Minutes of the 38th Meeting of the Advisory Group on Community Action - National Health Mission
Population Foundation of India
July 16, 2018

Members of Advisory Group on Community Action (AGCA) present

1. Mr A R Nanda
2. Dr Abhay Shukla
3. Dr Abhijit Das
4. Mr Alok Mukhopadhyay
5. Mr Gopi Gopalakrishnan
6. Dr H Sudarshan
7. Ms Indu Capoor
8. Dr M Prakasamma
9. Ms Mirai Chatterjee
10. Dr Narendra Gupta
11. Ms Poonam Muttreja
12. Dr Sharad Iyengar
13. Dr Vijay Aruldas

Officials of Ministry of Health and Family Welfare (MoHFW) present

1. Ms Amita Chauhan, Senior Consultant- Public Health Policy and Planning

Officials of National Health Systems Resource Centre (NHSRC) present

1. Mr Arun Srivastava, Consultant- Community Processes

AGCA Secretariat and PFI staff present

1. Mr Krishnan Pallassana, Chief Operating Officer, PFI
2. Mr Bijit Roy, Team Leader, AGCA Secretariat
3. Mr Daman Ahuja, Program Manager, AGCA Secretariat
4. Ms Seema Upadhyay, Program Manager, AGCA Secretariat
5. Mr Saurabh Raj, Program Manager, AGCA Secretariat
6. Mr Sanjoy Samaddar, Program Manager, AGCA Secretariat
7. Ms Jolly Jose, Program Associate, AGCA Secretariat
8. Mr Ravindra Narayan Singh, Programme Coordinator, PFI
9. Ms Sharmistha Chakraborty, Program Manager, PFI

AGCA members who could not attend the meeting

1. Dr Thelma Narayan
2. Dr Saraswati Swain

Permanent invitees who could not attend the meeting

1. Dr Rajani Ved, Executive Director, NHSRC

Ms Poonam Muttreja welcomed the AGCA members to the 38th meeting of the Advisory Group on Community Action (AGCA) and introduced Mr Krishnan Pallassana, Chief Operating Officer and Ms Sharmistha Chakraborty, Programme Manager-Advocating Reproductive Choices (ARC), who joined PFI recently.

Dr Saraswati Swain was unable to attend the AGCA meetings for the last four years due to health reasons. The members suggested the Secretariat sending a letter regarding her availability to contribute time and participate in the AGCA meetings.

The objectives of the meeting were to:

1. Share an update on 'Strengthening Community Action for Health (CAH) under the National Health Mission' programme for the period December 2017 to May 2018.
2. Overview of current priorities of the MoHFW.
3. Discussions on:
   i) Developing a robust and accountable health referral system: Experiences from Rajasthan.
   ii) Priorities:
      a. Role of Civil Society Organisations (CSOs) in facilitating implementation of CAH processes in the states.
      b. Roll out of Decentralised Participatory Health Planning (DPHP).
      c. Monitoring roll out of Comprehensive Primary Health Care.
   iii) Building a Momentum for Universal Health Care.

Members confirmed the minutes of the 37th AGCA meeting held on December 7, 2017.

Compliance on Action Points from the 37th AGCA meeting

Mr Bijit Roy shared an update on the action points identified at the 37th AGCA meeting.

Sl. No.	Action Points	Action taken
1.	Request Mr Manoj Jhalani, Additional Secretary and Mission Director, NHM, MoHFW to deliver the keynote address at the National Consultation on CAH scheduled to be organised on January 24, 2018.	A request was sent to Mr Manoj Jhalani on December 8, 2017.
2.	Organise the National Consultation on CAH on January 24, 2018.	National Consultation was organised on January 24, 2018
3.	Develop a list of community monitoring indicators along with NHSRC, which can be included in the Health Management Information System (HMIS)	Shared with Dr Rajani Ved (Executive Director, NHSRC) on May 15, 2018.
4.	Submit the revised CAH training manual to the MoHFW	Revised CAH training manual was submitted to the MoHFW on March 28, 2018

1. Update on Progress of AGCA Activities for the Period December 2017 to May 2018

An update on the programme 'Strengthening Community Action for Health under the National Health Mission' was shared with the MoHFW and the AGCA members. A copy of the update is enclosed for reference as **Annexure 'A.'**

The group made the following suggestions:

- An analysis of Mera Aspatal (My Hospital) data can be undertaken in coordination with the MoHFW. Since data is not currently available in the public domain, a request can be sent to the MoHFW to share the data.
- Mera Aspatal data has the potential to be used at the Rogi Kalyan Samiti (RKS) meetings for review and planning corrective actions. In addition, hospital score cards generated through Mera Aspatal can be displayed at health facilities for public information.
- Inclusion of monitoring indicators in the Health Management Information System (HMIS) would greatly help in understanding the functioning of VHSNCs and RKSs across blocks and districts in the country. This should be finalised with NHSRC and submitted to the MoHFW.

- The process of triangulation of HMIS and community monitoring data need to be initiated at joint reviews at the PHC, block and district levels.
- A village level dashboard can be developed to display the status on key indicators on health, nutrition and sanitation. This can be displayed at the gram panchayats and sub health centres for the general public. Dr M Prakasamma volunteered to take a lead in developing the dashboard along with the AGCA Secretariat.
- The AGCA Secretariat should send a request to Dr Manohar Agnani, Joint Secretary, Policy, MoHFW to communicate with the State NHM Mission Director, Karnataka to reinitiate CAH processes through Karnataka Health Systems Resource Centre (KHSRC).

2. Brief on MOHFW's current programme priorities

Ms Amita Chauhan, Senior Consultant-Public Health Policy and Planning, MoHFW shared the following current priorities:

- The MoHFW is currently focusing on strengthening two initiatives:
  (i) Accelerating progress on health and social determinants in 115 aspirational districts identified by Niti Aayog across 28 states.
  (ii) Extended Gram Swarajya Abhiyan (EGSA): Recognising the success of the Mission Indradhanush campaign, the MoHFW has extended the Gram Swarajya Abhiyan to more than 49,000 villages and renamed it as EGSA. The campaign's focus is on: (a) operationalizing Health and Wellness Centres (HWCs) in the aspirational districts; (b) increasing immunization coverage through Mission Indradhanush; and (c) encouraging private providers' notification of tuberculosis patients under the Revised National Tuberculosis Control Programme (RNTCP).
- Infrastructure at HWCs is being branded and strengthened with placement of a trained mid-level service provider (Community Health Officer) at the Sub Health Center (SHC) level and an MBBS doctor at the PHC level. The HWCs will mainly focus on rolling out services for screening and referral of Non-Communicable Diseases (NCDs), besides providing the existing package of reproductive and child health services.
- States are facing challenges to operationalize HWCs at the SHC levels. Therefore, states are opting to operationalize the mandated HWC services initially at the PHC level.

The group made the following suggestions:

- The AGCA Secretariat should develop and submit a note to the MoHFW and Niti Aayog on 'Strengthening Community Action and Engagement for Ayushman Bharat'. This note should encompass both National Health Protection Scheme (NPHS) and HWCs.
- A detailed meeting of the AGCA should be organised in September 2018 to discuss the role and engagement strategies of the group in the context of Ayushman Bharat.
- The MoHFW has committed to eradicate TB and Leprosy by 2025 and 2018, respectively. The AGCA can suggest community level strategies to accelerate and complement MoHFW's efforts towards eradication of these diseases.
- The NHSRC and AGCA should work collectively to develop capacities in the states to strengthen functioning of the VHSNCs, RKSs and MASs.
- Strategies need to be developed to engage Self Help Groups in community mobilization and promotion of health services.
- AGCA members should actively participate in the forthcoming Common Review Mission (CRM) organised by the MoHFW.

3. Need for a robust and accountable health referral system: Experiences from Rajasthan

Dr Sharad Iyengar, Member AGCA shared experiences from the Action Research and Training for Health (ARTH) initiative on 'Improving quality of referral and emergency maternal and neonatal health care services in Bharatpur, Chittorgarh and Sawai Madhopur districts of Rajasthan'. Institutional readiness to provide referral and emergency care for maternal and newborn complications was reviewed across 47 public health facilities (3 District Hospitals, 1 Sub Divisional Hospital, 28 CHCs, and 15 PHCs). A copy of the presentation is enclosed as **Annexure B**.

The following findings were highlighted:

- 90% patients used the 104/108 ambulance services for transportation.
- In 13% cases, there was a delay of more than 30 minutes for first checkup upon arrival at health facilities.
- In 40% cases, there is a time interval ranging from 61 to 120 minutes for the arrival of ambulance services and drop patients at the District Hospitals. The MoHFW's operational guidelines on Maternal and Child Health 2010 mentions: 'Every women

delivers in an institution with access to a referral centre within 60 minutes in case of complications, requiring surgery and blood transfusion.'

- Relatives were being asked to arrange blood prior to the treatment from government blood bank, which is often very far away from the main hospital. Private agents often take benefits of their ignorance and escort them to private blood bank, which results in lot out of pocket expenditure.
- Majority of referrals are being done without proper diagnosis, readable notes, and details of the referral facilities to which the patients are sent.
- 32% maternal referrals and 7% of neonatal referrals could have been managed at the SDH and CHC levels.
- 58% of women with delivery complications did not get a stretcher upon arrival at the hospitals.
- 28% of women received first checkup by a trained nurse on arrival. However, in case of sick newborn almost all were attended by a doctor upon arrival.
- 15% of women delivered through Lower Segment Cesarean Section (LSCS) out of 4,271 cases sent to referral facilities. 21.5% of women, who delivered through LSCS, received blood transfusion. This questions the accuracy of diagnosis**.**
- Despite Janani Shishu Swasthya Karyakram (JSSK), out of pocket expenditure is being incurred on medicines, blood transfusion, investigations and ultrasound, especially during night time.

The group made the following suggestions:

- An institutional mechanism should be developed for regular monitoring of the essential protocols. This will bring in systemic change and improve accountability.
- Regular monitoring of the essential protocols should also apply to private hospitals being empanelled under the NHPS.

4. Discussion on AGCA Priorities

4.1 Role of Civil Society Organisations in facilitating implementation of CAH process in the states

Bijit Roy made a presentation on the 'Role of Civil Society Organisations (CSOs) in facilitating implementation of CAH process in the states.' During the pilot phase and in the subsequent years, the CSOs played a pivotal role in the implementation of CAH processes in facilitating capacity building of VHSNCs, community based monitoring and planning, public dialogues and follow up action for redressal of grievances and gaps. Over the years, the space for CSO engagement is being gradually reduced. There is a shift from the State Nodal NGOs to State Health Systems Resource Centres (SHSRC)/ASHA Resource Centres

managing implementation of CAH processes in Assam, Chhattisgarh, Jharkhand and Odisha. A copy of the presentation is enclosed as **Annexure C.**

The group made the following suggestions:

- There is a need to customize community monitoring and accountability approaches based on specific context for each state as uniform models would seldom produce the desirable results.
- CAH process should be flexible and should address the immediate priorities and performance anxieties of policy makers in the states.
- The SHSRCs and ASHA Resource Centers have competing priorities and are unable to lead and manage CAH implementation. In addition, monitoring and accountability aspects are greatly compromised in the absence of CSO engagement. A consortium based approach involving SHSRC and CSOs, can be entrusted to manage CAH processes.
- Community based resource centres such as SEWA Shakti Kendras run by the local women groups provide information and access to government schemes and services in many rural and low-income areas. This can be used as a platform to strengthen community action.

4.2 Roll out of Decentralised Participatory Health Planning (DPHP)

- The decentralised planning is one of the priority areas of the National Health Policy 2017, which mentions ensuring community participation in developing the decentralised health plans.
- Based on the NHSRC and AGCA deliberations, a guideline on DPHP has been developed and submitted to the MoHFW for final inputs in March 2018. To begin with, the DPHP process was implemented across 14 districts of Maharashtra and 2 districts of Bihar.
- DPHP should also cover aspects of nutrition, water and sanitation -Swachh Bharat Abhiyan.
- The process especially requires an active facilitation to ensure incorporation of community priorities and corresponding budgets into the District and State Programme Implementation Plans (PIPs).
- The RKS participatory audit and planning piloted in Maharashtra can be part of the DPHP process.
- Additional funds can be leveraged from the 14th Finance Commission and the Panchayats Extension to the Scheduled Areas (PESA) funds (wherever is applicable) for addressing community needs identified through the DPHP process.

4.3 Monitoring roll out of Comprehensive Primary Health Care

- A meeting with Niti Aayog team can be organised after the note on Strengthening Community Action for Ayushman Bharat is shared.
- The AGCA Secretariat is providing support to the State NHM team in Assam in developing community monitoring strategy for HWCs.

5. Building a Momentum for Universal Health Care (UHC)

Ms Mirai Chatterjee, Member AGCA shared details of the UHC round table meeting organised by SEWA in April 2018. At the round table, it was suggested that regional consultations could be organised to brief and seek inputs on UHC priorities from grassroots workers and community leaders. The first consultation is being jointly organised by SEWA, PFI and PHFI in New Delhi on August 20-21, 2018, with support from the World Health Organisation (WHO). Efforts are being made to also bring representation and perspectives from non-health sector actors- trade unions and cooperatives.

- A note on UHC has been developed by Dr Abhay Shukla, Member AGCA which is being translated into Hindi.
- A short video is planned to be developed which highlights the community needs and priorities for UHC.
- The AGCA members were invited to participate in the consultation.

The meeting ended with a vote of thanks by Ms Poonam Muttreja.

Action Points from the 38th AGCA Meeting

Sl. No.	Action Points	Responsibility
1.	Submit a note to the MoHFW and Niti Aayog on 'Strengthening Community Engagement and Action for Ayushman Bharat.'	AGCA Secretariat
2.	Organise a meeting with Niti Aayog team to brief AGCA's work on CAH and communitisation strategies for Ayushman Bharat.	AGCA Secretariat
3.	Organise AGCA meeting in September 2018 to discuss on the AGCA's priorities and engagement strategy.	AGCA Secretariat
4.	Develop a village level dashboard on key indicators on health, nutrition and sanitation.	Dr M Prakasamma and AGCA Secretariat

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Annexure 'A'

Slide 1

Progress Update on AGCA Activities

December 2017 till date
38th AGCA Meeting
July 16, 2018

Slide 2

National level processes

- *National Consultation on CAH:* Organised on January 24, 2018. 103 participants from 23 states participated.
- *Support in developing CAH component of the State PIPs:* 23 states.
- *Trainers' Manual on CAH:* Incorporated MoHFW 's inputs and shared final document on March 28, 2018.
- *Participation in RKS ToTs* organised by NHSRC in Delhi and Guwahati
- AGCA proposal submitted to the MoHFW on March 16, 2018

Slide 3

State level processes

CAH processes being implemented in 23 states (around 2,01,755 villages, across 340 districts)

Assam

- Implementation scaled up from 4,420 villages to 14,900 villages (27 districts and 149 blocks)
- Adaptation and translation of community monitoring tools.
- 2818 ASHA Supervisors trained on CAH processes.
- Review of field implementation by Dr Prakasamma and Seema in April 2018.
- Developed plans for piloting community monitoring of Health and Wellness centers

Sikkim

- Review of VHSNCs and RKS functioning in District Hospital, Namchi
- Planning meeting with State Mission Director and State Nodal Officers
- State orientation workshop planned for strengthening VHSNCs and RKSs.

Slide 4

State level processes

Meghalaya

- Community monitoring completed in West and South West Garo Hills districts
- 3 Jan Samwads organised
- Supported Meghalaya Society for Social Audit and Transparency (MSSAT) in designing the monitoring tools and participated in National Convention organised in December, 2017.
- Meeting with MSSAT and State NHM teams planned on July 18, 2018 to discuss integration and scale up of community monitoring.

Nagaland

- Facilitated State level ToT to pilot CAH in March 2018. State and District NHM staff from Peren and Kohima districts participated.
- Briefed the State Mission Director on implementation design.

Manipur

- Developed plans to initiate implementation in two districts – West Imphal and Thoubal in January 2018.

Slide 5

State level processes

Bihar

- CAH scaled up from 4 blocks to 32 blocks in 2 districts: Darbhanga and Nawada (across 2331 villages)
- Facilitated District ToTs in December 2017
- Community monitoring completed and 6 block level Jan Samwaads organised.

Jharkhand

- Facilitated State TOT for RKS strengthening – State and District NHM staff from Ranchi and Hazaribagh districts participated.
- Participated in CAH review meeting: Dumka, East Singhbhum, Hazaribagh, Khunti and Palamu districts.

Odisha

- Developed plans to involve Bharat Nirman Volunteers (BNVs) to strengthen functioning of VHSNCs in 55 blocks.
- Scale up planning for 37 cities with Additional Mission Director and State NUHM team.
- Review of CAH implementation in Bhubaneswar.

Slide 6

State level processes

Uttar Pradesh

- Dissemination of report on the Functioning of Quality Assurance Mechanisms in Lucknow district- December, 2017
- Orientation of RKS members on quality assurance and grievance redressal in Lucknow district- April, 2018
- Supported SPMU in developing plan for scaling up RKS strengthening in 10 districts

Uttarakhand

- Facilitated refresher ToTs for state and district trainers -December 2017 and January 2018
- Community monitoring completed across 11 districts
- 88 Jan Samwads organized at the block level

Slide 7

State level processes

Madhya Pradesh

- Participated in State MGCA meeting December 2017
- Supported in conceptualizing the National CAH Consultation -June, 2018
- Orientation of MGCA members and revision of community monitoring tools – Dr. Gupta and Daman- July 12-13, 2018

Rajasthan

- District CAH orientations completed in all 6 districts - Ajmer, Bikaner, Baran, Bundi, Chittorgarh and Dholpur
- Supported in Village Health Action Planning process across all 33 Districts.

Gujarat

- CAH guidelines adapted and translated in Gujarati.
- Facilitated State ToTs for VHSNCs trainers in 25 districts-Dec 2017 and Jan 2018.
- CAH processes initiated in 5,000 VHSNCs (77 high priority blocks,22 districts)
- 6 Jan Samwads organised in 3 districts: Aravalli, Tapi and Bharuch
- Field implementation review

Slide 8

State level processes

Haryana:

- Supported State NHM team in developing plans for community monitoring of Health and Wellness Centers

Jammu and Kashmir

- Participated in State Community Processes review meeting and meeting with State Mission Director May 2018
- Facilitated State ToT for district master trainers from Kashmir division July 3-5, 2018

Himachal Pradesh

- Planning for district level VHSNCs trainings, post the State ToT organised in Nov, 2017
- Training of district level VHSNC trainers completed. Facilitated training in Una.

Slide 9

State level processes

Karnataka

- Oriented Karnataka Health System Resource Centre (KHSRC) team on CAH –Dr. Sudarshan, Dr. Narayan, Sanjoy and Bijit -March 2018
- Supported revising the State PIP proposal

Tamil Nadu

- Orientation of State NHM officials in March 2018 –Dr. Narayan, Ameer and Daman
- Meeting with State Mission Director and Community Process team to discuss on the implementation issues

Telangana

- Development of State PIP to initiate CAH implementation –Dr. Shukla and Bijit
- Meetings with State NUHM and Mission for Elimination of Poverty in Municipal Area (MEPMA) teams to strengthen implementation of community processes in urban areas- April 2018
- Orientation of 90 Urban PHC Medical Officers on communitization processes - Dr Prakasamma and Sanjoy -June 2018

Slide 10

State level processes

Maharashtra:

- CBMP processes undertaken in 45 blocks across 19 districts
- Decentralised Health Planning process completed in 30 blocks across 14 district
- State AGCA Review organised in March, 2018. Dr. Gupta, Dr. Narayan, Dr. Shukla and Seema

Kerala

- Planning meetings with Mission Director and the State NHM team -February, 2018
- Facilitated 2 state level ToTs- 84 nodal officers and 10 MPH students participated, March and April 2018
- Community monitoring indicators included in the Arogram Puraskaram initiative

Goa

- Facilitated 2 state ToTs : (a) Rogi Kalyan Samitis and (b) CAH – March, 2018
- Meetings with Mission Director and the State NHM-March, 2018 on implementation

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Support required from the MoHFW

- *Facilitate approvals:*

i. AGCA proposal for FY 2018-19
ii. Television and radio spots
iii. CAH training manual
iv. Reimbursement of expenses for Quarter 4 (January- March, 2018)

Slide 12

Thank you

Annexure 'B'

The quest for effective and accountable referral and emergency care:

Some pointers from an intervention in Rajasthan (2014-18)

Sharad Iyengar, AGCA member

Intervention objectives

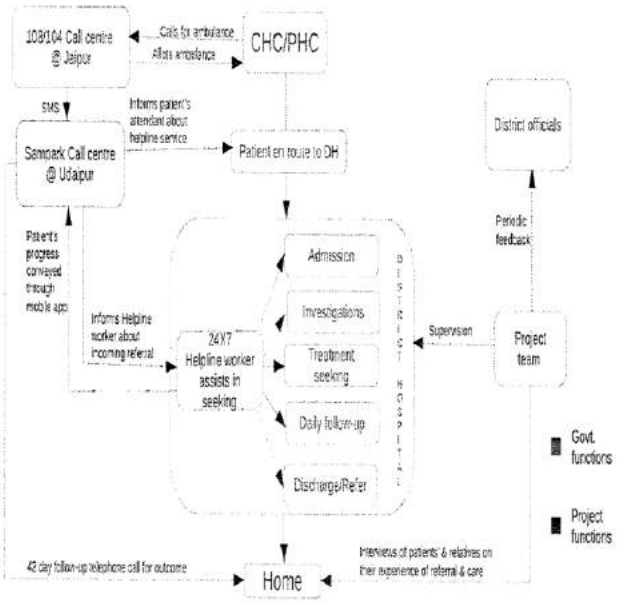
- To improve effectiveness and quality of referral & emergency care for maternal & newborn complications in three districts
- To assess and strengthen institutional readiness to refer and/or manage maternal - newborn complications

Focus on 44 peripheral facilities (1 SDH, 28 CHCs, 15 PHCs) and 3 District Hospitals for institutional readiness to provide referral & emergency care

Sampark districts	Population - 2014* (in 100 thousand)
Bharatpur	27.1
Chittorgarh	16.2
Sawai Madhopur	14.1
Total	57.4

*Projected from Census 2011

Sampark intervention - 1: 24 x 7 Helpline



How do helpline workers assist in patient care? (1)

Receive patient at DH & facilitate admission for timely initiation of care:

- Wait at the gate of Zanana hospital for the ambulance
- Arrange stretcher trolley as per patient's condition
- Assist in getting first check-up done quickly by medical staff
- Assist with admission to LR, OT, SNCU etc.
- Assist in getting investigations done
- Assist in arranging blood from blood bank
- Feed patient's detail in arrival form of Sampark App
- Give contact card for future assistance during hospital stay

How do helpline workers assist in patient care? (2)

Daily follow-up till patient exits from District Hospital:

- Daily visit in the ward for follow-up
- Inform attendants of available facilities and govt schemes
- Record patients' progress on app
- Counsel & provide support to attendants
- Provide specific assistance to patients when they ask for it
- Communicate with hospital staff on behalf of attendants, in case of difficulty

Sampark App: Tool for Data collection and tracking patient progress

Sampark App: Arrival form

Sampark App: Tool for Data collection and tracking patient progress

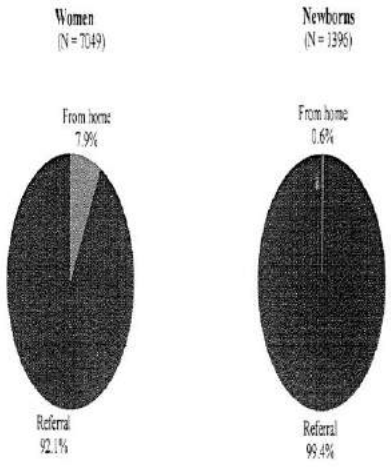
Referral and emergency care

July 2015 – June 2017

How many referrals?

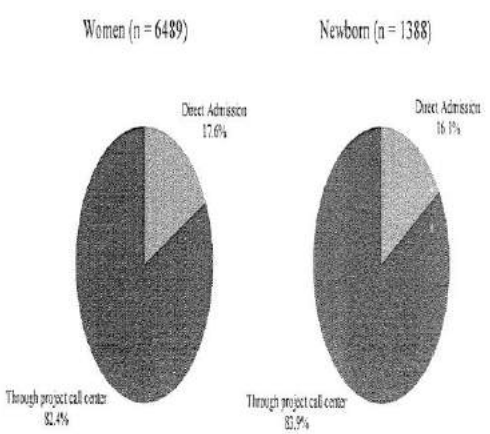
How many patients were received by helpline workers?

N = 8445



What was the source of referral information?

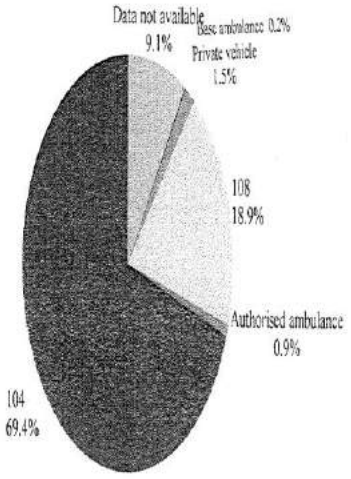
N = 7877



Timeliness of referral & admission

How did patients reach the district hospital?

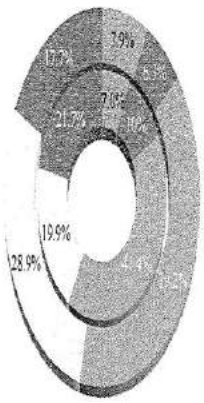
(N = 7877)



What was the time interval between ambulance call and arrival at District Hospital?

Outer wheel = Women

Inner wheel = Referred newborns



Patient category	Mean (mins.)	Range (in mins)	Number of patients	Data not available
Women (n = 5347)	62.8	(1 – 236)	4925	422 (7.9%)
Referred newborns (n = 1165)	62.6	(1 – 238)	1083	82 (7%)

Time intervals:

- 1-30 mins.
- 31 -60 mins.
- 61- 120 mins.
- >120 mins.
- No data

Delay in emergency referral transport

Operational guidelines on Maternal and Newborn Health 2010*	Main reasons for delay

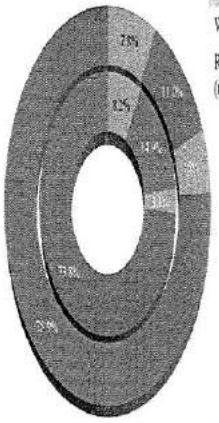
"Referral Linkage and Transport: This is for access to emergency services. **The ideal situation is where every mother delivers in an institution with access to a referral centre within one hour in case of complications, requiring surgery and blood transfusion.** District health plans must conform to a roadmap to reach this ideal, respecting and supporting the wishes of families at every stage."	• Distant location of some facilities (~50-70 kms.)
	• Delay in arrival of ambulance to receive patient due to:
	  • Ambulance busy with other patient
	  • Near ambulance is out of order
	  • If allotted ambulance breaks down on the way

*Ministry of Health and Family Welfare (MoHFW), Government of India. Operational Guidelines on Maternal and Newborn Health. New Delhi: NRHM, MoHFW; 2010.

What was the time interval between arrival and first check-up at District Hospital?

Outer wheel = Women

Inner wheel = Referred newborns



Patient category	Mean (mins.)	Range (in mins)	Number of patients	Data not available
Women (n = 6489)	8.3	(1 – 74)	5983	506 (7.8%)
Referred newborns (n = 1388)	7.3	(1 – 65)	1274	114 (8.2%)

Time intervals:

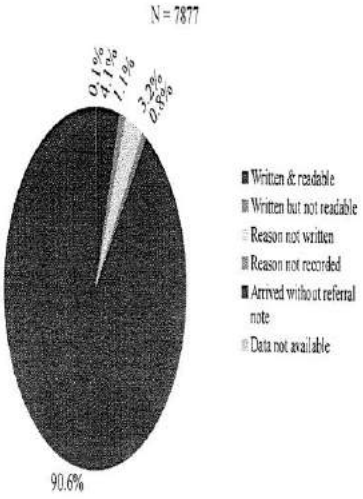
- 1 - 15mins.
- 16- 30 mins.
- >30 mins.
- No data

Main reasons for delay:

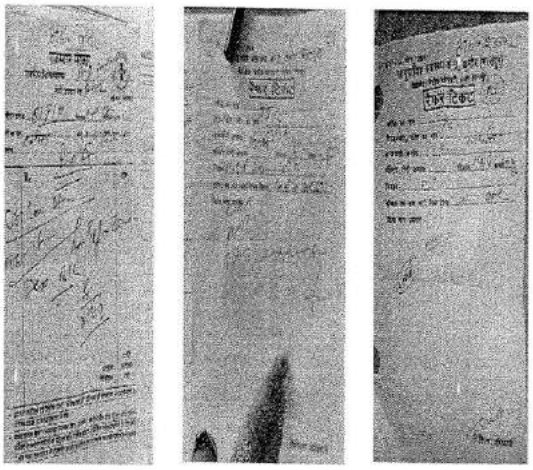
- In Chittorgarh, for intial few months of the project the newborn patients were first taken to District Hospital and then back to Maternal and newborn hospital for admission.

Indications for referral

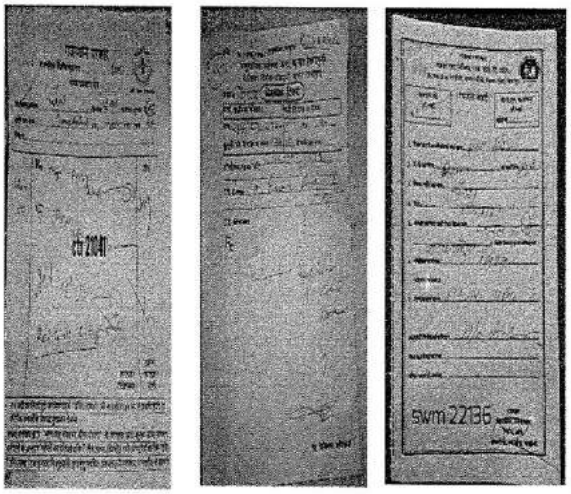
Referral note sent along with patient?



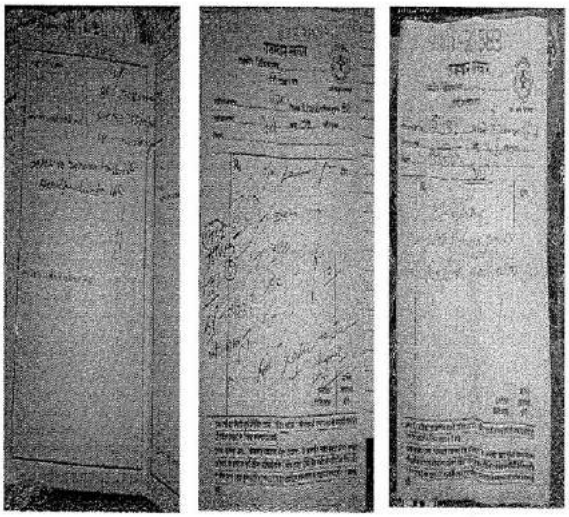
Referral note sample: Not readable (1)



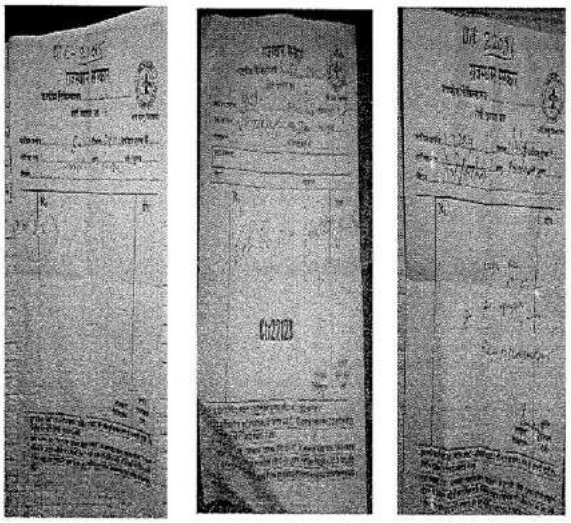
Referral card sample: Not readable (2)



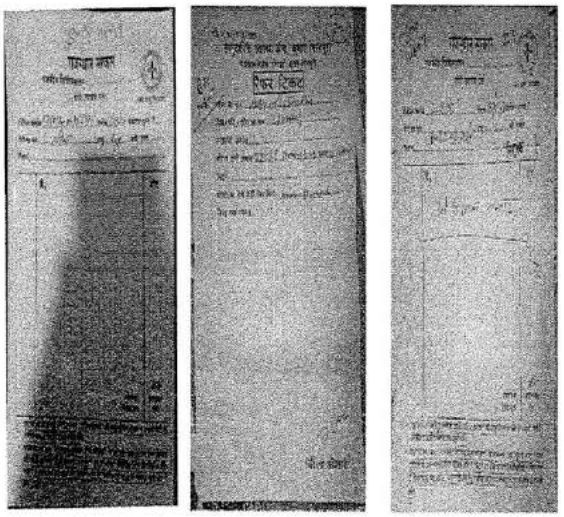
Referral note sample: symptoms listed



Referral note sample: reason not mentioned (1)



Referral note sample: reason not mentioned (2)



Who makes a diagnosis?

- Referring institutions send patients with or without
  - a diagnosis,
  - readable notes
  - using prescribed forms
  - informing or consulting the referral hospital in advance
  - following up on referral outcome
- The 108 service has instructions to transport all patients without questioning the indication
- Referral hospitals tend to initiate treatment without recording a provisional diagnosis

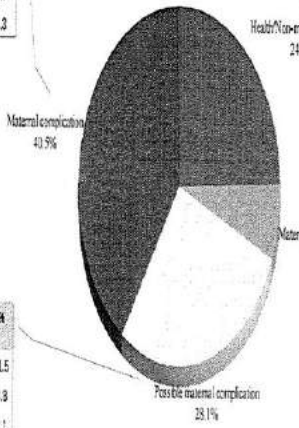
Hence it is difficult to assess the appropriateness of referrals

Categorizing indications based on referral note

Referral reason category	Definition
M1/N1: Probable or definite complication	A condition which is usually managed in a District Hospital, for which the patient is referred from a peripheral facility
M2/N2: Possible complication	A condition which has not been clearly described in the referral note, or if severe enough, could suggest a complication, but in some cases could be stabilized / managed at a peripheral facility
M3/N3: Health problem, not complication	A condition that can be treated at a peripheral facility or may be referred on a routine basis, does not require emergency referral or management.
MX/NX: A health condition or other non-medical situation	Can be managed at a peripheral facility, does not require referral to a District Hospital for complication.

Reasons for maternal referral

(N = 5884)



M1: Maternal complication	%
Prolonged labour	6.6
APH	5.9
PPH	5.1
Breech	4.9
Previous LSCS	4.3

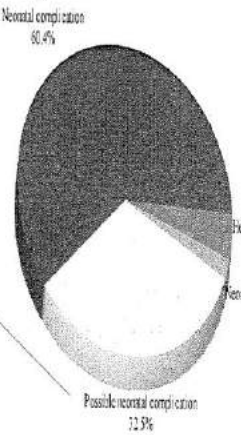
MX: Health/Non-medical condition	%
Labour pain	19.5
Primi gravida	3.5
Pregnancy	0.2
Lack of staff	0.2
Vomiting	0.1

M2: Possible mat. complication	%
Anemia	11.5
Non prog of labour	3.3
High or low BP	2.1
Leaking PV	1.7
FHR (+or-)	1.6

M3: Mat. problem not complication	%
Vaginal discharge	4.8
Bleeding PV	0.8
Abdominal pain	0.5
Rh incompatibility	0.3
HIV positive	0.06

Reasons for neonatal referral

(N = 1254)



N1: Neonatal complication	%
Respiratory distress	17.5
Asphyxia	10
Refusal to feed	8.8
Neonatal jaundice	3.9
Premature baby	3.9

NX: Health/Non-medical condition	%
Excess crying	2.3
Crying	0.5
Cough & cold	0.2
Eye problem	0.2
Follow-up	0.2

N2: Possible Neonatal complication	%
Low birth weight	16.2
Dyspnea	8.1
Fever	3.1
Meconium	2.5
Vomiting	0.6

N3: Neo. problem not complication	%
Diarrhea	0.6
Abdominal distension	0.2
Breast feeding problem	0.2
Malnutrition	0.2
Cleft lip	0.2

Top 10 reasons for maternal referrals to District Hospital (N = 5884)

Jul'15 - Jun'17

Rank	Referral condition	Referral category	Number of patients (%)
1	Labour pain	MX	1150 (19.5)
2	Anemia	M3	675 (11.5)
3	Prolonged labour	M1	387 (6.6)
4	Antepartum hemorrhage	M1	346 (5.9)
5	Post-partum hemorrhage	M1	301 (5.1)
6	Breech	M1	286 (4.9)
7	Vaginal discharge	M3	281 (4.8)
8	Previous LSCS	M1	254 (4.3)
9	Obstructed labour	M1	236 (4)
10	Non progress of labour	M1	225 (3.8)
	Total		4141 (70.4)

Top 10 reasons for neonatal referrals to District Hospital (N = 1254)

Jul'15 - Jun'17

Rank	Referral condition	Referral category	Number of patients (%)
1	Respiratory distress	N1	219 (17.5)
2	Low birth weight	N2	203 (16.2)
3	Asphyxia	N1	125 (10)
4	Refusal to feed	N1	111 (8.9)
5	Dyspnea	N2	102 (8.1)
6	Neonatal Jaundice	N1	49 (3.9)
7	Premature baby	N1	49 (3.9)
8	High fever	N1	46 (3.7)
9	Fever	N2	39 (3.1)
10	No cry after birth	N1	31 (2.5)
	Total		974 (77.7)

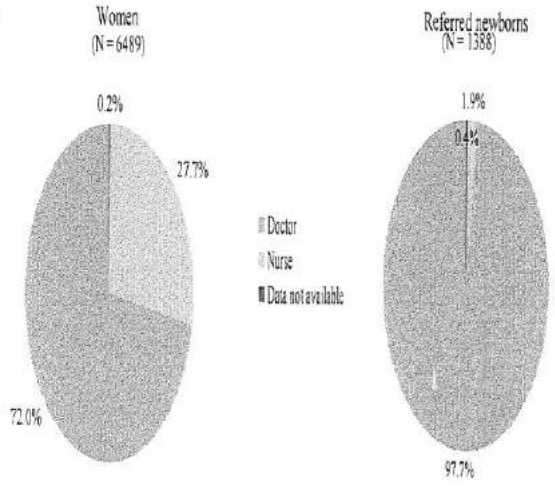
Emergency care

Maternal referrals: How did women enter the hospital?

(N = 6489, Referral reason not available for 605 patients)

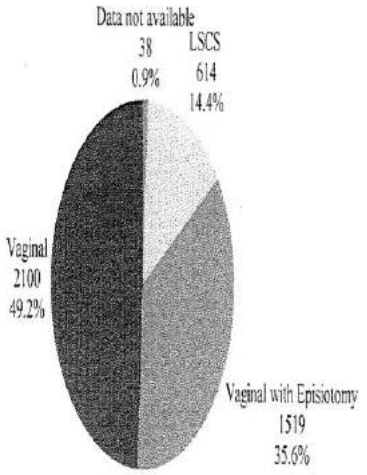
Patient brought in the hospital:	Patients with complication N (%)	Patients with no complication N (%)
On a Stretcher	792 (19.6)	153 (8.3)
Walked supported by attendants	2337 (57.9)	1131 (61.1)
Walked on her own	895 (22.5)	559 (30.2)
Lifting	8 (0.2)	6 (0.3)
Data not available	1 (0.02)	2 (0.1)
Total	4033 (100)	1851 (100)

Who did the first check-up on arrival of patient?



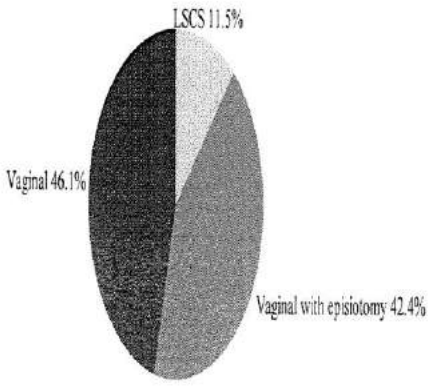
Type of delivery among women who delivered at District Hospital

(N = 4271)



Type of delivery among Primigravidae

(N = 165)



Why LSCS?

Top 10 referral conditions following which women underwent LSCS

(N = 614, reason not available for 26 [4.2%] patients, **LSCS rate = 14.4%**)

Rank	Referral condition	Referral category	Number of Cesareans (%)	% women with this condition undergoing LSCS
1	Previous LSCS (n = 254)	M1	127 (20.7)	50
2	Labour pain (n = 1150)	MX	96 (15.6)	8.3
3	Breech (n = 286)	M1	44 (7.2)	15.4
4	APH (n = 346)	M1	42 (6.8)	12.1
5	Prolonged labour (n = 387)	M1	38 (6.2)	9.8
6	Obstructed labour (n = 236)	M1	36 (5.9)	15.2
7	Vaginal discharge (n = 281)	M3	27 (4.4)	9.6
8	Non progress of labour (n = 225)	M1	21 (3.4)	9.3
9	Primi gravida (n = 204)	MX	19 (3.1)	9.3
10	Cephalopelvic disproportion (n = 71)	M1	18 (2.9)	25.3
	Total		478 (76.2)	

Why blood transfusion?

Top 10 referral conditions following which women received blood transfusion

N = 913 (ref reason NA in 55 (6%) cases)

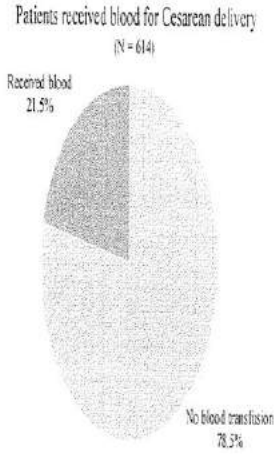
591 (65%) families donated blood as replacement, 64.3% in APH+PPH+All anemia

Rank	Referral condition	Referral category	Number of women received blood transfusion (%)	% women with this condition that recd blood transfusion
1	Anemia (n = 675)	M2	263 (28.8)	40
2	PPH (n = 301)	M1	146 (16)	48.5
3	APH (n = 346)	M1	69 (7.6)	19.9
4	Labour pain (n = 1150)	MX	69 (7.6)	6
5	Previous LSCS (n = 254)	M1	48 (5.3)	18.9
6	Prolonged labour (n = 387)	M1	28 (3.1)	7.2
7	Severe anemia (n = 46)	M1	26 (2.8)	56.5
8	Obstructed labour (n = 236)	M1	23 (2.5)	9.7
9	Breech (n = 286)	M1	19 (2.1)	6.6
10	Vaginal Discharge (n = 281)	M3	15 (1.6)	5.3
	Total		706 (77.3)	

How many women who delivered through LSCS were transfused blood?

(614 women underwent Cesarean)

- 614 women delivered through cesarean section among 4271 women who delivered at DH



What was the duration of hospital stay among those who were discharged? (excludes LAMA)

Referred Patient category	Mean days of stay	Range (days)	Number of patients	Data not available
Women who delivered at DH (N = 3087)	3.7	0 – 28	3078	2 (0.06%)
Women who did not deliver at DH (N = 2133)	2.7	0 – 29	2127	6 (0.3%)
Referred newborns (N = 824)	4.8	0 – 40	818	6 (0.7%)

Outcomes: Out of pocket expenditures

How much did families spend on care of women? (1)

Expenses on items	Women who paid (%)	Among those who paid		Women who did not pay (%)
		Average expenditure (Rs.)	Range (Rs.)	
Food	4820 (74.3)	862.6	100 - 4460	1669 (25.7)
Medicine	1740 (26.8)	295.4	32 - 3350	4749 (75.8)
Investigations	675 (10.4)	609.4	50 - 2280	5814 (89.6)

How much did families spend on care of women? (2)

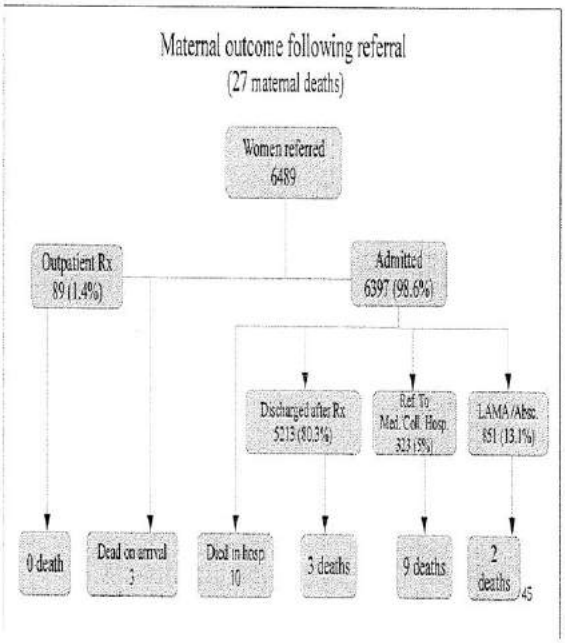
Expenses on items	Women who paid (%)	Among those who paid		Women who did not pay (%)
		Average expenditure (Rs.)	Range (Rs.)	
Blood transfusion	31 (3.4)	2844.2	50 - 18000	883 (96.4)
Cesarean section	43 (7)	702.3	200 - 2000	571 (93)
Other	1170 (18)	510.8	50 - 2700	4173 (82)

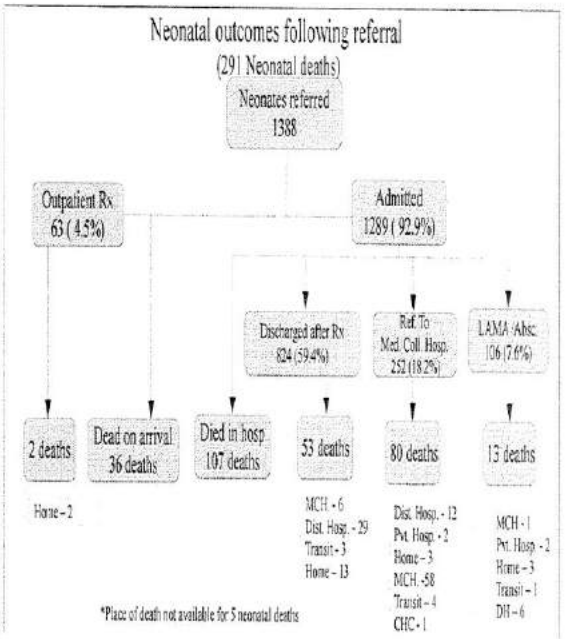
How much did families spend on care of referred newborns?

(N = 1388)

Expenses on items	Families who paid (%)	Those who paid		Families who did not pay (%)
		Average expenditure (Rs.)	Range (Rs.)	
Food	896 (64.5)	1211.2	100 - 7205	492 (35.5)
Medicine	468 (33.7)	233.7	50 - 900	920 (66.3)
Investigations	106 (7.6)	419.3	90 - 850	1282 (92.4)
Others	220 (15.8)	146.9	50 - 400	2314 (84.2)

Outcomes: survival & mortality





Maternal & perinatal outcomes

Patients	Number	Could not be tracked	Follow-up done	Survived	Still births	Died	Rates/Ratio (For followed-up cases)
Referred Women	6489	899 (13.8%)	5590	5563	NA	27	MMR 483 per 100000 women
Neonates born to admitted women	4271	505 (11.8%)	3766	3461	119	186	SBR 28 per 1000 births NMR 46 per 1000 live births PNMR 52 per 1000 births
Referred neonates	1388	180 (13%)	1208	917	NA	291	NMR 241 per 1000 live births

Key learning for the NHM

- Referral per se, stresses the health system and families – tracking the process can help to improve it
- The current emergency transport system is effective, yet transport and referral audits can help to improve performance
- In the absence of adequate institutional linkage, referrals are not as per well defined protocols
  - significant proportion of referrals are not for complications
  - patients with complications largely deliver without LSCS
  - a peer accountability and system accountability is lacking
- Out of pocket expenditures do occur in a fraction of patients – these should be tracked to assess how JSSK is performing
- Neonatal referrals, emergency care and follow up especially need separate attention to improve mortality outcomes

Questions for the NHPS

- Referrals from PHCs and CHCs to private hospitals through and without 108 will require families to cope with a sudden transfer across two different systems. How do we ensure that the process follows technical norms while also being responsive to patient needs?
- How will referral and emergency care be audited – institutional readiness, cesareans, blood transfusion, out of pocket expenditures, outcomes....?
- How will quality and accountability of referral link to insurance related processes?

Thank you

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Engagement of NGOs in CAH

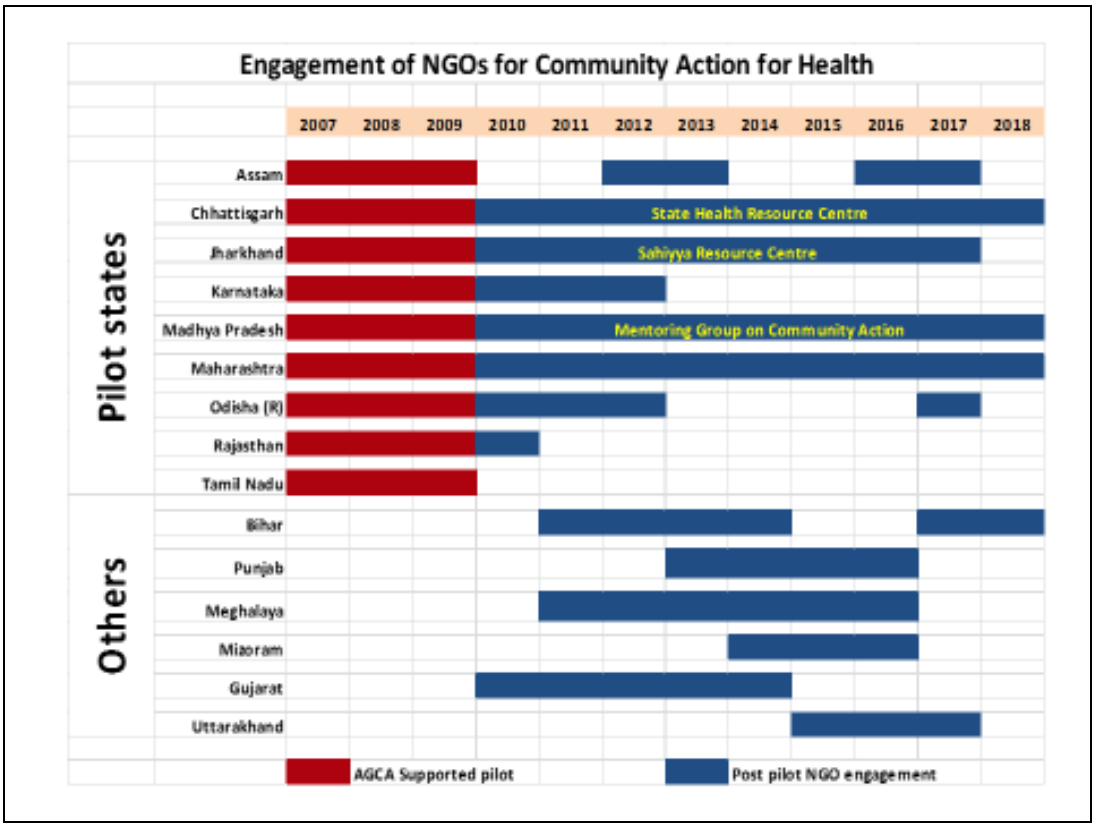
38th AGCA Meeting
July 16, 2018

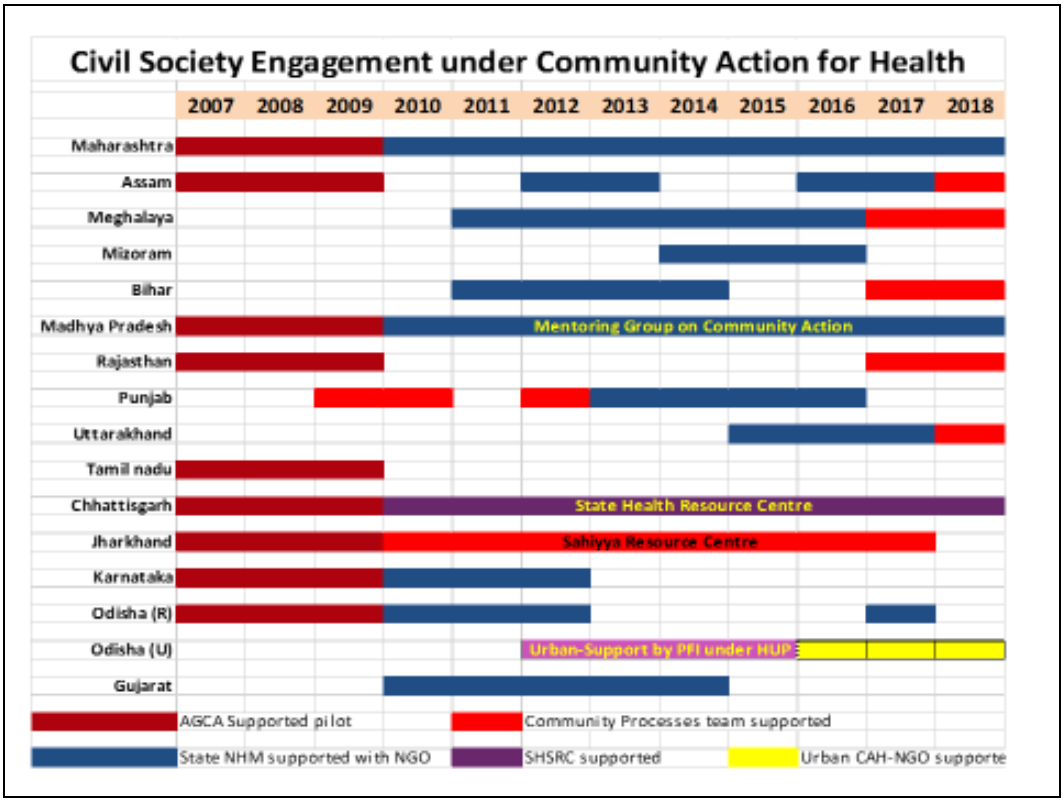
Policy commitments in NHM

- Framework of Implementation

  Upto 5% of the NHM budget to be used to support NGOs for a range of activities-implementation support, undertake service delivery in remote areas, community monitoring, capacity building and innovations in community processes, implementation research, impact assessments and research.

- Guidelines for NGO engagement


Engagement of NGOs for Community Action for Health
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Pilot states
Assam
Chhattisgarh
Jharkhand
Karnataka
Madhya Pradesh
Maharashtra
Odisha (R)
Rajasthan
Tamil Nadu
State Health Resource Centre
Sahiyya Resource Centre
Mentoring Group on Community Action
Others
Bihar
Punjab
Meghalaya
Mizoram
Gujarat
Uttarakhand
AGCA Supported pilot
Post pilot NGO engagement


Civil Society Engagement under Community Action for Health
2007
2008
2009
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2017
2018
Maharashtra
Assam
Meghalaya
Mizoram
Bihar
Madhya Pradesh
Rajasthan
Punjab
Uttarakhand
Tamil nadu
Chhattisgarh
Jharkhand
Karnataka
Odisha (R)
Odisha (U)
Gujarat
Mentoring Group on Community Action
State Health Resource Centre
Sahiyya Resource Centre
Urban-Support by PFI under HUP
AGCA Supported pilot
Community Processes team supported
State NHM supported with NGO
SHSRC supported
Urban CAH-NGO supporte

NGO level issues

- Uncertainty due to annual approvals
- Delayed release and reimbursement of funds
- No clear guidelines on progress reporting
- Selection process repeated annually
- Support from district and block officials in implementing processes
- Leadership changes at the state level
- Regular guidance and support from state

System level issues

- Complexities in selection process- elaborate, time consuming, influence/ interference, court cases
- Non approval of PIPs with NGO engagement plans
- Renewal of NGO MoU's based on PIP approval
- Engagement based on the individual inclination of officials
- Additional investment and competing priorities deters engagement with NGOs
- Capacity and limited geographical reach of NGOs
- State NGO Cell non existent

VHSNC strengthening through NGO facilitation in Assam