

DRAFT

Project Proposal

Pilot for Universal Health Care – in 30 districts:

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1. Universal Health Coverage: Definitions:

- 1.1. **The HLEG definition:** “Ensuring, equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative) as well as public health services addressing the wider determinants of health delivered to individuals and to populations, with the government being the guarantor and enabler, although not necessarily the only provider of health and related services.
- 1.2. The goals of NRHM are “attainment of universal access to equitable, affordable and quality health care, which is accountable and responsive to the needs of the people”. There is considerable overlap between these definitions- and both uses certain key terms whose meaning we need to have consensus on.
- 1.3. In operational terms “the **meanings of universal**” are:
 - 1.3.1. Universal in terms of access- physical and social
 - 1.3.2. Universal in terms of equity-
 - 1.3.3. Universal meaning comprehensive- all illnesses addressed.
 - 1.3.4. Universal in terms of levels- primary, secondary and tertiary.
 - 1.3.5. Universal in terms of including promotive, preventive, curative and rehabilitative dimensions of attaining higher health status.
 - 1.3.6. Universal in terms of quality of care
 - 1.3.7. Universal in terms of affordability.
- 1.4. There are further **operational definitions** needed for some of the words above.
 - 1.4.1. *Access- physical* needs some a time standard- One could suggest for emergencies it is usually within one to two hours, for acute care it is within a day, and for chronic illness within a week. Time of day is

also a factor for chronic illness- but this we will consider under quality of care.

- 1.4.2. *Access- social-* refers primarily to lack of exclusions. For very marginalized sections- affirmative action/additional support may be required. (e.g. for homeless, street children, destitute etc.). The term equity is also similar and is measured by the difference between different social groups in terms of access to services and health outcomes. The more equitable it is, the less there should be differences in health between groups. It also means that there is a greater need to cover the out of pocket expenditure of the poor and marginalized.
- 1.4.3. *Equity-* more than equality- needs a purposive focus on ensuring access for marginalized and vulnerable populations.
- 1.4.4. *Comprehensive* – refers to diagnosis, treatment and care for entire range of illnesses, trauma, pregnancy, disability, and old age. Only very limited categories like cosmetic care get excluded.
- 1.4.5. *Primary Care:* This is one term used in multiple ways. If we go by current usage (WHO World Health Report 2008, pg. 55) it includes the preventive, promotive care and action on social determinants, plus primary curative care and what is called referral support. In practice the term “comprehensive primary health care” includes all of secondary care- or in operational terms all the care provided by a district health system, with a district hospital at its apex. Primary Care is certainly not first contact care, nor is it care for common illnesses. One can have primary care for cancer – (eg screening, follow up, assistance to access speciality care etc.) and one could have tertiary care for diarrhea and fevers(not responding to treatment etc.). Primary care also has a gate-keeping role vis a vis tertiary care.
- 1.4.6. *Secondary Care-* both CHC and DH provided care are secondary care, and this term is used when we are saying both primary and secondary care would be provided.
- 1.4.7. The term *tertiary care* is best confined to medical colleges and specialist hospitals and hospitals where super-specialty services are available.
- 1.4.8. All *promotive care and preventive* care need not cost the health department. For example one may reduce road traffic accidents by better policing and roadways management. But both the term primary care and universal health care imply that health department takes the initiative and lead in ensuring that not only individual life styles, but collective action and multi-sectoral governmental action required for health are put in place.
- 1.4.9. *Assured quality of care* implies- that the care provided is effective in achieving outcomes desired, that it is safe, that is satisfying- which includes patient comfort and that the dignity, privacy, confidentiality and “autonomy” of the service users are respected. Further it is assured only if there is a system for quality in place- and that it is verified and certified,

- 1.4.10. *Affordability* (in the current UHC discourse) has two dimensions- no out of pocket expenditure at the point of care, and that if pre-payments are required, they are affordable and collected as part of taxation. Small co-payments /user fees to prevent irrational consumption and to use as shadow costs for measuring care provision are acceptable.
- 1.4.11. *Responsive*- refers to health service delivery and health care action matching both real needs and the felt needs as expressed by communities. In operational terms this has implications for both defining the set of services, the priorities and the ability for appropriate resource allocation. In the general economy market forces ensure responsiveness- but in public systems it is resource allocation based on information on consumption patterns.

2. Objectives of Pilot Project:

- 2.1. To build a public health system that leads to measurable improvements in health outcomes- not only in under 5 MR MMR and TFR, but also in age specific death rates of 5 to 15 years, 15 to 49 years, and life expectancy at the age of 50, as well as some key morbidity indicators.(see annexure 3)
- 2.2. To build a public health system which leads to a measurable decrease in out of pocket cost of care, protects from catastrophic health care expenditure and increases public share of total health expenditure to at least 50% of total health expenditure in the first phase and 70% in the next phase.
- 2.3. To build a public health system, supplemented where essential by private health care providers, which achieves the standards of access, comprehensiveness, quality and affordability of care that is specified as the objectives of UHC in the first three/five years.
- 2.4. To estimate the financial and human resource requirements for a nation wide move to universal health care.
- 2.5. To understand the institutional requirements-(in terms of organisations, rules for resource allocation, HR management policies, work flows, norms and standards, purchasing of care etc) required for achieving UHC and for a nationwide scale up of the pilot model.
- 2.6. To develop and validate the methods for making periodic measurements of health outcomes, health expenditure and the progress against the key standards that define UHC and integrating this as part of a health information architecture that can be taken to scale in the next phase.

3. Broad Approach to Achieving Pilot Objectives:

- 3.1. Select Pilot Districts and Matching Control Districts- control districts should have similar socio-economic profile and health outcomes. Pilot districts would include 12 pilot districts where population is largely rural (over 80%) and RCH goals are largely

met (IMR less than 20, TFR less than 2.1, SBA delivery over 90%), as well as another 12 pilot rural districts where RCH goals are some distance away- IMR less than 50, TFR less than 2.4, and deliveries over 70%. We would also attempt implement a UHC pilot in 6 of the high focus district- to understand how far one is able to go in such a context. The districts should also have a minimum number of public health facility density in place- for if new hospitals have to be built- then a two year time frame would be unrealistic.

- 3.2. Measure baselines in terms of access to services, quality of services, OOPs in the public hospital and in a sample population, range of services, and in terms of health status by key indicators. Using this to set objectives
- 3.3. Putting in place an information system- using a mix of survey data, routine reporting and sentinel sites, which would help, guide progressive measurements. It would also be able to guide financial and human resource allocation.
- 3.4. Develop the district plan which has specifies the timelines and budgets for achieving universal health care. The district plan would specify in the least the following components and the pilots are about achieving this. There are other policy changes related in particular to health related policies in other sectors, and even some of the social determinants that would not be a part of this pilot programme.
- 3.5. A plan for convergence with related social sectors such as nutrition, water and sanitation, womens empowerment, involving community based women's groups would also be part of the pilot programme.
- 3.6. The district plan should also have carefully mapped access of different social sections and different habitations and be able to show by both measurement of indicators and financial allocation rules, that equity considerations are a part of the plan.
- 3.7. The pilots would draw up an implement an effective plan for BCC and strengthening community process and action on social determinants, which would be funded on a capitation basis.
- 3.8. The district plans would have specified the assured health care services that the different district health care facilities will provide. The pilots would identify the gaps. These gaps would then be closed through HR initiatives (largely recruitment and training), infrastructure development, better drug logistics and diagnostic services, and through improved emergency and patient transport systems and referral linkages.
- 3.9. The pilots would develop an appropriate strategy for responsive public financing of public provisioning as well as for purchasing of care to close the gaps.
- 3.10. Create the necessary institutional capacity and the institutional innovation required for realization of assured service and community level changes to occur.

4. Action at the community level:

- 4.1. The pilots would put in place and implement a district specific integrated BCC package (RCH- CD- NCD). The BCC package would be based on scientific identification of key health behaviors to be addressed, the determinants of the inappropriate health behaviors, the mix of media- message- and communicators that would have maximal impact, and ways of measuring progress on these lines.
- 4.2. There would be well-documented efforts to involve panchayats at village, block and district level.
- 4.3. One major component of community level action is the vitalization of the VHSNCs and its use for two specific purposes a) identifying and addressing intra-panchayat inequities in access to services, and b) convergent action on social determinants.
- 4.4. A major component of community action is the role of ASHAs. The roles of the ASHAs are always defined as organizing the community component of a district wide intervention package where other facilities and players perform different roles- never as a stand-alone programme. Thus an ASHA manages minor illnesses in children- as part of an effort to identify and refer severe illness early and thereby improve child survival. There is also her major responsibility for inter-personal communication based BCC done at the family level for improving child survival. ASHAs roles can be expanded or skill specific sub-cadre of ASHA could be developed for other areas like community level geriatric care, screening for NCDs, disability interventions, HIV etc- but only provided that it is clearly defined that she is playing an important but very supplementary role. These roles will flow out of the district health and disease profile and the burden of tasks the ASHA already has.
- 4.5. Community monitoring and social audits with community participation would also be an important part of the accountability framework for the plan.
- 4.6. At the block and district level, health assemblies would be held and would serve to bring together different local stakeholders onto an understanding of what changes are required.
- 4.7. Such policy interventions and measures by other sectors such as are essential and feasible at district level, which would address determinants of health and illness would be taken up. Not all determinants would lend themselves to improvement by district level interventions. The importance is to show a clear relationship between intervention and reduction in morbidity- for example improved drinking water quality leading to a reduction in water-borne diseases as measured by incidence of typhoid and hepatitis, and outbreaks of diarrhea.

5. Assured Health Care Services

- 5.1. The district plans would define the assured set of health and health related services that would be available in a population catered to by a primary health center (henceforth referred to as a sector) - inclusive of its sub-centers, ASHA and anganwadi centers, schools, and water and sanitation facilities. The set of services and standards for these are detailed in annexure 1. These are to be achieved in the two or three year period.
- 5.2. Each individual in the sector would have an ID number and a health card as part of a family record. They would also have a case record of illness and its management, for which the inclusion is encouraged but not obligatory. All records need not be stored physically in the PHC, but eventually they should be electronically accessible at the PHC. Initially it would be not much more than a family health register. Every individual in the district would belong to a primary health center. Those near a CHC or DH would belong to a notional PHC situated in the CHC or DH, which caters to that "sector".
- 5.3. The infrastructure and staff required in this unit would broadly be based on IPHS. It could be less where case-loads are minimal and it could be increased if the population of the sector is more and the case loads are more.
- 5.4. The assured services in this level of the sector are such that a team of appropriately trained mid level care providers could provide the same. So with a combination of fresh recruitments and skill training we should be able to close the HR gaps needed to provide this level of services.
- 5.5. Orientation and work flow organisation to move from a clinical response to those seeking care to a public health response to the whole population is the key to UHC at this level.
- 5.6. For the public hospitals- the CHC, the SDH and DH - we would define the set of services that would be available. These are largely curative functions with a focus on referral care. Again IPHS is the guide for inputs, and both staff and infrastructure will vary with case-loads.
- 5.7. Every public hospital would be placed on a quality improvement system- and scored for quality at baseline- so that achievements on quality of care can be measurably demonstrated – along with external certification by an appropriate system.
- 5.8. Adequacy in roadways and ERS (emergency response systems) and PTS (patient transport systems) would ensure that standards of access in terms of time to care are achieved. Gaps in these would need to be closed- by deploying and tweaking the ERS and PTS strategy.
- 5.9. The public hospitals within the district health system are also seen as the main gateway for accessing tertiary care services where required. The tertiary care that is not covered by such access- would be specified by a negative list.
- 5.10. Any primary or secondary care that is part of the assured services list, but fails to be delivered by the public health facilities- must be

purchased on behalf of the service user from accredited private health care facilities, at rates specified by the government. Conflict of interest situations in such referrals and purchase of care would be avoided by clear anti kick back statutes.

- 5.11. Ensuring adequate drug logistics as part of efficient drug procurement and logistics systems is also essential. States, which have not put this in place, will not be able to use this approach to UHC.
- 5.12. Ensuring universal access to all essential diagnostics would be through a right combination of outsourcing and in hospital services.
- 5.13. In the districts where RCH figures are already at desirable levels, the efforts would be to achieve universal health care services

6. Financing Public Provisioning and Purchasing of Care:

- 6.1. One of the keys to improving health care delivery is in responsive financing. Every facility is granted a fixed untied fund already. In addition each facility would be provided a variable untied fund from a district-untied pool. Districts would be allowed to make rules for the most appropriate resource allocation of this pool- within a framework that is provided. The framework would specify that this variable untied fund would cover operational costs other than for drugs which would vary with volume of cases handled, range of services provided and that the per unit reimbursement would be higher for facilities which are quality certified, and that the health team that managed the higher case load would get financial and non financial incentives as well- in proportion to volume, range and quality of care.
- 6.2. There is no central way of doing this intra-district resource allocation and many district level ways of managing this. The standard approach internationally is to look at costing packages of care and then reimbursing on a fee per service basis, or using an insurance like payment with a number of head-wise caps. For a number of reasons, which we argue out separately, we would argue for a “cost driver” approach- using a limited range of indicators of volume, range and quality of services to allocate the untied funds and incentives. But yes- we are not committed to any one way- the larger principle is to allow flexibility for local district health societies to make appropriate resource allocation rules.
- 6.3. This approach applies only to hospital care. This same district untied pool is also to be used for purchase of services to close gaps. In that sense – this district untied pool could be called the UHC district fund.
- 6.4. For action at the community level, when the pilots are scaled up the resource allocation is on a per capita basis- within which the entire set of activities outlined in section 4.0 would be undertaken. The pilots help arrive at this per capita basis sum. The pilots themselves will finance community level action on a whatever it

costs basis. The costs could be very high because of the additional technical and implementation capacity that would have to be recruited- and which in a context where pilots are disbursed across districts would be very high.

7. Institutional Innovation:

- 7.1. One of the most important reasons why we need any pilot at all is institutional innovation. In a sense this is what would be “new.” After all the rest of what we are saying is nothing very new. Institutional Innovation is closely related to the concept of institutional capacity- and the lack of institutional capacity is one of the biggest constraints.
- 7.2. Institutions are the instruments through which policy is implemented. By institutions we refer to the set of rules within which the system operates- both the formal rules, and the informal rules. Both the rules made by government, and the rules made within the organisation to organize the work flow and allocation of resources. Informal rules include conventions and norms of behavior, and work practices and ways of doing things which have become established
- 7.3. One area where institutional innovation is critical is for responsive and equitable resource allocation. A proposal like flexible resource allocation on a cost driver approach and incentivizing quality, volume and comprehensiveness of care would be new.
- 7.4. Another area of institutional innovation is the rules required for creating new organisations or re-vitalising existing ones, and providing them a framework within which they can make their own rules. Enhancing institutional capacity requires the ability to create or recruit and manage institutions better.
- 7.5. A third area of institutional innovation is HR management policies. The manner of recruitment, training, supporting, and rewarding the workforce is well recognized as making a major difference to outcomes. In particular skill building depending only on training camps, with available trainers is not going to achieve the results and alternatives have to be found.
- 7.6. A fourth area of institutional innovation is the health management information system. The systems should meet standards of interoperability, and should have user-friendly analytic capacities at each point of entry and mid-level management, with information needs of higher centers coming out as a by-product of local use.
- 7.7. A fifth area of institutional innovation is procurement and logistics- but fortunately we have a best practice in the form of TNMSC for this.
- 7.8. A sixth area of institutional innovation is different systems of purchase of services to fill gaps in public provisioning. We need systems, which are transparent and robust, which hold the private

- provider accountable, and equally important hold the government officials accountable for honoring the contracts they sign.
- 7.9. The design of programme management units, the HR required for public health management and its relationship to health societies and directorates is also an area of capacity development.
 - 7.10. Finally the organization of knowledge management on a continuous basis- the resource centers- whether it is for district planning, or for BCC or for community participation or for data analysis also requires much institutional capacity development.
 - 7.11. One point to be kept in mind is that there is no ideal set of rules. There is a need to allow organisations like the DHS to make its rules for its needs- while staying within a larger framework of rules. An understanding that this is what would lead to leakage is flawed. Of course we must have a robust way of measuring outcomes, and achievements against service delivery standards. Decentralization in essence must mean the powers to make rules.
 - 7.12. In a sense what ails public service delivery is not just a constraint in the resources – but also, or even more so- the institutional constraints and the lack of institutional capacity. The pilot programmes address and find solutions to these constraints. This is an important concept to keep in mind. We can for example hire a NGO whose credentials are well known, to train ASHAs in the pilot districts. But on scaling up this would no longer be available. The pilot must therefore recruit NGOs through a process, which lends itself to scaling up across the nation.

8. Human Resources

- 8.1. A unit of 30,000 population (20,000 in tribal areas) - otherwise referred to as a sector –has a PHC with 2 doctors and one AYUSH doctor, one of whom at least is a lady doctor, preferably one of whom is a lady, 5 nurses, 1 dental hygienist/dentist and 3 to 4 multi-skilled support workers (for pharmacy, laboratory, and ophthalmic assistants) and two or three support staff for data entry, accounts and administration. In addition it has 12 plus 1 ANMs, 6 male workers and 6 public health supervisors or mid level care providers (6 sub-centre teams of 2 ANMs and 1 one male worker and one mid level care providers)- and 2 supervisors at sector level, a total of about 39 care providers. It also had about 30 ASHAs, (which could increase to 60 ASHAs) and 30 anganwadi workers. *In other words without ASHAs we have approximately one skilled care provider per 1000 population and including them and three health workers per 1000 population.* This should be adequate workforce to deliver the following services, provided they are in place and appropriately skilled.
- 8.2. Please note that of the 2 doctor/team leaders, at least one should be public health qualified at a graduate or post graduate level. whether or not they are doctors. Ideally we would like a masters in public health, but a bachelors with some experience would also

suffice. (There could in addition be a AYUSH doctor if the AYUSH doctor is not one of these two).

- 8.3. The mid level care provider is in addition to the male health worker- and could be male or female with a qualification of B.Sc in community health. She could also be called the public health supervisor. Since there are currently no graduates in this area, we could start with AYUSH doctors with some induction training. (See the note on “second sub-center worker” to understand how we could expedite this process. (annexure 4). Two of the senior staff at this level should have explicit training and skills in counseling and another two in health communication- which skills they would help others in the team to gain also.
- 8.4. The Achilles heel of this arrangement is the leadership at the sector level. The sector level PHC doctor is a fresh graduate, with little interest, often forced to go there and with no experience. He or she is unable to provide leadership to such a potentially vibrant team. That is why the suggestion that the second person be a promoted mid level care provider or a MPH. In the immediate protocol, it should be a MSW or MBA or other contractual worker like we have for the DPMU. Also we may have to start by posting one to the block level, rather than one per PHC- if we do not find enough such qualified persons.
- 8.5. We do not recommend that at the national level we separate out the work between the doctors, nurses, ANMs, mid level care providers, ASHAs, AWWs. Depending on the burden of disease, the skills levels, the availability of staff, etc work is distributed within this team such that together they provide the services. This distribution is done at the district level, within rules that the state has created.
- 8.6. The strategy of developing skills in this team- in a time bound and urgent way requires recruiting in of considerable external trainer capacity backed by electronic systems of learning and on the job support.
- 8.7. The HR requirements of the public hospital are to be elaborated upon later. (Not completed as of now).

9. Timelines:

- Initial discussion with states- August 30th, 2012
- Finalization of pilot districts-September 30th, 2012
- Work on district planning begins in one third of district October 3rd, 2012.
- Recruitment of partners and technical support agencies for the all 30 districts. November 30th, 2012
- Draft district plans for one third of pilot (about 10 districts)- November 30th, 2012: (this would be done with initial partners- PHFI, NHSRC, NIHFW, SHSRCs etc)
- Approval of budgetary requirements over the next 3-year period.
- Draft district plans for all pilot districts January 30th, 2013.

- Approval of rules and procedures framework required for implementing pilots- March 30th 2013- both in state and at national level.
- Capacity Building for Programme Management in districts.
- Building up organizational structures and key recruitments- May 30th 2013.
- First installment of funds received, May 2013.
- Measurement of baselines completed and presented- June 30th 2013.
- Review of time-lines and approach and the plans- national consultation- July 30th, 2012- in three groups – three workshops of 5 days each.
- Recruitments, training, facility development, and other components of programme start up.
- Quarterly progress review, and annual progress review.
- June 30th, 2014. Progress measurement against baseline.
- July 30th, 2014, Course corrections and further planning and financial inputs.
- June 30th, 2015. Progress measurement against baseline.
- July 30th, 2015, Progress measurement against baseline.
- Interim assessment of the larger plan and goal- and mid course corrections.

10. Budgets

Annexure- 1:

The Primary Care List of Assured Services

The assured services provided by a primary care team (includes staff of PHC, sub-centers and CHWs) is as follows.

1. In Reproductive and Child Health

- i. Care in pregnancy- all care including identification of complications- but excluding management of complications requiring surgery or blood transfusion.
- ii. Essential newborn care- all aspects.
- iii. Care in common illnesses of newborn and of children- with skills to identify, stabilise and refer life threatening conditions and

conditions beyond the approved skill sets of the mid level care provider.

- iv. Immunisation
- v. Universal use of iodised salt.
- vi. All aspects of prevention and management of malnutrition, excepting those that require institutional care.
- vii. All family planning services except female sterilization.
- viii. Provision of safe abortion services medical and surgical.
- ix. Identification and management of anemia,
- x. Common sexual, urogenital problems- which can be treated syndromically, or diagnosed with point of care diagnostic- and identification of those which need referral.
- xi. All Public health measures as would lead improved maternal and child survival and less RCH morbidity.
- xii. All health education and individual counseling measures needed for promotion of desirable health behaviours and health care practices and change from inappropriate health care practices and behaviours- as related to RCH.
- xiii. All school health activities.
- xiv. All laboratory support needed for the same.
- xv. Patient transport systems that can bring and drop back patients at a certain priority level- eg newborns for first 28 days, for access to skilled birth attendant, for disability, special problems of access due to lack of transport,

2. In Emergency and Trauma Care:

- a. Prevention and appropriate management in bites and stings- snakes, scorpions, wild animals.
- b. Complete first aid skills including management of minor injuries
- c. Stabilisation care in poisonings and major injuries and ensuring pick up by emergency response systems.

3. In the Control of Communicable Disease.

- a. Screening for leprosy, referral on suspicion, and follow up on cases with confirmed diagnosis and prescribed treatment.
- b. Referral of suspect tuberculosis, family level screening of known patients, and follow up on cases with confirmed diagnosis and prescribed treatment.
- c. HIV testing, appropriate referral and follow up on specialist-initiated treatment.
- d. All measures for the prevention of vector borne diseases and early and prompt treatment for these diseases- with referral of complicated cases.
- e. Control of helminthiasis.
- f. Reduction in burden of waterborne disease, especially diarrhoeas and dysentery, typhoid and water borne hepatitis and prompt and appropriate care leading to reduction of mortality and morbidity due to these diseases.
- g. Reduction of infectious hepatitis B and identification and referral for the same.

- h. Primary care for other infectious diseases, presenting as fevers- especially ARI , UTI with referral where institutional care is required or where diagnosis is not ascertained.

4. In Non- Communicable Disease:

- a. Screening for breast and cervical cancers in all women over the age of 40.
- b. Screening for mental disorders and counseling, and follow up to specialist initiated care.
- c. Detection of epilepsy and stroke- and follow up to specialist initiated drugs and rehabilitative measures.
- d. Screening for visual impairments and correction of refractive errors and referrals for the rest.
- e. Screening for diabetes and hypertension- all population above 30 annually.
- f. Ensuring follow up on doctor initiated drugs in diabetes and hypertension- and secondary prevention – so that no complications develop.
- g. Prevention – primary, secondary and tertiary preventive care in rheumatic heart disease. (Prevention of rheumatic disease, prevention of rheumatic heart disease, and prevention of mortality and excess morbidity in rheumatic heart disease).
- h. Primary and secondary prevention in COPD and bronchial asthma, with provision of follow up care in patients put on treatment by specialists.
- i. Counseling and support to victims of violence.
- j. Preventive measures against all harmful addictive substances- tobacco in the main, but also alcohol and addictive drugs.
- k. Community based geriatric care support.
- l. Preventive and promotive measures to address musculo-skeletal disorders- mainly osteoporosis, arthritis of different sorts and referral or follow up as indicated.
- m. Community based rehabilitative and disability care support.

Technical Content of Assured Services:

The technical content of services would need to be discussed in terms of a) what is appropriate in the Indian context b) what is effective- and at times the most cost effective alternative c) what is feasible given the skill sets and time available and what is culturally appropriate and finally d) what choices people make. One important such area of choice is in AYUSH- and the role of local health remedies and traditions and finding the space to assess them and reinforce those practices and traditions that are both acceptable and are known to be safe. Standard treatment guidelines would have to be modified locally based upon a process that is both consultative and which understands the nuances of judgments on efficacy in this context.

There is also scope for searching for technical innovation to improve point of care diagnostics so that a greater range of care is possible with the skills levels available.

Annexure 2

Hospital and Referral Care that would be available within the district (to be written up).

Annexure 3-

The Second Sub-center Health Worker- From Multi-purpose worker to Graduate in Community Health

The Context:

Of the two health workers in the sub-center, one is a woman with training as a female multipurpose health worker. This 18 month training for the female MPW, also referred to as ANM, focuses on all the outreach services required by Reproductive and Child Health- midwifery , antenatal care and post natal care, immunisation, contraception promotion including insertion of IUDs, health education and counselling and management of minor illness. The second health worker is currently defined as a male MPW with predominant role in national disease control programmes and epidemic control. In practice there are less than 30% of these male workers in place, their training institutions are non functional and there is little role clarity or health outcomes for those in position- except perhaps in malaria endemic areas, where there is a fair workload as related to malaria.

The NRHM encouraged revitalisation of the male MPW by linking it to the sanction for a second ANM. This worked to fill up vacancies to a limited extent, but does not fully address the requirements of public health. One major problem has been that there are very few male MPW training institutions left. Not more than 49 training institutions exist and most of these have an intake of less than 30 and some of these are almost non functional. A related problem is that their syllabus is considerably outdated. More important there is a whole range of new communicable and non communicable disease programmes being launched, but there is no synergy between this and the plans for revival of the ,male MPW. The faculty of these institutions are also of varied quality and not up to the public health challenges of the day.

Given the changes in disease profile, with non communicable diseases and communicable diseases (other than those on the national programme list) contributing a major part of the disease burden there is a need to rethink and redefine the role of the second health worker at the sub—center.

There is a need to generate a cadre of health care providers for the sub-center, who by virtue of the way they are chosen, trained, deployed and supported,

would be motivated to live in and provide public health services and primary health care in rural areas. This should, along with a continued increase in public health investment, better governance of public health system and better management of public health facilities make universal access to primary health care, even in the most remote rural areas, a reality by the year 2020.

The Objective:

To select, train and deploy a second health worker in the sub-center who is able to provide public health services at the village level and complement the RCH services provided by the first health worker- the ANM.

Design Principles of the second health worker:

I. Role Clarity:

- a. Be able to understand and measure the health status and disease load of the population in his or her area.
- b. Be able to implement public health strategies that prevent illness and promote good health through action on social determinants of health as well as through health education and health communication.
- c. Be able to locate sources of outbreaks of waterborne disease and work with both communities and public health engineering departments to eliminate sources of such infection.
- d. Be able to screen for communicable and non communicable diseases and provide health check ups to different sections of the population- newborn, pre-school child, school child, adolescent, young people, elderly.
- e. Be able to follow up on care prescribed by doctors through appropriate examination and investigations with enough skills to decide on when to refer for complications and when to manage locally and how to ensure secondary and tertiary prevention effectively in the case of chronic diseases.
- f. Be able to provide appropriate community level care for minor illnesses and common ailments where referral is not needed, and support referral where it is needed.
- g. Be able to support the RCH worker/ANM in the conduct of her services, especially with regards to immunisation, adolescent health and family planning. We note that other than midwifery services and insertion of IUCD, all the other skills would overlap between the first worker or ANM and the second worker.
- h. Be able to support and guide community based nutrition rehabilitation programmes and reinforce the convergence between the health department and other programmes addressing malnutrition- both child malnutrition, and malnutrition in the school going age. Also support school health and convergence with education department.

II. Selection:

- A. There would be four categories from which they are selected:

- a. The AYUSH Graduate who would undergo a one year/six months bridge course to an undergraduate diploma in public health or a two year post graduate diploma in public health.
- b. Any B. Sc on Pharmacy, physiotherapy or dental sciences with a one year bridge course to an post graduate diploma in public health. The BSc has to be from a recognised college and university and quality standards may be prescribed for this.
- c. The MPW school graduate: few functional MPW training schools. These are geared to providing a two year undergraduate diploma/certificate in public health.
- d. A new B.Sc in public health graduate: This course does not exist – it is proposed. To be conducted by university affiliated rural colleges or public health institutes or medical colleges with attachment to district hospitals.

Reasons : The gap is large- by allowing entry from all four streams, we can move fastest to closing the gap.

- B. For undergraduate Diploma/certificate from a MPW training institute and for a B.Sc degree in public health, Minimum eligibility criteria would be a 12th class education pass. Could be science or humanities stream for the 12th class- and need not be confined to science stream.
- C. For AYUSH graduates stream any four year degree course in one of the recognised AYUSH educational institutions and courses. Any B.Sc in Pharmacy or dentistry or physiotherapy from a recognised university and college. Additional quality standards could be prescribed.
- D. Selection would be *restricted to candidates who are from within the district/cluster of districts* and are more likely to work there. They should have completed school from within the district. More selection marks for rural residence in a remote block. This should be linked to creating a district cadre for this staff- and not a common state cadre.
- E. Reservation of 30% (? 50%) for women. *Thus the second worker is not necessarily a male worker.* This is an important departure. There is no reason why a male worker is more suited for disease control or for public health functions.
- F. Selection would give preference to candidates who are already working as ASHAs or AWWs or other staff if they are 12th class pass and age is below 35.
- G. Selection could involve sponsorship from panchayats which are considered difficult/most difficult areas within the district.

III> Training

1. The essential skills package:

- a. For all candidates: Focus on public health skills- measuring health of population, and understanding public health strategies, national health programmes and appropriate data analysis. Basic clinical

skills as provided for a paramedical in modern medicine and a course on essential drugs and rational drug use. This would include

- b. For 12th class entrants into diploma and degree in public health: in addition to the above a basic understanding of health and disease, of how ill health is caused, prevented and treated.

2. A pro-primary health care pedagogy:

- a. Teaching of the rural health care provider should occur in settings similar to where they would have to live and work.
- b. Their role models would be others with public health functions and primary care physicians serving communities with the limited tools available.
- c. Faculty development would be required.
- d. Teaching would be in the state language.

3. Certification and Evaluation:

- a. For undergraduate diploma the government would act as the certifying body- perhaps with some link to the paramedical council.
- b. For undergraduate degree in public health- B.Sc in public health- the university would act as the examining and certifying body.
- c. For AYUSH and pharmacy and dental and physiotherapy graduates who undertake the one year bridge course- and get a PG diploma, the certifying body could be the university.
- d. Since all graduates are ensured government employment, these terms can be part of the agreement with the university. Universities would also have to recognise that this certificate course is only upto the limit of vacancies in the public sector and would have to limit intake and syllabus to these specifications. The state governments which opt for the course would take the initiative of finding and finalising terms with suitable universities for this purpose.

IV. Deployment and Career Paths:

- 1. Posting:** Only in health sub-centers.
- 2. Name:** These second workers could be called MPWs or could be called public health assistants. (Their supervisors could be called assistant public health managers and at the block we could have block public health managers and above this district programme managers. – for supervisory structure see the next section)
- 3. Registration:** This would be with the state paramedical council.
- 4. Payments:** This needs to be less than the payment for the pharmacist and equivalent to the current payments for the ANM. If it is an post graduate

diploma (that is an AYUSH or pharmacy graduate with a diploma in public health) there could be an extra allowance as given to a PG diploma.

5. **Conditional Licensing :** Those who are qualified are eligible for work only in the places where they are posted. Normally they would be part of a district cadre and thus eligible for a choice of posting or transfer only within the district. After five years they are eligible for higher courses, which they can qualify in and then leave for postings outside the district, within or outside the public health system. No private practice is allowed and indeed since they are not clinicians the problem should not arise at all.
6. **Positive practice environments:** These rural practitioners could be provided with referral electronic and transport linkages to more qualified doctors and specialists to provide consultation and referral support to them. They could also be organised into mutual support groups and networks and provided the service conditions that would enable a positive practice environment.
7. **Career Paths:** After five years of service the PG diplomas in public health and those with B.Sc in public health would be eligible and encouraged to qualify for a master's in public health- MPH which is a two year course. This would make them eligible for block programme manager, district programme manager, block or district HMIS manager, hospital manager , drug inspector, food safety inspector,etc. Those with AYUSH/Pharmacy/Physiotherapy etc qualifications could also enter into regular posts for such service providers- like AYUSH doctors, pharmacists etc. Those who have done an undergraduate diploma in public health- direct from school into a MPW training school could do one more year for a full B.Sc in public health from a university which should be available in distance education mode to them and then they could go onto MPH if so required.

4. Institutional Arrangements and Financing: Deliverables and Design Variations:.

- a. The second health worker of the sub-center would be completely funded by the central government, provided the basic principles of design as elaborated above, with mutually agreed upon adaptations where necessary, are made part of a binding agreement between state and the center.
- b. The health care outputs and public health outputs expected at the level of each sub-center shall be spelt out and linked to the financing of the second worker. It is for a set of services that the second worker is being financed.

- c. These deliverables shall vary across the states according to the epidemiological profile and the size of the population being served and distance from nearest alternative public health care facility providing out patient services. Broadly there would be three types of second worker deliverable areas. One is the context of the high focus states – the high fertility, high IMR and MMR context, where support to RCH and care for ARI and diarrhoea and other minor illness would predominate. Another is the malaria/kalazar endemic zone, where elimination of these diseases in addition to RCH and minor illness care would be dominant. The third would be states which have achieved population stabilisation goals and the load of children and pregnant women per sub-center is low, and malaria is not a problem. Here the focus would be on non communicable diseases.
- d. Approximately every 20 second worker would have a supervisor and every 5 ANMs have a LHV supervisor. This supervisor could be called the assistant block public health manager. This supervisor would be part of the block programme management unit and would have the skills to measure public health and make suitable local plans. . This implies that there is a block programme management unit similar to the district programme management units in place. The qualification of the supervisor is a masters in public health or a bachelors in public health or equivalent with experience. Masters in Public Health would then become the basic requisite for the district programme manager. If we are talking of 150,000 second workers this would mean at least 7000 supervisors. The current supervisors would just need to be absorbed into other functions – health educators, block programme managers etc. These 7000 would gradually become available as current MPWs get trained further and qualify for the assistant block public health manager.
- e. To ensure that the products of these MPW training institutions and graduates in public health are oriented towards recruitment and services most of these institutions should be publicly financed. Many of these would be run by partnerships with suitable not for profit hospitals- like mission hospitals which have a high reputation for motivated rural service.