PERFORMANCE BASED INCENTIVES TO STRENGTHEN PRIMARY HEALTH CARE IN HARYANA STATE, INDIA:

FINDINGS FROM A FORMATIVE INVESTIGATION

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PERFORMANCE BASED INCENTIVES TO STRENGTHEN PRIMARY HEALTH CARE IN HARYANA STATE, INDIA: FINDINGS FROM A FORMATIVE INVESTIGATION

CONTENTS

ACRONYMS

ANM	Auxiliary nurse midwife
ASHA	Accredited social health activist
BMO	Block medical officer
CHC	Community health center
DHIS	District Health Information System
HFG	Health Finance and Governance Project
MCTS	Mother and Child Tracking System
MOIC	Medical officer in-charge
NHM	National Health Mission
PBI	Performance based incentives
PGIMER	Postgraduate Institute of Medical Education and Research (Chandigarh)
PHC	Primary health center
RMNCH	Reproductive, maternal, newborn and child health
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

The Government of Haryana is interested in adopting a performance-based incentive (PBI) scheme aimed at strengthening primary health care results. In December 2014, the USAID-funded Health Financing and Governance (HFG) project conducted a qualitative investigation among 10 public health facilities in two Blocks in Haryana (Nuh Block, Mewat District and Rai Block, Sonipat District) in order to understand the existing incentive and operating environments and to inform the design of a PBI scheme. This report presents the findings of the formative investigation and relevant contextual information on the health system in the selected districts with a view toward supporting an effective PBI scheme in Haryana. The findings and considerations will feed into a stakeholder PBI design workshop in early 2015.

A positive, yet guarded reaction to PBI

The formative investigation found a potentially receptive environment for PBI in the two Blocks. Focus group and in-depth interview participants had an overall positive, if guarded, reaction to the concept of PBI. They generally welcomed the opportunity to earn more for achieving clear targets. They also recognized that there was room to improve performance and were supportive of working harder as a team and individually to achieve results. The study suggested strongly that a PBI scheme—communicated clearly and perceived as fair—could lead to a change in the overall work culture from one that inadvertently encourages passivity to one that promotes teamwork, engagement, initiative, transparency and accountability.

The participants' overall positive response was qualified, however, by several factors. Participants had some difficulty fully grasping the notion of being paid for achieving targets. They tended to conflate incentives with fees for each unit of output provided, which they were familiar with because of the well-known model of compensating ASHA workers in India. They were also concerned that significant external barriers beyond their control, namely inadequate infrastructure and manpower shortages, would prevent them from achieving established targets. Some participants raised concerns about unintended consequences of PBI such as increased tension among staff and a distortion in priorities if staff made decisions based on financial reward rather than medical need. Lastly, participants felt strongly that the responsibility for improved health outcomes rests not solely with facility workers, but is shared with the government and the catchment population.

PBI can build upon and strengthen existing systems

A well-functioning PBI scheme requires multiple operational elements: establishing indicators, setting targets, training, results reporting, results verification, incentive payment operations, monitoring, knowledge-sharing, program evaluation, and scheme revisions. The formative investigation revealed that existing systems and programs are in place that could be built upon to support a PBI scheme in Haryana State, including the current reporting and supervision structure, initiatives for monitoring or program evaluation, government experience with indicator-tracking, and the existence of facility bank accounts. The process of utilizing these systems to implement PBI, and the required enhancements needed for PBI to function well, would contribute to strengthening these systems, thus contributing to broader health system strengthening in Haryana.

For example, the Indian Public Health Standards set out the roles and responsibilities for health facilities and facility-level supervisors and staff throughout the Block structure, including Community Health Centers, Primary Health Centers and Sub-centers. These Standards also address the mechanism for facilities to meet, share information, coordinate care, manage funds, and involve the community. They do not, however, clearly address performance management and accountability for following through on the Standards. In this way, a PBI scheme can serve to support and augment the public health system goals in Haryana.

Similarly, as PBI requires strong data recording, reporting and verification, implementation of a PBI scheme would necessarily strengthen the health management information systems in Haryana. Facilities presently keep detailed records of their services and feed into several online portals for tracking health statistics, with all facilities feeding into the District Health Information System (DHIS) and PHCs and Sub-centers also feeding into the Maternal and Child Tracking System (MCTS). Various data integrity and management issues, however, raise concerns about the accuracy and efficiency of data reporting, and would need to be addressed as part of a PBI design and implementation plan. In addition, two existing means of external verification of reported data (MCTS and the NHM Concurrent Evaluation conducted by Chandigarh's Postgraduate Institute of Medical Education and Research) could be enhanced to serve as complementary verification tools.

Challenges for PBI to consider

The formative investigation highlighted several challenging conditions in the current incentive and operating environment in the two Blocks that need to be considered when designing and implementing the PBI scheme. Participants repeatedly described how supply-side shortages (staffing, drugs, medical equipment) and inadequate facilities hinder their delivery of health services. Another challenge is the deep set of grievances over pay, and particularly over the large disparity in wages for 'regular' versus 'contract workers' who perform the same tasks. There is also a weak performance management culture at public health facilities, with staff and supervisors unaccustomed to being held accountable for health results for the populations they serve and for taking the initiative to solve problems. When it comes to improving health facility performance, the overall work culture and mindset tends to look to external barriers and solutions, rather than to internal innovation and initiative. PBIs can address each of these challenges and lead to deep and lasting culture and behavior change.

Key considerations

Considerations for PBI design in terms of incentive amounts and allocation, measurement, targets, verification, payment and rollout are peppered throughout this report, and will feed into the PBI development consultations in early 2015. The key considerations are grouped and presented below:

Messaging

- Use clear messaging to explain why PBI is being introduced, how it will work, and the multiple benefits – recognition, rewards, improved teamwork, strengthened data and reporting systems, greater autonomy, and improved health service delivery.
- Make clear that PBI will not solve all the problems in the health system and is just one tool to improve performance.
- Make clear that PBI is to be earned as a team, with a portion of the overall incentive payment for investing in the facility and the remainder for rewarding staff.

- Reinforce the message that effort by facility staff and the entire primary health care network can have a significant impact on health care utilization, even in challenging areas.
- Complement PBI with other visible measures to address infrastructure and manpower challenges.

PBI Management

- Establish a PBI Unit within the government to perform core PBI functions relating to policy, guidelines, training, technical support, verification, payment and oversight.
- Establish roles and responsibilities and provide necessary training for the government administrator(s) who will oversee and carry out payment operations for the PBI scheme.
- Provide specific expectations, guidelines or protocols for the services incentivized through the PBI scheme.
- Provide all facility teams with clearly defined performance criteria and incentive targets at the team level.
- Promote use of data by making visible use of data for decision-making and providing regular feedback to facility teams based on reported data.
- Ensure incentive payment transfers are timely and transparent.
- Investigate and address, as necessary, broader challenges in the procurement and hiring process that may undermine using PBI to improve workplace conditions.
- Provide ongoing mentoring in the form of technical assistance to support supervisors and foster a new management culture.
- Hold semi-annual meetings to review PBI progress and share experiences and learning.

Incentive Amount and Allocation

- To avoid deepening the salary disparity between regular and contract workers, consider basing maximum incentive amounts for all workers on regular workers' salary scale irrespective of contractual status or experience.
- Include an incentive amount that can be used to enhance the performance of health facilities.
- Calculate the incentive envelope for each facility based on official manpower guidelines, regardless of the actual number and composition of staff.
- Use PBI to strengthen the enabling role of Block Medical officers as supervisors, mentors and problem solvers by providing reputational and possibly also financial incentives linked to how all public facilities in the block perform.
- Use PBI to promote Block-level teamwork and accountability by linking a portion of facility supervisors' incentives to the performance of the lower level facilities they are responsible for.

Indicators and Targets

- Use targets to create specific expectations for delivery of priority services and achievement of priority goals.
- Select indicators for the PBI scheme from the current DHIS list.
- Consider indicators that capture that services were given to each cohort in each stage in the life cycle, from pregnancy to delivery to newborn to postnatal and young child period.
- These RMNCH+A indicators may be complemented by indicators that capture detection and treatment for NCDs such as diabetes and hypertension.
- Base team-based incentives on satisfactory achievement of approximately 10 health services-related targets during the selected performance period.
- To acknowledge localized barriers and challenges, implement a common set of indicators for all participating facilities to work towards, but set the target for each indicator as an improvement relative to each facility's unique baseline performance.
- Set targets in bands matching improvements targets to current performance levels (low, medium, high).
- To promote cooperation between facilities, the amount of a PHC and CHC's incentive could reflect a weighted average of lower-level facility success for the performance period.
- Tie supervisors' incentives to team performance and include facility maintenance activities, and timely PBI incentive payments among supervisors' indicators.
- Consider additional indicators such as spending the full amount of untied funds for facility improvements, outreach, and timely and accurate data reporting.

Data Reporting

- Use existing DHIS monthly reports for data reporting.
- Incentivize supervisors at facilities to do internal data quality monitoring prior to report submission.
    - o Randomly select indicators to reconstruct using data from registers
    - o Monitor trends to see if reported information appears odd
    - o Compare related service indicators within or across months to see if data conform to expectations and are internally consistent
- Promote culture shift to improve motivation for accurate reporting by reinforcing messages, demonstrating publicly use of data at multiple levels, following up with facilities when data look odd, providing regular feedback reports, and making available technical assistance when reporting or interpreting data.

Verification

- Provide data reporting technical assistance, training and guidance to facilities and allow a grace period to account for the learning curve
- Consider ways to incorporate data from the NHM Haryana Concurrent Evaluation in the PBI scheme as an independent measure of facility health service delivery and population health.
- Compare MCTS Call Center data to facility-reported data to identify discrepancies. Facilities with discrepancies over a given threshold should be flagged for audit.

Payment

- Transfer incentive payments directly to facility bank accounts and ensure transparency in funds transfer and allocation.

1. BACKGROUND AND INTRODUCTION

1.1 Why this formative investigation?

The National Health Mission (NHM) in India is encouraging States to adopt performance based incentives to improve the performance of public sector facilities to deliver a range of primary and secondary care services and to reach a larger proportion of their catchment populations with priority services. The widely diverse context in India, along with sharp variations in the many well documented challenges afflicting the Indian health care system—from shortages in human resources and supplies to inadequate facilities and monitoring and supervisory systems—have led to large disparities in the nature and quality of delivery of health services and access and utilization of priority services throughout the country. However, several studies in India and elsewhere have demonstrated that there is room for public sector facilities to make improvements in key areas such as preventive, promotive and curative care; service quality, staff productivity, and staff-patient relationships, which would result in increased care seeking behaviors, higher patient satisfaction, and higher quantities of higher quality preventive and curative care services delivered to the population.[1]

The Government of Haryana is interested in adopting a performance-based incentive (PBI) scheme aimed at strengthening primary health care results and they reached out to the USAID-funded Health Financing and Governance (HFG) project for support in the design and development of such a scheme. In the fall of 2014, several consultations took place between HFG team members and representatives from the National Health Mission at the national level, the Haryana State Government and the USAID Mission. As a result of these consultations, HFG was requested to design a PBI initiative that will be tested in two Blocks in Haryana state in 2015. The focus of the model will be at the primary health care level and will provide financial incentives that reward population outreach for promotive and preventive care, as well as to reward delivery of RMNCH+A services.

In order to support the design of the PBI initiative and explore reactions to different design elements, HFG conducted this qualitative investigation in two Blocks selected by the Government of Haryana in December 2014. This report presents the findings of the formative investigation, which will feed into a stakeholder consultation on the draft PBI design in early 2015. The report presents the formative investigation background and main findings, which include recommendations for the PBI design, followed by detailed annexes on the health status of Haryana and various tools used for recording, reporting and verifying statistics on population health and health service delivery.

[1] HFG Guidelines for Facility Based Provider Incentives

1.2 What is PBI?

Performance based incentives (PBI) are attracting much global attention as a strategy to achieve health results. PBI introduces incentives (generally financial) to reward attainment of positive health results. Recipients of performance incentives – which on the supply side can be facility teams, supply chain actors, or entities responsible for health at subnational levels – receive performance payments only if specified results are achieved (no result, no performance payment). By doing so, PBI can promote hard work, innovation, accountability and results – as opposed to simply paying for inputs, such as equipment, training, fixed salaried staff, and drugs.

In essence, PBI involves "any program that rewards the delivery of one or more outputs or outcomes by one or more incentives, financial or otherwise, upon verification that the agreed-upon result has actually been delivered."[2]

A supply-side PBI scheme may, for example, tie health facility bonuses to the achievement of key performance targets such as an "increased number of women that receive an ante-natal check-up in the first trimester of pregnancy" and/or an "increased number of fully immunized children."

The introduction of PBI can have a positive effect on broader health systems issues such as poor reporting information systems and low productivity. Such positive effects have been demonstrated even in post-conflict countries or unstable environments.

The PBI Cycle

While the concept may sound straightforward, designing and implementing a well-functioning and truly motivating PBI scheme is complex, particularly in countries that are grappling with inadequate infrastructure, shortages of human resources, weak information and financial management systems, competing priorities, high burden of disease, and limited funds. An effective PBI scheme needs to take into account the local context, existing compensation and incentive environment, work culture, staff knowledge and abilities, etc. The design of a PBI scheme must

[2] Musgrove, *Rewards for Good Performance or Results: A Short Glossary*

answer key questions on who and what will be rewarded, how much will the incentives be and how will they be allocated, how will results be reported and verified, and how will management be supported in implementing PBI. It also needs to be mindful of the potential pitfalls of PBI schemes, such as fraudulent reporting of data, undermining internal motivation, increasing tension among staff, and/or distorting priorities.

1.3 Study Description

1.3.1 Formative Investigation Goals and Objectives

The primary goal of the formative investigation was to support the development of the PBI design by exploring:

- how best to design a PBI initiative to strengthen primary health care results in Haryana that would be truly motivating, given current knowledge, skills, attitudes, behaviors and challenges faced in the overall operating environment

The specific objectives of the formative investigation were to understand and explore the following factors critical to an effective PBI:

- current compensation and incentive environment
- staff knowledge of the catchment area and population
- operating practices and environment
- performance criteria, motivation and assessment
- reactions to PBI (amount, allocation, non-monetary incentives)
- potential indicators and targets
- data recording and reporting practices
- potential verification systems
- PBI roll-out and sensitization

1.3.2 Methodology and Approach

To realize the formative investigation goals and objectives, we relied on desk research on the structure and operations of the Indian public health system at the Block level, and on qualitative research in the form of focus group discussions and in-depth interviews.

The qualitative research was carried in two Blocks—one low performing and one average performing in terms of health indicators. The two Blocks were selected by the Haryana State Government and might also serve as the sites for the initial PBI demonstration. The two blocks were:

1. Nuh Block, Mewat District: low performing
2. Rai Block, Sonipat District: middle performing

The qualitative research elements included:

- Observational site visits to community health centers, primary health centers and sub-centers (type A and B, delivery and non-delivery)

- In-depth interviews with Block-level medical officers and the medical officers in charge at public health facilities
- Focus groups among staff at public health facilities

From 15-19 December 2014, the HFG team conducted a total of 6 focus group discussions (FGDs), 10 in-depth interviews (IDIs), and 10 facility site visits, broken down as follows:

Qualitative Data Collection Per Block

	Block Medical Officer	1 Community Health Center	2 Primary Health Centers	2 Sub Centers (Type A & B)
# of FGDs		1 (mixed staff)	2 (mixed staff)	
# of IDIs	1		2 medical officers in-charge	2 auxiliary nurse midwives
# of Site Visits		1	2	2

1.3.3 Caveats

As this was a qualitative investigation, the reported views and behaviors are not necessarily representative of health facility staff and supervisors throughout the two Blocks, Districts and State of Haryana. In addition, as this was a formative investigation, the instruments and approach remained flexible, allowing the HFG investigative team to delve into issues as they arose in order to maximize learning around specific PBI-related issues. The recommendations for the PBI design will be discussed and vetted by HFG and Haryana State health experts during the design consultations in early 2015.

2. FORMATIVE INVESTIGATION MAIN FINDINGS

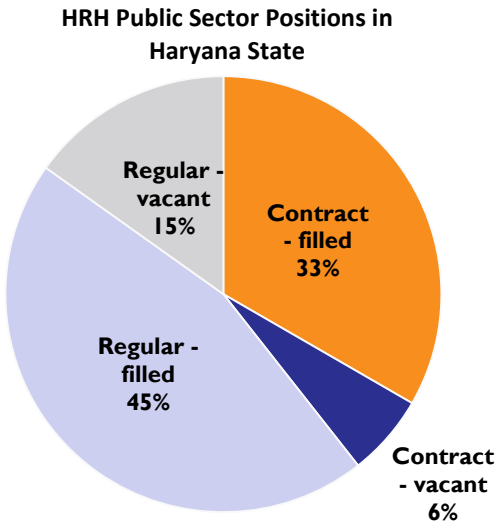
2.1 Incentive Environment and PBI Design Challenges

A key objective of the formative investigation was to understand the current incentive environment in order to understand what contributes to current performance levels and how PBI can stimulate changes in behavior. A PBI scheme that is truly motivating needs to take into account the facility staff grievances over their compensation and work environment, public health utilization issues, and the existing performance management and work cultures that are discussed in this section.

2.1.1 Contract and Regular Worker Salary Disparity

A major issue to consider in the design of a PBI scheme in Haryana is the different incentive environments for "regular" and "contract" workers. High vacancy rates for health workers on the formal government payroll (regular workers), and the cumbersome bureaucratic process to fill those vacancies, has led to an increase in workers hired on a temporary, contractual basis (contract workers). Contract workers comprise more than 40 percent of all filled health worker positions in Haryana State (Figure 1), but they are paid about 40-60 per cent of regular workers' salaries for doing the same jobs (Table 1). In addition, contract workers do not receive benefits and have no real job security, all of which contributes to their low morale and grievances.

The formative investigation revealed that this double-standard in the public health workforce dominates most contract workers' thoughts and affects their motivation and attitudes. Most contract workers hope to become regular workers as soon as possible; only a small percentage may be satisfied with using their temporary position to gain experience and earn pay as they prepare to enter graduate medical programs. However, there is no mechanism for a contract worker to automatically convert to a regular position — contract workers must apply for regular government positions like any other candidate. As a result, many facility workers remain contractual for many years with little to no prospect of advancement.



In addition, while all workers complained about their perceived overall low compensation, the contract workers were particularly indignant, stating that their salaries are too low to lead a decent life and support a family, and do not reflect their skills and responsibilities.

"Even the butcher is better off…" (A Medical Officer)

The following evidence from the focus group discussions and in-depth interviews illustrated the different incentive environments for contract and regular workers:

- Several key informants independently gave feedback that contract workers often have more recent training, work harder and provide better quality of care than their regular worker counterparts.
- Regular workers were less likely than contract workers to agree that introducing "targets" and "incentives" are a good idea.
- Supervisors at CHCs and PHCs believe the pay differential and differences in job security for the same job is a major demotivating factor for their contract staff.
- Regular workers, contract workers and supervisors all said that the poor working conditions and supply and manpower shortages are major issues (see Section 2.1.2 for more details). However, regular workers and supervisors appeared to feel more strongly that the solution to improving health outcomes in Haryana rest with Government's investment in facilities, supplies and human resources, rather than with a PBI scheme. By contrast, contract workers appeared to be more receptive to PBI because they saw it as a chance to increase their pay.

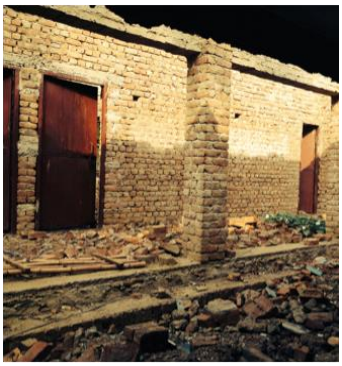
Considerations for PBI Design

- Use clear messaging to reinforce understanding that PBI is not a mechanism for achieving salary parity between contract and regular workers.
- To avoid deepening the salary disparity between regular and contract workers, consider basing incentive amounts for all workers on regular workers' salary scale irrespective of one's contractual status or years of experience.
    - However, note that this strategy may still create the perception that a contract or less experienced workers will have "more to lose" if their team doesn't meet targets; the incentive will be a larger percentage of their base salaries than it would be for regular, more experienced workers.

2.1.2 Workplace Grievances

The site visits, focus group discussions and in-depth interviews highlighted a series of workplace grievances that contribute to low morale and need to be considered in the design of a PBI scheme aimed at motivating facility staff and promoting behavior change:

- **Human Resource Shortage:** Major concerns arose in all of the focus groups and in-depth interviews around the shortage of manpower. Facility staff seemed well aware of the minimum manpower requirements established by the official Indian Public Health Standards and of shortages in human resources at their own facilities. The grievances around this issue were twofold: first, facility workers did not feel they could serve their catchment populations well without the basic numbers of required medical and supporting staff; second, they felt they were going above and beyond their call of duty by having to serve rapidly growing catchment populations without any increase in staff numbers.
- **'Hardship Incentives'**: Several respondents in Mewat mentioned that this District is often used as a punishment posting because of the poor and difficult working conditions, human resource shortages, and the challenges in servicing the catchment population. To attract medical officers, however, these positions are given a form of hardship pay (referred to as the "Mewat incentive"). This additional payment is not available to workers in other positions, resulting in a sense of unfairness for those who are also serving in Mewat, raising questions about medical officers' motivations for serving there, and undermining the sense of "*we're all in this together*."
- **Poor Working Conditions**: Staff and supervisors alike at the studied facilities complained about the poor state of basic infrastructure, including lack of heat and electricity, cracked ceilings and crumbling walls, lack of functioning medical equipment, and overall lack of cleanliness. These infrastructure issues were cited repeatedly as contributing to low morale and lack of dignity, and sending the message that the well being of health workers and the catchment populations is not a high priority. Infrastructure issues were also seen as a major impediment to proper health service delivery. There was no mention, however, of how the facility team could solve some issues with the poor physical conditions at the facility themselves. (See discussion of issues relating to facilities' untied funds in section 2.3.1.) Rather, in discussion of what could be done to improve health service delivery in Haryana, the first reaction was often "*the Government can start by improving facilities.*"



PHC Hallway, Mewat

"We have thousands of constraints. I may have tools, but I don't have electricity." (Dentist)

"We are doing the best we can. We are only dreaming that one day we will have a decent building." (Medical Officer)

- **Physical Security:** Another issue that came up repeatedly during the discussions was physical security. According to the Indian Public Health Standards, Primary Health Centers (PHCs) are supposed to provide 24-hour emergency care. These overnight emergencies are often deliveries, and there is often only one staff nurse or one auxiliary nurse midwife to attend. The Medical Officers In-Charge were very concerned about the risks involved in leaving a female staff member on the premises overnight without a security guard. They saw this as a requirement to serving their catchment populations and saw lack of security as a problem for the Government to solve.

Considerations for PBI Design:

- Be aware that PBI is not a mechanism for solving all workplace grievances. While PBI can be used to incentivize keeping facilities clean and basic equipment in working condition, it cannot be used for major building upgrades or staff expansion.
- Make it clear that part of the overall incentive payment is to cover investing in the facility and teams can have a say in how this money is used.
- Consider financial and/or reputational incentives for supervising medical officers for improving facility conditions as well as the supply and functioning of basic equipment.
- Investigate and address, as necessary, challenges and disincentives in the procurement process applied to use of facility untied funds that may undermine using PBI to procure products and services to improve workplace conditions such as hiring cleaners, purchasing cleaning supplies, or contracting equipment repair services.
- Complement PBI with other visible measures to improve working conditions. Facility staff and supervisors may be more motivated to improve their performance when they see tangible Government investments in improved infrastructure.
- Messaging is key: when rolling out a PBI scheme, the Government should communicate how it is actively working to improve health outcomes through a variety of measures (such as PBI, investing in facilities, etc.) to show that it is doing its part to match the extra effort of the health workers. At the same time, PBI is part of the broader strategy of motivating and empowering facilities to solve problems and improve health service delivery on their own.

2.1.3 Care-seeking behavior

Participants consistently found it easier to blame poor performance on external barriers that are the responsibility of others beyond the facility to solve, rather than focusing on ways they might take actions to address poor working conditions such as improving cleanliness or fixing broken equipment. Another frequently mentioned external barrier to better health outcomes was poor health seeking behavior among the catchment population. Facility staff in Nuh Block, Mewat in particular described major challenges they face in performing their duties because of local population attitudes and beliefs. There was consensus around cultural barriers in the community that dissuade people from using modern health services for prevention and treatment. Staff also felt the community they served did not accept them because they are not local to the area.

Staff also attributed poor care-seeking behavior and poor health outcomes to occasional supply chain interruptions, which they said are outside of their control. Participants explained that supply chain interruptions contribute to low expectations by the population that needed medicines or supplies would be in stock at the facility, leading to less willingness to come access care.

Respondents did not mention, however, that low care-seeking behavior might also be a result of low expectations of provider availability or quality of care. For example, if a sub-center is staffed with only one ANM instead of the desirable two, the ANM needs to spend some time away from her sub-center making house visits or participating in the weekly immunization camp. If a person from one of the sub-center's villages makes the trip to the sub-center and does not find the ANM, it discourages the person from making that trip in the future. Additionally, if the patient does not perceive his or her visit to be a positive experience or the care received to have been helpful, the person is less likely to seek timely care in the future.

Considerations for PBI Design:

- Use PBI to reinforce the message that facility staff efforts and attitudes can have a significant impact on care-seeking behavior, even in challenging areas. Teams of health workers that are resourceful and put in effort to achieve targets can earn incentives.
- Offer guidance and propose strategies that health workers could use to promote increased utilization; but also encourage health workers to devise innovative strategies that work in the local context.
- To acknowledge localized barriers and challenges, implement a common set of indicators for all participating facilities to work towards, but set the target for each indicator as an improvement relative to each facility's unique baseline performance.
- Reward facilities for improved performance with untied funds to be used to address facility challenges and to support outreach activities.

2.1.4 Performance Management

Designing and implementing a PBI scheme requires deep understanding of how roles and responsibilities are defined and how performance criteria are determined, communicated, monitored and managed. A well-designed PBI system should clarify areas of responsibility and performance expectations for supervisors and staff alike. It should also over time lead to a change in work culture from one that inadvertently encourages passivity to one that promotes, teamwork, engagement, initiative, problem-solving, transparency and accountability.

The formative investigation found, on the one hand, that are elements of a sound performance management system are in place, including:

- definitions of the functions of the different public health facilities within the Block system (based on the Indian Public Health Standards);
- established roles and responsibilities for all the positions within the different facilities (based on the Indian Public Health Standards);
- understanding of facilities' goals in health service delivery, as well as the specific health issues and health seeking behavior of the catchment population, and
- systems for recording, entering, reporting and monitoring data on population health and health service delivery.

At the same time, the formative investigation also revealed that these performance management elements—individual job responsibilities and accountabilities throughout the Block structure, performance expectations and feedback, and data reporting systems—will all need to be strengthened in order to support a successful PBI scheme.

2.1.4.1 Supervision Structure

The Indian Public Health Standards outline the supervision structure for within the Block-level public health system and we observed only slight variations in this structure (due to unfilled positions, such as Health Assistant Females):

- Block Medical Officers supervise CHC staff and the Medical Officers In-Charge of affiliated PHCs
- Medical Officers In-Charge supervise the PHC staff and sub-center staff
- ANMs at the PHC and sub-center mentor and coordinate activities for ASHAs

(For a full description of the supervision structure within the Block-level public health system, see Annex A.)

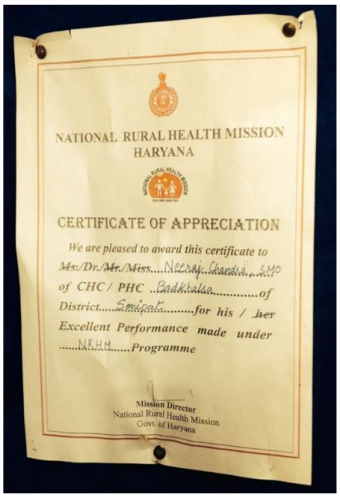
The job descriptions of supervisors (specifically, Block Medical Officers and Medical Officers In-Charge) in the Indian Public Health Standards convey the government's intention to hold supervisors accountable for the health status of the catchment population and for improvements in staff performance in the quantity and quality of care delivered. The Standards describe a Block Medical Officer as someone who will be:

"responsible for coordination of NHP [National Health Programs], management of ASHAs[,] Training and other responsibilities under NHM apart from overall administration/ Management of CHC etc. He will be responsible for quality & protocols of service delivery being delivered in CHC."[3]

The Standards describe a Medical Officer In-Charge at a PHC as someone who is:

"responsible in his individual capacity, and as over all in charge. It is not possible to enumerate all his tasks. However, by virtue of his designation, it is implied that he will be solely responsible for the proper functioning of the PHC, and activities in relation to RCH, NHM and other National Programs."

Nevertheless, the formative investigation revealed that supervisors have little guidance for carrying out their roles, and that managerial style and intensity varies from facility to facility. There seems to be little feedback to show managers whether or not they are doing a good job, and lack of clarity as to what are their performance criteria. For example, given the many working environment constraints discussed above, is a supervisor performing well if there is low staff turnover? high volume of facility-based services? better-than-average health outcomes in the catchment population? As with the services the facilities are supposed to provide, the performance management culture within public facilities could benefit from clarifying expectations for a supervisor's role, objectives and targets, and from holding supervisors accountable for meeting those expectations.


NATIONAL RURAL HEALTH MISSION
HARYANA

CERTIFICATE OF APPRECIATION

We are pleased to award this certificate to
Ms./Dr./Mr./Mrs. Neeraj Chandra, MO
of CHC / PHC Gadkalan of
District Sonipat for his / her
Excellent Performance made under
NRHM Programme

Mission Director
National Rural Health Mission
Govt. of Haryana

Certificate of Appreciation, CHC/PHC, Sonipat

Similarly, our interviews and observation revealed that supervisors at the Block level appear to have few actual tools ("carrots" to incentivize people to perform better, and "sticks" to punish people for performing below expectations) to manage and motivate their staff. In terms of "carrots," if a staff member is performing well, the supervisor can provide verbal or written recognition of the person, but even this may be limited, as it appears that official written recognition would need to come from a higher level of government. Supervisors can potentially recommend high-performing staff for awards and/or promotion, or authorize training (as training is sometimes perceived as a benefit), but it was not apparent that supervisors used these tools. In terms of "sticks," supervisors can recommend to higher authorities that a regular worker be moved to a different location (for example, a hardship location) or recommend that a contract worker be terminated. It appeared that most

[3] Ministry of Health and Family Welfare, Government of India. *Indian Public Health Standards: Guidelines for Community Health Centers.* Revised 2012.

supervisors primarily relied on using staff meetings and one-on-one conversations to motivate their staff to perform well.

The interviewed supervisors expressed mixed views on whether financial incentives would be appropriate for supervisors and motivate them to perform their jobs differently. A few insisted that supervisors are or should be intrinsically motivated and should not be incentivized through monetary incentives. Others appeared accepting of the idea of non-monetary or monetary incentives for themselves if their team does well. All supervisors, however, were still quick to blame poor outcomes on the external barriers discussed above. Some cautiously mentioned issues surrounding staff motivation (aside from salary grievances and high turnover), but also referred to the absence of effective management tools to correct issues of absences or poor skill sets. These few interviews with supervisors were not conclusive on whether and how supervisors would change their day-to-day management strategies to meet targets and whether they would be receptive to incentives.

Considerations for PBI Design:

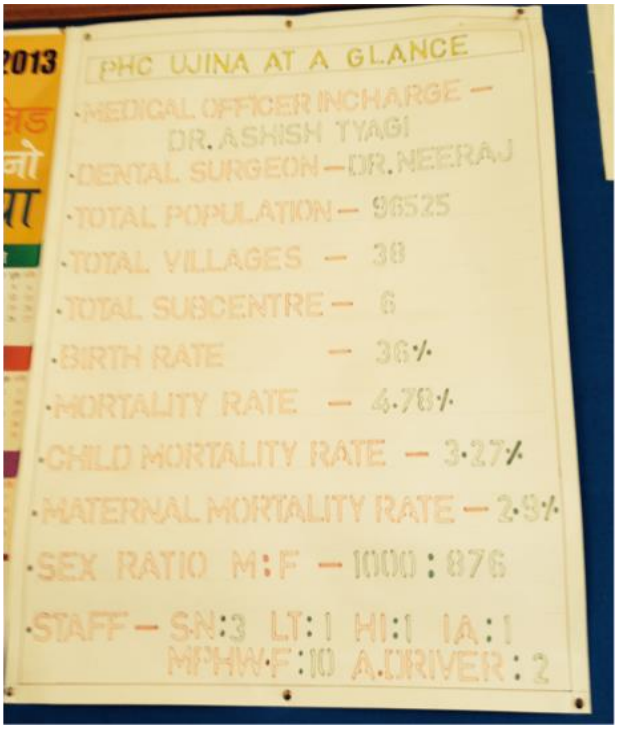
- Use the existing Block-level supervision structure to promote a team-based approach to population health management. Supervisors at all levels within the Block can use existing monthly meetings among facilities, and with staff, to review feedback and progress reports and discuss strategies for meeting targets.
- Provide all facility supervisors and staff with clearly defined performance criteria and incentive targets. Explore whether reputational incentives, monetary incentives, or some combination of the two would be most effective in motivating Block and facility supervisors.
- Reinforce the message that effort by facility staff and the entire primary health care network can have a significant impact on health care utilization, even in challenging areas. Health workers that prove to be resourceful and put in more effort in order to achieve targets can earn incentives.

2.1.4.2 Accountability and Population Health Management

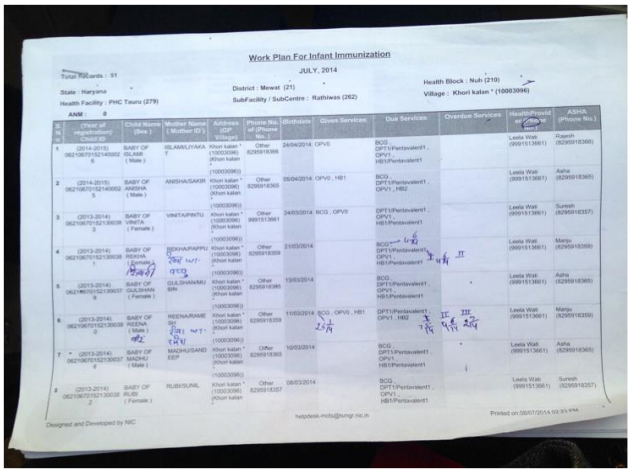
Being accountable means having the obligation to answer questions regarding decisions and/or actions. Performance accountability refers to demonstrating and accounting for performance in light of agreed-upon performance targets.[4] Performance accountability in a public health care system, which is meant to ensure universal health coverage, means that someone is held responsible for ensuring that every person can access the services he is she needs. Historically, the government is the party that has shouldered most if not all accountability. But a global movement to shift some accountability to health care providers is taking place. In India, this means that health care workers and facility supervisors at CHCs, PHCs and sub-centers take some accountability for ensuring that every person in the facility's catchment population receives high quality preventive and curative care that he or she needs. These workers and supervisors demonstrate and account for their performance toward this goal.

[4] Brinkerhoff, Derick. January 2003. Accountability and Health Systems: Overview, Framework, and Strategies. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

Throughout the formative investigation, while we observed diligence in data recording and reporting by health facilities, it appears that measurement of performance is limited and the use of targets is essentially non-existent. As a result, health workers and supervisors feel little accountability for current performance on health indicators.



Wall poster at PHC in Sonipat



A midwife's monthly Due List from MCTS

We observed evidence of some baseline performance measurement and information flowing from a government administrative level to facilities. Hand-written posters on the walls of offices in facilities displayed overall demographic information and key health outcomes (for example, size of the facility's catchment area, district maternal mortality ratio, district infant mortality ratio). The source or date of the information was often unclear, but the poster's presence evidenced some appetite for facility-specific statistics. Supervisors appear to know the information on the poster well, while staff demonstrated some knowledge of demographic indicators such as total catchment population.

Nevertheless, there is room to expand the use of data for understanding facility baseline performance. This poster and ones like it are snapshots of a facility's statistics, and health outcomes indicators are likely derived from infrequent Nation- or State-wide household surveys. The poster does not indicate whether the facility is performing well relative to any standard. Meanwhile, facilities submit monthly reports through a District Health Information System (DHIS) that could feed into interesting trend analyses and serve as helpful management tools, but these data are not displayed prominently on the walls of facilities. Instead, it is not clear the extent to which supervisors and facility staff self-monitor performance based on facility-reported data from the DHIS.[5]

Population health management means that facility staff and supervisors at CHCs, PHCs and sub-centers take proactive steps to ensure that every person in the facility's catchment area receives appropriate preventive and curative services. In other words, health workers and supervisors at a facility are aware of how many people require

[5] We know that DHIS data are used within the Government. Annex B includes a list of indicators that had been aggregated at the district level for the 2012-2013 and 2013-2014 reporting periods. This report was created by the NHM in Haryana. It is not known at this time whether these results or others such as facility-level trend reports trickle down to the facilities on any regular basis.

which services and work towards serving every person who has not received that service elsewhere (such as a private facility). Health workers have some experience with using data for population health management, but this experience appears to be concentrated at sub-centers and there is room to expand.

Health workers have demonstrated willingness and ability to use data for population health management. The Mother and Child Tracking System (MCTS), a national initiative, provides a patient tracking report or "Due List" to each ANM every month based on the services the sub-center provided in previous months. The Due List is a tool that that ANMs and ASHAs use to help them keep track of pregnant women, mothers and children in her catchment area who are due for various services. The MCTS initiative reportedly contacts ANMs when individuals have remained on the Due List for too long. ASHAs and ANMs interviewed attested that this tool helps them keep the community healthy. This initiative successfully introduced a population health management tool and is fostering a sense of accountability among ANMs and ASHAs to provide timely RMNCH services (for more information on the MCTS initiative and how the initiative may be leveraged for PBI verification and program monitoring, see Section 2.3.3.2.2).

Considerations for PBI Design:

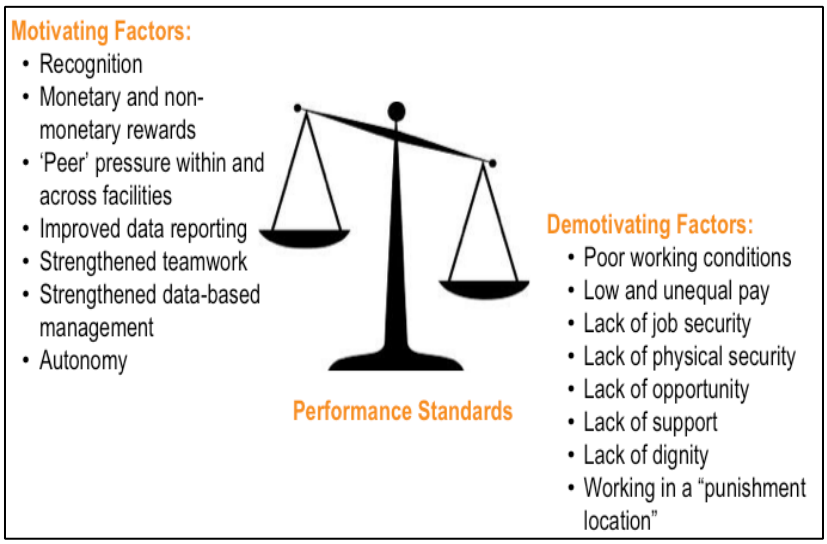
- Use PBI baselines and targets to hold health workers and supervisors at CHCs, PHCs and sub-centers accountable for ensuring that people living in the facility's catchment area receive the appropriate preventive and curative services.
- Use PBI baselines and targets to promote population health management by facility staff and supervisors.
- Supply timely, facility-specific population health management reports and tools (such as the MCTS Due List) to facilities.
- Provide training, technical assistance and guidance to facilities to help staff and supervisors use the reports and tools.
- Establish clear baselines of current performance on agreed upon indicators.
- Base targets on current baselines and provide facility teams with regular feedback on progress toward their targets.
- Use targets to create specific expectations for delivery of priority services.
- Promote data-driven behavior by providing regular feedback to facility teams based on reported data.

2.2 Reactions to PBI Concept

2.2.1 Overall Reaction

Although the challenges we observed at the public health facilities were very real and the participants' grievances we heard were pronounced, the formative investigation findings suggest that there is indeed room for PBI to spur performance improvements. Many of the participants used the presence of external researchers as an opportunity to vent their frustrations and discontent. When the discussion was able to move beyond workplace grievances, however, there was openness among some participants to the idea of increasing pride in their work and in earning something extra for achieving something extra. For example, one ANM, when asked what she could do to earn an incentive, was quick to come up with ideas for reaching out to the community to increase the volume of patients for her sub-center.

PBI Can Improve Motivation & Performance Standards



The overall reaction to the concept of PBI could be described as 'qualified positive." In the abstract, participants seemed to like the idea of working as a team to achieve clear and feasible targets, receiving financial recognition for their achievements, and improving overall facility performance. Contract workers tended to be the most positive because they saw PBI as a way to earn more. Yet there were several factors that qualified the overall positive response:

- **Confusion over 'incentives':** The notion of target-based incentives was a bit difficult for the participants to fully comprehend. Responses in the interviews and group discussions suggested that many participants interpreted 'incentive' as 'fee for service,' along with lines of the "ASHA model" under which ASHA workers are compensated per patient referred to the sub-center or service delivered (see Annex A for the ASHA payment list). In spite of clarifying explanations, some participants liked the idea of a fee for service model because they saw it as a way to earn more as individuals.
- **Concern over external barriers:** While many participants agreed that there is room to improve facility performance, they repeatedly raised concerns over the significant factors beyond their control that would prevent them from achieving the targets. For example, how could they increase facility births if the facilities are inadequate and the local population does not come to the facilities, or how could they increase out patient visits when medical staff and medicines are in short supply?
- **Concern over unintended or distorting effects of targets**: Some of the medical staff questioned the appropriateness of targets for medical workers generally. They worried that targets could lead to increased tension among staff or potentially to a decline in the quality of care if medical workers based decisions and set priorities on the basis of financial reward rather than

medical need. A few also felt that medical workers should be sufficiently motivated by helping the local population and should not need incentives to improve their performance.

- **Belief that health outcomes are a shared responsibility**: There was broad consensus in the interviews and group discussions that improved health outcomes are an important and achievable goal. However, they did not feel that responsibility for this goal rest solely with facility workers. Rather, they expressed strong views that the government has a role to play in investing in infrastructure and manpower, as does the local population, which needs to take greater responsibility for their own health.

Concerns over PBI varied depending on participants' position, with regular workers generally more skeptical and contract workers generally more positive about the potential for PBI to drive improved performance and culture change. Regular workers thought that a PBI scheme would not be effective unless it were accompanied by improved facilities and increased staff. Contract workers worried that the incentive amounts would be insufficient to address their salary inequity and lack of job security. Supervisors expressed concern over the potential for increased tensions among the staff, distortions in task focus and priorities, and fraudulent reporting and gaming of the system. They also worried about the disruption caused if a PBI scheme were only temporary, and cited the example of an earlier scheme to increase the number of female births, which was cancelled after unsuccessfully providing incentives of 400 INR per male and 600 INR per female newborn.

2.2.2 Reaction to PBI Design Elements

2.2.2.1 PBI Amount and Allocation

When it came to discussing specific elements of a PBI design, there was no clear consensus on what would be the appropriate incentive amount. Some participants were uncomfortable discussing specific monetary incentives, particularly in a group setting. Others conveyed simply that something was better than nothing and still others could not get past seeing incentives as a form of a pay increase.

When asked to react to specific PBI scenarios, all participants thought that the hypothetical figure of five percent of one's annual salary would be insufficiently motivating. Suggestions ranged from 10 to 50 percent of a facility worker's salary and all seemed to agree that payments should be on at least a quarterly basis. Many participants also welcomed the idea of non-monetary incentives, such as increased opportunity for training and promotion.

With regard to the allocation of PBI, there was broad support for the idea of earning incentives as a team, although there were a few detractors who preferred the opportunity to earn incentives individually. "If I worker harder, I should get more," one participant said.

There was less agreement, however, on how PBI incentives should be allocated among the team. While many liked the idea of everyone receiving the same amount, some preferred that workers receive the same percentage of their annual salary, and still others felt that everyone should receive the same flat amount. Contract workers wanted the incentives to address the salary inequity issue and regular workers wanted tenure to factor into incentive determination.

There was less support for the idea that a percentage of the incentive pool would be awarded to the facility. The consensus was that increased financing for facility improvements is a basic responsibility of the government rather than something that the staff should have to earn. There was also some concern that individual-level bonuses would not reach staff if incentive funds flowed to the facility's account and not directly to individuals' accounts.

2.2.2.2 PBI Targets

The interviewed facility staff and supervisors appeared to have good knowledge of their catchment populations, to be aware of the levels of service they provide (e.g., how many deliveries, outpatient visits, lab tests per day), and to understand the overall goals for health outcomes in their catchment areas (e.g., reduce maternal mortality, increase facility births, expand infant vaccination coverage). Supervisors also appeared to have access to data on specific priority population groups that could help in facility target setting and planning. However, none of the facilities or individuals taking part in the formative investigation could cite specific performance targets to which they are held accountable.

Facility staff and supervisors interviewed had difficulty suggesting targets for a PBI scheme, as well as distinguishing between basic performance criteria and criteria for earning an incentive on top of one's salary. With prompting, there was generally positive response to current facility and individual performance serving as a baseline for incentive targets. Once again, however, participants were quick to point out to multiple factors they saw as necessary for achieving targets, with improved facilities and increased manpower being chief among them.

Considerations for PBI Design

- Incentives should be earned as a team and split between the facility and the individual staff members, with the bulk going to the staff
- Incentives for facility staff should be set at the same percentage of annual salary (e.g., 10 per cent), regardless of contractual status
- Each facility should receive the same envelope based on the Indian Public Health Standards essential manpower requirements per facility, regardless of the actual number of staff

Team Indicators and Targets

- Base team-based incentives on satisfactory achievement (defined below) of 10-15 health services-related indicators during the selected performance period
- Select indicators from Annex B and measure them using DHIS data (refer to Section 2.3.2 for more details on DHIS data)
- Indicators should reflect total catchment area population health
- Indicators can either reflect a snapshot of performance or reflect output during a performance period
    - Snapshot of performance: # children <1 with full vaccination in catchment area / total children <1 in catchment area (as of end of the performance period)
    - Output during a performance period: # children <1 brought to full vaccination status during the performance period / total home and institutional births in prior 12 months
- Indicators must be measurable using DHIS monthly reports
- Set baseline as the current performance and target as a percent improvement over current performance
- Set target bands based on current performance:
    - Target should be based on a reasonable increase above the facility's specific baseline
    - Very low baseline performance on the indicator should be matched with larger percent improvements than medium baseline performance
    - High baseline performance should be matched with smaller percent improvements
- Team may receive less than 100% of possible incentive depending on performance
- To promote cooperation between facilities, the amount of a PHC and CHC's incentive could reflect a weighted average of lower-level facility success for the performance period

Supervisor Indicators and Targets

- Supervisor only receives incentive if the team does as well
- Additionally, include the following:
    - 1 indicator related to responsiveness to the PBI Unit related to outstanding data reporting issues or ongoing audits (refer to Section 2.3.3 for more details on PBI Unit)
    - 1 indicator related to audit failure or approval (indicator only relevant if audit was performed during the performance period)
    - 1 indicator related to continued timely payment of incentive payments to staff
    - 1 indicator for ensuring that the untied funds for facility improvements actually get spent

Other Targets and Incentives

- Annual incentive payment **for the team** if a facility-specific list of facility maintenance activities is fully implemented by the end of the 12-month period.
- Annual incentive payment **for the facility supervisor** if a facility-specific list of facility maintenance activities is fully implemented by the end of the 12-month period.
- All-or-nothing incentive based on facility audit by District health authorities

2.3 Existing Systems to Support PBI

A PBI scheme involves several critical steps: creating and signing performance agreements, reporting and monitoring, verification, payment, and reviewing and revising. A PBI scheme that is well integrated within the existing health system, as opposed to being run in parallel, is more sustainable from a managerial and financial standpoint and can serve to strengthen existing structures and systems. The formative investigation revealed that there are several systems and programs in place that can be leveraged to support several of the critical steps for implementing a PBI scheme in Haryana . Facility and individual health worker bank accounts, facility-based reporting, external data collection initiatives, and government experience with indicator-tracking are all existing systems that can contribute to the PBI scheme.

2.3.1 Leveraging Existing Sources for Paying Incentives

The Government uses payment systems to electronically transfer funds directly to facility and individual health worker bank accounts. Facility bank accounts may receive untied funds that cover costs for various facility maintenance activities. (For detailed guidelines on permissible expenditures using untied funds, see http://www.nrhmharyana.gov.in/page.aspx?id=63.) Procurement at the CHC and PHC level using untied funds is managed and overseen by a committee called Swasthya Kalyan Samitti, which should be comprised of supervisors and staff from the CHC and PHCs as well as community leaders. Procurement does not require prior approval from District Health and Family Welfare Society/Civil Surgeon, but the committee must submit monthly expenditure reports.

During the formative investigation, we observed and heard testimony to gross inadequacies with respect to facility maintenance. This may be because the amount of untied funds is inadequate, the procurement process by Swasthya Kalyan Samitti is broken, or a combination of both. Anecdotally, we understand that Swasthya Kalyan Samitti are often reluctant to undertake procurement activities because of the bureaucratic effort required to do so and because of financial scrutiny procurement activities invite from higher authorities. In other words, it is easier for the Swasthya Kalyan Samitti to not take action for facility maintenance. The committee is not held accountable for spending untied funds and for improving and maintaining the facility.[6]

One scheme design under consideration in Haryana State involves earmarking a portion of a team's earned incentive for facility improvements, with the remaining to be split among individual team members. There are two main payment operation designs to consider:

> ***Option 1***: transfer the entire incentive payment to the facility; the facility supervisor distributes payments to individuals.
>
> ***Option 2***: transfer the facility portion of the incentive to the facility; separately transfer each individual's bonus to his/her individual bank account (similar to how salaries are paid).

We need to weigh the two payment operation options for stakeholder preference and operational feasibility and respective costs. Health workers stated a preference to receive their portion of the total incentive payment directly through a bank transfer to their individual bank accounts as opposed to receiving the incentive payment from the facility. Health workers did not provide specific reasoning for this preference. If taken at face value, this preference would suggest that Option 2 is preferable to health workers. However, we may assume that health workers preferred this option because of concerns that

[6] For studies on the use of untied facility funds see the following links: http://www.biomedcentral.com/1753-6561/6/S1/P8; http://www.biomedcentral.com/1753-6561/6/S1/P7; http://www.ncbi.nlm.nih.gov/pubmed/20108876

bonuses would not be distributed honestly or timely. There are various ways to mitigate these risks, such as publicly posting bonus amounts each level worker should receive, requiring and verifying paper receipts when bonuses are distributed, randomly checking with individual staff at the facilities to confirm they received payments, and providing a mechanism for staff to contact government authorities if they do not receive proper bonus payments.

Supervisors stated a preference not to be responsible for deciding how much money each worker should receive. Supervisors preferred that incentive payments for each individual were predetermined by the government. Either option will accommodate this preference because the government can provide detailed guidelines for payment distribution.

Feasibility is another important factor to weigh because an overly complex operational system risks payment delays and is more resource-intensive. Option 1 is much simpler than Option 2. In Option 1, the government administrator will transfer one lump payment to the facility bank account. In Option 2, the government administrator will need to make one transfer to the facility and one transfer to each individual at the facility. The government administrator would also need to ensure that each individual payment transfer is correct. Once the PBI scheme scales to the State level and involves several thousand health workers, the operations for Option 2 may become overwhelming if an automated payment system is not in place. Operational feasibility likely outweighs stakeholder preferences in this case.

Considerations for PBI Design:

- Implement Option 1: transfer the entire incentive payment to the facility; the facility supervisor distributes payments to individuals.
- Before launching the PBI scheme, establish a payment operations working group comprised of PBI scheme designers, government administrators, health workers and facility supervisors to identify the most feasible and acceptable option for transferring incentive payments to facilities and individuals. The working group should ensure the process is operationally feasible prior to launching the scheme.
- Establish roles and responsibilities and provide necessary training for the government administrator(s) who will oversee and carry out payment operations for the PBI scheme.
- Ensure incentive payment transfers are timely and transparent by doing some or all of the below:
  - publicly post bonus amounts each level worker should receive
  - require paper receipts when bonuses are distributed
  - randomly spot check paper receipts
  - randomly check with individual staff at the facilities to verbally confirm bonus receipt
  - provide a complaint-filing mechanism so staff can report payment issues to government authorities
- Provide specific guidelines and sufficient training to supervisors on rules related to bonus amounts, timelines for bonus payments, and receipts.

2.3.2 Leveraging Existing Sources for Data Reporting

In the context of PBI schemes in the health sector, data reporting and verification represent critical steps in the PBI cycle. This cycle typically starts with the signature of performance contracts with PBI recipients (in this case, Block Medical Officers, CHCs, PHCs and sub-centers). Among other things, these contracts stipulate how the PBI recipient's performance is to be defined, measured, reported and rewarded. The second step in the PBI cycle involves data reporting (the compilation and transmission of performance data by PBI recipients), usually accompanied by a payment request. The verification of this data is the third step in the cycle. It aims to ensure that reported data accurately reflects actual performance, both by detecting and correcting misreporting, and by identifying and deterring fraud. Next in the PBI cycle is the payment of PBI recipients, based on their reported and verified performance. The cycle ends with a review of any design and implementation problems and the adoption of appropriate corrective measures to get ready for the start of a new cycle.

Data reporting is important because a facility must demonstrate that it met its targets when it requests an incentive payment. The public health system in India is already engaging in electronic reporting that will be helpful for PBI implementation. CHCs, PHCs and sub-centers routinely collect and report progress on many indicators. The NHM in Haryana derived information for the list of indicators in Annex B from facility-based reports. Annexes C and D are shells of the District Health Information System (DHIS), which is an online portal facilities use for monthly reporting. Annex E shows data fields collected through separate online portals for select patient-level reporting. The PBI scheme can leverage this routine data collection and reporting system for purposes of the data reporting step in the PBI cycle.

2.3.2.1 Record-keeping

Staff at CHCs, PHCs and sub-centers maintain required registers relevant to the services they provide or tasks they perform. A data assistant at the PHCs or CHCs enters some of the patient-level information from registers into an online portal on a daily basis; other registers only inform monthly reporting of aggregate indicators (such as number of institutional deliveries in the month). The data assistant at the CHC reports the CHC's data and the data assistant at each PHC reports the PHC's data and the data from sub-centers. We observed the following online portals that require patient- or commodity-level data:

- Home-Based Postnatal Care Tracking (patient-level)
- Tuberculosis-Tracking (patient-level)
- Mother and Child Tracking System (patient-level)
- Maternal Death Reporting System (patient-level)
- Infant Death Reporting System (patient-level)
- Anemia Tracking System (patient-level)
- Online Drug and Supply Chain Management System (commodity-level)

We noted that the online portals were not integrated with each other and that there may be some duplication. For example, it appears that an anemic pregnant woman would need to be entered into the Anemia Tracking System and the Mother and Child Tracking System separately.

Many services that are supposed to be provided by facilities, such as non-communicable diseases screening, are not entered electronically at the patient-level. Many of these services are aggregated from

handwritten registers at the end of the month and it is the aggregate number that is reported electronically.

2.3.2.2 Monthly Reporting

Facilities report on a monthly basis through a separate online portal called the District Health Information System (DHIS). We understand monthly reporting within a Block to generally operate as follows:

- ASHAs assemble at their sub-center once a fortnight or month to provide input to the sub-center's monthly report
- Sub-center staff deliver the monthly report to the PHC (usually during the monthly meeting attended by PHC and sub-center staff)
- PHC data assistant enters sub-centers' monthly reports and PHC's monthly aggregate data into DHIS. If data are missing, the data assistant or Medical Officer In-Charge of the PHC may call the sub-center's ANMs or ASHAs to ask for required inputs.
- CHC data assistant enters CHC's monthly aggregate data into DHIS.

2.3.2.3 Data Quality Control at the Facility

As the PBI scheme will use information from facility reports to measure against targets, it is important to ensure that reports are accurate. Although data assistants at CHCs and PHCs prepare reports, the supervisors perform quality control and should be accountable for report accuracy.

We do not know the degree to which supervisors at facilities currently perform quality control on reports prior to submission, but this would be a reasonable function of supervisors. To hold supervisors accountable for report accuracy, the PBI scheme could use incentives for supervisors. The incentive could take different forms:

a. the supervisor or facility receives an extra bonus for his/her facility meeting reporting timeliness and accuracy requirements;

b. the supervisor's or facility's bonus is reduced if inaccuracies are later identified; or

c. the supervisor or facility is placed on probation for reporting inaccuracies during which no incentives are awarded.

Supervisors can use various methods to monitor reporting inaccuracy. Supervisors can follow up with patients in the community on a random basis to ensure the information recorded in registers for that patient is accurate. This activity is time consuming and should only be used occasionally as a deterrent for misreporting by staff.

Another method supervisors can use for monitoring against inaccurate reporting is to perform various logic checks on reported data. For example, a simple method that could be used by supervisors would be to monitor his/her facility's historical trends on different indicators to see if reported data appear odd. Additionally, supervisors could look for ways to compare indicators within a given month or across months to see if the data conform to expectations and appear internally consistent. An example may be to compare number of institutional deliveries from last month to number of post-natal care visits in the current month. Since these indicators are related, one can expect the trends of the latter to reflect the former.

Supervisors will require specific guidelines, training and technical assistance to build capacity in this role.

Considerations for PBI Design:

- Use existing DHIS monthly reports for data reporting (second step of the PBI cycle).
- Incentivize supervisors at facilities to do internal data quality monitoring prior to report submission.
  - Randomly select indicators to reconstruct using data from registers
  - Monitor trends to see if reported information appears odd
  - Compare related service indicators within or across months to see if data conform to expectations and are internally consistent
- Provide guidelines, training and technical assistance to supervisors to build capacity for data monitoring.
- Promote culture shift to improve motivation for accurate reporting by reinforcing messages, demonstrating publicly use of data at multiple levels, following up with facilities when data look odd, providing regular feedback reports, and making available technical assistance when reporting or interpreting data.
  - This culture shift will likely have positive spillovers for other parts of the public health system.

2.3.3 Leveraging Existing Sources for Verification

Once facilities report data and submit a payment request, verification is critical. Part of the reason for this is that once facilities have a financial incentive to report strong results, they may be tempted to falsify data to earn the maximum payment. The main goal of verification in the context of PBI is to ensure the credibility of the PBI scheme; the different stakeholders need to trust that the performance that is being reported and rewarded is real. The verification mechanisms need therefore to be designed and implemented in a way that is sustainable, both institutionally and financially. [7] After facilities report data, PBI scheme administrators or an external party undergo efforts to ensure accuracy of the reported data before authorizing payments.[8,9]

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[7] Ergo, Alex and Ligia Paina. August 2012. *Verification in Performance-Based Incentive Schemes.* Bethesda, MD: Health Systems 20/20, Abt Associates Inc.

[8] Note, the term "misreport information" encompasses all inaccuracies in data caused by something along a spectrum of "intention." Acts of misreporting data may be very intentional and therefore fraudulent. They can also be entirely accidental or they can fall within a gray zone where the information is not black-and-white and could be construed in different ways, albeit some ways more logical than others. The risk of misreported data anywhere on this spectrum of intention can be mitigated through monitoring and verification efforts.

[9] Note that even without tying money to targets, there are still incentives for facilities to misreport information (perhaps to make the facility look better or to please government administrators). Haryana State and the Government of India have already identified issues with misreported data. Five-year District Level Household Survey data show worse health outcomes in Haryana State and Districts than are reported through facility data. Additionally, one of the objectives of the NHM's Concurrent Evaluation in Haryana State is to estimate the extent of inaccurate reporting on some indicators (see Section 2.3.3.2.3). Through anecdotal evidence gathered during the formative investigation, we understand the following specific indicators to be particularly inaccurate when calculated using facility-reported data:
ANC registration in the first trimester. There is some evidence that many pregnancies were farther along at time of registration. This indicator may improve over time with the rollout of new verification efforts by MCTS (see Section 2.3.3.2.2).

One option is for Haryana State to consider establishing a "PBI Unit" comprised of government administrative staff who are dedicated to the verification step of the PBI scheme. This Unit would serve several functions, each of which are further described below:

Function 1: Perform verification of facility-reported data using logic checks

Function 2: Perform additional verification on an ongoing basis using external data sources

Function 3: Recommend payment once results are verified

Function 4: Recommend and impose consequences for identified misreporting

Function 5: Draft PBI reporting guidance documents, provide training and provide technical support

Function 6: Contribute to policy discussions as the Government reviews and modifies the PBI Scheme design

2.3.3.1 Function 1: Perform Verification of Facility-Reported Data Using Logic Checks

Under Function 1, the PBI Unit would perform logic checks using the other facility-reported data available. This activity would preclude authorization of incentive payments. Triangulating facility-reported data is a cost-effective way of verifying reported data. The Unit can use some of the logic checks described below.

For each PBI indicator,

- plot the facility's monthly data graphically to see whether data are conforming to expected trends
- reconstruct randomly selected aggregate indicators from data available through online patient-level portals
- compare the facility's trend data to a non-participating facility to see if diverging trends emerge.
- logically compare indicators within a given month or across months to see if the facility's data conform to expectations and appear internally consistent (e.g. comparing number of institutional deliveries from last month to number of post-natal care visits in the current month).

The process might work as follows: If logic checks flag indicators for further review, the PBI Unit would then contact the facility supervisor by phone to discuss the findings and provide an opportunity for the facility to double-check reported data. The supervisor has the option to resubmit data through DHIS or submit a justification memo to explain the reported data.

This first step in the verification process may not confirm that certain indicators are misreported. The PBI Unit may have to give facilities the benefit of the doubt in some cases. The recourse for the PBI Unit is to flag a facility for a possible audit.

Outreach activities in general, such as the number of eligible couples counseled on family planning. Reproductive, maternal, newborn and child health outreach indicators may also improve over time with the rollout of new MCTS verification activities.
Cause of neonatal death/number of stillbirths. This indicator is less likely to improve through MCTS verification because households cannot easily verify medical cause of death.

2.3.3.2 Function 2: Perform additional verification activities on an ongoing basis using external data sources

Data reporting audits

A data reporting audit protocol could be utilized to provide a secondary level of verification. As the time required to conduct a data audit would delay payment of the performance incentives, it would be practical to conduct audits after payment has occurred. In cases where the PBI Unit is not convinced that odd findings from the primary verification are explainable, they can follow up with field checks. To deter facilities from false reporting, facilities could be told that they would be subject to a random audit and that they would suffer consequences for failing the audit.

Data reporting audits would involve two types of activities: first, PBI administrators would organize field visits facilities to conduct administrative audits of registers to confirm that reported results are reflected in facility registers; second, a small sample of patients listed in registers would be interviewed to confirm that the patient received the recorded service.

Mother and Child Tracking System (MCTS) Call Center

The MCTS Call Center initiative represents an opportunity for the PBI program to leverage an existing initiative for additional, secondary level verification.

MCTS Call Center staff make phone calls households[10] to confirm that each woman registered during her pregnancy, or the child of that woman, received appropriate and high quality reproductive, maternal, newborn or child health care services as reported by the sub-center (through the patient-level MCTS online portal). This activity is likely to reduce data reporting errors and discourage falsified data. It sends a message to facilities that higher authorities care about these data, the patients, and whether these specific services are being provided.

This initiative collects external data that could be used to triangulate some of the indicators in the PBI scheme. Analyses using these data will happen on an ongoing basis but would not preclude incentive payments. Analyses on these external data are also not feasible for use in authorizing incentive payments due to a few limitations:

- A woman will only be contacted if her mobile phone number was reported by the ANM/ASHA
- Not all households have mobile phones
- ANM/ASHAs may be disincentivized to provide woman's phone numbers to MCTS in fear of PBI scheme verification
- Questionnaires will not be administered to a representative sample of women in the catchment area; by definition non-registered woman are excluded

Despite these limitations, MCTS Call Center data may be useful to help the PBI Unit identify facilities that have provided low quality care to women in their catchment area or identify facilities that have reported a woman or her baby received certain services when in fact they did not. Facilities found to have these types of problems will be candidates for an audit and/or face other consequences.

[10] The Call Center also calls ANMs and ASHAs and administers a short "quiz" testing their knowledge of reproductive, maternal, newborn or child health care services required under their job descriptions. This initiative is likely to motivate ANMs and ASHAs to familiarize themselves with their job descriptions and relevant clinical guidelines, if applicable, with the aim of translating to better service delivery for the population.

NMH Concurrent Evaluation

The NHM Concurrent Evaluation, being carried out by the Chandigarh Postgraduate Institute of Medical Education and Research (PGIMER), might have potential for being leveraged for the PBI scheme. However, for this to happen the evaluation would have to be redesigned and expanded. We found that current design features of the Concurrent Evaluation make it unusable for purposes of measuring against targets to trigger incentive payments, but it may be useful for program monitoring or program evaluation purposes.

Evaluation Background

The National Health Mission (NHM) in Haryana State identified a need to assess the quality of routine data reporting by facilities, evaluate progress toward achieving universal health coverage and the utilization and provision of health care services, and monitor the progress of NRHM-sponsored public health programs. An existing national survey called the District Level Household and Facility Survey is inadequate for this type of analysis because its main objective is to provide valid results on health status at the District or State level. It is usually performed once in 5 years, the latest published survey being 2012-2013. Data collected through routine reporting by facilities is reputed to have issues with incompleteness, over-reporting and poor quality.

In response, the NHM in Haryana commissioned the Postgraduate Institute of Medical Education and Research (PGIMER) to perform a NHM Concurrent Evaluation in the State. The stated objectives of the study are to:

- Assess the coverage of reproductive and child health services at the District and Block level
- Assess coverage of various social determinants, water and sanitation, education and welfare services
- Validate the quality of data routinely reported by facilities through the health information system
- Assess the effectiveness of certain health care interventions
- Ascertain the extent of universal health coverage

Evaluation Methodology

Study design and period:

- Community based cross-sectional survey
- Started in September 2012, planned for three years
- Surveyed in Haryana to date:
  - 603 sub-centers surveyed (470 rural, 133 urban)
  - 73,444 households
  - 394,448 individuals
  - 13,027 women (for collecting ante-natal and post-natal care information)
  - 10,802 children 12-23 months
  - 47,930 eligible couples
  - 33,125 children <5
  - 41,271 individuals (for eliciting cost of medical care information)

Written informed consent is taken from every survey participant.

Data collection:

- Random selection of sub-centers in all districts
- 30 field investigators perform simultaneous data collection during a 15 day-period from a given sub-center catchment area
- Household level data collected electronically using laptops with same-day data transfer to PGIMER servers through online project portal

Records on the same individuals are obtained from the auxiliary nurse midwife for validation at the end of a 15-day period.

Survey Instrument

See Annex F

Applicability to a PBI scheme

Based on the Concurrent Evaluation's scope and methodology, this three-year data collection exercise will not be able to serve as a trigger for authorizing incentive payments in a PBI scheme. Data from the Evaluation will represent a snapshot of the performance of primarily sub-centers within a Block or District in Haryana State and does not intend to provide comparable results for the same catchment area over time. Additionally, the scope of the Evaluation is limited. It focuses on services provided by sub-centers, which provide the bulk of routine reproductive, maternal, newborn or child health services, and is collecting very little data regarding outpatient services provided at PHCs and CHCs.

The PBI Unit could potentially use household survey data from this Evaluation to triangulate a facility's performance on some of the indicators reported by the facility for the PBI scheme. The Evaluation only collects data on one facility at a time, so as a facility's data become available, the PBI Unit could analyze the household data and identify whether any data previously reported by the facility appear to be inaccurate. The analysis would only provide a measure of data reporting reasonableness because data collected in the Evaluation covers a different time period (e.g. "in last 12 months") than data from monthly reports and also relies heavily on patient recall. Regardless, it will serve as a helpful reasonableness test to facility-reported data and, like the MCTS Call Center analyses, could help identify facilities for audits.

2.3.3.3 Function 3: Recommend payment once results are verified

Once the PBI Unit completes logic checks and works with facilities to obtain data corrections or justification memos, the PBI Unit will make a recommendation to release incentive payments. A senior government official will ultimately approve the release of funds. The PBI Unit will provide any data files necessary to allow automation of payments from Government accounts.

2.3.3.4 Function 4: Recommend and impose consequences for identified misreporting

It is common for data to fluctuate after introducing an intervention related to data reporting accuracy. Indicators that were historically inaccurate may become more accurate, causing the more recent data to look like outliers. Or, data that were historically accurate might be reported less accurately now that health workers know that someone is monitoring the indicator. The PBI Unit should work closely with facility staff to understand changes in indicators. It is advisable to allow a grace period to account for the learning curve and forgive data inaccuracies identified during the grace period.

Once facilities have had a reasonable grace period, it will be important to specify and follow through with consequences for facilities if the PBI Unit identifies non-compliance with accurate data reporting requirements.

2.3.3.5 Function 5: Draft PBI reporting guidance documents, provide training, and provide technical assistance

The PBI Unit would be responsible for providing sufficient data reporting guidance to facilities participating in the scheme. The Unit shall draft and publish guidance documents, provide training, and provide technical assistance.

2.3.3.6 Function 6: Contribute to policy discussions as the Government reviews and modifies the PBI Scheme design

In addition to serving the administrative function for verification in the PBI scheme, the Unit should use the expertise it will gain through the program to contribute to policy discussions related to data reporting and verification. Step 5 of the PBI cycle involves review and revisions to the scheme, and this Unit would make important contributions to those revisions.

Considerations for PBI Design:

- Provide data reporting technical assistance, training and guidance to facilities and allow a grace period to account for the learning curve
- Establish a PBI Unit within the government
  - Staff should include people with data analysis skills and people with policy analysis skills, and someone with sufficient seniority to recommend payment of incentives payments and impose consequences for misreporting
- The PBI Unit shall perform the following functions:
  - Function 1: Perform verification of facility-reported data using logic checks
  - Function 2: Perform additional verification activities on an ongoing basis using external data sources
  - Function 3: Recommend payment once results are verified
  - Function 4: Recommend and impose consequences for identified misreporting
  - Function 5: Draft PBI reporting guidance documents, provide training, and provide technical assistance
  - Function 6: Contribute to policy discussions as the Government reviews and modifies the PBI Scheme design
- Consider ways to incorporate data from the Concurrent Evaluation in the PBI scheme:
  - Use Concurrent Evaluation data to estimate variances across settings to determine if targets should be based on historical performance at the facility-, Block- or District-level.
  - Leverage the large effort already undertaken for the Concurrent Evaluation by expanding the scope of the Evaluation and funding it for future years. Expanded funding and scope could build on the existing evaluation by providing a robust, institutionalized and independent performance measurement, monitoring or evaluation scheme for the PBI initiative.
  - If the Concurrent Evaluation were funded for future years and became a confirmed annual and indefinite data source, incorporate annual results from the Evaluation into longer-term incentive payments.
- Compare MCTS Call Center data to facility-reported data to identify discrepancies. Facilities with discrepancies over a given threshold should be flagged for audit.

2.3.3 Indicators already Tracked by DHIS

The Government already has experience measuring indicators. Annex B includes a list of indicators that had been aggregated at the District level for the 2012-2013 and 2013-2014 reporting periods by the NHM in Haryana.

Some of the indicators already tracked may be logical choices for indicators to incentivize under the PBI Scheme. The government has already learned how to aggregate them, facilities have already learned how to report on them, and the government has already demonstrated interest in these indicators.

Considerations for PBI Design:

- Select indicators for the PBI scheme from this DHIS list.
- One option is to group indicators through the life cycle from pregnancy to delivery to newborn to postnatal and young child period. Consider indicators that capture that services were given to each cohort in each stage in the life cycle.
- These RMNCH+A indicators may be complemented by indicators that capture detection and treatment for NCDs such as diabetes and hypertension.
- To keep PBI moving on schedule, an indicator that rewards timely and accurate reporting might be considered.

ANNEX A: HARYANA HEALTH ENVIRONMENT AND HEALTH SYSTEM

A.1 Health Status: Haryana State

Haryana is a relatively small state with a population of approximately 25.5 million people, 2 percent of the national population. The State's mean household size is 4.9.[11] The State has 21 Districts comprising 6,841 villages and 154 towns spread over 4,421 sq. km.[12] Nearly two-thirds of the population lives in rural areas.

Some health indicators show little difference between rural and urban populations within the State, while others show large discrepancies. Total unmet need for family planning is 30.4 and 30.5 percent among rural and urban populations, respectively; meanwhile, pregnant women who received any antenatal check up was 67.2 and 77.7 percent among rural and urban women, respectively.[13]

Several innovative public health initiatives originated in Haryana State. In 2010, Haryana was the first state to implement a child-screening program at schools and anganwadi centers which screened children for disease, deficiency and disability and referred children to appropriate care. This initiative scaled up nationally in 2013 as the Rashtriya Bal Swasthiya Karyakram (RBSK) program. Janani Shishu Suraksha Karyakram (JSSK), a package of care for pregnant women and infants up to 1 year, began in 2011. The Mukhyamantri Muft Ilaaj Yojana (MMIY) scheme, which launched in 2014, provides a package of free secondary and tertiary services (including 215 surgeries, all basic lab investigations, and all in-patient services) at government hospitals.[14]

Haryana State's health outcomes do not reflect its relatively high level of economic development. Table 1 compares national statistics with those of the State. In Haryana, literacy rates are higher than the national average and the State experienced higher than average growth. However, the maternal mortality ratio in the State has remained static despite national gains and the child sex ratio compared to the national average indicates Haryana's challenges with sex-sensitive abortions and preferential treatment for boys.[15]

Socio-economic development, like what has been seen in Haryana, is typically associated with a transition from a high prevalence of infectious diseases to a high prevalence of chronic and non-communicable diseases (the epidemiological transition). Centre for Global Health Research found that non-communicable diseases caused 51 percent of deaths of people under 70 in an analysis of Indian states similar to and including Haryana and observed a double burden of chronic and infectious diseases in these States.[16]

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[11] District Level Household and Facility Survey, 2012-13
[12] "Health Status in Haryana" article produced by HFG India
[13] District Level Household and Facility Survey, 2012-13
[14] "Health Status in Haryana" article produced by HFG India
[15] Jha, P. and Laxminarayan, R. (2009). *Choosing health: an entitlement for all Indians*. Centre for Global Health Research.
[16] Registrar General of India and Centre for Global Health Research, 2009; Jha and Laxminarayan, 2009

Table 1 : Demographic, Socio-economic and Health profile of Haryana State vis-a-vis to India figures		
Indicator	Haryana	India
Total population (Census 2011) (in crore)	2.53	121.01
Decadal Growth (Census 2011) (%)	19.9	17.64
Infant Mortality Rate (SRS 2013)	41	40
Maternal Mortality Rate (SRS 2010-12)	146	178
Total Fertility Rate (SRS 2012)	2.3	2.4
Crude Birth Rate (SRS 2013)	21.3	21.4
Crude Death Rate (SRS 2013)	6.3	7
Natural growth rate (SRS 2013)	15	14.4
Sex Ratio (Census 2011)	877	940
Child Sex Ratio (Census 2011)	830	914
Total Literacy Rate (%) (Census 2011)	76.64	74.04
Male Literacy Rate (%) (Census 2011)	85.38	82.14
Female Literacy Rate (%) (Census 2011)	66.77	65.46
Source: http://nrhm.gov.in/nrhm-in-state/state-wise-information/haryana.html#health_profile		

A.2 Health Status: Sonipat and Mewat Districts

Haryana is faced with large inequities in health care service coverage across Districts as well as large discrepancies between coverage of specific services. Figure 1 shows the wide range of universal health coverage (UHC) across the State, which ranges from 71 percent in Kurukshetra to 12 percent in Mewat.[17]

Table 2 shows how Sonipat and Mewat Districts stack up against the State average.[18] With respect to health status, Mewat is considered low-performing and Sonipat is middle-performing. Half of the eligible population in Sonipat use any family planning method compared with less than a quarter of the eligible population in Mewat. Conversely, less than a quarter of deliveries are in the home in Sonipat while almost half are in the home in Mewat.

[17] Haryana N. Concurrent Evaluation of NRHM Haryana. June 2014, biannual report

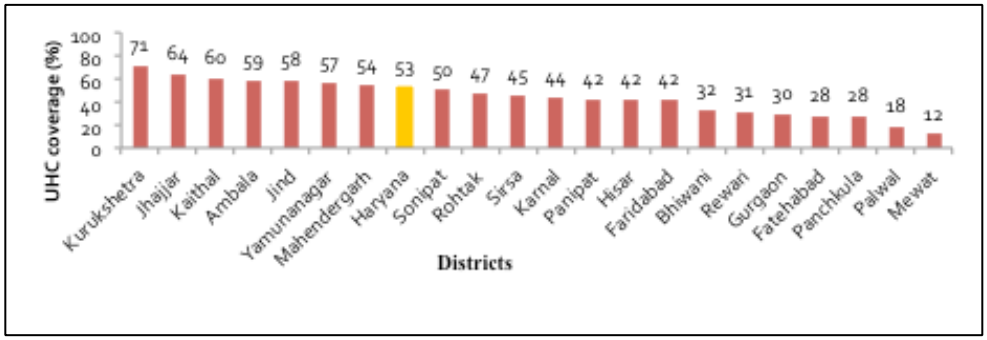
[18] District Level Household and Facility Survey, 2012-13

Table 2: Haryana State, Sonipat District, Mewat District

KEY HEALTH INDICATORS	HARYANA	SONIPAT	MEWAT
% of Pop literate age 7+ years	77.7	83.1	68.5
Mean household size	4.9	5.1	5.5
Sex ratio at birth (male per 100 female)	113	111	112
% of households having electricity	97.7	98.1	98.9
% of households having access to improved toilet facility	83.7	82.2	70.6
% use of any family planning method	51.6	53.2	23.5
% unmet need for family planning	30.4	31.9	54.8
% pregnanat women who received any antenatal check-up	70.8	45.6	45.5
% pregnant women who had antenatal check-up in first trimester	49.6	20.9	33.6
% pregnant women who had full antenatal care	15.0	6.1	1.7
% of women who had institutional delivery	77.0	75.6	51.2
% delivery at government health institutions	42.4	44.7	32.1
% delivery at private health institutions	34.6	30.9	19.1
% delivery at home	22.5	22.9	48.5
% children aged 12-23 months fully vaccinated	52.1	32.8	27.3
% children age 0-5 months exclusively breastfed	64.0	42.6	69.1
% reported disease of respiratory system	9.5	15.6	8.0
% reported disease of cardiovascular system	5.4	9.3	2.2
% of people suffering from tuberculosis	1.3	2.2	1.8
% people age 20+ having anemia	52.6	60.9	67.2
% people age 18+ with hypertension	24.5	14.4	10.7

Above and below the state-level percentage

Figure 1: UHC Coverage in Districts in Haryana State



A.3 Health Care Delivery

The population seeks health care services through public facilities, private not-for-profit facilities, private for-profit facilities and practitioners of traditional medicine (Allopathy, Ayurvedic, Unani, Siddha and Homeopathy, or AYUSH). The private sector in India reportedly provides mostly curative services to those who can pay, while the public sector provides publicly financed and managed promotive, preventive and curative health services.[19] Public sector facilities act as a social safety net for health care both from a physical proximity and a financial standpoint. These facilities represent the government's strategy to ensure universal health care coverage by ensuring all communities have physical access to a nearby facility and all people can access free or low cost health services. Facility staff also act as local health managers by implementing national- or state-sponsored public health programs. Within a Block (the government administrative unit below the District), public sector facilities provide primary and secondary care to the population. Patients requiring tertiary care are referred to sub-district or district hospitals. Several Blocks comprise a District (for the formative investigation, we visited Nuh Block in Mewat District and Rai Block in Sonipat District).

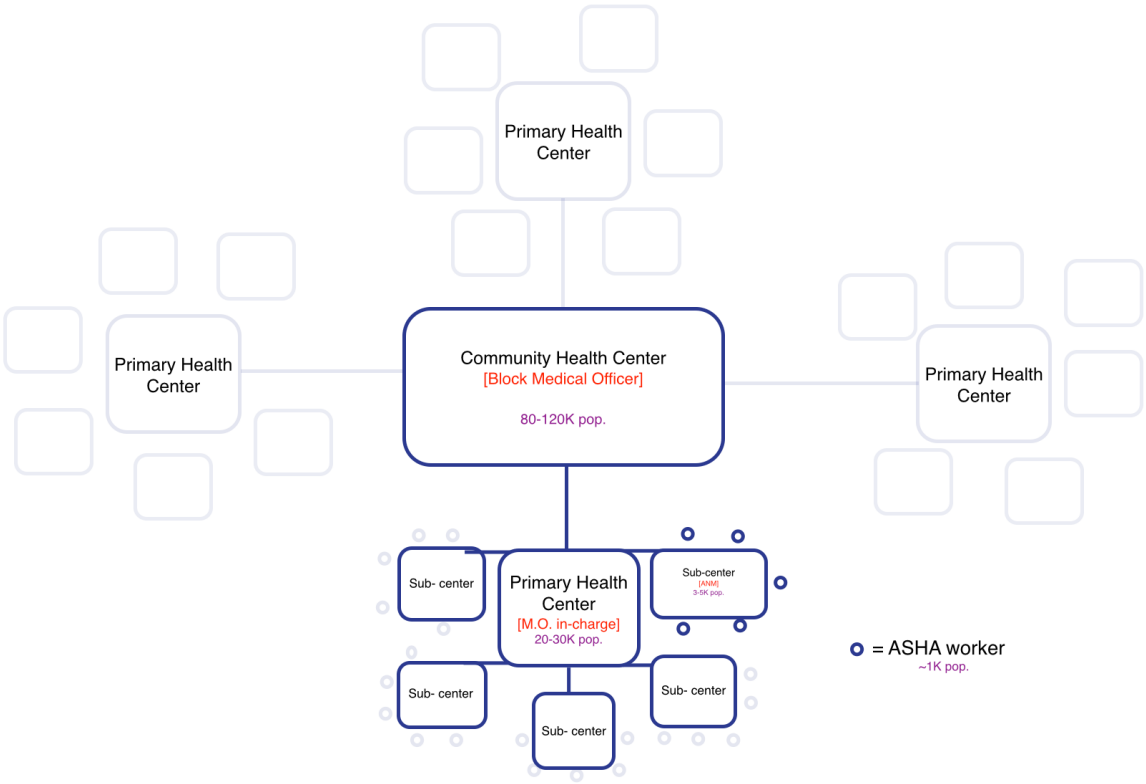
A.3.1 Public Sector Primary and Secondary Care Referral Network

The Government of India articulated a clear vision of a primary and secondary care referral network at the Block level in the 2012 revision of the Indian Public Health Standards. The referral network at the primary and secondary care level is comprised of community health centers (CHCs), primary health centers (PHCs), and sub-centers.

Figure 2 shows a representation of the envisaged primary and secondary care network within a Block.[20] A typical CHC will cater to approximately 80,000 people in tribal/hilly/desert areas or 120,000 people in plain areas. Four PHCs will be established under each CHC, and a typical PHC will cover 20,000 people in hilly, tribal, or difficult areas or 30,000 people in plain areas. However, given the population density in the country is not uniform, the number of PHCs will depend on the case load. Six sub-centers will be established under each PHC, and a typical sub-center will cover 5,000 people in plain areas or 3,000 people in hilly/tribal/desert areas. However, as the population density in the country is not uniform, the number of sub-centres and number of auxiliary nurse midwives (ANMs) staffing them will depend on the case load of the facility and physical distance of the villages and habitations in the catchment area. Indeed, during the formative investigation we observed that many facilities serve larger catchment populations than envisaged in the Indian Public Health Standards (see further discussion in Section 2.1.2).

[19] Ministry of Health and Family Welfare, Government of India. *Annual Report to the People on Health*. December 2011.
[20] Authors' rendition

Figure 2: Indian Primary Health Care Network Structure



Community health centres (CHCs) constitute the secondary level of health care and are designed to provide referral as well as specialist health care to the rural population. These facilities are envisaged to act both as a Block level health administrative unit and gatekeeper for referrals to higher level of facilities. The head of the CHC is the Block Medical Officer. CHCs are expected to provide outpatient and inpatient services for general medicine, surgery, obstetrics, gynecology, pediatrics, dental, and AYUSH services; eye specialist services (one for every 5 CHCs); emergency services; laboratory services; maternal health; newborn health; family planning; and national health programs which include prevention and early detection of non-communicable diseases.[21]

Primary health centers (PHCs) and sub-centers represent the primary level of health care in the public health system. A medical officer (MO) in-charge heads up each PHC; this manager oversees the PHC as well as the sub-centers serving the catchment area. Type A PHCs can handle up to 20 deliveries per month and Type B PHCs can handle over 20. PHCs are expected to provide outpatient services; laboratory services; 24 hour emergency services; referral services; limited inpatient services; maternal health; newborn care; family planning; reproductive health; nutrition services; school health services; adolescent health care; sanitation promotion; and national health programs which include prevention and detection of non-communicable diseases.[22]

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[21] Ministry of Health and Family Welfare, Government of India. *Indian Public Health Standards: Guidelines for Community Health Centers.* Revised 2012.

[22] Ministry of Health and Family Welfare, Government of India. *Indian Public Health Standards: Guidelines for Primary Health Centers.* Revised 2012.

Sub-centers are staffed by one or two ANMs and are the home base for Accredited Social Health Activists, or ASHAs. Type A sub-centers do not accommodate deliveries while Type B sub-centers do. Sub-centers are expected to register pregnant women and provide ante-natal care; promotion of institutional deliveries; delivery services (Type B); referral of high-risk pregnancies; post-natal care; newborn care (Type B); promotion of breastfeeding; family planning and contraception; curative services for minor ailments; school health services; sanitation promotion; outreach; home visits; and national health programs which includes information, education and communication for non-communicable diseases.[23]

ASHAs are volunteer health workers who hail from the community they serve. Ideally, each ASHA serves approximately 1,000 people. ASHAs are commonly described as the link between the community and the public health system. This large cadre of health workers, which scaled up nationally in 2005, plays a vital public health role by encouraging patients to seek services from public health facilities. ASHAs receive monetary incentives for performing specified outreach and health promotion tasks. Table 3 lists the incentivized tasks and honorariums for ASHAs.

A.4 Supervision Structure

CHC and Block Medical Officer

A CHC is the highest level facility in the Block. At its helm is a Block Medical Officer who is the most senior health official in the Block. The Block Medical Officer reports up to District-Level health leadership such as the District Civil Surgeon and his colleagues. The Block Medical Officer manages the CHC facility and is responsible for the lower-level facilities in the Block's referral network.

PHC and Medical Officer In-Charge

Each PHC is led by a Medical Officer In-Charge who reports up to the Block Medical Officer. The Medical Officer In-Charge in turn supervises his or her PHC facility and has management authority over the affiliated sub-centers.

Sub-Center and ANM

Each sub-center is led by either one or two ANMs. If there is one regular ANM and one contract ANM, we believe that the regular ANM assumes implicit seniority. According to the Indian Public Health Standards, ANMs are supposed to report up to a female staff member at the PHC called a Health Assistant Female. We did not encounter any Health Assistant Females during the formative investigation 24— it is likely this position is generally vacant or being held informally by one of the more experienced ANMs at the PHC. As a result, there may be less direct supervision over ANMs than intended in the Standards.

ASHAs

An ANM in turn is supposed to oversee the ASHAs assigned to her sub-center. We use the term 'oversee' instead of 'supervise' intentionally, as we did not perceive much actual supervision authority by ANMs over ASHAs. ANMs appear to play more of a mentoring role than a supervisory role with respect to ASHAs. Additionally, we understand that one ANM at the PHC or at one of the sub-centers may also serve as an ASHA Coordinator over the 30 or so ASHAs that operate through the PHC's sub-centers. ASHAs are technically voted into their roles by the local Village Health and Sanitation

[23] Ministry of Health and Family Welfare, Government of India. *Indian Public Health Standards: Guidelines for Sub-Centers.* Revised 2012.

[24] Ministry of Health and Family Welfare, Government of India. *Indian Public Health Standards: Guidelines for Primary Health Centers.* Revised 2012.

Committee. Therefore, ASHAs may not technically be supervised in the true sense of the word by anyone within the public sector facility network.

Table 3: ASHA Incentives

Program		ASHA Activities	Honararium (In INR)	Frequency
Mother's Health	1	Monthly listing of Pregnant Ladies	100	per month
	2	Registration, Pregnancy 1st trimester 1st check-up and ANC -1	125	per case
	3	Pregnancy 2nd trimester and ANC -2	75	per case
	4	Pregnancy 3rd trimester and ANC -3	50	per case
	5	Institutional Delivery (Over and above JSY Case)	200	per case
	6	Clinical Abortion (MTP)	100	per case
	7	Pregnant Lady/ Infant - Death Registration	100	per case
	8	Community inspection of Mother Death (As Committee Member)	100	per case
Janani Suraksha Yojana (JSY)	9	Rural SC/ BPL Pregnant Women ANC - 1,2,3 Checkup in the respective Trimesters	300	per case
	10	Urban SC/ BPL Pregnant Women ANC - 1,2,3 Checkup in the respective Trimesters	200	per case
	11	Institutional Delivery of Rural SC/ BPL Pregnant Women in Public Healthcare Facility and Infant Immunization (First 14 weeks)	300	per case
	12	Institutional Delivery of Urban SC/ BPL Pregnant Women in Public Healthcare Facility and Infant Immunization (First 14 weeks)	200	per case
Child Health	13	Home care of Pregnant, Lactating Mother and Infant under HBPNC (From Pregnancy till 42 days of Delivery)	250	per case
	14	Preparing Monthly Due List - Infant Immunization	100	per month
	15	Providing Immunization Services	150	per session
	16	Full immunization of 0 - 1 year age	100	per case
	17	Full immunization of 1 - 2 year age	50	per case
	18	Infant Death Reporting (Other than Governmental Institute)	100	per case
	19	Community inspection of Infant Death (As Committee Member)	100	per case
Family Welfare	20	Monthly listing of Eligible Couple	100	per month
	21	PPIUCD referral	150	per case
	22	02 years spacing between marriage and 1st child	500	per case
	23	Spacing of 3 years between 1st and 2nd child	500	per case
	24	Motivating husband/ wife for Permanent methods of Contraceptive	1000	per case
Iodine Deficiency Control Program	25	Salt Sample testing for Iodine deficiency	25	per 50 samples
Rashtriya Kishore Swasthya Karyakaram	26	02 Peer Educator (1 teenage boy and 1 teenage girl) Identification in the designated geographical territory (once in 2 years)	100	per 2 years
	27	Supervision of monthly meeting organized by peer educators (Ambala, Bhiwani, Jind, Karnal, Palwal, Panipat, Panchkula and Yamuna Nagar Districts)	50	per month
	28	Selling Sanitary Napkin to Teenage Girls for Menstrual cleanliness (Incorporates as a commission in MRP of sanitary napkin packet)	1	per packet and 1 packet for self usage
	29	Monthly meeting with teenage girls for awareness on menstrual cycle cleanliness	50	per meeting
Additional	30	Compiling the list of families and renewal on half-yearly basis	100	per 6 month

Program		ASHA Activities	Honararium (In INR)	Frequency
responsibilities under NHM	31	Maintenance of Village Health Register and census registration of birth-death	100	per month
	32	Conducting monthly meeting of Village Health, Sanitation and Nutrition Society (due for approval from GoI)	150	per month
	33	Celebrate Village Health and Nutrition day (due for approval from GoI)	50	per month
	34	Participate in Monthly ASHA meeting held at PHC	150	per participation
Other National Health Programs	35	Full treatment of TB (DOT)	250	per case
	36	Radical treatment of Malaria (Karnal, Hisar, Kurukshetra, Mewat, Palwal, Sirsa and Yamuna Nagar Districts)	75	per case
	37	Identification of Leprosy patient	250	per case
	38	Arranging for the treatment of M.B. Leprosy Case	600	per case
	39	Arranging for the treatment of P.B. Leprosy Case	400	per case
	40	Any other Activity		

1. From Feb. 2014: a fixed honorarium of INR 500/- per month (Preceding govt. enhanced it to INR. 1000/- in Sept. 2014, which is being reviewed/ vetted by the present government)
2. 50% extra on earned honorarium under NHM (applicable from Feb. 2014)
3. Institutional Delivery in Public Healthcare facility @ Rs. 200 per case (over and above JSY)(From April 2013)

ANNEX B: INDICATORS TRACKED THROUGH DHIS DATA

Number	Indicator
1	Total number of pregnant women Registered for ANC
2	Number of Pregnant women registered within first trimester
3	Number of Women registered under JSY
4	% 1st Trimester registration to Total ANC Registrations
5	% JSY registration to Total ANC Registration
6	Number of pregnant women received 3 ANC check ups
7	TT2 or Booster given to Pregnant women (numbers)
8	% Pregnant Woman received 3 ANC check ups to Total ANC Registrations
9	% Pregnant women received TT2 or Booster to Total ANC Registration
10	Number of Pregnant women given 100 IFA tablets
11	% Pregnant women given 100 IFA to Total ANC Registration
12	Number having Hb level<11 (tested cases)
13	Number having severe anaemia (Hb<7) treated at institution
14	% Pregnant women having severe anaemia (Hb<7) treated at institution to women having hb level<11
15	% New cases detected at institution for hypertension to Total ANC Registrations
16	Number of Home deliveries
17	Number of home deliveries attended by SBA trained (Doctor/Nurse/ANM)
18	Number of home deliveries attended by Non SBA trained (trained TB/Dai)
19	% SBA attended home deliveries to Total Reported Home Deliveries
20	Mothers paid JSY incentive for home deliveries
21	% Mothers paid JSY incentive for home deliveries to Total Reported Home Deliveries
22	Deliveries Conducted at Public Institutions
23	Number of Women Discharged under 48 hours of delivery in public facilities
24	% Women discharged in less than 48 hours of delivery to Total Reported Deliveries at public institutions
25	Institutional deliveries (Public Insts.+Pvt. Insts.)
26	% Institutional Deliveries to total ANC registration
27	Total reported deliveries
28	% Institutional deliveries to Total Reported Deliveries
29	% Safe deliveries to Total Reported Deliveries
30	% Home deliveries to Total Reported Deliveries
31	Number of C-section deliveries conducted at public facilities
32	Number of C-section deliveries conducted at private facilities
33	% C-section deliveries (Public + Pvt.) to reported institutional (Public + Pvt.) deliveries
34	% C-sections conducted at public facilities to Deliveries conducted at public facilities
35	% C-sections conducted at Private facilities to Deliveries conducted at private facilities
36	% Deliveries conducted at Public Institutions to Total Institutional Deliveries

Number	Indicator
37	% Mothers paid JSY Incentive for Delivery at Public institution to Total Public Deliveries
38	% of cases where JSY Incentive paid to ASHA for Delivery at Public institution to Total Public Deliveries
39	% Deliveries conducted at Private Institutions to Total Institutional Deliveries
40	Women received post partum check-up within 48 hours of delivery
41	Post - Natal Care / Women got a post partum check up between 48 hours and 14 days
42	% Women receiving post partum check-up within 48 hours of delivery to Total Reported Deliveries
43	% Women getting Post Partum Checkup between 48 hours and 14 days to Total Deliveries
44	Total Number of reported live births
45	% Total Reported Live Births to Total Deliveries
46	Total Number of reported Still Births
47	% live birth to Reported Birth
48	Number of Newborns weighed at birth
49	% Newborns weighed at birth to live birth
50	Number of Newborns having weight less than 2.5 kg
51	% Newborns having weight less than 2.5 kg to Newborns weighed at birth
52	Number of New Borns Breast Fed within 1 hour
53	% Newborns breast fed within 1 hour of birth to Total live birth
54	Number of New Borns visited within 24 hrs of Home Delivery
55	% newborns visited within 24hrs of home delivery to total reported home deliveries
56	Sex Ratio at birth (Female Live Bitrths/ Male Births *1000)
57	% cases of Pregnant women with Obstetric Complications and attended to reported deliveries
58	% Complicated Pregnancies treated with IV antihypertensive/Magsulph injection to Total Women with Obstetric Complications attended
59	% Complicated Pregnancies treated with IV antihypertensive/Magsulph injection to Total New cases detected with Hypertension
60	% Complicated Pregnancies treated with Blood Transfusion to Total Women with Obstetric Complications attended
61	% Post - Natal Care / PNC maternal complications attended to Total Deliveries
62	Total Number of Abortions (Spontaneous/ Induced) Reported
63	Total Number of MTPs (Public) reported
64	% MTPs (Public) to Abortions
65	% MTPs up to 12 weeks of Pregnancy to Total MTPs at Public Institutions
66	% MTPs more than 12 weeks of Pregnancy to Total MTPs at Public Institutions
67	% MTPs Conducted at Public Institutions to Total MTPs
68	% MTPs Conducted at Private Institutions to Total MTPs
69	% Total MTPs (Public) Conducted to Total ANC Registration
70	% Number of Wet Mount Tests conducted to Number of new RTI/ STI female cases for which treatment initiated
71	Number of Vasectomies Conducted (Public + Pvt.)
72	Number of Tubectomies Conducted (Public + Pvt.)
73	Total Sterilisation Conducted
74	% Male Sterlisation (Vasectomies) to Total sterilisation

Number	Indicator
75	% Tubectomies to Total sterilisation
76	Total Sterlisation (Tubectomies and Vasectomies) conducted at PHC
77	Total Sterlisation (Tubectomies and Vasectomies) conducted at CHC
78	Total Sterlisation (Tubectomies and Vasectomies) conducted at SDH/DH
79	Total Sterlisation (Tubectomies and Vasectomies) conducted at Other public Institutions
80	Total Sterlisation (Tubectomies and Vasectomies) conducted at Private institutions
81	% Total Sterilisation (Tubectomies and Vasectomies) conducted at PHC to Total Sterlisation
82	% Total Sterilisation (Tubectomies and Vasectomies) conducted at CHC to Total Sterlisation
83	% Total Sterilisation (Tubectomies and Vasectomies) conducted at SDH/DH to Total Sterlisation
84	% Total Sterilisation (Tubectomies and Vasectomies) conducted at Other public Institutions to Total Sterlisation
85	% Total Sterilisation (Tubectomies and Vasectomies) conducted at Private institutions to Total Sterlisation
86	% Laparascopic sterlisations to Total Female Sterilisations
87	% Mini Lap Sterlisations to Total Female Sterilisations
88	% Post Partum Sterlisations to Total Female Sterilisations
89	% Laparascopic sterlisations at Public Institutions to Total Laparascopic Sterilisations
90	% Mini Lap sterlisations at Public Institutions to Total Mini Lap Sterilisations
91	% Post Partum sterlisations at Public Institutions to Total Post Partum Sterilisation
92	Total cases of deaths following Sterlisation (Male + Female)
93	IUD Insertions done (public facilities)
94	IUD insertions done (pvt. facilities)
95	Total IUD Insertions done(public+private)
96	% IUCD insertions in public plus private institutions to all family planning methods (IUCD plus permanent)
97	Oral Pills distributed
98	Condom pieces distributed
99	Centchroman Pills distributed
100	Number of Infants given OPV 0 (Birth Dose)
101	Number of Infants given BCG
102	% Newborns given OPV0 at birth to Reported live birth
103	% Newborns given BCG to Reported live birth
104	Number of Infants given DPT1
105	Number of Infants given DPT2
106	Number of Infants given DPT3
107	Number of Infants given Measles
108	% Infants 0 to 11 months old who received Measles vaccine to reported live births
109	Number of fully immunized children (9-11 months)
110	% Drop Out between BCG & Measles
111	Vitamin - A dose 1
112	% Children given Vit A dose1 to Reported live birth
113	% Children given Vitamin A Dose 9 to Children given Vit A dose1
114	Adverse Events Following Imunisation (Others)

Number	Indicator
115	% immunisation Sessions Held to Immunisation Sessions Planned
116	% Immunisation Sessions where ASHAs were present to Immunisation Sessions Planned
117	% Diptheria in Children 0-5 Years of Age to Total Reported Childhood Diseases 0-5 Years
118	% Pertusis in Children 0-5 Years of Age to Total Reported Childhood Diseases 0-5 Years
119	% Tetanus Neonatorum in Children 0-5 Years of Age to Total Reported Childhood Diseases 0-5 Years
120	% Tetanus Others in Children 0-5 Years of Age to Total Reported Childhood Diseases 0-5 Years
121	% Polio in Children 0-5 Years of Age to Total Reported Childhood Diseases 0-5 Years
122	% Measles in Children 0-5 Years of Age to Total Reported Childhood Diseases 0-5 Years
123	% Diarrhoea and dehydration in Children 0-5 Years of Age to Total Reported Childhood Diseases 0-5 Years
124	% Malaria in Children 0-5 Years of Age to Total Reported Childhood Diseases 0-5 Years
125	% Adult Female Inpatients to Total Adult Inpatient
126	% Children Inpatient to Total Inpatient
127	% Female Inpatient Deaths to Total Inpatient Deaths

ANNEX C: DHIS MONTHLY FORM FOR SCS

Version 1.1.5 updated as on 19-06-2014 **NRHM/HR/HSC/3/M**

National Rural Health Mission, Health Department ,Haryana
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन, स्वास्थ्य विभाग, हरियाणा

Monthly Format for SC & Equivalent institutions
मासिक प्रपत्र-उपस्वास्थ्य केंद्र

State: राज्य:		**Due for Submission on 5th of following Month** जमा करने की अवधि हर माह की 5 तारीख तक		
District: जिला:		**Month** महीना		
Block/CHC: ब्लॉक/ सीएचसी:		**Year** वर्ष		
City/ Town / Village Name: शहर/नगर/ गांव का नाम:				
Facility Name: संस्था का नाम:				
Facility Type: संस्था के प्रकार:	**Public** सरकारी भवन ○ **Private** किराये का भवन ○			
Location: स्थान:	**Rural** ग्रामीण ○ **Urban** शहरी ○			

SINGLE REPORTING PROFORMA FOR MATERNAL & CHILD HEALTH AT SUBCENTRE/EQUIVALENT INSTITUTIONS
उप केन्द्र अथवा समकक्ष संस्थानों में मातृ एवं शिशु स्वास्थ्य के लिए रिपोर्टिंग प्रोफार्मा

State: राज्य:		Due for Submission on 5th of following Month जमा करने की अवधि हर माह की 5 तारीख तक
A. MATERNAL HEALTH **मातृ स्वास्थ्य**		
A1	**Ante Natal Care Services (ANC)** **प्रसवपूर्व सेवायें (ANC)**	
A1.1	Total number of new pregnant women Registered for ANC **माह मे कुल नई पंजीकृत गर्भवती महिलाओं की संख्या**	
A1.1.1	Of which Number registered within first trimester (within 12 weeks) **माह मे प्रथम तिमाही के अन्दर पंजीकृत गर्भवती महिलाओं की संख्या** (12 **हफ्तों के भीतर**)	
A1.2	New pregnant women registered under Janani Suraksha Yojna(GOI) **माह मे जननी सुरक्षा योजना** (GOI) **के अंतर्गत पंजीकृत की गई नई गर्भवती महिलाओं की संख्या**	
A1.2.1	Out of the A1.2 No. of BPL under JSY JSY **मे पंजीकृत बीपीएल की संख्या** (**कालम** A1.2 **मे से**)	
A1.2.2	Out of the A1.2 No. of SC, but not BPL under JSY JSY **मे पंजीकृत अनुसूचित जाति की संख्या जो बीपीएल नहीं हैं** (**कालम** A1.2 **मे से**)	
A1.3 a	Number of pregnant women who have received 3rd ANC check up in the reported month **उन गर्भवती महिलाओं की संख्या जिनकी इस माह मे तीसरी** ANC **जांच हुई हो**	
A1.3 b	Number of pregnant women who have received 4th ANC check up in the reported month **उन गर्भवती महिलाओं की संख्या जिनकी इस माह मे चौथी** ANC **जांच हुई हो**	
A1.3.C	Out of the A1.3b couselled on IYCF Practices (Breastfeeding practices)	
A1.4	**Number of pregnant women given TT Immunization** **गर्भवती महिलाओं की संख्या जिन्हे इस माह में निम्न टीटी टीकाकरण दिया गया**	
A1.4.1	TT1 **टीटी1**	

State: राज्य:		Due for Submission on 5th of following Month जमा करने की अवधि हर माह की 5 तारीख तक
A1.4.2	TT2 given and TT Booster given (TT2 **ओर** TT **बूस्टर**)	
A1.5	**Number of pregnant women given:-** **(One PW will be counted only once during pregnancy)** **उन गर्भवती महिलाओं की संख्या जिन्हे**:- **(एक गर्भवती महिला को गर्भावस्था के दौरान केवल एक बार ही गणना की जाए)**	
A1.5.1	Number of pregnant women given full course of 100 and more IFA tablets **कुल गर्भवती महिलाओं की संख्या जिन्हे** 100 IFA **गोलियों का कोर्स पूरा करने की तीसरी किस्त दी गई हो**	
A1.5.3	Number of new Pregnant women initiated on 50 Folic Acid tablets in the reporting month **माह मे नई गर्भवती महिलाओं की संख्या जिन्हे पहली बार** 50 **फोलिक एसिड का कोर्स शुरू किया गया**	
A1.5.4	Number of Pregnant women given Albendazole tablet in the second trimester in the reporting month **माह मे गर्भवती महिलाओं की संख्या जिन्हे दूसरी तिमाही के दौरान** albendazole **की गोली दी गयी हो**	
A1.5.5	Total number of new Pregnant women initiated on Calcium during reporting month **नई गर्भवती महिलाओं की कुल संख्या जिन्हे रिपोर्टिंग माह के दौरान कैल्शियम का कोर्स शुरू किया गया हो**	
A1.5.6	Total number of new Pregnant women initiated on Vitamin B12 tablets/ capsule **नई गर्भवती महिलाओं की कुल संख्या जिन्हे**a **विटामिन बी**12 **की गोलियाँ/ कैप्सूल का कोर्स शुरू किया गया हो**	
A1.5.7	Total number of new Pregnant women initiated on Vitamin C tablets/ capsule **नई गर्भवती महिलाओं की कुल संख्या जिन्हे रिपोर्टिंग माह में विटामिन सी की गोलियां / कैप्सूल शुरू की गई हो**	
A1.6	**New** cases of **Hypertension (BP≥140/90)** detected at facility (One PW will be counted only once during pregnancy) **माह मे नई उच्च रक्तचाप वाली महिलाओ की संख्या जिनका बीपी** (BP ≥ 140/90) **हो- (एक गर्भवती महिला की गर्भावस्था के दौरान केवल एक बार ही गणना की जाए**)	

State: राज्य:		Due for Submission on 5th of following Month जमा करने की अवधि हर माह की 5 तारीख तक
A1.7	**Pregnant women with Anaemia during reporting month (One PW will be counted only once during pregnancy)** **रिपोर्टिंग माह में खून की कमी वाली गर्भवती महिलाऐsa (एक गर्भवती महिला की गर्भावस्था के दौरान केवल एक बार ही गणना की जाए)**	
A1.7.1	Number having Hb level 7-11 gm (One PW will be counted only once during pregnancy) **गर्भवती महिलाऐ जिनका** Hb **स्तर** 7-11 **ग्राम के बीच मे हो (एक गर्भवती महिला की गर्भावस्था के दौरान केवल एक बार ही गणना की जाए)**	
A1.7.2	Number having Hb level less than 7 gm (One PW will be counted only once during pregnancy) **गर्भवती महिलाऐ जिनका** Hb **स्तर 7 ग्राम से कम है (एक गर्भवती महिला की गर्भावस्था के दौरान केवल एक बार ही गणना की जाए)**	
A1.7.3	**Total (A1.7.1+A1.7.2)**	
A1.8	**Complicated/ High Risk Pregnancies** **जटिल या उच्च जोखिम गर्भधारण अवस्था की पहचान**	
A1.8.1	No. of High Risk Pregnancies Identified **माह में गर्भवती महिलाओं की संख्या जिन्हे उच्च जोखिम गर्भावस्था** (High Risk Pregnacy) **के रूप मे पहचान की गई हो**	
	No. of High Risk Pregnancies Referred out	
A1.8.2	**Reasons for Complicated/ High Risk Pregnancies Referred Out: (Give Numbers)** **जटिल या उच्च जोखिम गर्भधारण के कारण रैफर किया (Referred out): (संख्या दीजिए)**	
A1.8.2.1	Ante partum heamorrhage (APH) (Vaginal Bleeding) **प्रसव पूर्व रक्तस्राव** (APH) **(योनि से खून बहना)**	
A1.8.2.2	Multiple Pregnancy **एक से अधिक** Fetus	
A1.8.2.3	Hypertension/ Pregnancy Induced Hypertension (PIH) **उच्च रक्तचाप / गर्भावस्था प्रेरित उच्च रक्तचाप** (PIH)	
A1.8.2.4	Malpresentation **मॉलप्रैजैन्टेशन**	

State: राज्य:		Due for Submission on 5th of following Month जमा करने की अवधि हर माह की 5 तारीख तक
A1.8.2.5	Anaemia **एनीमिया**	
A1.8.2.6	Bad Obstetric History **खराब प्रसूति इतिहास**	
A1.8.2.7	Convulsions **ऐंठन/दौरा पडना**	
A1.8.2.8	Diabetes **मधुमेह**	
A1.8.2.9	More than one complications **एक से ज्यादा जटिलताऐं**	
A1.8.2.10	any other **कोई अन्य कारण**	
A2	**DELIVERIES** **प्रसव**	
A2.1	**Deliveries conducted at Home** **घर पर हुए प्रसव**	
A2.1.1	**Number of Home Deliveries attended by** **घर पर हुए प्रसव किसके दवारा करवाये गये**	
A2.1.1.a	SBA Trained (Doctor/Nurse/ANM) **एसबीए प्रशिक्षित व्यक्ति दवारा (डॉक्टर / नर्स / एएनएम)**	
A2.1.1.b	Non SBA (TBA/Relatives/etc.) **अप्रशिक्षित व्यक्ति दवारा (दाई/ रिश्तेदारों / आदि.)**	
A2.1.1.c	**Total {(a) to (b)}**	
A2.1.2	Number of mothers visited within 24 hours of home delivery by ANM **माताओं प्रसूता की संख्या जिन्हें** 24 **घंटे के अन्दर** ANM **दवारा घर पर भेंट की गई**	
A2.2	**Deliveries conducted at facility** **संस्थागत प्रसव**	
A2.2.1	Out Of which, Number discharged within 48 hours of delivery **प्रसवो की संख्या जो** 48 **घंटे के अंदर डिस्चार्ज हुए हों**	

State: राज्य:		Due for Submission on 5th of following Month जमा करने की अवधि हर माह की 5 तारीख तक
A2.2.1	Out of total A2.2, no. of females couselled on IYCF practices (early initiation,importance of colostrum & exclusive Breastfeeding for 6 months)	
A2.2.2	No. of Delivery Cases Referred Out from facility **संस्था से बाहर रैफर किये गये डिलीवरी** Cases **की संख्या**	
A2.3	**JSSK Benefit (No Out of Pocket expenditure)** **जननी शिशु सुरक्षा कार्यक्रम (JSSK) के तहत लाभ (बिना कोई जेब खर्च का)**	
A2.3.1	**No. of Pregnant Women who delivered at the facility; out of which who received following** **गर्भवती महिलाओं की संख्या जिनका संस्था मे प्रसव हुआ हो व जिन्हें निम्न सुविधाये दी गई हो**	
A2.3.1a	Free Drugs & Consumables **मुफ्त दवाऐं और कनजूमैब्ल**	
A2.3.1b	Free Diet **मुफ्त डाइट**	
A2.3.1c	Free Diagnostic **मुफ्त डायग्नोस्टिक**	
A2.3.1d	Free Referral Transport Home to facility **घर से संस्था के लिए मुफ्त रेफरल वाहन सेवा**	
A2.3.1e	Free Referral Transport Drop back to Home **घर के लिए ड्रॉप बैक के लिए मुफ्त रेफरल वाहन सेवा**	
A2.3.1f	Free Referral Transport to higher level facility for complications **प्रसव संबन्धित जटिलताओं के लिए उच्च स्तर की संस्था मे रेफरल के लिए प्रयोग किये गये मुफ्त रेफरल वाहन की सेवा**	
A3	**Pregnancy outcome & details of new-born** **प्रसव का परिणाम व नवजात शिशु जानकारी**	
A3.1	**Pregnancy Outcome (in number) (Facility + Home)** **प्रसव का परिणाम (संख्या में) (संस्थागत एंव होम)**	

State: राज्य:		Due for Submission on 5th of following Month जमा करने की अवधि हर माह की 5 तारीख तक		
A3.1.1	**Live Birth** **लाइव बर्थ**	**Facility** **संस्थागत**	**Home** **होम प्रसव**	**Total**
A3.1.1a	Male **(बालक)**			
A3.1.1b	Female **(बालिका)**			
A3.1.1c	**Total {(a) to (b)}**			
A3.2	**Still Birth** **स्टिल बर्थ**	**Facility** **संस्थागत**	**Home** **होम प्रसव**	**Total**
A3.2a	Male **मेल फ्रेश**			
A3.2b	Female **फिमेल**			
A3.2e	**Total**			
A3.3	**No of Abortion (spontaneous)** **गर्भपात (स्वतः) की संख्या**			
A3.4	**Gestational Age at Birth (Live + Still Births)** **जन्म के समय गर्भकाल**	**Male**	**Female**	**Total**
A3.4.1	Early Preterm Births (upto 34 weeks)			
A3.4.2	Preterm Births (>34 and upto 37 weeks)			
A3.4.3	Term Births (>37 and upto 42 weeks)			
A3.4.4	Post Term Births (>42 weeks or more than 294 days)			
A3.5	**New Born Care Corner (NBCC)** **नवजात देखभाल कॉर्नर (NBCC)**			
A3.5.1				
A3.5.2	Total No. of new born who required resuscitation at birth in Facility **संस्था में रिससिटेट किये गये नवजातों की संख्या**	**Male**	**Female**	**Total**

State: राज्य:		Due for Submission on 5th of following Month जमा करने की अवधि हर माह की 5 तारीख तक		
A3.5.3.4	No of newborns adminstered Inj. Vitamin K within 6 hours of birth **उन नवजातो की संख्या जिन्हे जन्म के 6 घटे के अंदर इंजेक्टेबल विटामिन K दिया हो**			
A3.5.4	Total No. of new born referred out to higher facilities from NBCC **उन नवजातों की संख्या जिन्हें एनबीसीसी से उच्च स्वास्थ्य केंद्रों में रैफर किया गया हो**			
A3.6	**Details of Newborn children weighed** **नवजात शिशुओं का वजन विवरण**	**Male**	**Female**	**Total**
A3.6.1	Number of Newborns weighed at birth **उन नवजात शिशुओं की संख्या जिनका जन्म उपरान्त वजन किया**			
A3.6.2	Weight < 1500 gm			
A3.6.3	Weight 1500-2499 gm			
A3.6.4	Weight > 2500gm			
A3.7	Number of Newborns breast fed within 1 hour **जन्म के एक घंटे के भीतर स्तनपान कराये गये नवजातों की संख्या**			
A3.7	Number of Newborns breast fed within 1 hour **जन्म के एक घंटे के भीतर स्तनपान कराये गये नवजातों की संख्या**			
A3.8	No of children given prelacteal feed like Janam Ghutti, Tea, honey etc **उन बच्चों की संख्या जिन्हें** prelacteal **फ़ीड जैसे की जन्म घुटटी, चाय, शहद आदि दिया गया**			
A4	**Post - Natal Care** **पोस्ट नेटल केयर**	**ANM**		
A4.1	Women receiving first post partum checkup within 48 hours of **home delivery** (by ANM & ASHA) **उन महिलाओं की संख्या जिनकी होम डिलीवरी उपरान्त** 48 **घंटे के अन्दर प्रथम प्रसवोत्तर जांच की गई हो** (ANM **एवं आशा द्वारा**)			

State: राज्य:		Due for Submission on 5th of following Month जमा करने की अवधि हर माह की 5 तारीख तक
A4.1 a	Women getting a post partum check up between 48 hrs and 14 days (by ANM & ASHA) **उन प्रसूता महिलाओं की संख्या जिनकी** 48 **घंटे से** 14 **दिनो के अन्दर प्रसवोत्तर जांच की गई** (ANM **एवं आशा द्वारा**)	
A4.2	No. of women who delivered at any private/govt institutions and discharged early and given 1st PNC visit within 48 hours(by ANM) **संस्थागत डिलीवरी उपरान्त** 48 **घंटे के अन्दर डिस्चार्ज हुई महिलाए जिनकी प्रथम प्रसवोत्तर जांच हुई हो** (ANM **द्वारा**)	
A4.8	No. of Women getting complete post partum check up by ANM upto 6 weeks in this month **उन प्रसूता महिलाओं की संख्या जिन्हें** 6 **सप्ताह तक** ANM **द्वारा सभी प्रसवोत्तर सुविधाऐं दी गई**	
A4.9	**No. of Women identified and referred out due to PNC Complication with following reasons:** **प्रसवोत्तर कोमप्लिकेशन (जटिलता) की पहचान एंव रैफर**	**ANM**
A4.9.1	PPH (Heavy Bleeding) **प्रसवोत्तर रक्तस्त्राव (भारी रक्तस्त्राव)**	
A4.9.2	Hypertension (including all cases of convulsion/fits) **उच्च रक्तचाप (दौरे/ फिट)**	
A4.9.3	Perpural Sepsis (infection with high grade fever/ Foul Smelling Discharge) **ज़च्चा सेप्सिस (उच्च ग्रेड बुखार / बदबू निर्वहन के साथ संक्रमण)**	
A4.9.4	Wound abcess (episiotomy wound/ C-section wound) **घाव फोड़ा** (episiotomy **घाव / सीजेरियन घाव**)	
A4.9.5	UTI (Lower Abdominal pain with burning micturation with or without fever) **यूटीआई**	
A4.9.6	Post Partum psychosis **प्रसवोत्तर मनोविकृति**	
A4.9.7	Anaemia (<7gm) **एनीमिया** (<7gm)	

State: राज्य:		Due for Submission on 5th of following Month जमा करने की अवधि हर माह की 5 तारीख तक
A4.9.8	Any other problem in passing urine, stool **कोई अन्य समस्या (मूत्र, मल के पारित होने मे या अन्य)**	
A4.9.9	More than one complications **एक से ज्यादा जटिलताऐं**	
A4.11	No. of New Borns visited with 3 (three) PNC with in 10 days of birth (Home + Institutional Births) **नवजातों की संख्या जिन्हे जन्म के 10 दिनों के अंदर ANM द्वारा 3 (तीन) पीएनसी भेंट की गई (होम एंव संस्थागत डिलीवरी)**	
A4.12	**No. of New Borns identified and referred out to Higher Facilities with following reasons:** **नवजात शिशुओं की संख्या जिन्हे उच्च स्तर की संस्था मे रैफर निम्नलिखित कारणों के पहचान के कारण किया गया**	**ANM**
A4.12.1	Convulsion/fits **दौरा/ फिट**	
A4.12.2	Fast breathing (>=60) **सांस का तेज चलना (> = 60)**	
A4.12.3	Severe Chest indrawing **छाती का धंसना**	
A4.12.4	Not taking feed **मां का दूध ना लेना**	
A4.12.5	Temperature < 97.6 or > than 99.5 F or <36.5 or > 37.5 C **तापमान <97.6 या> तुलना में 99.5 F या <36.5 या> 37.5 C**	
A4.12.6	Baby Lethargic/ Poor activity **बच्चे का सुस्त पड़ना**	
A4.12.7	10 or more skin pustules or 1 large boil **दस या अधिक त्वचा मे फुंसीया या एक बड़ा फोड़ा होना**	
A4.12.8	Yellow soles or palms **तलवों या हथेली का पीला पड़ना**	
A4.12.9	Weight at Birth < 2000 gm **जन्म के समय वजन <2000 ग्राम**	

State: राज्य:		Due for Submission on 5th of following Month जमा करने की अवधि हर माह की 5 तारीख तक	
A4.12.10	Newborn with more than one danger signs(any combination) **नवजातों की संख्या जिनमे एक से अधिक खतरे के निशान पाये गये (ऐनी कॉम्बिनेशन)**		
A6	**Patient Services** **रोगी सेवाएँ**	**Planned**	**Conducted**
A6.1	No of Anganwaadi centres reported VHNDs **आंगनबाड़ी केन्द्रों की संख्या जहां** VHND **हूए हों**		
A6.3	**Outpatient Services** **आउट पेशेंट सेवाएँ**		
A6.3.1	OPD attendance (All) **ओपीडी उपस्थिति (सभी)**		
A7	**Laboratory Testing** **प्रयोगशाला परीक्षण**		
A7.1	Number of Hb tests conducted (Non ANC cases only) Non ANC cases **के एचबी परीक्षणों की संख्या**		
A7.2	Of which Number having Hb < 7 gm (Non ANC only) Non ANC cases **में से जिनका एचबी 7 ग्राम से कम हो**		
A7.3	No. of sreening Tests done for Urine Sugar **मूत्र में शुगर एंड एल्बुमिन के लिए किए गये स्क्रीनिंग टेस्ट की संख्या**	**ANC**	**Non-ANC**
A7.5	No. of Patient found Positive for Urinary Sugar **मूत्र में शुगर के लिए पॉजिटिव पाये गये** Patient **की संख्या**		
	No. of sreening Tests done for Urine Albumin **मूत्र में शुगर एंड एल्बुमिन के लिए किए गये स्क्रीनिंग टेस्ट की संख्या**		
A7.4	No. of Patient found Positive for Urinary Albumin **मूत्र एल्बुमिन के लिए पॉजिटिव पाये गये रोगीयो की संख्या**		

ANNEX D: DHIS MONTHLY FORM FOR PHCS AND CHCS

State:			**Due for Submission on 5th of following Month**		
District:		**Month**			
Block/CHC:		**Year**			
City/ Town/ Village:					
Facility name					
Facility Type	**Public** ○ **Private** ○				
Location	**Rural** ○ **Urban** ○				

SINGLE REPORTING PROFORMA FOR GH/SDH/CHC/PHC/EQUIVALENT FACILITIES/VIRTUAL FACILITIES

A. MATERNAL HEALTH		
A1	**Ante Natal Care Services (ANC)**	
A1.1	Total number of **new** ANC Examined in OPD (first visit)	
A1.1.1	Total No. of ANC examined in 1st trimester (out of A1.1) (within 12 weeks)	
A1.2	**Number of pregnant women given TT immunization (By Staff Nurses/ in OPD/ on Daily Basis at PHC/CHC/SDH)** Note: To give TT immunization report & Iron Tablet Report, these two things must be issued to OPD/ Labour Room Staff Nurse & she has to maintain the register	
A1.2.1	TT1	

State:			Due for Submission on 5th of following Month
A1.2.2	TT2 given and TT Booster given		
A1.3	**Number of pregnant women given Iron Folic Acid Tablets/ Syrup, Albendazole, Calcium & Vitamin Tablets (One PW will be counted only once during pregnancy)**		
A1.3.1	Number of pregnant women given full course of 100 IFA tablets [Large (Mother) Prophylactic] by the facility		
A1.3.2	Number of pregnant women given full course of 200 IFA tablets [Large (Mother) Therapeutic] by the facility		
A1.3.3	Number of **new** Pregnant women initiated on 50 Folic Acid tablets in the first trimester in the reporting month by the facility.		
A1.3.4	Number of **new** Pregnant women given Albendazole tablets in the second trimester in the reporting month		
A1.3.5	Total number of Pregnant women initiated at facility on Calcium in the reporting month		
A1.3.6	Total number of new Pregnant women initiated on Vitamin B12 tablets/capsule		
A1.3.7	Total number of new Pregnant women initiated on Vitamin C/tablets capsule		
A1.4	**Pregnant women with Hypertension (BP=>140/90) (One PW will be counted only once during pregnancy)**		
A1.4.1	New cases detected at facility (One PW will be counted only once during pregnancy)		
A1.5	**Pregnant women with Anaemia during reporting month (One PW will be counted only once during pregnancy)**		
A1.5.1	Number having Hb level 7-11 (tested cases) (based on the first time test conducted).		
A1.5.2	Number having Hb level < 7 gm (based on the first time test conducted)		
A1.5.2a	Out of which, Number having Hb < 7 gm **treated/ managed** at Institution		

State:			**Due for Submission on 5th of following Month**		
A1.5.3	No. of Women given Injectable Iron (**1st dose** only)				
A2	**Deliveries**	**Normal Deliveries**	**Instrumental (Forceps / Vaccum) Deliveries**	**C- Section at facility**	**Total**
A2.1	Deliveries conducted at facility				
A2.1.1	Of which Number discharged within 24 hours of delivery				
A2.1.2	Of which Number discharged within 24- 48 hours of delivery				
A2.1.3	Of which Number discharged after 48 hours of delivery				
A2.2	**Number of cases where Janani Suraksha Yogna (GOI) incentive for institutional delivery Paid to:**	**RURAL**		**URBAN**	
		BPL	**SC**	**BPL**	**SC**
A2.2.a	*Mothers*				
A2.2.b	*ASHAs*				
A2.3	Number of cases where Janani Suraksha Yogna (GOI) incentive paid to mothers for **home delivery**				
A2.4	***No. of Cases where JSY State plan incentive paid to SC Beneficiary***	**Total No. of SC Beneficiaries**			
A2.4.1	*Rural government institutional*				
A2.4.2	*Urban government institutional*				
A2.4.3	*Private Institutional*				
A 2.5	**JSSK Benefit (No Out of Pocket Expenditure)**				
A2.5.1	**No. of Pregnant Women who delivered at the facility; out of which who**	**Normal / Instrumental**	**Caesarean**	**Total**	

State:			Due for Submission on 5th of following Month	
	received	**Deliveries**	**Section**	
A2.5.1.1	Free Drugs & Consumables			
A2.5.1.2	Free Diet			
A2.5.1.3	Free Diagnostic			
A2.5.1.4	Free Blood			
A2.5.1.5	Free Referral Transport Home to Health Instt.			
A2.5.1.6	Free Referral Transport Drop back to Home			
A2.5.1.7	Free Referral Transport to higher level facility for complications			
A2.5.2	**Total No. of Sick Neonates who availed the JSSK Benefit**	**Free Drugs & Consumables**	**Free Diagnostic**	**Free Blood**
A2.5.2a	Free Referral Transport Home to Health Inst			
A2.5.2b	Free Referral Transport Drop back to Home			
A2.5.2c	Free Referral Transport to higher level facility for complications			
A3	**Delivery outcome & details of new-born**			
A3.1	**Delivery Outcome (in number)**			
A3.1.1	**Live Birth**			
A3.1.1a	Male			
A3.1.1b	Female			

State:			Due for Submission on 5th of following Month	
A3.1.1c	Total {(a) to (b)}			
A3.2	**Still Birth**	**Male**	**Female**	**Total**
A3.2a	Fresh			
A3.2b	Macerated			
A3.2c	Total {(a) to (b)}			
A3.3	No. of **Abortion (spontaneous/ induced)**			
A3.4	**Gestational Age at Birth**	**Male**	**Female**	**Total**
A3.4.1	Early Preterm Births (less than 34 weeks)			
A3.4.2	Preterm Births (more than 34 weeks and less than 37 weeks)			
A3.4.3	Term Births (between 37 and 42 weeks)			
A3.4.4	Post Term Births (beyond 42 weeks or more than 294 days)			
A3.5	**New Born Care Corner (NBCC)**	**Labour room**	**OT**	
A3.5.1	Is NBCC functional at ? (0-N, 1-Y)			
A3.5.2	No. of new born baby born at facility with spontaneous cry	**Male**	**Female**	**Total**
A3.5.3	Total No. of new born who required **resuscitation** at birth	**Male**	**Female**	**Total**
A 3.5.3.1	Out of, A 3.5.3, Number of New Borns resuscitated with bag and mask			
A3.5.3..2	Out of, A 3.5.3, number of newborns with Hypothermia			

State:			Due for Submission on 5th of following Month		
A3.5.3..3	Out of, A 3.5.3, number of newborns managed using radiant warmer				
A3.5.3..4	Out of, A 3.5.3, number of newborns administered Inj. Vitamin K within 6 hours of bith				
A3.5.4	No. of New Borns referred from **Maternity Ward/ labour room to SNCU** of Facility				
A3.5.5	No. of New Borns referred out to **Higher Facilities**				
A3.5.5.1	Out of referred No. of new borns availed Referral Transport System(102)				
A3.6	**Details of Newborn children weighed**	**Male**	**Female**	**Total**	
A3.6.1	Number of Newborns weighed at birth (out of A3.1.1c)				
A3.6.2	Weight <1000 gm				
A3.6.3	Weight 1000-1499 gm				
A3.6.4	Weight 1500-1999				
A3.6.5	Weight 2,000-2,499 gms				
A3.6.6	Weight 2,500 gms and above				
A3.7	Number of Newborns **breast fed** within 1 hour				
A3.8	Number of children given prelactal feed like Janam Ghutti, Tea, Honey etc.				
A3.9	**Total number of Complicated pregnancies**				
A3.9.1	**Number of Complicated pregnancies treated with**				
A3.9.1a	Intra Venous Antibiotics				

State:			Due for Submission on 5th of following Month
A3.9.1b	Intra Venous Antihypertensive		
A3.9.1c	IV/ IM Magsulf		
A3.9.1d	Intra Venous Oxytocis		
A3.9.1e	Blood Transfusion		
A3.9.1f	4 Tab. Misoprosol P/R (Adult dose: 200mg x 4 tab)		
A3.9.1g	Total Complicated Pregnancies treated		
A3.9.2	Number of Eclampsia cases managed during delivery (Out of A 1.4.1)		
A3.10	**Treatment of Referred Pregnant Women in facility**		
A3.10.1	No. of Referred cases(Pregnancies) treated		
A3.10.2	**No. of Pregnancy/Delivery cases Referred to Higher Institution(Give Reasons):-**		
A3.10.2.1	**Pregnancy Cases**		
A3.10.2.1a	Ante partum heamorrhage (APH) (Vaginal Bleeding)		
A3.10.2.1b	Multiple Pregnancy		
A3.10.2.1c	Hypertension/ Pregnancy Induced Hypertension (PIH)		
A3.10.2.1d	Malpresentation		
A3.10.2.1e	Anaemia		
A3.10.2.1f	Bad Obstetric History		
A3.10.2.1g	Convulsions		
A3.10.2.1h	Diabetes		

State:			Due for Submission on 5th of following Month		
A3.10.2.1i	More than one complications				
A3.10.2.1j	Other				
A3.10.2.2	**Delivery Cases**				
A3.10.2.2a	Pre eclampsia and Eclampsia				
A3.10.2.2b	PPH (Heavy Bleeding)				
A3.10.2.2c	Sepsis				
A3.10.2.2d	Obstructed labour				
A3.10.2.2e	Non progress of labour				
A3.10.2.2f	foetal Distress (Normal FHS is 120 to 160)				
A3.10.2.2g	More than one complications				
A3.10.2.2h	Other				
A3.11	**Medical Termination of Pregnancy (MTP)**				
A3.11.1	**Number of MTPs conducted at facility**	**Surgical**	**Drugs**	**Total**	
A3.11.1a	Up to 12 weeks of pregnancy				
A3.11.1b	More than 12 weeks of pregnancy				
A3.11.1c	Total				
A3.11.2	**AGE-WISE MTP**				
A3.11.2a	Less than 15 yrs				

State:			Due for Submission on 5th of following Month
A3.11.2b	15-19		
A3.11.2c	20-24		
A3.11.2d	25-29		
A3.11.2e	30-34		
A3.11.2f	35-39		
A3.11.2g	40-44		
A3.11.2h	45 & above		
A3.11.2i	**Total (Agewise)**		
A3.11.3	**RELIGION-WISE MTP**		
A3.11.3a	Hindu		
A3.11.3b	Muslim		
A3.11.3c	Christian		
A3.11.3d	Sikh		
A3.11.3e	Others		
A3.11.3f	**Total (Religion-wise)**		
A3.11.4	**REASON FOR TERMINATION OF PREGNANCY**		
A3.11.4a	Danger to life of Pregnant Women		
A3.11.4b	Grave injury to the physical health of the pregnant woman		
A3.11.4c	Grave injury to the mental health of the pregnant woman		

State:			Due for Submission on 5th of following Month	
A3.11.4d	Pregnancy caused by rape			
A3.11.4e	Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities to be seriously handicapped.			
A3.11.4f	Failure of any contraceptive device or method			
A3.11.4g	**Total**			
A3.11.5	No. of **Death** Reported due to MTP			
A3.11.6	No. of **Complications** reported under MTP			
A4	**Post - Natal Care**			
A4.1	No. of Women receiving first post partum checkups within 48 hours after delivery			
A 4.1.1	No. of newborns receiving first post natal checkups within 48 hours after birth			
A 4.1.2	Total number of stable LBW/ preterm newborns managed with Kangaroo mother Care			
A 4.1.3	Total number of newborns with cord/ eye infection			
A4.2	Women getting a post partum checkup between 48 hours and 14 days			
A4.3	PNC maternal complications attended at facility (within 21 days of delivery)			
A5	**Reproductive Tract Infections/Sexually transmitted infections (RTI/STI) Cases**			
A5.1	Number of new RTI/STI identified for treatment	***Male***	***Female***	**Total**
A5.2	Number of new RTI/STI counselled for treatment			

State:			Due for Submission on 5th of following Month		
A5.3	Number of new RTI/STI for which treatment initiated				
A5.4	Number of new RTI/STI referred out to higher facility for treatment				
A5.5	Number of wet mount tests conducted				
A6	**MATERNAL DEATHS**				
A6.1	Abortion				
A6.2	Obstructed/prolonged labour				
A6.3	Severe hypertension/fits				
A6.4	APH				
A6.5	PPH				
A6.6	High fever				
A6.7	Anaemia as cause of Direct/Associated with other Medical Disease				
A6.8	Other Causes (including causes not known)				
A7	No. of MDR done during the month				
A8	No. of Neonatal death audit during the month				

ANNEX E: PATIENT TRACKING PORTALS

Anaemia Tracking Data	Infant Deaths and Still Birth Line Listing Data Sample	Maternal Deaths Line Listing Data Sample	AWC Childern Line Listing Data Sample	School Students Line Listing Data Sample
Report Type	Department	Mother_ID	Child_ID	Child_ID
Facility Name	Date Of Entry	Department	IBSY_AWC_Card_ID	IBSY_Child_health_card_school_ID
District Name	Year1	year1	Name_of_Child	Name_of_Child
Entry Date	Year2	year2	Sex	Sex
Name Of Pregnant Women	Official Record Reference	Official_Record_Reference	Father	Class
Husband Name	Type Of Informer	Informer_Type	Mother	Section
Rural_Urban	Name Of Informer	Informer_Name	Contact_No	Father
SubCenter	Informer Contact	Informer_Contact	Address	Mother
Town_Village	Is Stillbirth/Infant	Deceased_Name	Date_of_Visit	Contact_No
Permanent Address	Deceased Name	Husband_Name	Age	Address
Phone No	Father Name	Husband_Contact	Ageinmonths	Date_of_Visit
Age	Mother Name	Deceased_Age	AgeInDays	Age
Religion	Father Contact	State	Weight	Ageinmonths

Anaemia Tracking Data	Infant Deaths and Still Birth Line Listing Data Sample	Maternal Deaths Line Listing Data Sample	AWC Childern Line Listing Data Sample	School Students Line Listing Data Sample
Caste	Age In Months	Permanent_Address	Height	Weight
Admission Date	Age In Days	District Name	W_H_Classification	Height
Admission Time	Age In Hrs	CHC Project Name	MUAC	BMI
HB Teste at time of Admission	Gender	PHC Sector	Bilateralpitting	BMIClass
BP Diastolic Recorded At AdmissionTime	PermanentAddress	SubCenter Name	BPO	BP_systolic
BP Systolic Recorded At AdmissionTime	State	Village Name	WtHtRatio	BP_Diastolic
Urine Tested	District Name	AWWName	HB	Defects_at_Birth
Term	CHC Project Name	Death_Date	HeadCircumference	Deficiencies
Delivery Date	PHC Sector	Death_Place	Defects_at_Birth	Childhood_Diseases
Delivery Time	SubCenter	Death_Place_Address	Deficiencies	Developmental_dealy_and_ disability
Delivery Conducted	Village/ICDSVillage	Place_Of_Delivery	Childhood_Diseases	Adolosent
No Of Baby	Village Name	Period_Of_Death	Developmental_dealy_and _disability	Other
Refer To Higher	Death Date	Cause_Of_Death	Other_diseases	On_the_spot_treatement
PPIUCD Insertion	Date Of Birth	Religion	On_the_spot_treatement	Already_on_Treatment

Anaemia Tracking Data	Infant Deaths and Still Birth Line Listing Data Sample	Maternal Deaths Line Listing Data Sample	AWC Childern Line Listing Data Sample	School Students Line Listing Data Sample
Type Of PPIUCD Insertion	Place Of Death	Caste	Already_on_Treatment	If_referred_Place_of_Referral
Instrument used	Place Of Address	Pregnancy_Outcome	Referr_place	Name_of_Visiting_Doctor
Woman Edu Status	Place Of Delivery	User id	If_referred_Place_of_Referral	Contact_of_Visiting_Doctor
Husband Edu Status	Cause	Date of Entry	Name_of_Visiting_Doctor	dateofentry
Woman Counselled By	Religion		Contact_of_Visiting_Doctor	userid
	Caste		DiagnosisStatus	Child_id1
			AttendanceStatus	Unique_Child_ID
			dateofentry	recID
			userid	Name
			Child_id1	Father1
			Unique_Child_ID	Mother1
			recID	Sex1
			Name	Contact
			Father1	Address1
			Mother1	School_AWC
			Sex1	MCTSNo

Anaemia Tracking Data	Infant Deaths and Still Birth Line Listing Data Sample	Maternal Deaths Line Listing Data Sample	AWC Childern Line Listing Data Sample	School Students Line Listing Data Sample
			Contact	AadhaarNo
			Address1	Id
			School_AWC	Unique_School_Id
			MCTSNo	Date_of_entry
			AadhaarNo	Date_of_Visit1
			id	District
			Dateofentry1	CHC
			uid	PHC
			district	Mobile_health_Team_ID
			chc	Village
			phc	School_Name
			date_of_visit1	School_Id
			mht_ID	Contact_details_of_School
			village	Type_of_school
			awc	Category_of_school
			aww	Year1
			contact1	Year2

Anaemia Tracking Data	Infant Deaths and Still Birth Line Listing Data Sample	Maternal Deaths Line Listing Data Sample	AWC Childern Line Listing Data Sample	School Students Line Listing Data Sample
			year1	Name_of_head_of_school
			year2	Contact_of_Head_of_School
			cdpo	Name_of_BEO
			contactcdpo	Contact_no_of_concerned_BEO
			enrolledChildern	No_of_Enrolled_Childern
			maleChildern	No_of_Enrolled_MaleChildern
			femaleChildern	No_of_Enrolled_FemaleChildern
			user_id	User_Id
			Round	id1
			ID1	district1
			District1	dcode
			CHC1	chc1
			PHC1	chcID
			Village1	phc1
			AWC1	phcID
			AWW1	village1
			Contact2	Vcode

Anaemia Tracking Data	Infant Deaths and Still Birth Line Listing Data Sample	Maternal Deaths Line Listing Data Sample	AWC Childern Line Listing Data Sample	School Students Line Listing Data Sample
			AWCID	SchoolName
			EnrolledChildern I	SchoolID
			TeamID	TeamID

ANNEX F: PGIMER CONCURRENT EVALUATION QUESTIONNAIRE

Concurrent Evaluation of NRHM:
The Haryana Health Survey

District: _____

CHC:_____

PHC:_____

Sub Centre: _____

Type of locality *(See code)*: ☐

Village/ Urban ward: _____

Is the sub-centre located in this village? ☐
(See code)

If no, approximate distance of sub-centre from village (in km) _____

Form S. No. __ __ __ - __ - __ __ - __ __ - __ __ __

A. Area and household characteristics

1. Name of the respondent:
   _____
2. Head of the household:
   _____
3. Religion *(See code)*: ☐
4. Social group *(See code)*: ☐
5. Occupation *(See code)*: ☐
6. Education *(See code)*: ☐
7. Does this household have a Below Poverty Line (BPL) card? *(See code)*: ☐
8. What is the current monthly family income? Rs. _____
9. Did any usual resident of this household including children die within last 1 year? *(See code)*: ☐
10. If yes, what was the age at death?
    ____ years, _____ months, _____ days
    Don't know... 998 N/A...999

    Gender of the person: ☐

    Education of the person *(See code)*: ☐

    Occupation of the person *(See code)*: ☐

    Relationship to head:
    _____

    Was the person hospitalised at the time of death? Yes...1 No...2

11. Household Assets (for assessing socioeconomic status) *(See codes)*:
    a. Type of house ☐
    b. Main source of drinking water ☐
    c. Main source of lighting ☐
    d. Main type of fuel used for cooking ☐
    e. Ownership of any irrigated agricultural land ☐
    f. Ownership of any livestock ☐
    g. Ownership of house ☐
    h. Toilet facility ☐

11 i. Household items present *(See codes)*							
A cot or bed?		A bicycle/ tricycle?		A radio or transistor?		A sewing machine?	
A mattress?		A motorcycle or scooter?		A black & white television?		A pressure cooker?	
A sofa set?		An animal-drawn cart?		A colour television?		A water pump?	
A table?		A car?		A computer?		An air cooler?	
A chair?		A tractor?		A mobile telephone?		A refrigerator?	
Any watch or clock?		A thrasher?		Any other type of telephone?		A washing machine?	

Household Composition

Person ID	Name	Age (y/m)	Sex (m/f)	Marital status*	Relation to head#	Education *(See code for Question No.6)*	Occupation *(See code for Question No.5)*	Whether delivered a child in last 1 year (yes/no)	Whether currently pregnant (yes/no)	Any Illness in last 15 days (yes/no)	Any hospitalisation in last 1 year (yes/no)
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
11.											
12.											
13.											

*Single/Married/ Widow or widower/ Divorced

Self/ Wife/ Husband/Father/ Mother/ Father-in-law/ Mother-in-law/ Brother/ Brother's wife/ Sister/ Sister's husband/ Son/ Daughter-in-law/ Daughter/ Son-in-law/ Grandson/ Grand-daughter-in-law/ Grand-daughter/ Grandson-in-law/ Uncle/ Aunty/Domestic help/Others

Household Composition

Person ID	Name	Age (y/m)	Sex (m/f)	Marital status*	Relation to head#	Education *(See code for Question No.6)*	Occupation *(See code for Question No.5)*	Whether delivered a child in last 1 year (yes/no)	Whether currently pregnant (yes/no)	Any Illness in last 15 days (yes/no)	Any hospitalisation in last 1 year (yes/no)
14.											
15.											
16.											
17.											
18.											
19.											
20.											
21.											
22.											
23.											
24.											
25.											

*Single/Married/ Widow or widower/ Divorced

Self/ Wife/ Husband/Father/ Mother/ Father-in-law/ Mother-in-law/ Brother/ Brother's wife/ Sister/ Sister's husband/ Son/ Daughter-in-law/ Daughter/ Son-in-law/ Grandson/ Grand-daughter-in-law/ Grand-daughter/ Grandson-in-law/ Uncle/ Aunty/Domestic help/Others

Form S. No. __ __ __ - __ - __ __ - __ __ - __ __ __

Person ID- __ __ **B - __ __ __**

B. Ante-natal care, delivery, post-natal care and immunization for infant < 1 yr. module

Name of respondent: _____

Relationship to the woman who delivered a child in last year: _____

Name of husband of the woman who delivered child in last year: _____

B.1 Was the last pregnancy of the woman who delivered in last year registered? *(See code)* ☐

If No, go to question number B.9

B.2 With whom was the pregnancy registered? (First point of contact with health services) *(See code)* ☐

B.3 How many times were antenatal check-ups received by her during last pregnancy? _____

Don't know… 998

B.4 If antenatal care was received at least once for last pregnancy, from where was it received? ☐
(Put codes for multiple options, separated by commas, if required)

For others, specify: _____

B.5 Who facilitated or motivated her to avail antenatal care? ☐
(Put codes for multiple options, separated by commas, if required)

For others, specify: _____

B.6 As part of the antenatal care during last pregnancy, were any of the following done at least once?

	Yes	No		Yes	No
Weight measurement	1	2	Abdominal examination	1	2
Height measurement	1	2	Ultrasound	1	2
BP measurement	1	2	Delivery date told	1	2
Blood test	1	2	Delivery advice given	1	2
Urine test	1	2	Nutrition advice given	1	2

B.7 During the last pregnancy, how many of the following were received from ANM/Govt. Medical Officer: *(Put 998 if the respondent doesn't know the answer)*

Number of Iron Folic Acid (IFA) Tablets _____ Number of Syrup bottles _____

How many Iron Folic Acid (IFA) Tablets/Syrup bottles were taken by the woman and for how many days? *(Put 998 if the respondent doesn't know the answer)*

IFA Tablets

Number of days _____

Number of tablets _____

IFA syrup

Number of days _____

Number of bottles _____

B.8 During last pregnancy, how many times were Tetanus injections received? _____ Don't know/998

1

Jump to question B.10

B.9 Why was the pregnancy not registered/antenatal check-ups not done? ☐
(Put codes for multiple options, separated by commas, if required)

For others, specify: _____

B.10 What was the outcome of pregnancy? *(See code)* ☐

If the answer to B.10 is option 3, terminate the interview for Section B; otherwise proceed to next question.

B.11 Where did the last delivery take place? *(See code)* ☐

Others, specify _____

B.12 Are you aware of *Janani Suraksha Yojana* (JSY)? *(See code)* ☐

B.13 Did the woman receive any Govt. financial assistance for delivery care under the *Janani Suraksha Yojana* (JSY) / State Specific Scheme? *(See code)* ☐

B.14 Did ASHA escort/accompany the pregnant woman to health facility for delivery? *(See code)* ☐

B.15 Did ASHA stay with the concerned woman in the health facility till after delivery? *(See code)* ☐

B.16 Date of delivery (dd – mm – yyyy) : ____ ____- ____ ____ - ____ ____ ____ ____

B.17 What was the type of delivery? *(See code)* ☐

B.18 How was the facility for delivery reached? *(See code)* ☐

Others, specify: _____

B.19 What transport was used to go back home? *(See code)* ☐

Others, specify: _____

If answer to B.18 or B.19 is option 1, proceed to question number B.21; Otherwise, continue to B.20

B.20 Are you aware of Ambulance 102 service? *(See code)* ☐

B.21 Expenditure incurred for delivery:

Hospital charges	_____	Transportation	_____
Doctor's /Nursing staff fee	_____	Others	_____
Medicines	_____	Total expenditure	_____
Diagnostic tests	_____		
Boarding/ Lodging for relatives	_____	Expenditure incurred, but not in knowledge	☐

B.22 During the first 6 weeks after delivery did the woman experience any of the following health problems?

	Yes	No		Yes	No
• Foul smelling vaginal discharge	1	2	• Lower abdominal pain	1	2
• Excessive bleeding	1	2	• Convulsions	1	2
• High fever	1	2	• Severe headache	1	2

• Any other? _____

2

If the answer to B.10 was option 2, terminate the interview for Section B; Otherwise proceed to question number B.23

New-born and Infant Care

B.23 How many days after delivery did you return to your present home? No. of days _____

B.24 a) How many days after delivery did the mother and child's first post natal check-up take place?

Number of days _____ Don't know... 998 Has not taken place as yet… 999

B.24 b) Where did the first post natal check-up take place? *(See code)* ☐

Others, specify _____

B.25 Did ASHA do any post natal check up visit? *(See code)* ☐

B.26 If yes, how many times did ASHA pay a post natal visit within 10 days of delivery?

No. of visits _____ Don't know... 998

B.27 How many home visits were made by the ASHA to check the child during first 42 days of birth?

No. of visits: _____ Don't know... 998

B.28 How many home visits were made by the ANM to check the child during first 28 days of birth?

No. of visits: _____ Don't know... 998

B.29 When did the first breastfeeding take place for this child? *(See code)* ☐

B.30 Was milk colostrum "*khees*" (yellowish thick milk), secreted by mother during the first few days after child birth, fed to the child? *(See code)* ☐

B.31 In the first 1 hour of birth, what else was given to the child before starting breast milk? ☐
(Put codes for multiple options, separated by commas, if required)

Others (specify) _____

B.32 During the first six months of child, what else was given to the child apart from breast milk? ☐
(Put codes for multiple options, separated by commas, if required)

Others (specify) _____

B.33 Is exclusive breastfeeding still continuing Yes ☐ No ☐

If no, for how many days/ months was the child exclusively breastfed? (Nothing other than mother's milk)

Months:_____

(If less than one month, write number of days) Days:_____

B.34 Did the baby ever fall sick during first 28 days of birth? *(See code)* ☐

B.35 If yes, whether it received any treatment? *(See code)* ☐

B.36 If yes, where was the treatment taken? ☐
(Put codes for multiple options, separated by commas, if required)

Others, specify _____

3

B.37 Cost of treatment:

Hospital charges	_____	Transportation	_____
Doctor's /Nursing staff fee	_____	Others	_____
Medicine	_____	Total expenditure	_____
Diagnostic tests	_____		
Boarding/ Lodging for relatives	_____	Expenditure incurred, but not in knowledge	☐

B.38 Does the family have immunisation card of the child? Yes... 1 No... 2

B.39 Where did the following vaccinations of the child take place? *(See code)*

First vaccination: ☐ Others, specify _____

Last vaccination: ☐ Others, specify _____

B.40 From whom did you come to know about the last vaccination site? *(See code)* ☐

Others, specify _____

B.41 Current immunisation status of the infant:

Vaccine	**Whether received vaccination** $ (Yes…1/ No…2)	**Date of vaccination** $ (dd – mm – yyyy)
BCG*		
OPV# 0		
Hepatitis B 0		
OPV 1		
OPV 2		
OPV 3		
DPT@ 1		
DPT 2		
DPT 3		
Hepatitis B 1		
Hepatitis B 2		
Hepatitis B 3		
LPV% 1		
LPV 2		
LPV 3		
Measles vaccine		
Vitamin A		

$ To be filled by mother's recall if card is not present with the family.
* BCG: Vaccine for prevention of Tuberculosis
# OPV: Vaccine for prevention of Polio
@ DPT: Vaccine for prevention of Diphtheria, Pertusis and Tetanus
% LPV: Liquid Pentavalent Vaccine for prevention of Diphtheria, Pertusis, Tetanus, Hepatitis B and Haemophilus Influenzae

Form S. No. __ __ __ - __ - __ __ - __ __ - __ __ __

Person ID- __ __ **C - __ __ __**

C. Immunisation completeness module for children between 12-23 months of age

Name of the respondent: _____

Relationship to the child: _____

C.1 Do you have the immunisation card of the child? Yes... 1 No... 2

C.2 Current immunisation status of the child:

Vaccine	Whether received vaccination $ (Yes...1 No...2)
BCG*	
OPV# 0	
Hepatitis B 0	
OPV 1	
OPV 2	
OPV 3	
DPT@ 1	
DPT 2	
DPT 3	
Hepatitis B 1	
Hepatitis B 2	
Hepatitis B 3	
LPV% 1	
LPV 2	
LPV 3	
Measles vaccine 1	
Vitamin A 1	
OPV Booster dose	
DPT Booster dose	
Measles vaccine 2	
Vitamin A 2	
Vitamin A 3	

$ To be filled by mother's recall if card is not present with the family.

* BCG: Vaccine for prevention of Tuberculosis

OPV: Vaccine for prevention of Polio

@ DPT: Vaccine for prevention of Diphtheria, Pertusis and Tetanus

% LPV: Liquid Pentavalent Vaccine for prevention of Diphtheria, Pertusis, Tetanus, Hepatitis B and Haemophilus Influenzae

Form S. No. __ __ __ - __ - __ __ - __ __ - __ __ __

Person ID- __ __ **D - __ __ __**

D. Family planning module for 15-45 years married women

Name of the respondent: _____

Relationship to the 15-45 year old married woman: _____

D.1 Are you/your husband currently doing something or using any method to delay or avoid getting pregnant? *(See code)* ☐

If yes, proceed to question number D.5
If no, proceed to next question

D.2 If not using any method, do you want a child now? *(See code)* ☐

If yes, proceed to question number D.8
If no or don't know, proceed to next question

D.3 If no, would you like to have a child in a few years from now? *(See code)* ☐

D.4 Since you don't want a child now, why are you not using any method for contraception? ☐
(Put codes for multiple options, separated by commas, if required)

Others, specify _____

Proceed to question number D.8

D.5 If answer to D.2 is yes, which method are you/your husband currently using to avoid pregnancy? ☐
(Put codes for multiple options, separated by commas, if required)

Other, specify _____

D.6 Where did you obtain it (current method of contraception) the last time? *(See code)* ☐

Others, specify _____

D.7 Who facilitated or motivated you to use current family planning method? ☐
(Put codes for multiple options, separated by commas, if required)

Others, specify _____

D.8 In the last 3 months have you met any of the following for consultation regarding family planning?

	Yes	No
1. ASHA	1	2
2. AWW	1	2
3. ANM	1	2

D.9 In the last few months have you heard/seen any message on family planning on the following:

	Yes	No
1. Radio	1	2
2. Wall paintings/hoardings	1	2
3. Newspaper	1	2
4. Television	1	2
5. Others,specify _____		

1

Form S. No. __ __ __ - __ - __ __ - __ __ - __ __ __

Person ID- __ __ **E - __ __ __**

E. Under-5 year child module

Name of the respondent: _____

Relationship to the child: _____

E.1 Did _____ suffer from diarrhoea in the last two weeks? *(See code)* ☐

If no, proceed to question number E.8; If yes, continue to question number E.2

E.2 During this episode of diarrhoea have you given the following liquids to the child?

	Yes	No		Yes	No
Plain water	1	2	Gruel made from rice (other local grain)	1	2
Salt and sugar solution	1	2			
Fruit juice	1	2	Home remedy	1	2
Lime water	1	2	Child on breast milk	1	2
Others, specify _____					

E.3 Did you give ORS solution to child during this diarrhoea episode? *(See code)* ☐

E.4 How much _____ was breastfed during the last episode of diarrhoea? *(See code)* ☐

E.5 Whether normal feeding was continued during the diarrhoea episode? *(See code)* ☐

E.6 Did you seek advice or treatment for this illness of the child from any source? *(See code)* ☐

E.7 Where did you seek advice or treatment from for this episode? *(See code)* ☐

Others, specify _____

E.8 Has _____ been ill with fever at any time in the last two weeks? *(See code)* ☐

E.9 Has _____ been ill with cough or cold at any time in the last two weeks? *(See code)* ☐

If no, proceed to question number E.13; If yes, continue to question number E.10

E.10 When _____ had this illness with a cough, did he/she breathe faster than usual with short, rapid breaths or have difficulty in breathing? *(See code)* ☐

E.11 Did you seek advice or treatment for the illness of the child from any source? *(See code)* ☐

E.12 If yes, then where did you seek treatment from? *(See code)* ☐

Others, specify _____

E.13 Do you know about the danger signs of Pneumonia? *(See code)* ☐

Form S. No. __ __ __ - __ - __ __ - __ __ - __ __ __

Person ID- __ __ **F - __ __ __ __**

F. Morbidity, Care-seeking and Cost of Care module

F.1 Name:										
F.2 Age:										
F.3 Sex: M / F	Illness in last 15 days				Hospitalization in last 1 year					
F.4 Type of ailment *(See code)*										
F.5 Where did you seek treatment from *(See code)*										
F.6 Cost of treatment per care provider	1	2	3	4	1	2	3	4	5	
Doctor consultation										
Medicines										
Diagnostic tests										
Hospital charges										
Transportation										
Any other										
Total										
F.7 Reason for preferring this care provider during last episode *(Put codes for multiple options, separated by commas, if required)*										
F.8 What problems do you realise when you go to a government facility for seeking health care? *(Put codes for multiple options, separated by commas, if required)*										
F.9 Expenses in item F.6 by source of finance (Rs)										
Salary										
Household income/savings										
Borrowings										
Contributions from friends and relatives										
Insurance cover *(See code)*										
Sale of physical, household assets										
Others										

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BOLD THINKERS DRIVING
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