Government of Nagaland
Existing Evaluations	None
Documents Reviewed	Based on Power Point presentation supplied by the North East Regional Resource Centre (NE-RRC)

Objectives: The model was initiated in 2002 and predates the NRHM. The objective of the model is to engage the community in the management of health centre services from the sub-centre upwards to encourage ownership. So far, 397 sub-centres, 63 PHCs and 31 CHCs have been notified under the scheme and have the appropriate levels of health committees. The NRHM untied funds are also being passed to the committees.

Strategies: The Government of Nagaland enacted the Nagaland Communitisation of Public Institutions and Services Act, 2002, in March 2002, thereby creating the legal and institutional context for the communitisation process to take off. In the first phase, all health sub-centres were communitised. The key strategies include:

1. Establishing committees with representatives of the user community to forge a partnership between the Government and the user community.
2. Powers and management functions of the Government were transferred to the committees, including salary disbursal to staff running the utilities, power to exercise a 'no work, no pay' principle.
3. Assets of the Government were transferred to the committee, with transfer of ownership of public resources and assets, control over service delivery became part of the process.
4. A fund was created where salaries, along with other Government grants and community contributions, were credited for running and developing the utilities.
5. Decentralisation and delegation: Powers and responsibilities were conferred to these authorities, including critical supervisory and supportive assistance.
6. Capacity building at all levels, including orientation and sensitisation.

Outcomes:

- There has been a significant increase of more than 50% in children accessing the health centres across all villages
- 75-90% villages reported improvement in health staff attendance. Attendance improved to over 90% in the sampled villages, with unauthorised absence reduced to zero
- At least 83 sub-centres, which had no staff earlier, provided one ANM through redeployment

Lessons learnt: Communitisation of health services need legislative and administrative reforms and a very systematic and intensive approach that takes time to mature. Communitisation or decentralisation efforts cannot be sustained on individual commitment alone. Decentralisation or communitisation processes can quickly reverse if the Government leadership changes and there is no sustained support system in place. Government-led communitisation efforts often face the challenge of resistance by officers in the line department on one hand and assertion of leadership by the community on the other.

Conclusions: This model is an attempt at promoting community ownership and the management of public health facilities and is being implemented on a large scale. It provides an experience for the communitisation process of the NRHM and an in-depth assessment that focusses on monitoring, capacity building, staff motivation and retention and organisation of logistics and supply systems, as well as the nature of community engagement (attention to the poor and marginalised), which would yield valuable information to the rest of the country.

ANNEXURE 9.3.12

Community Monitoring (Rayagada), Orissa

Title	People's Health Management Information System (PHMIS), Rayagada
State	Orissa
Geographic Area of Coverage	Rayagada district (evaluation in 22 villages)
Target Population	Not applicable
Project Life	2003-2006
Budget	Yearly budget PHMIS (including epidemiology consultancy and validation system and capacity building for Panchayat Health Management Information System)—Rs. 16.60 lakh
Implementing Partners	Joint venture of UNICEF, Rayagada District Administration and Mitra, Christian Hospital, Bissamcuttack
Existing Evaluations	
Documents Reviewed	Project Report (1 December 2005 to 30 November 2006) by PHMIS team, Rayagada, Orissa; presentations on the initiative

Objectives: This initiative of information management system along with community monitoring was introduced as a pilot in Rayagada, an underdeveloped district, which has the highest BPL population in the country and a high concentration of underserved people, 56% ST and 14% SCs. Rayagada is also a part of the KBK area inhabited by the poorest people of Orissa. The PHMIS project was launched in this district to add epidemiological insights in the data collected through the District Level Advisory Committee (DLAC) of the MOs, Child Development Project Officers and Block Development Officers, to set up a validation system to enable triangulation of data that would provide alternative information to the districts through random sample surveys and to involve the community (Panchayat) in monitoring and participation in an alternative Health Information System.

Strategies: The key strategies of the project were:

1. To utilise the development, health and ICDS machinery through an integrated mechanism to tackle problems related to reduction of IMR.
2. To ensure cross-validation of data and problems reported.
3. Ensure better analysis and management of information generated from the field.
4. Ensure optimal utilisation of scarce resources.
5. Ensure team work at the block level.
6. Devise solutions that are evidence-based.

The project envisaged capacity of local teams consisting of PRI representatives, SHG members, community leaders and frontline Government staff in six Gram Panchayats in Bissamcuttack block and eight in Rayagada block for setting up and managing a Gram

Panchayat Health Management System for tracking births and deaths in these areas. These groups would meet every month to monitor the status of the people and to dialogue on the issues that matter. This is turn would lead to village-level interventions, besides providing district administration with information from the grassroot level.

The project builds on the process where relevant information is generated from the field on a monthly basis, evaluation and analysis, which sets the basis for monthly dialogue.

Outcomes: As a result of the introduction of this project, individual case-wise infant death data/details became available for review, reporting on infant mortality improved, under-reporting decreased from 61%-26%; involvement of Gram Panchayats and women SHGs increased along with experts in epidemiology to validate the process and give guidance to the DLAC initiative. The introduction of verbal autopsy by frontline field workers under this initiative has improved the quality of analysis of the causes of deaths. Public health decisions are reportedly more evidence-based, unique epidemiological variations are now visible and block-specific trends can be discerned easily. Perinatal mortality has come to be recognised as a critical issue. Strategic interventions are made on actual epidemiological data, which has led to reduction of ARI deaths.

Lessons learnt: The pilot project in Rayagada could identify three priority issues responsible for more than 60% infant deaths in the district—LBW, premature births, ARI and malaria. Subsequently, three multi-disciplinary core groups were set up to devise district-specific strategies to bring about changes in these three areas. Several important stakeholders have been convinced of the value of participatory management and information management skills. The project has shown that evidence-based models of development are effective in making the health system more transparent. Performance of the District Public Health system can be enhanced through effective leadership, inter-sectoral involvement and in–sourcing of technical resources from civil society. Further, chances of sustainability improve increasingly with information management systems in place at multiple levels. Even issues perceived as technical such as IMR and MMR can be demystified and handled by non-technical people including community members through continued capacity building. The project has created space for meaningful community participation that will enable change in the health system and make it more responsive.

Conclusions: The Rayagada model builds on the strength of an effective MIS to provide necessary inputs for analysing and resolving problems and monitoring capacities of the community-based groups. However, the output of the information management system needs to be utilised effectively to spark off public debate, dialogue and facilitate advocacy for changes in the existing administration. The process of validation and evaluation needs to be standardised and yet should be flexible enough to keep up with the emerging trends. Greater participation of women needs to be ensured in discussions and deliberations related to infant mortality and maternal mortality at the village level.

ANNEXURE 9.4.1

Maternal and Perinatal Death Inquiry and Response

Title	Maternal and Perinatal Death Inquiry and Response (MAPEDIR)
State	**From 2005 to 2007:** Madhya Pradesh, Rajasthan, West Bengal, Orissa, Jharkand, Bihar **In 2008:** Maharashtra and Assam **In 2009:** Uttar Pradesh and Chhattisgarh
Geographic Area of Coverage	Rural areas
Target Population	At household level: family of the deceased woman At community level: partner with communities. Community awareness and mobilisation to avert maternal deaths
Project Life	Launched in 2005 and scaled up in phases
Budget	Based on State-specific budgets, for example, MAPDA in Assam in two districts: Rs. 20 lakh at the rate of Rs.10 lakh per district
Implementing Partners	MNGOs and FNGOs; the NRHM of all the States
Existing Evaluations	None
Documents Reviewed	Concept Note Maternal and Perinatal Death Enquiry Response: Empowering Communities to Avert Maternal Deaths in India: UNICEF India Country Office, 2008

The MAPEDIR tool underscores the need for information about the underlying causes of maternal deaths in remote and inaccessible villages in order to achieve RCH II and NRHM priority objectives. The MAPEDIR puts in place a process that uses a confidential inquiry tool to examine maternal deaths, generate local evidence, sensitise communities and health officials and galvanise them into taking action to reduce such deaths.

Objectives:

- Sensitise communities on maternal and prenatal health issues, including the need for birth preparedness, complication readiness and inquiries into maternal and prenatal deaths
- Identify recent maternal deaths and conduct community-based inquiries with close acquaintances of the women
- Share the findings of the death inquiries with communities and help them interpret the data to develop appropriate local interventions and advocate for improvements in health care
- The technical agency supporting the innovation (UNICEF) would use the findings of the investigations to advocate with policy-makers for improvements in health care

The MAPEDIR was piloted in Purulia, one of the poorest and most backward districts in West Bengal, in June 2005 and has been scaled up subsequently. Currently it is being implemented in 16 districts in six States with high MMR: West Bengal (Purulia); Rajasthan (Dholpur, Udaipur); Jharkhand (Ranchi, Khunti); Madhya Pradesh (Guna, Shivpuri, Gwalior, Bhopal); Orissa (8 Navajyoti districts—Nuapada, Koraput, Kalahandi, Bolangir, Sonepur, Malkangiri, Nabarangpur, Rayagada); and Bihar (Vaishali). The scheme is being rolled out in Maharashtra in its initial phase and is also planned for implementation in Assam and Haryana.

The scheme involves the private sector as well as the network of NGOs created under the MNGO scheme**.**

Strategies:

MAPEDIR Tools
Suspected maternal death inquiry questionnaire
Childbearing age female death notification format
Trainer's manual, presentation slides and related training materials
Interviewer's reference manual, and interviewer and supervisor checklists
Web-based data entry and analysis software (coming soon)
Data sharing guide (draft)

MAPEDIR Functions and Partners
Coordination and monitoring—Health department, NGOs
Computer data entry and analysis—UNICEF, NGOs, academic institutions
Conduct and supervise inquiries—Health (BPHN, LHV, BEE, MO), ICDS (supervisor), NGO
Community-based maternal death reporting—Health (ANM, ASHA), ICDS (AWW), NGO
Sensitise and share MAPEDIR data with the community—NGO
Training and technical support —UNICEF, medical colleges

Data Sharing Activities
National, State, district, block and GP dissemination meetings
Multi-sector district and block meetings (PRI, Health, ICDS, etc.)
Village meetings and data sharing (VHCs, SHGs)

Outcomes:

In the States where the MAPEDIR is being implemented maternal deaths are being identified and investigated:

- In Rajasthan: 122 maternal deaths have been identified and investigated
- West Bengal has identified 375 maternal deaths of which 285 deaths have been investigated
- Jharkhand: 101/112 maternal deaths have been investigated
- Madhya Pradesh: 127 maternal deaths identified of which 117 have been investigated using the MAPEDIR system of enquiry
- Orissa: 800 maternal deaths have been identified and investigated

- Bihar: 76 maternal deaths identified; 63 investigated using the MAPEDIR technique

Lessons learnt:

The MAPEDIR has brought about data-driven interventions and has created awareness among the community and district officials and at other levels for the need to reduce maternal deaths; increased the significance of upgrading institutions, for example, SHCs and PHCs for providing 24/7 and EmOC services. Some of the positive changes reported from the various States implementing the MAPEDIR are:

In Rajasthan the taxi union/NGO/District/UNICEF: Obstetric helpline and referral transport in all of Dholpur District.
In West Bengal: District/block: Health Department disseminates data; all Heath and Family Welfare *samities* consider MAPEDIR data in monthly action plans.
In Jharkhand: District and block officials meet one or two times/month with MOIC, ANMs, AWWs and BLMC for discussing the MAPEDIR. Folk songs/street dramas have been used to raise awareness on maternal deaths.
In Madhya Pradesh: Monthly audit of maternal deaths undertaken by 413 Gram Panchayats in Guna District. Districts are using MAPEDIR data to make RCH II programme implementation plans. Guna District mapped maternal deaths to prioritise and upgrade SHC and PHCs in border areas for 24/7 safe delivery; ensure referral transport for all 22 PHCs; PRI (one block) introduced referral transport link for remote villages to upgrade SHCs

Conclusions: The MAPEDIR has been recognised as a powerful tool to investigate maternal deaths at community level. This investigation is the basis of the missing data for improvements in maternal health programming.

ANNEXURE 9.4.2

Tamil Nadu Medical Services Corporation

Title	Tamil Nadu Medical Services Corporation, TNMSC
State	Tamil Nadu
Geographic Area of Coverage	All districts of Tamil Nadu
Target Population	Not applicable
Project Life	1994
Budget	Budget from three separate directorates (Directorate of Medical Education, Directorate of Medical and Rural Health Services and Directorate of Public Health and Preventive Medicine) 2000-2001—Rs. 93.94 crore 2001-2002—Rs. 91.53 crore 2002-2003—Rs. 93.09 crore
Implementing Partners	Government of Tamil Nadu
Existing Evaluations	
Documents Reviewed	Access to Medicines: Initiatives in Policy Making and Delivery of Drugs—A Case Study of Tamil Nadu by N. Lalitha

Objectives: The TNMSC is a drug management system that aims to ensure regular and effective supply of drugs to the districts.

Strategies: This basic function of the Corporation is to identify and formulate a list of essential drugs, procuring them through appropriate procedures and distributing these to the districts though the Corporation.

The specific strategies of the Corporation involved:

1. Preparation of a list of essential drug list, finalising the cost of drugs and the quantities essential for the institutions based on the needs of various health levels, which were decided by a drug committee.
2. Planning and preparation of tender documents.
3. Identification of suppliers, manufacturers and streamlining their supplies to the warehouses.
4. Building warehouses with standard structure and design in 24 districts.

Outcomes: The following are the key outcomes of the TNMSC:

- The drug procurement and distribution system across the State was streamlined
- With continued vigilance, the TNMSC procured medicines at competitive prices and of better quality
- Transparency in selection of suppliers was ensured

- After the Corporation was set, prices of medicines were rationalised compared to the previous years
- Training of pharmacists in the warehouse in drug storage, handling and distribution improved their efficiency

As a result of the meticulous planning and improved procurement system, the TNMSC was able to reduce its expenditure and undertook several welfare activities (for example, purchasing equipment for master health check-up programme in hospitals) with the savings made.

Lessons learnt: A research project for studying the reform measures initiated by the TNMSC and for assessing the availability of drugs indicates that availability of drugs and their utilisation has improved in the PHCs. There has been no instance of stock-out of drugs in the PHCs; a recording system through 'OP chits' has facilitated in assessing the availability of drugs; drugs are dispensed only on the basis of the doctor's prescription, which has reduced pilferage of drugs. The findings of the research study shows that medicines were available in the facilities and patients received them soon after their visit or from the nearest GH. Patients interviewed in the course of the research study could distinguish perceptible changes in the quality of drugs provided 'few years ago' and 'now'. *

Conclusions: The TNMSC model appears to have been successful in terms of facilitating smooth drug procurement and distribution system in the State of Tamil Nadu. The model has considerable potential for replicability in other States (the TNMSC is already providing procurement assistance to some States) through formidable partnership with the private sector. However, regulation of the private suppliers and capacity building of the private service providers will have to be ensured. Acceptance of an essential drug list also appears to be a challenge as it is opposed to the interest of the private pharmaceutical companies. Quality assurance of the supplies will be crucial.

*_Access to Medicines: Initiatives in Policy Making and Delivery of Drugs: A case study of Tamil Nadu._ By N. Lalitha.Patients perspective gathered during interviews in PHCs

Annexure 10

School Health

ANNEXURE 10.1

School Health Programme, Gujarat

Title	School Health Programme
State	Gujarat
Geographic Area of Coverage	Entire State
Target Population	All the school-going students across the State
Project Life	
Budget	Rs. 7.12 crore in 2007-2008 and Rs. 14.37 crore in 2008-2009
Implementing Partners	Education departments. Directorate of Education, SSA, SCERT, BRC, CRC and School Authorities
Existing Evaluations	
Documents Reviewed	Programme implementation plans

Objectives:

1. Effective implementation of School Health Programme across the State.
2. All school-going students to be screened, provision of services and giving adequate care.

Strategies:

Under this Programme all students are screened for a minimum set of pre-defined conditions which would include:

1. Common skin diseases and infestations, scabies, pyoderma, acne and lice being some of the most common. These are contagious and simultaneous treatment of all those affected is the easiest and surest way to cut down the spread. The School Health Programme was an innovative initiative of the Gujarat Government. It is carried out every year from November to February. MOs of their respective areas are responsible for examining all the children at the ICDS centre—7-14-year-old children of primary and secondary schools and 15-18-year-old children of high school. Non-school-going children are also included in this special school health drive. Children with minor ailments are treated on-the-spot in the schools. Children requiring examination by specialists are being sent to the related referral centres where different medical experts such as ophthalmic surgeon, physician, paediatrician, dentist, skin specialist and E.N.T. surgeons examine and treat them. Thus, children who require spectacles are provided free of cost.

2. Heart defects—rheumatic and congenital. There have been cases where these have been detected and managed appropriately through School Health Programmes.

3. Disabilities—visual, hearing, locomotor and others. Children with disabilities have special needs to be able to keep up with the class. Equipment, as well as support and guidance, could help them through School Health Programmes. Detection and creating awareness about the special needs of people with disabilities is included in the programme.

4. Learning disorders/problem behaviours/stress/anxiety: Teachers need to be sensitised to identify children with such problems and send them for appropriate referral centres. This may not be detected in the screening camp, but a trained teacher would notice it during the regular course of school. This is a part of the School Health Programme.

Gujarat is a pioneer in the adolescent anaemia control intervention and the programme is in place since 2002. Ninety-two percent of the school-going adolescent girls (Standards 8 to 12) are given one tablet of IFA every Wednesday; almost 10 lakh girls are benefited by 'Adolescent Girl's Anaemia Control Programme' in Gujarat in secondary and higher secondary schools. Also included in the school health check-ups is therapeutic doses to students with signs and symptoms of Vitamin A deficiency.

Planning for remedial action at the school itself

There is also considerable remedial action that would be taken at the school itself. One is appropriate first-line treatment for small cuts and injuries and certain common illnesses such as skin ailments, which would otherwise spread among the children. For this, a first aid kit should be put in place. There would be one such first aid kit for every 250 children. This is useful irrespective of the screening. Immunisation with DT at six years and with tetanus toxoid at 10 and 16 years is also another action, but this would need the nurse and could be combined with the screening.

Documentation and health records

Teachers would maintain health records of each student in the school in a child health card and a school health register that ensures that each child who has been screened gets the follow-up required.

Transport for screening and referrals

Adequate provision for funds would be ensured to provide appropriate transport (including provision for hiring vehicle, if necessary) to the health staff to visit the schools and, more important, to take children for referral.

Outcomes: Gujarat's School Health Programme has a State-level Steering Committee chaired by the State Health Minister, with Chief Secretary, Additional Secretary (Health), Additional Secretary (Education), Additional Secretary (Finance) and Members of Legislative Assembly as members. Certain aspects of its programme are similar to most States. One key element is microplans, prepared at the PHC level, which includes details of the schools and *anganwadis* to be visited for health check-ups. It lists the other activities to be carried out. All these plans are collected, collated and analysed by the State-level Health Education Bureau to provide the State Plan for the School Health Scheme.

Lessons learnt: Coordination with NGOs and UN agencies for piloting projects under School Health Programmes has been beneficial.

Conclusion: The strength of the Gujarat programme: Children suffering from heart, kidney and cancer diseases are provided treatment at apex tertiary care hospitals, and not only is the cost of treatment borne by the State Government, referral transport is also ensured. If needed, specialist treatment outside the State is also provided.

New initiative: A ‘Health Promoting School’ has been started with assistance from the WHO in four districts and one urban area. The programme will take care of the quality of water and sanitation in schools and augment capacity building of teachers so as to achieve the holistic and sustained promotion of health in schools.

ANNEXURE 10.2

School Health Programme, Kerala

Title	School Health Programme
State	Kerala
Geographic Area of Coverage	Entire State
Target Population	Number of Government schools: 14,000 (50 lakh students) Number of Block Panchayats: 152 Number of Block PHC and CHC (111+114): 225 Number of NRHM block Co-ordinators: 243 Number of schools selected: 10,001 school/Panchayat/ municipality/ corporation
Project Life	
Budget	Rs. 2.50 crore in 2007-2008 and Rs. 4 crore in 2008-2009.
Implementation Partners	Directorate of Education, SSA, SCERT and other UN agencies working in the field, NGOs
Existing Evaluations	
Documents Reviewed	Project implementation plans, district plans

Objectives:

1. Implementation of the School Health Programme with a dedicated JPHN for every 2,500 students (around two to five schools) and a school team regularly visiting the schools and providing services ranging from catering to minor health problems, referral when needed, health awareness classes for students, teachers and parents and data compilation of the comprehensive health of the students.

2. Intersectoral coordination with the DPI and the SSA for the smooth running of the School Health Programme. Coordination of the other line departments such as education, local Self-Government and sports and youth affairs for the smooth running of the programme.

3. Enhancing the physical, mental and environmental health of the students and thereby promoting messages to the society.

Strategies:

1. A full-time dedicated JPHN will be appointed to cover 2,500 students (one to five schools) to facilitate all the school health activities, namely, planned health check-up one day per week of the selected school, promotion of immunisation programme, facilitating blood group checking, measuring height, weight, BMI and physical and psychological health status, re-organisation of school health clubs, referral services for both medical and counselling to trained counsellor, health education for the students, teachers and parents and propagation of health message in the schools. Thus the health examination and anthropometric

measurements of the students will be recorded twice at an interval of six months in the School TC Health Record. One JPHN in charge of 2,500 students in an area and will visit each school once per week. She will compile all data pertaining to the students and document it.

2. The School Health Team comprising the Medical Officer, Health Supervisor, Lady Health Supervisor, Health Inspector, Lady Health Inspector, Junior Health Inspector, Junior Public Health Nurse, Block Arogya Coordinator, Ophthalmic Assistant, Teacher Coordinator/Teacher Counsellor (male/female), PTA Representative, ASHA/AWW and Dental Hygienist to visit the schools once a week as per schedule for periodic health check-ups of school children after giving sufficient information to parents to ensure their involvement and also support the JPHN in conducting health education classes for the primary section students and organising the medical camps.

3. Printing and distribution of school TC Health Record and referral cards and regular updating of child's health profile to be maintained at school. This health record 'Minus Two to Plus Two' will be maintained at the schools from enrolment to passing out after Plus Two and a record of the comprehensive health of the child. This card also contains the TC. The conduct certificate will be transferred when the child shifts or passes out to a different school.

4. A module development for the public health awareness of the students. A School Health Programme manual is to be developed with information on the programme, roles and responsibilities of JPHN and other school health team members, dos and don'ts manual for the teachers, module for health education of the students, etc.

5. Training of the school health team, local doctors, teachers, PTA members, DPMs, DMOs, counsellors, JPHNs, parents, etc., would be conducted.
6. Development, printing and distribution of FAQ booklets, pamphlets, posters, calendars and other BCC materials for students and schools.

7. Provision of health advice, micronutrients and de-worming during periodic medical check-ups. A screening medical camp with specialist doctors under the initiative of the school health MO and team would be held in each school in July and a specialist medical camp with a cadre of specialist doctors would be conducted in December-January every year in each school.

8. Training on adolescent problems, parenting and counselling of the special teachers of the Sarva Shiksha Abhiyan (SSA) for children with disability would be conducted and their services may be made use of as teacher counsellors or facilitators. There are 408 such teachers in Kerala who report at the Block Resource Centre (BRC) and also meet parents of the children every Saturday at the BRC. The medical camps scheduled for the schools and follow-up counselling with parents can be held at the BRC regularly since they already have a building and infrastructure.

9. Special sessions to sensitise teachers and parents if possible regarding preventive and promotive health care including mental health, using technical support from nearby health care providers can be conducted on Saturdays.

10. Training of the specialised teachers from the DPI appointed on school basis, whose services may also be made use of at the school level for the programme. Wherever this teacher is not present, the SSA teacher would provide services.
11. Revival of the school health clubs involving students and committed teachers. These can be registered for effective functioning with financial support, if needed, from the local Self-Government. The members would help in disseminating the health messages at the assembly and in organising health melas, observing important health days in school, competitions quiz and medical camps. The school children may even be taken for trips to the bank, post office, fire station, small-scale industries, etc., to see things at first hand as part of the health club activities. Strengthening of practice of yoga and physical exercises in schools as an initiative of the volunteers in the school health club. Rs. 5,000 will be provided by the local Self-Government for the setting up of the health club on request from the concerned schools. Anonymous question boxes in the health clubs to facilitate students to come out with their doubts and apprehensions regarding health, diseases and misconceptions. These questions will be answered once a week by the MO and other technically qualified health personnel, appropriately maintaining the confidentiality of the student and placed on the notice board. This would be placed in the health club in each school.

12. Exhibiting health messages in classrooms and school premises to educate children on health issues, disease source, etc. One health message per week for the 38 working weeks will be rotated in each class on public health issues.

13. Imparting health education, family life education, life skills, etc., to the students and promoting health messages at the classes, assembly or health clubs. There may be sessions taken by the parents of the students from different professions, talking to the children not only about their professions but also about the health hazards faced in the profession and their preventive steps facilitated by the class teacher. Parents can also be involved to give information on road safety, clean environment, personal hygiene, saving precious water by conservation, farming at home and terrace farming, waste disposal by earthworm compost, etc. One period in a week may be set aside for health awareness by the local doctor, officials from different departments or the NRHM for conducting sessions.

14. Providing dental care in schools through PPPS with the Indian Dental Association to provide preliminary screening, treatment through referral at subsidised rates.

15. Giving Health Minister's trophies and cash prizes as incentive to the best performing three school health clubs and school health team/JPHN in the State would be initiated.

16. Providing regular counselling services to the students through a trained counsellor and referral when needed would a major aspect of personality development and academic performance. Helping students for career building through counselling in needy schools. The

services of counsellors already appointed in schools under the Social Welfare Department would be made use of.

17. Data analysis and compiling with monthly reports to the block MO/RCH officer/DPM and NRHM headquarters would be done by the JPHNs. Data would be analysed on the main health problems faced by students, the relation of anaemia to academic performance, the impact of counselling and services of the school health team in the academic performance of the students, etc., would be done periodically and reported.

Outcomes:

- Revival of a regular school health programme providing quality services and well monitored in all selected Government schools
- A well coordinated programme under a JPHN appointed exclusively for school health with the SSA, DPI and the NRHM working as a team for the smooth functioning of the School Health Programme with all line departments
- A wholesome and comprehensive development of the health of school children and awareness creation among them and the society on public health issues

Lessons learnt: Giving Health Minister's trophies and cash prizes as incentive to the best performing three school health clubs and school health team/JPHN in the State would be initiated. Providing regular counselling services to the students through a trained counsellor and referral when needed would be a major aspect of personality development and academic performance. Helping students for career building through counselling in needy schools; the services of counsellors already appointed in schools under the Social Welfare Department would be made use of,

Conclusions: The School Health Programme has been revived under the NRHM with a medical team regularly visiting the schools and providing services for minor health problems, referral when needed, health awareness classes and parents and data compilation of the comprehensive health status of students. The Cotton Hill Girls Higher Secondary School at Trivandrum is selected as the first model school in the State to put the school health scheme in place, and scaling of the model is made to all schools in a phased manner. Health-promoting schools are being initiated with a dedicated team.

ANNEXURE 10.3

School Health Programme, West Bengal

Title	School Health Programme
State	West Bengal
Geographic Area of Coverage	147 blocks across 15 districts in West Bengal.
Target Population	School students from Classes I to XII across the State
Project Life	
Budget	Rs. 11.12 crore in 2008-2009
Implementation Partners	PRI, Education department at all levels
Existing Evaluations	
Documents Reviewed	District plans from the districts

Objectives: To improve the health of school-going children through:

1. Promotion of health education including adolescent health arising out of physical, emotional and different stresses and strains prevailing in the present social psyche.
2. Prevention of diseases and promotion of immunisation.
3. Early detection, diagnosis and treatment of diseases.
4. Provisions for referral services to higher health centre.
5. Building health awareness in the community.
6. Development of habits on personal hygiene and cleanliness.

Strategies:

1. Initially, the programme has been launched in 147 blocks across 15 districts in West Bengal. These 147 blocks would be identified on the basis of female literacy rate of the block.
2. Two GNMs would be assigned for each block specifically for school health. Referral linkages with Government health facilities would be strengthened to cater to the needs of these school children.
3. The intervention would strongly involve the participation of students, principals, teachers, parents and the community (SHGs/CBOs/ASHAs, etc). The ICDS functionaries, PRI representatives and NGOs would also actively support the initiative.

4. Preparation of a block-level calendar on the school health camp and quarterly health camps. After the listing of the schools in the block the two GNMs in each block would prepare their individual calendar and prepare a block-level calendar. They also have to intimate the GP-level functionaries about their tour plans. The plans with the dates would be shared with the respective school before hand.

5. Issuance of Student Health Cards—all students in the listed schools will be allotted a Student Health Card.

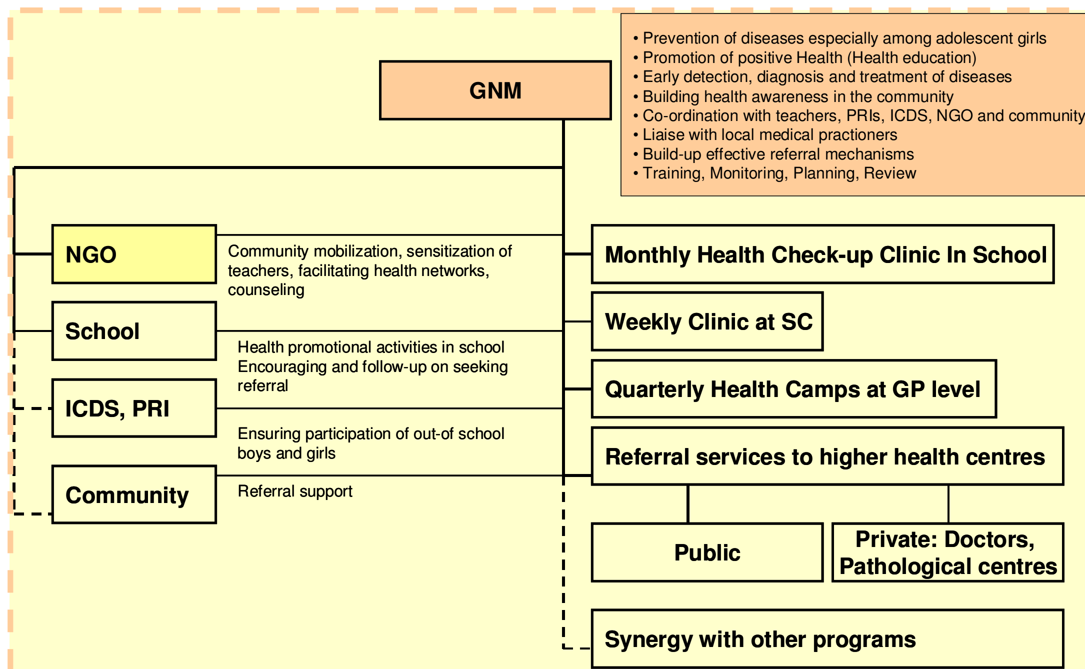
6. Monthly Health Check-up/Clinic in School—each school will organise a school health clinic, every month. The GNM will visit the school on that particular day and provide clinical service to all students. During the routine examination of students, health education would also be been given at individual level and in a group. The GNM is expected to provide all preliminary medications and micronutrient supplementations to students-in-need. After screening, the students found to be suffering from any disease that needs to be referred would be sent to the nearest health facility.

7. Orientations of teachers and parents—teachers and parents have to be oriented on issues related to health, nutrition, sanction and hygiene from time-to-time. While teachers can undergo training workshops, parents have to be communicated through group meetings. This would be a key role of the NGOs.

8. Formation of peer leaders—students would be oriented to act as peer leaders for the primary school students. They would be expected to conduct health education classes and also monitor personal cleanliness, etc. They would also spearhead physical activities in school in the form of yoga, sports, etc.

9. Sensitising community on good health issues—this would primarily be the role of the NGOs. Organising events to **encourage health promotional activities in the community**.

10. Participation of each school in quiz contests, debates, skits, community orientation and other activities to be held quarterly, to keep the parents and communities aware and supportive of the programme and explore possibilities of reaching to the out-of-school girls after refresher trainings are completed. The teacher in-charge of the programme will be responsible primarily with the Head Teacher in organising. Health staff will participate as facilitators.



Outcomes:

- Formation of peer leaders—students would be oriented to act as peer leaders for the primary school students. They would be expected to conduct health education classes and also monitor personal cleanliness, etc. They would also spearhead physical activities in school in the form of yoga, sports, etc.

- Sensitising community on good health issues—this would primarily be the role of the NGOs

- Organising events to encourage health promotional activities in the community

Lessons learnt:

1. GNMs to be assigned for each block specifically for school health.
2. Referral linkages with Government health facilities to be strengthened to cater to the needs of these school children.
3. Schools to do advocacy and social mobilisation with parents, PRIs and community using the IEC material.
4. Each school to call at least one parent-teacher meet in the month of November to reinforce the objectives of the programme to the parents.

Conclusions: Very well planned and systematic intervention on health screening, services as well as referral schemes.

ANNEXURE 10.4

School Health Programme, Dadra and Nagar Haveli

<table>
<tr><td>Title</td><td>School Health Programme</td></tr>
<tr><td>State</td><td>Dadra and Nagar Haveli (Union Territory)</td></tr>
<tr><td>Geographic Area</td><td>72 villages, 11 patelads, 301 schools</td></tr>
<tr><td>Target Population</td><td>58766 students in 301 schools</td></tr>
<tr><td>Project Life</td><td></td></tr>
<tr><td>Budget</td><td>Rs. 25 lakh under the NRHM and financial RKS and Industrial Association.
Budget -2008-2009 (in Rs. lakh)
<table>
<tr><td>Salary</td><td>Honorarium</td><td>Vehicle</td><td>Stationery</td><td>Medicines</td><td>First Aid Kit</td><td>Training</td></tr>
<tr><td>12.86</td><td>00.60</td><td>3.00</td><td>00.50</td><td>5.00</td><td>3.00</td><td>00.04</td></tr>
</table></td></tr>
<tr><td>Implementing Partners</td><td>Shri Vinoba Bhave Civil Hospital, Medical and Public Health Department, Education Department, District Panchayat (primary education)</td></tr>
<tr><td>Existing Evaluation</td><td>Not applicable</td></tr>
<tr><td>Documents Reviewed</td><td>Guideline on School Health Programme, Ministry of Health and Family Welfare</td></tr>
</table>

Objectives:

1. Promotion of positive health and healthy environment.
2. Prevention of disease.
3. Early diagnosis/treatment/follow-up/referrals.
4. To enlighten the district-level, block-level officials and school heads on health issues.
5. Awakening of health consciousness.
6. To provide platform for practising healthy habits.

Strategies:

The School Health Programme is running since 13 October 2006 in the Union Territory and is catering the best medical services to a total of 58,766 children of 301 schools.

The programme is working under various phases for appraisals of student health.

Phase I

- Appointment of medical and paramedical staff
- Development of software, where all students carry a health identity card and health card with a photograph at every school
- A centralised data bank at the office of the SHP
- Provision of vehicle for free referral services

Phase II

- One-day orientation programme conducted for school heads, teachers and Education Officials in the presence of Secretary, Health and Education
- Basic medicine kit is made available at all schools

Phase III

- Advance tour programmes of school health check-up in the month of June every year to all schools and a reminder is sent a week in advance
- Primary data entry sheet is given to each school teacher
- Diagnostic check-up by the medical team at school-level consisting of paediatricians, ophthalmologists, dermatologists, ENT surgeons, dental surgeons and MOs with paramedical staff
- Monitoring of the immunisation status.
- Health education especially on hygiene, nutrition, psychology and adolescent sex education

Phase IV

- Therapeutic aid at the school level and referral services to the district hospital (Shri Vinoba Bhave Civil Hospital) for specialty and super-specialty management (through telemedicine and if necessary referrals to super-specialty hospitals in Mumbai) for curative treatment through referral cards
- Free spectacles are provided to all children with refractive errors

Phase V

- Maintenance and analysis of student health records for follow-up services under health I-card software
- Every referred child is brought to Shri VBCH within 15 days by the teacher of the class with the parents. If the child doesn't report, a letter is sent to the principal or the headmaster. If no action is taken then the letter is sent to education officer and Secretary Education

Phase VI

- Regular follow-up by MO PHC, LHV and MPW's. Follow-up of children suffering from diseases is done in vacations by the school health team by involving the parent-teacher associations of every school

Phase VII

- Dental health curative camps have been set up to treat children at the school level

Outcomes:

Year	Total Students to be	Total Students Examined and Carry Health-I	Total Children Diseased	Total Children Treated at	Total Referrals Advised	Total Referral Treated at

	Examined	Cards		School Level		VBCH
2006-2007	40,512	27,535	14,369	14,782	263	
207-2008	48,652	20,377	15,718	15,716	175	
2008-2009 Up to February 2009	58,766	48,597	12,736	22,580	736	487

Number of Children Given Treatment On-the-spot for Various Diseases

Sr. No.	Name of Disease	Number of Children Suffering from the Disease During 2006-2007	Number of Children Suffering from the Disease During 2007-2008	Number of Children Suffering from the Disease During 2008-2009 up to December
1	Vitamin A Deficiency	481	398	3
2	Cornel Opacity	58	16	0
3	Pyoderma	715	700	192
4	Scabies	504	450	126
5	T. Versicolor	415	375	26
6	P. Alba	334	250	7
7	Alopecia Areata	12	7	0
8	Lichen Planus	76	50	0
9	T. Corporis	98	50	0
10	CSOM	147	120	115
11	URTI	850	1,005	1,487
12	Sinusitis	35	20	0
13	Sensorinural deafness	27	23	15
14	Dental problem	10,598	12,226	9,742
15	Cardiac problem	1	3	2
16	Physical handicap	15	5	35
17	Leprosy	3	20	20

- Well maintained records with elaborated reporting leading to good follow-up action
- Referrals are done periodically and tracking of the child is done
- Dental treatment camps organised at school level
- Improved quality of nutrition by training of parents and teachers by dietician

Lesson learnt: Involvement of all the stakeholders through orientation and advocacy has brought a lot of support from all sectors. A full-time school health co-ordinator is needed.

Conclusions: A dedicated team is available for SHP activities and their involvement in screening and service provision is very encouraging. Process documentation and reporting is very elaborate, enabling analysis of disease patterns in school-going children and planning of strategic interventions in the future.

Annexure 11

List of Innovations Recommended for In-depth Review

ANNEXURE 11

List of Innovations Recommended for In-depth Review

The categorisation and desk review of innovations in the directory has enabled the identification of some innovations that have the potential to be scaled up, but need additional in-depth assessments. These in-depth assessments would need to focus on the seven criteria (listed in Annexure 2) in order to appraise the potential for the innovation to be scaled up at State and/or national levels. Attachment A of this Annexure lists those innovations that should be considered for an in-depth scalability assessment.

The desk review of these innovations is the first step in assessing the scalability of the innovations. Following is a brief summary of the issues identified during the compilation of the directory, which need to be considered during the in-depth reviews:

1. The term 'innovations' has been used flexibly, and encompasses pilot projects (for example, a novel service delivery approach, organisational modifications to improve performance, use of incentives to attract and retain human resources), creative use of public-private (with for-profit and not-for-profit organisations) partnerships across a range of services, use of cash transfers and demand-side financing mechanisms to improve outcomes such as maternal mortality and also to address equity issues and basic strategies such as mapping of health facilities, planning for coordinated action at block and district levels.
2. The priority accorded to evidence is mixed, which is a critical factor to be considered in scalability. Considering that most of the innovations are of recent vintage, very few of the innovations in the list actually had evidence of the impact, although outcomes are measurable in many cases. However, it is clear that most of the innovations, which have been scaled up, have met with some degree of success.
3. Paucity of documentation was a key limitation to compiling the innovations as well as to the desk reviews. Lack of detail on project design and/or progress of implementation significantly impacted the quality of information in the directory and the desk reviews.
4. Lack of cost data is another issue. While many of the desk reviews do include budget figures, it is difficult to understand the cost of the interventions and the cost of the technical assistance that was provided. However, once the innovations stabilise, the programme managers are bound to look at the costs.
5. A significant number of innovations have been piloted by the State Governments and some are designed and initiated by the DPs. There is little information to enable assessment of the cost of the components provided by the external agencies, and of the nature of involvement by the local implementing partners, be it the State, district or block-level public health system.
6. A combination of factors was used to recommend a model/innovation for in-depth review. These included the following:

- Substantial information about innovation exists, but needs additional validation and expert team assessment
- There is opportunity for crucial elements of the innovation to be successfully scaled up
- Models implemented in social, political and governance contexts that are substantially similar to other environments to make scaling up effective

7. Attachment A: Innovations Identified for In-depth Evaluation for Scalability

Sl. No.	Name of Innovation	State	Evaluated (if Yes, by Agency)	Currently being Evaluated by	Planned for Evaluation	Timeline
1.	Chiranjeevi Yojana	Gujarat	Y (IIM-A and UNFPA)	UNFPA		2008-2009
2.	Delivery Huts	Haryana	N		Y	2008-2009
3.	Ambulance Scheme	West Bengal	Y (DFID)			
4.	Rural Emergency Health Transportation Scheme	Andhra Pradesh		MSI		2008-2009
5.	Mobile Health Clinics:	West Bengal	Y (DFID)			
6.	Mobile Boat Clinics in Riverine Areas	Assam				
7.	Subcontracting out: (i) Diagnostic Services in Rural Areas, (ii) Security, Scavenging and Waste Management Functions, and (iii) Mechanised Laundry	West Bengal	Y (DFID)			
8.	Management of PHC by NGOs	Arunachal Pradesh				
9.	Communitarian Private Public Partnership for management of Health Centres	Nagaland				
10.	Rapid diffusion of IUCD Training Programme Using Alternative Training Methodology in 12 States, MoHFW	12 States				
11.	Fractional Franchising for Injectables through the Private Sector	Uttar Pradesh, Jharkhand, Uttarakhand				

Sl. No.	Name of Innovation	State	Evaluated (if Yes, by Agency)	Currently being Evaluated by	Planned for Evaluation	Timeline
12.	Shishu Samrakshak Maah	Chhattisgarh				
13.	Muskaan Project	Bihar				
14.	Dular Project	Bihar				
15.	Alternative Health Service Delivery	Punjab				
16.	Family Counselling Centres	Madhya Pradesh, Rajasthan, Orissa, Maharashtra, Kerala		MSI		
17.	Swasth Panchayat	Chhattisgarh		MSI		
18.	Jeevan Deep Samiti	Chhattisgarh				
19.	Community Monitoring	Orissa, Rayagada				
20.	Tamil Nadu Medical Services Corporation	Tamil Nadu		World Bank		

List of Abbreviations

Note: We have prepared a pretty comprehensive list, but need some to be filled out by you. They will then be inserted in the relevant places and finalised. Thank you

ADC: Autonomous District Council
AKF: Aga Khan Foundation
ANC: Ante Natal Care
ANM: Auxiliary Nurse Midwife
APL: Above Poverty Line
ARI:
ARSH: Adolescent Reproductive and Sexual Health
ARTH: Action Research and Training for Health
ASHA: Accredited Social Health Activist
AWW: Anganwadi Worker
BCC: Behaviour Change Communication
BISR: Birla Institute of Scientific Research
BL:
BPL: Below Poverty Line
BPM:
CDC: Child Development Centre
CHC: Community Health Centre
CHCMI: Community Health Centre Management Institute
CHW: Community Health Worker
CLICS: Community-led Initiative for Child Survival
CmOC:
CMS: Commercial Marketing Strategy
CMO: Chief Medical Officer
C-NES: Centre for North East Studies
CO: Community Organiser
CRP: Community Resource Person
DC:
DCTC: Divisional Clinical Training Centre
DHS: District Health Service
DLAC: District Level Advisory Committee
DM: District Magistrate
DMMTT: District Mobile Monitoring Training Team
DMO: District Medical Officer
DMPA: Depot Medroxy Progesterone Acetate
DOH: Department of Health
DP: Development Partner
DPM: District Programme Manager
DPMU:

DST: District Support Team
ECTA:
EL:
EmOC: Emergency Obstetric Care
EMRI: Emergency Management and Referral Institute
FCC: Family Counselling Centre
FHPL: Family Health Plan Limited
FNGO: Field Non Government Organisation
FP: Family Planning
FPP:
FRU: First Referral Unit
FOGSI: Federation of Obstetrics and Gynaecology Societies of India
GIS: Geographical Information System
GoC: Government of Chhattisgarh
GoI: Government of India
GP: Gram Panchayat
HBNC: Home-based Newborn Care
H&FWD: Health & Family Welfare Department
HRA:
ICDS: Integrated Child Development Scheme
ICTC:
IEC: Information Education and Communication
IFA:
IKP: Indira Kanthi Padham
IMNCI: Integrated Management of Neonatal and Childhood Illnesses
IMR: Infant Mortality Rate
IPC: Interpersonal Communication
IPD:
IRDA:
ISM: Indian System of Medicine
ITAP:
IUD: Intra Uterine Device
IYCF: Infant and Young Child Feeding
JAC: Juvenile Aid Centre
JDH:
JHPIEGO:
JPHN: Junior Public Health Nurses
JSY: Janani Suraksha Yojana
LRP: Local Resource Person
LSGI:
LT:
LBW: Low Birth Weight
LRG: Local Resource Group
MAG: Married Adolescent Girl
MAPDA: Maternal and Perinatal Death Autopsy
MAPEDIR: Maternal and Perinatal Death Enquiry and Response

MCH: Maternal and Child Health
MDG: Millennium Development Goal
MI: Micronutrient Initiative
MHC: Mobile Health Centre
MMH: Marwari Maternity Hospital
MMT:
MMU: Mobile Medical Unit
MNGO: Mother Non Government Organisation
MO: Medical Officer
MoHFW: Ministry of Health and Family Welfare
MoU: Memorandum of Understanding
MSI:
MSW:
NACO: National AIDS Control Organisation
NCCS: National Counselling and Childcare Sessions
NCD: Non-Communicable Disease
NCW: National Commission for Women
NE-RRC: North East Regional Resource Centre
NFHS:
NGO: Non Governmental Organisation
NHSRC:
NIN: National Institute of Nutrition
NNMR:
NM:
NPSP: National Polio Support Programme
NRHM: National Rural Health Mission
NUHM: National Urban Health Mission
OC: Oral Contraceptive
OPD: Out Patient Department
ORS: Oral Rehydration Salt
PAC: Project Advisory Committee
PD: Positive Deviance
PFI:
PHC: Primary Health Centre
PHMIS: People's Health Management Information System
PHNO: Public Health Nursing Officer??
PHTS:
PIP: Project Implementation Plan
PMU: Programme Management Unit
PNC: Post Natal Care
PPP: Public Private Partnership
PPTCT:
PRI: Panchayati Raj Institution
RACHNA: Reproductive and Child Health, Nutrition and HIV/AIDS
RAPS:
RCH: Reproductive and Child Health

RKS: Rogi Kalyan Samiti
RH: Rural Health
RI:
RSBY: Rashtriya Swasthya Bima Yojana
RTI: Reproductive Tract Infection
SDH:
SHG: Self-Help Groups
SHC: Sub Health Centre
SHRC: State Health Resource Centre
SIFPSA:
SIHFW: State Institute of Health and Family Welfare
SHS: State Health Society
SN:
SOE:
SRS: Sample Registration Survey
SSA: Sarva Shikhsha Abhiyan
SSM: Shishu Samrakshak Maah
STD: Sexually Transmitted Disease
STI: Sexually Transmitted Infection
TBA: Traditional Birth Attendant
TNMSC: Tamil Nadu Medical Services Corporation
UIP: Universal Immunisation Programme
UPHSDP: Uttar Pradesh Health Systems Development Project
USHA: Urban Social Health Activist
UTI: Urinary Tract Infection
VAW: Violence Against Women
VCC: Village Coordination Committee
VCD: Village Contact Drive
VGKK: Vivekananda Girijana Kalyana Kendra
VHAI: Voluntary Health Association of India
VHC: Village Health Committee
VHND: Village Health and Nutrition Day
VHP: Village Health Plan
VHSC: Village Health and Sanitation Committee
VMA: Voucher Management Agency
VO: Village Organisation
WHO: World Health Organisation
YCFHCS: Yeshasvani Co-operative Farmers Health Care Scheme
ZS: