Uttar Pradesh Health System Stregthening Project

BEST PRACTICES

2018

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The Uttar Pradesh Health Systems Strengthening Project (UPHSSP), an initiative supported by the World Bank, aims to **strengthen systems and institutions and their capacity to deliver quality services in a manner that makes them accessible to people**, to the poor in particular with a focus on women and underserved people in remote areas. UPHSSP, a five-year project with an outlay of US$ 170 million, started in June 2012.Now the project has been extended for another two years (2017-2019).It intends to build on the achievements of the UPHSDP and complement on-going initiatives under the National Health Mission (NHM). It is envisaged that the activities under UPHSSP will also contribute towards achievement of the related Sustainable Development Goals-3 (SDG), as we indirectly by improving the health system delivery in the most populous state of the country.

This document captures the good practices/lesson learnt while implementing the various component of the project. The specific objectives of the documentation are:

- To promote sharing of evidence-based practices that have shown to be successful in improving systems and institutions and their capacity to deliver quality services
- To promote scaling up/replication of proven critical success factors and lessons learnt so as to increase coverage of quality services and accelerate progress towards universal access to quality services

BEST PRACTICES

The document address the following areas emerged as Best Practices from Uttar Pradesh Health System Strengthening Project (UPHSSP)

1. Use of Patient Diagnostic Information System
2. Drivers of NABH Entry level Accreditation for Public Hospitals in Uttar Pradesh
3. Improved Data Based Decision Making Through Quality Management Information System
4. Community Based Monitoring: A Social Accountability Initiatiative
5. Evidence to Action: Formulation of State Health Policy (2018-2030)
6. Real time Monitoring of Outbreaks and Infectious Disease: State Outbreak Reporting System (SORS)
7. Formation of Information, Education, Communication (IEC) Cell
8. Revamping of District Hospitals: A Cluster Champion Approach

1 Use of Patient Diagnostic Information System

Introduction

Uttar Pradesh with 199.8 million populations, if considered as a country, would be the fifth most populous nation on the globe. Given the enormously large size in terms of population density, UP will play a crucial role in country's health related Millennium Development Goals achievement. One of the ways of improving health care services in public hospitals is by providing quality diagnosis & treatment to patients through high quality laboratory tests. Our previous studies & evidences show that government district hospitals are not well equipped with diagnostic labs & are short on quality staff to carry out pathology tests. These challenges forced doctors to refer patients to private pathology labs for test & diagnosis, which was costly affair for underprivileged rural patients. The findings from National Samples Survey Organization (NSSO 60th round) showed, that Diagnostics services account for 14% & 15.4% of out-of-pocket (OOP) expenditure in public facilities in rural & urban areas of UP respectively(NHA 2004-05). Lack of availability & accessibility to laboratory services was one of the reasons behind substantially low hospitalization rates observed in UP Govt setup in comparison to national average.

Challenges Addressed

Some of the challenges that required our attention are listed below

Poor Public Health System: Overall per-capita spending on health is very low(372) hence, there has been a capacity deficit within the govt. run secondary care hospitals to provide affordable & quality laboratory services. Government units are overburdened & non-availability of human resource, equipment & systems to maintain the service delivery poses a serious health risk scenario.

Out of Pocket Expenditure: 8% of households in the state fell below the poverty line due to health related out of pocket expenditures (versus a national average of 6.2%). Lack of quality pathological lab services in government hospitals forced patients to avail these services from private providers at very high rates.

Prescription of High End Tests & Longer Treatment Time: It was the challenge to provide proper treatment to the patients due to lack of these laboratory services in government hospitals.

Effective monitoring: Identifying implementation loopholes & fixing the lacunae is crucial for the success of any project with this huge investment.

UPHSSP identified these potential gaps in public health care facilities & in consultation with Word Bank introduced a brand new concept of engaging High End private diagnostic labs under public private partnership(PPP) model. Under this partnership model, the project introduced performance based contract system, first of its kind being implemented in Uttar

Pradesh. The performance is evaluated on the basis of Turnaround Time(TAT). The TAT would be calculated starting from the time sample is taken from the patient up to successfully uploading the test result on the website of Patients Diagnostic Information System(PDIS-http://pdis.uphssp.org.in/). This website is an in-house production of UPHSSP which is handled & managed by UPHSSP & after the project period it shall be managed by GoUP. UPHSSP has also hired an External Quality Assurance Agency (BIO-RAD) to do monthly audit & maintaining quality standards of the equipment of service provider ensuring for accurate test results which ensures better diagnosis & treatment planning.

Impact:

With the rise in number of patients in less than two years of time, this project has achieved many quantitative milestones & has potential impact which is cost effective for patients as well as for government. The qualitative findings are encouraging where we saw an overall improvement in quality of patients care & treatment. However, we have proposed for more in-depth qualitative evaluation of this project after completion of 2 years when we have sufficient data to back our findings. Some of the major impact factors are:

- *Significant increase in number of patients*: Tremendous increase in the patients availing quality diagnostic services in these laboratories are available within the hospital premises since last 2years.The number of patients increased from 11314(Dec, 2015) to 1369864(Dec, 2017) & have been benefited with range of 173tests.An internal survey was conducted in 9districts in state to understand the perception of the patients regarding these laboratory services which revealed that 90% patients were satisfied with quality, behavior, getting report on time etc.

- *Cost effectiveness of interventions*: Reduction in service delivery cost has major impact on patients & govt. authorities. The 52 district hospitals are segregated in 11 clusters in such a way, that the rates quoted during competitive bidding were an average of 20% below of the Central Govt. Health Service's rate. The present running cost of high end test is Rs.463 per patient. As per the study by the Karnataka Infrastructure Development Project, the annual cost for setting & running laboratory in secondary care public hospital is around Rs.2.86 Cr (excluding space cost), while the project has set up the same through PPP at no cost. The recurring cost for service delivery is three times lesser than what was spent by government in past.

- *Online Access of the Test Result*: The result of these tests are made available online for patients & has been designed in such a way that the reports are kept private as well as accessible through login ID. The result comes on specially designed software known as Patient diagnostic information system (PDIS), which is available on UPHSSP website (http://pdis.uphssp.org/frm_publicview.aspx)

- *PPP Policy*: The innovative initiative has been designed & implemented inline of Health PPP policy of the state govt. The project initiative has demonstrated the application of PPP policy that has given confidence to various private players to come forward and invest.

Lesson Learnt

- *Stakeholder consultation is a key for assessing the marke*t: Initially there was strong retaliation within the public sector when it came to involvement of private sector. However, with continuation consultation with private sector, it has helped in understanding the market opportunities & influencing factors for negotiating rates. After assessment the rates for high end tests were negotiated through various discussions with private players on key concerning issues like mode of operations, types of test, mode of payments, TAT, MIS system etc.

- *Cluster approach* for making the package more attractive: Given the wide spread of health facilities in the state, the hospitals were divided into 11 clusters covering all 52 hospitals keeping in the view of regional proximity, distance, foot fall at hospital & available resources. The concept of clustering was also to ensure cross subsidization for private sector to make profit from this activity and also for the project & state to understand the potential of these hospitals & the project learned the skills of bidders to deliver services.

- *Inclusion of quality parameters for performance based payment*: Many contracts which follow the payment on inputs have the risk of compromising on quality. In light of that, the project has set up the external quality assurance service (EQAS) which is linked to performance for payment. EQAS measures the standardized quality control checks for tests conducted in laboratories to ascertain quality & subject to satisfactory report, 10% payment which is linked to quality parameter is released to service provider. Similarly, another 10% of the payment is released on compliance to timely delivery of test reports to patients.

- *Use of technology* for *synchronizing the data was critical for monitoring*: An important learning is the availability of central data base generated through online software. This is the major achievement at the state level. Now the online data can be accessed at the health system level for monitoring purpose & providing information regarding the level of epidemic or disease in the state.

- Retaining the available services & adding the services of high end pathology not available at hospital was a key as it sustains the available capacity then to replace with new: Introduction of free of cost High End Pathology Services to the patients seeking treatment in Public Hospital is an additional benefit with the current pathology system of Hospital.

Level of Innovations

The implementation of performance based contract for delivering high end laboratory services in the public health facility is first of its kind in the context of Uttar Pradesh. The design of the contract have followed the unique process to understand the potential of partnership with private sector through stakeholder consultation where we assessed the needs through market survey, conducted cost benefit analysis using available data and most importantly put the beneficiary at forefront while designing the intervention. The result of intervention have provide the level of satisfaction among users, ensured quality assurance through robust system, ensure timely monitoring to make mid-course corrections &

demonstrated the most viable model which can be replicated across state & country. The most innovative parts of the intervention are: performance linked payment; continues process of patient feedback; online system for real time monitoring, compatibility of system for patients to view and generate their reports & introduction of private sector in the most complex areas of health sector. The intervention has also helped in developing the knowledge repository with disease profile to understand the health profile of selected districts. This has also contributed in improving efficiency of the health service delivery & set the higher standards in public health facility & contributed to overall improvements of health system. In terms of effectiveness it was clearly seen in bringing the desired changes in providing the high end laboratory services. In terms of value for money, this innovation proved cost effective. This initiative was equitable & adequately attempted to address the needs of different sections of the society such as women, poor, religious minorities, who usually face disproportionately tougher barriers to access basic health services particularly availing the laboratory service. The study conducted by the project validates that, about 21 % patients might not have visited hospital & remained at home if this free of cost test service was not introduced at the hospital level (as per the study conducted by the UPHSSP).

Replicability

- After a year of good experience and outcome of the High End Tests has indicated that this innovation sets a milestone for replication in other states as well as other developing countries. Innovation shows that the benefits towards the patients and the system which include reducing patient waiting time, ensures accurate tracking of specimen collection of patients, facilitates easy access to patient reports through patient portal and manages overall billing within the health facility can be easily replicated in other places.

- Through the competitive bidding process, the best services which lead to the quality of services for the patients are hired by the private agencies. The process of the High End Laboratory Services is managed and maintained at the hospital level; pathologist being the nodal officer supervises and monitors the technical and verification of monthly payment. This is the performance based contract and payment is made on the basis of pre-defined outputs. So the focus is on strong element of service delivery aspects and compliance on pre-determined and measurable standards.

- The results from the intervention have triggered the replication across state. This model has been adopted by National Health Mission of Uttar Pradesh and being scaled up to 95 district hospitals and 822 Community Health Centers (CHC) in the state.

- The cost/ rates of the high end diagnostic test services have been taken from the CGHS approved rates, lowest rate in the country. Thus government need not pay a huge amount for the services to the private operators and becomes easy to take policy decision for replication.

- The online PDIS software designed for monitoring is developed on simple, secured and open source platform which is compatible for migration and replication. The software is the key towards performance based contract management system which is integral part of any public funded projects.

- The project has not developed any separate structure but this adds on for the existing structure. Once the high end tests are included in the existing pathological centers in the hospitals, these tests which are provided by service agencies will be withdrawn as and when government adopts the system.

Sustainability

This innovative public private partnership model has win-win situation for all the three stakeholders. Patients are getting quality services which is their right, free of cost, pathology labs are getting reimbursed against their service delivery cost (rates are much lower than normal rates) from government and government as access to high end pathology lab centers with spending any amount in infrastructure and human resources and is only paying for the services, that too labs are providing services to government referred patients at much lower rate as labs are being able to manage their expenses through higher footfall of patients. This has proved to be a very cost and time efficient system and has immensely helped in saving lives of underprivileged citizens of country. Also, this model is very robust, transparent and full-proof enabled through web based platform with real-time tracking, monitoring and performance evaluation system, which helps in faster decision making. Therefore this performance based contracting system model has all the potential to become a self-sufficient and sustainable model which is currently being operated by UPHSSP.

This model is currently being funded through World Bank project, however government of Uttar Pradesh has agreed to adopt this model for future as well and sees a much bigger opportunities in these kind of PPP based project model.

2 Drivers of the NABH Entry level Accreditation for Public Hospitals in Uttar Pradesh

Introduction

Uttar Pradesh Health System Strengthening Project (UPHSSP), which began in 2012, has gone through three distinct phases- i) Initial phase (2012-2015), ii). Performance Phase (2015-2017) and iii). Acceleration Phase (2017-2019). In the initial phase (2012-15) not much work was done however with strategic shift made during 2015-17, the work of UPHSSP came into prominence. During Performance Phase hospitals were provided with additional medical and paramedical staff, equipment, standardized medical records etc. Clinical and administrative trainings were given to hospital staff to improve the work efficiency of the care providers. To improve the general hygiene cleaning and gardening were outsourced with performance-based contract. Similarly to improve the access to timely diagnostics, high-end pathology services were outsourced to renowned laboratory service providers.

The project focus on improving quality of service delivery at public sector 51hospitals to enable them to be accredited under the National Accreditation Board of Hospitals (NABH).Under the project, Quality Assurance cell is fully functional in Directorate of Medical Health and project cell started showing results in terms of objectively defined indicators as given in project appraisal document (PAD), interventions were made to speed up the pace of project activities. Some of the key interventions taken to speed up the project processes are as follows:

- Augmenting Strengths of Human Resources
- Team building
- Motivating Hospital Managers (HMs) and Chief Medical Superintendents (CMS)
- Feedback Meeting with CMS.
- Performance Assessment of HMs and Staff

Augmenting Strengths of Human Resources:
Human Resource was major issue in most of the hospitals. Therefore, T&M an HR Agency was hired to recruit the medical and paramedical staff on contractual basis. Staff's gaps were identified from each of the 51 district level hospitals and a nodal HR person was designated to coordinate all issues of HR. Regular meeting are held with outsourced agency to handle it. Hospital Managers gives regular feedback about staff working in their hospital. Similarly, vacancies of PSU and TAP were regularly reviewed and recruitments were done to increase the bench strength. As of now almost all positions of PSU and TAP have been filled

Team Building:
Project realizes the importance of Team building. A series of interventions have been taken to create a sense of belongings among entire staff of UPHSSP. Two retreats were organized for staff and consultants of UPHSSP and TAP. Apart from this two training programs "Abhiprenana" & " Uddayan"was organized for hospital managers. These events were used

to do experience sharing, problem solving and promoting innovation. Also, awards were given to best performing hospital managers.

Motivating Hospital Managers and CMS:
Motivational workshops are regularly being held for hospital managers & CMS. A one-day motivational event Abhiprerana was held exclusively for hospital managers on March, 2017. Management experts were invited to discuss various topics on motivations. While motivating HMs, an attempt was made to see that HM understands goals and mission of UPHSSP. Awards were given to best performing hospital managers. Two-days motivational event Uddayan was held exclusively for hospital managers on September 13-14, 2018.

Three days workshop was held at Hotel Ramada during April 10-12,2018. All the hospital Managers, CMS/SIC/Director, and NABH coordinators of all 51 hospitals participated and shared their experience on revamping work. The best hospitals were awarded.

Exposure Visit
An exposure visit to Gujarat (Ahmedabad) was organised during 7-10 May,2018. The purpose of visit was to understand and learn the experience of revamping of hospitals carried out in public hospitals in Ahmedabad and Rajkot. The team consist of 19 members including CMS and Hospital Mangers from four hospitals visited Gujarat.

Feedback Meetings with CMS.
Regular feedback and review meetings are held with hospital managers and CMS to identify the bottleneck and challenges and immediate guidelines are issued and supportive interventions are initiated by PSU.

Performance Assessment of HMs and Staff
Since motivation alone does not help, monthly performance appraisal of all consultants of PSU and TAP is done to review consultant's work. Similar reviews are also done for hospital managers. One-months' notice was given to seven poorly performing hospital mangers. Thereafter, in a joint meeting with HM and CMSs, the services of five hospital managers were terminated. Similarly, salaries of those hospital managers who could not ensure timely data entry into the PDIS software, were withheld for the month of October 2017. Thus, a clear-cut message was given to everyone in the project to either perform or perish.

UPHSSP hospitals have now become showcase to the state health system to the extent that out of 65 hospitals, which got Kayakalp awards 26 are UPHSSP hospitals.

Key achievements of Quality Cell are given below:

- Entry Level Accreditation for 31 District Hospitals
- Minor civil alterations were carried out
- Training of Trainers was given to facilitate implementation of NABH Standard.
- Standard Forms and Formats as per NABH requirements implemented.
- To standardize the cardiac emergency care at the level of district hospitals, Advance Cardiac Life Support (ACLS)/Basic Life Support (BLS) trainings were imparted to selected staff of all hospitals.
- Essential equipments' calibration was done for 51 Hospitals
- Fire audits were being done for all 51 hospitals to prepare BOQ and procurement of necessary fire safety equipments.

3 Improved data based decision making through Quality Management Information System

Introduction

Uttar Pradesh Health System Strengthening Project (UPHSSP) focuses on improved use of data for program management. As a result, Data Resource Cell (DRC) was established in DGMH to improve evidence based decision-making. The project ensures that data collected at each level is utilized for improved management of health programs, improvement of service delivery quality and health outcomes, supporting the State's desire to focus on equity and reducing disparities in access to health care.

In view of that project has developed various need-based softwares. Among these, Quality Management Information System (QMIS) was developed to tap the data generated in 51public hospitals under NABH process.

Why there is need?

The UPHSSP has started the process of NABH accreditation in 51 Public health facilities. The purpose of accreditation is to improve the quality of services delivered in public health facilities. The overall objective is to reach the qualitative services up to the last people of the society with minimum or no expenditure.

QMIS is needed to provide a platform to identify all the Gaps, strengths which could be uses in planning process & in decision-making. Recently, the QMIS software awarded with Skoch award.

Monitoring and Evaluation

- Monitoring & Evaluation of the Progress on the internal gap analysis.
- There was a felt need of a tool for monitoring & update all NABH activities & Progress update from Hospitals & Agency.
- A single point where all Quality related documents Like Apex manual for QA, Forms and formats, Presentations, Guidelines from State and progress updates like status of Manpower, Equipment, Training, Assessment status, Audit status, Monthly & quarterly reports, FAQ etc. will be uploaded.
- It will synchronize all the data of Quality assurance at a single platform.

Supportive supervision

- Health facility on the prerequisite parameters.
- State officials can see the snapshot at a glance on the web portal as well as district can update all the information & can download any required information.
- Decision-making

- The QMIS will help in decision making like Bio-Medical equipment status, HR Deputation, Patient satisfaction by Grievance dashboard etc

Key Features

Act as a tool for all NABH activities & Progress update from Hospitals & Agency.

- A single point where all Quality related documents Like Apex manual for QA, Forms and formats, Presentations, Guidelines from State and progress updates like status of Manpower, Equipment, Training, Assessment status, Audit status, Monthly & quarterly reports, FAQ etc will be uploaded.
- It will synchronize all the data of Quality assurance at a single platform.
- Supportive supervision of the facility on the prerequisite parameters.
- Monitoring & Evaluation of the Progress on the internal gap analysis.
- State officials can see the snapshot at a glance on the web portal as well as district can update all the information & can download any required information.
- On further progress honorarium of Manpower of UPHSSP as well as agency will be linked by this web portal.

Challenges:

- Human Resources
- Implementation
- Resource Management
- Procurement
- Infrastructure

Scalability:

- Integration with Enterprise Resource Planning (ERP)
- Improved Care in Public Hospitals
- Model adopted by NHM for Quality Assurance Programme

4 Community Based Monitoring: A Social Accountability Initiative in Uttar Pradesh

Introduction

Uttar Pradesh being the most populace state has poor health indicators as compared to other states in India. The states with better health outcomes are also the ones with well-functioning, responsive health systems and better health care provider performance (supply side factors), as well higher levels of income and education (demand side factors). As such, improving the quantity and quality of publicly provided social services is a major priority for the State Government of UP. A low level of accountability of public providers towards the communities they serve is thought to be a major cause of the poor quality of public health services

The Uttar Pradesh Health System Strengthening Project (UPHSSP) supported by the International Development Association (IDA) introduced Social Accountability (SA) mechanism to improve health service delivery. The intervention is aimed to build trust and capacity among citizens by involving them in improving health service delivery mechanism and also holding Health Service Providers accountable and increasing their responsiveness to health needs of the community.

Goal

To develop sustainable Social Accountability Mechanisms to improve the delivery of healthcare services in the catchment area of the facility including all sub-Centres in the project area

Objectives

- To develop a design for the social accountability intervention at Block level and Village level to enable the community to be informed of their health entitlements.
- To facilitate monitoring based on agreed benchmarks / indicators & enable feedback on the indicators to the health system to facilitate corrective action in a framework of accountability.
- To enable the community to be partners in the process of improving the functioning of health system, as envisaged by NHM.

Structure

UPHSSP collaborated with the Deendayal Upadhaya State Institute of Rural Development (SIRD) to manage implementation of the interventions in the initially in selected 72 Blocks of 12 districts- named 1. Ambedkarnagar,2. Banda, 3. Basti, 4. Sant Ravidas Nagar (Bhadohi), 5. Chandouli, 6. Hapur, 7. Jyotiba Phule Nagar (Amroha), 8. Kushi Nagar, 9. Mau, 10. Moradabad, 11. Fatehpur (Random Control Trial) & 12. Sultanpur (Random Control Trial) of UP, covering 4238 Gram Panchayats.

State Programme Management Unit (SPMU), consisting of 8 programme staff, was established at state level. At district level, 7 District Coordinators (DC) and 17 Sub District Coordinators (SDC) were hired. At the grass root level, 316 Gram Panchayat (GP) Coordinators implemented the SA intervention.

The GPCs assist with community monitoring by facilitating the completion of scorecards, which are used to assess the work of AAAs and the status Action Taken Reports (ATRs), which are an official channel for airing grievances or reporting issues beyond the level of the GP and are submitted to the Block Development Office (BDO).

Process

Formation of VHSNC

The first step of the community level processes in the programme was to mobilize the community and form the VHSNC. The committee is formed at the revenue village level and it should act as a sub-committee of the Gram Panchayat. It should have a minimum of 15 members which should comprise of elected member of the Panchayat who shall lead the committee, all those working for health and health related services should participate, community members/ beneficiaries and representation from all community sub-groups especially the vulnerable sections and hamlets/ habitations. ASHA residing in the village shall be the member secretary and convener of the committee

Meeting of VHSNC-

The committee may, preferably, act as a sub-committee of Gram Panchayat and function under the overall supervision of Gram Panchayat. States are accordingly advised to issue the necessary notifications and guidelines on constitution of VHSNC to all concerned. States are also requested to consider notifying VHSNC as a subcommittee of Gram Panchayat. About 22898 VHSNCs meeting have been organised in 4238 Gram Panchayat till May 2017.

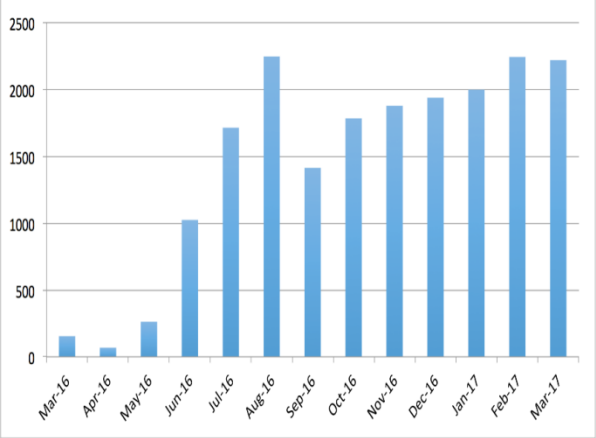


Figure 3. VHNSC meetings in UP, by month

Fund Utilization-

Involvement of community resulted in focusing on issues which the community had been facing. The community was urged to utilize the platform and use it as a discussion forum where they discuss the problems and try to find solutions for it. Regular meetings were held to discuss the issues related to fund utilization. Through proper fund utilization weighing machine, furniture's, dari, meeting refreshment and ANC table etc. was purchased. During discussion, few problems emerged from the community had been solved in the meeting itself while others were escalated to higher authorities.

Coordination with line department-

Project team interacted and coordinated block level officials to get information of VHSNCs and their respective members and met CDO, BDOs ADO Panchayats, Panchayats Secretary,

at block level and got the information on VHSNCs status. Further, wherever CDO was appointed as nodal officer and on regular basis collect updates, review and progress of the project activities. The progress of the SA intervention has led to regularization of VHSNC meetings- The meetings are organized regularly every month and members discussed on village related health, sanitation, hygiene, nutrition problems and other various issues in every VHSNC meeting. In case any issues are raised at the time of Village Health, Sanitation and Nutrition committee (VHSNC) which cannot be solved at Gram Panchyat level, Action Taken Report (ATR) is prepared after taking concern from all the members and the community.

Training of Trainers for VHSNC Training-

The Project envisages to inform the community for their health entitlements, facilitate monitoring based on agreed benchmark indicators, enable feedback on the indicators of the health system to facilitate corrective action in a framework of Social accountability, and enable the community to be partners in the process of improving the functioning of health system as envisaged by National Health Mission (NHM). Therefore for providing the training to the functionary i.e. ANM, ASHA, AGANWADI &VHSNC members a pool of Trainers was prepared and strengthen to meet out the specific objectives of the Project. Involvement of Governments officials (BDO/CDPO/ MOic/HEO/ADO Panchayat and ICDS supervisors etc.) in training Participations and facilitation not involving any NGOs/Outsources and external experts.

Training of VHSNC Members and AAA-

To strengthen AAA and VHSNC members by creating awareness them for latest Health Service Knowledge & understanding of regarding Community Score Card, Village Health Card, ANM Self Evaluation was done. Total of 28047 VHSNC members & AAA were trained out of 30000.

Preparation of Action Taken Report-

Prepared ATR required to besend to the concern departments. The meetings were recorded in the VHSNC meeting register.GPCs assisted in the submission of 3,074 ATRs, of which 1,899 are in compliance till May,2017. These issues comprised of immunization, cleanliness, hygiene, nutrition services, health check-ups and infrastructure etc.

Implementation of Community Score Card-

To gather the feedback of the services from service users and improve communication between communities and service provider's community score card was implemented. As such, it was designed to complement conventional supply-side mechanisms of accountability by bringing together service users and service providers first to identify the underlying obstacles to effective service delivery, and then develop a shared strategy for their improvement. Community Score card contains the questions related to ANM, ASHA, Anganwadi and VHSNC committee like regular attendance of ANM, about immunization as per schedule, counselling of pregnant ladies, issue of immunization card, regular check-up of pennant ladies, listing of pregnant ladies at village, information about VHND, regular counselling visit by ASHA, ,Growth of Children, regularity of THR distribution. A total of 1454 out of 4238 gram panchayats were covered. These community Score card activity can be used as a replicable model for community performance and appraisal which underlies in good and poor services. Poor services can be improved by regular advocacy and good will be appreciated by providing incentives.

Jansamvad Activity-

After the collection of issues from community score card, major issues were identified. These identified issues were taken to block level official through Jansamvad organised at block level. The major issues were related to Safaikarmi attendance and irregularity, VHSNC fund not released, VHSNC Bank account not opened, VHSNC Account signatory transfer, Infrastructure/ equipment issues, appointment of ASHA, distribution of THR, JSY Fund. Jansamvad was organised in 51 blocks in the month of March and April 2017. 210 Block level official and 28 District level officials participated

A small case study conducted by World Vision, one of the leading health partners in UP, further illustrates the positive impacts that appear to be a result of the SA interventions. Refer to Box 1 for a short summary

Box 1.

In September and October 2017, World Vision conducted a small assessment in three districts; one in which SA interventions were implemented, Banda, and two - Burabanki and Sitapur -which were used as control districts. Project staff met with Pradhans, ASHAs and AWWs, and additionally GPCs and a Sub-district coordinator in Banda.

In the two non-implementation districts, they found that VHSNCs had been formed but were not functioning. Some VHSNC members were not even aware of their membership. Key stakeholders – namely VHSNCs members – were unaware of the intended roles and responsibilities of the committee and of the meetings. The untied fund was also found to be either non-existent or used at the discretion of only a few members of the committee.

These findings contrast with those resulting in the implementation district of Banda. There they found a VHSNC functioning properly in one of the villages, with members aware of both the role of the committee as well as their own as a member of the committee. Meetings were carried out there on a regular basis and several relevant issues had already been raised and resolved as a result. Registers in this GP were found to be properly maintained and the untied fund appeared to be properly utilized. The Pradhan in this village also displayed much more involvement in the functioning of the VHSNC and its monitoring. The second village visited however showed less promise. The VHSNC there was no longer functional and meetings were not occurring regularly. The ANM was also unaware of other members on the committee. As this assessment was carried out after the contracts with GPCs had ended, the findings from the second village in Banda may be a demonstration of the negative impact this has had on some intervention areas.

Findings from this case study demonstrate the key role that UPHSSP/SIRD staff play in the formation and functioning of the VHSNCs. Service providers in the intervention districts reported that the UPHSSP staff were "critical" (UPHSSP report) in the operation of the VHSNC meetings. Further evaluation is needed to fully understand the impact of the GPCs and their role, but evidence from the case study suggests that further discontinuation of the field staff may negatively impact the functioning of the VHSNCs and the overall project goals.

An Impact assessment was carried out by World Bank in January,2018. The findings from assessment showed that use of Gram Panchayat Coordinators (GPCs) was an effective way of activating VHSNCs in areas where the committees were either not previously formed or were not functioning properly; the level of involvement of the GPCs was important in generating participation from the community in the VHSNC meetings; and that issues related to health, sanitation, and nutrition were being addressed at VHSNC meetings and were being addressed through official channels. Findings from assessment concluded that "*continuation of GPC activity in these areas is imperative to the project's overall success and that lessons learned from this intermediary evaluation should be incorporated into the interventions going forwar*d"

Outcomes

- Establishment of a formal space to facilitate community participation in health
- Monitoring and support of health systems by communities
- Increased accountability of front line health providers.
- Increased access of health care services especially for marginalized communities
- Increased demand for better quality of care
- Local action for better health care services
- Increased engagement of PRIs with health issues

Learnings

- Communities, when empowered with knowledge and awareness, will be able to monitor health systems and also initiate local action to support health care providers and services.
- Specific efforts need to be made to involve marginalized communities in such community action in order to increase their access to public services.
- Elected representatives can play an important role in supporting community participation and in balancing power hierarchies between communities and health providers
- Capacity building of state /districts and blocks level (Line departments) officials on social accountability interventions

The second phase of Social Accountability intervention started on 14 March 2018. The rollout of the intervention has started and activities are in placed.

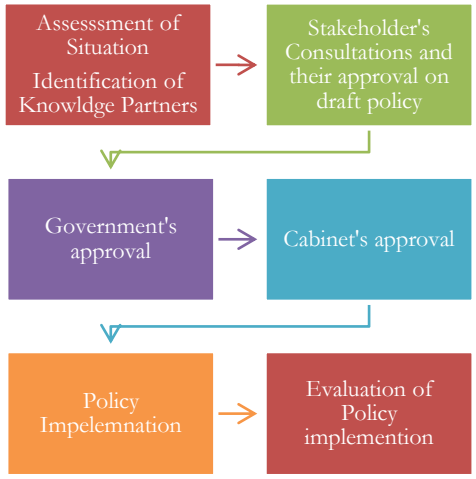
5 Evidence to Action: Formulation of State Health Policy (2018-2030)

Introduction

The Uttar Pradesh Health System Strengthening Project (UPHSSP) has taken initiative to formulate the 1st State's Health Policy (SHP) during 2017-2018. Currently, the policy is in the process of cabinet's approval. The SHP is a comprehensive document with clearly defined goals, objectives and interventions. The primary goal of this health policy is to attain the highest possible level of health and well-being for all people in Uttar Pradesh and of all ages. This is sought to be achieved by providing universal coverage of comprehensive care involving preventive, promotive, curative, rehabilitative and palliative care. The draft SHP is aligned with the National Health Policy 2017, State Vision Document for SDG-3 and the draft State Population Policy (2015). The State Health Policy will be effective for next 13 years to meet the specified health goals.

Processes Adopted for Formulation of Policy

The draft SHP is developed in the line with the WHOs building blocks of the health system. The building blocks are: Health workforce, service delivery, access to medicines and diagnostics, governance and regulations, health financing and social determinants of health. The UPHSSP played significant role in collecting, compiling and analysing data to identify trends, projections and opportunities for interventions. The State Health Policy takes into account of existing health policies, laws, regulations, state's demographic-epidemiological patterns and best practices from other states. A comprehensive situation assessment was led by UPHSSP.



Processes involved in policy formulation and its implementation

The State Health Policy 2018 adopted a detailed procedure for its formulation by involving various stakeholders from Government and Knowledge Partners. The process undertaken for drafting the SHP which included formation of thematic groups, subgroups, the core committee and the sub consultative committee. A series of consultations were undertaken with various stakeholders (officials from Directorate of Health and Family Welfare, Directorate of Medical Education, SIFPSA, UPNHM, UPSACS, representatives from the Medical, Nursing and Pharma Councils, Population Research Centre Lucknow, King George Medical University, Sanjay Gandhi Post Graduate Institute, and several other Government Departments) to seek inputs on the draft. Also, the draft policy of the State takes into account the regional disparities prevailing within the State for which two regional consultations were held with CMS, CMOs, Medical officers and DPMS of various districts.

Drafting of the State Health Policy document is led by a select group of UPHSSP consultants and Knowledge partners. The select group had closely worked with the different stakeholders and considered their views and interests while developing the policy. The stakeholder's and Government's endorsement were sought before processing the draft document for cabinet's approval.

Theme wise highlights of the draft policy recommendations are as follows:

Human Resource for Health

- The policy recommends for creating public health cadre to delink the administrative, managerial and financial functions of doctors and allied health professionals from their clinical and technical functions. These public health professionals can take up the task of hospital management, infection disease control, preventive and promotive services, immunization etc.
- The draft policy advocates for enhancing production of clinicians and allied health professionals by optimising the capacities of existing medical colleges by increasing the number of graduate and post graduate seats. Government can also explore options to meet the shortfall of specialists through offering post-graduation courses such as Diplomate National Board, College of Physicians and Surgeons to doctors working in rural areas.
- It recommends that the nurses must become the nerve centre of managing healthcare which will be a cost-effective strategy. Global experiences suggest that nurses deliver a variety of high quality protocol driven routine interventionist services and emergency care, performing effective gatekeeping functions for optimisation of healthcare services.
- In order to address the shortage of doctors, policy advocates for task shifting of AYUSH doctors. They can substitute allopathic doctors for public health program, outreach services, maternal and reproductive services.
- The policy recognises that the roles of ASHA workers have increased over the years and so number of ASHA workers can be doubled per defined population for smooth working purposes.
- The policy also talks about institutionalising a range of innovative processes for recruitment of medical and non – medical staff. Short term recruitment strategy can be developed to outsource the recruitment process especially where the scale of recruitment is high such as front-line workers. Long term strategy is to establish a HRH unit in the department to take care of recruitment, retention, promotion and deployment of all cadre of health workforce in the public health system.

Health Financing

- The policy proposes to step up public health spending from 1.4% to 2.5% of GSDP by 2025/30. The state may mobilise its funds from additional taxes on real estate, excise duties on alcohol, petroleum products, gems and jewellery.
- The policy envisages allocating nearly 70 % of all additional funds towards preventive and primary care.
- It recommends expanding and deepens risk pooling mechanism by increasing the funds for RSBY to Rs 945 crore in order to provide full coverage of the poor along with expanded service coverage.

- The policy envisage strengthening of Strategic purchasing route by reducing the cost of health care significantly, for instance moving away from current practice of involving financial intermediaries to direct buying.
- Reform Public finance management mechanisms by insurance of funds availability and disbursement on time to districts and frontline facilities by the State Treasury.

Access to Medicines, Diagnostics and Medical Technologies

- It recommends stepping up public spending on medicines by increasing the government spending on drug and equipment procurement from the current level of Rs. 5 per capita to over Rs. 50 per capita in one year which will be further increased to Rs. 70-80 per capita and thereafter sustained at that level.
- It proposes to select only generic and essential medicines- the new UPMSC must make sure that it procures drugs and supplies from States Essential Drug List that is updated every two years.
- It recommends that the UPMSC should centralise purchase of medicines and decentralise the systems of distribution and supply chain management by setting up district level warehouses and regional warehouses that must be organically linked to health facilities from medical colleges to sub-centres.
- The policy envisages that the warehouses must be linked with web-based application through 'e-Aushadhi' that ensures the drugs and supplies distribution. In order to ensure that facilities do not report stock outs a passbook system needs to be put in place.
- The policy puts emphasis on ensuring rationality in drug prescription and dispensing by strict adherence to Standard Treatment Guidelines (STGs), the prescribers and dispensers must be encouraged to distribute medicines rationally so they are safe and cost- effective.
- Continuous sensitization and orientation training in rational use of drug for prescribers.
- It recommends for regulating quality of drugs, supplies and equipment by administration of several layers of quality checks before a drug is supplied to public health facility by UPMSC.

Social and Environmental Determinants

- The policy advocates for taking effective measures to reduce malnutrition, anemia, and stunting would include- Active and early detection of malnourished children & women should be done in a community by ANM and AWW. A focus on nutrition Sensitive sectors- like agriculture, water, sanitation etc. by leveraging various existing programs. Food fortification should be positioned as a strategy to for addressing micronutrient deficiencies.
- Remedy artificially uneven sex ratio in U.P.- State should ensure stringent enforcement of the MTP act and PCPNDT Act with close monitoring and implementation including cancellation of registration.
- It suggests improving the status of women in health care.
- Policy also puts emphasis on addressing environmental factors which would be effective with reduction in household biomass usage; capacity for waste segregation, emission should be controlled by installing compliant DG sets.

Service Delivery

- It focuses on accelerating provisions of primary care services by public facilities, the top priority must be accorded to provide comprehensive primary health cadre in both rural and urban areas it can be done by expanding SC's, PHC's and ensuring fully functionality of existing CHC's and strengthened cadre of front line workers.
- It recommends that the preventive and promotive services must be strengthened involving holistic strategies.
- The policy assigns that the public health delivery system is expected to significantly accelerate the share of outpatient services from current 15% to 30% of all OPDs by 2025 and 40% by 2030.
- The policy recommends leveraging the large presence of AYUSH service providers in rural areas. Enhance and expands urban primary care through, coordination with urban local bodies.
- Strengthen provision of secondary and tertiary care services through fully equipped and functional district level hospitals and medical colleges. Strategic purchasing of secondary and tertiary services from public and private sectors.
- It recommends improving diagnostic, referral and emergency services, strengthening of referral services through robust IT enabled monitoring system along with an escalating response system.

Governance

- Improve Coordination, consolidation and convergence**:** For an efficient utilization of resources and for effective delivery of health care services, the five departments must improve their coordination (Department of Medical Health, Department of Medical Education and Training, AYUSH, Department of Women and Child Development, State Drug controller general of India) through formal institutional mechanism.
- It recommends that the Directorate of Medical Health and the Directorate of Family Welfare need to be increasingly closely engaged for achieving effective optimization of resources.
- It proposes setting up of several units in the Department for strengthening the directorate- Establishment of State Accreditation and Norm's unit; the State health Regulatory unit is expected to undertake the function of regulating both public as well as private sector.
- To augment the health workforce function there is a need to establish a unit for State Human resource for Health.
- A Public-Private interface unit is recommended to be set up for managing all public-private initiatives.
- It is proposed that the UPMSC must have two wings, one to deal with procurement of medicines, medical supplies etc... While the other wing will oversee the functions of strategic purchasing, including contracting in not for profit and for profit medical facilities.

Further Actions:

A comprehensive policy implementation plan will be developed and implemented in the State, after cabinet's approval on the State Health Policy 2018. The policy will also be evaluated on regular time interval to gauge the implementation progress. The effective implementation of the State Health Policy would definitely be helpful in providing the quality of health care services to all sections of the society and accelerating the pace of achieving the health outcomes

6 Real time Monitoring of Outbreaks and Infectious Disease: State Outbreak Reporting System (SORS)

Introduction

Uttar Pradesh is a vast state in terms of population and geographical dimension. If considered as a country, would be the sixth most populous nation on the world. Due to interplay among host, agent & environment, outbreaks do occur all across the state sporadically. To detect the outbreak impendency and prompt & effective response, Integrated Disease Surveillance Project (IDSP) was launched in 2008 by Government of India. This was done through the surveillance by tracking presumptive cases in OPD, laboratory confirmed cases in laboratory and syndromic cases at the community level. Moreover, outbreak cases were also reported through Early Warning Signal (EWS) format. However, majority of outbreak reporting is still done manually and there is no central repository for the information on outbreak. Therefore, it was felt by the department of Medical & Health to develop its own customized software application that can facilitate the timely collection, compilation & analysis of data and thereby, generate information and knowledge to mitigate outbreak severity. Directorate of Medical & Health Services, UP requested Uttar Pradesh Health System Strengthening Project (UPHSSP) to provide the technical assistance. The design of proposed software was conceived through discussion with various stake holders and current layout was finalized for the development of the software. Finally the software is developed and made live for all district level health care facilities.

The main Challenges for the department –

- The Department was lacking in Real-Time reporting of outbreaks. Outbreaks do have a tendency to spread rapidly, if initiation of effective control measures is delayed.
- Multiple sources of information often create confusion in the community and among relevant stakeholders & Decision makers.
- There was a lack of proper monitoring tool for outbreak response.

State Outbreak Reporting System (SORS) was developed to overcome all these challenges and with **objectives** of –

- Real time Reporting and Monitoring of outbreaks and Infectious Diseases
- To work as Central Data Repository and as a Single Source of Information
- To work as a tool for Prompt & Effective outbreak Management
- To replace Manual Reporting.
- To identifies districts with highest case load at any given point of time.
- To trace and follow Kala Azar cases.
- To report each cases of AES JE, influenza A H1N1, Dengue etc. real time.

Real time Reporting -

The state is the largest state in terms of population in the country and public healthcare facilities are overburden. The department is lacking of real time reporting of outbreaks and other healthcare indicators. The outbreaks spread over the community rapidly with time. Late reporting of outbreak causes difficulties in controlling and managing outbreak incidence.

To strengthen the disease surveillance & outbreak management in the state by establishing a centralized reporting system for epidemic prone diseases to detect the early warning signals, so that timely and effective public health actions can be initiated in response to control the challenges at the Districts level.

Single Source of Information-

The department is not having a single source of information. There is different mechanism to collect reports from district. Most of the program officer use as and when required practice. When there is a need of some data, it was collected from districts via e-mail, fax or manual. As there is manual intervention in reporting, there are always possibilities in data discrepancy.

Centralize Data Repository-

There is a single centralize database, so it is easy to manage data and single source of truth.

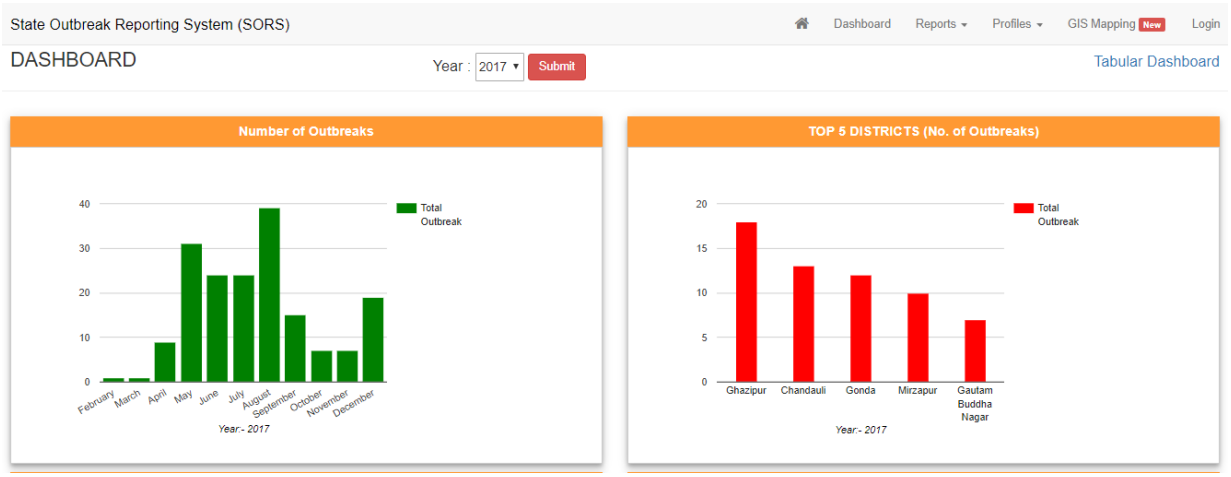


Fig 1- Month wise number of outbreak

Fig 2- Top 5 districts

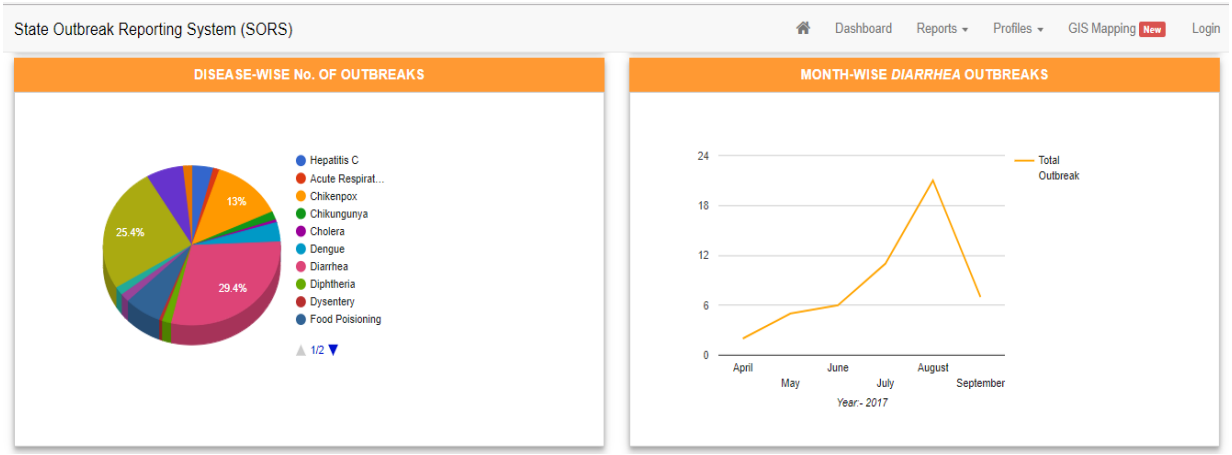


Fig 3- Disease wise distribution of outbreak

Fig 4- Diarrhea outbreak trend

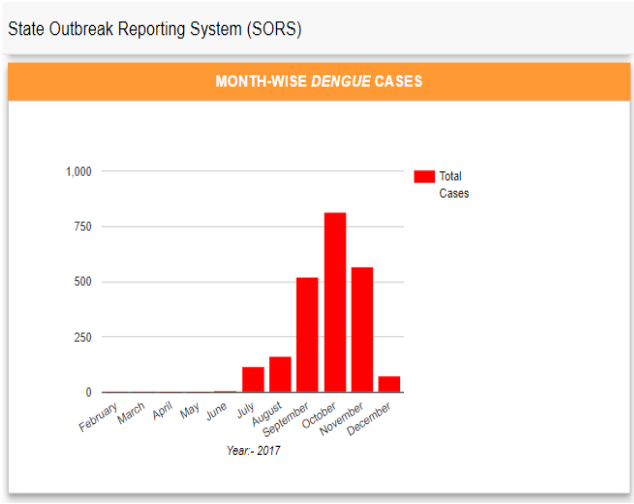


Fig 5- Month wise number of Dengue cases

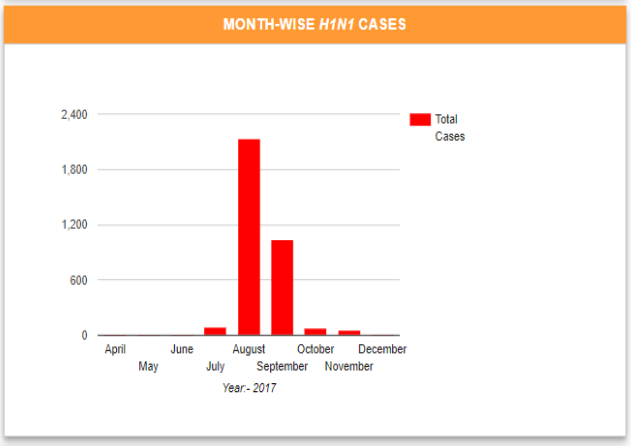


Fig 6- Month wise number of H1N1 cases

Number of outbreaks for *All DISTRICTS* for *ALL SOURCES* From *1/1/2018* to *5/4/2018*

SN	OUTBREAK SOURCE	TOTAL OUTBREAKS
1	Health Worker	64
2	Surveillance	27
3	Community Health Centre	21
4	Rumour Register	7
5	Others	5
6	Primary Health Centre	3
7	Print Media	3
8	District Administration	3
9	Public Representatives	1

Fig 7- Number of outbreaks on the base of Source of Information

- ***Media Alerts***- Media scanning is an important component of surveillance to detect the early warning signals. Media scanning and verification cell daily media alerts of unusual health events in the district which are detected and verified. The portal has the provision to show media alerts reports.
- ***Analytic Reports***- Different types of analytic reports are made available in the portal for district as well as state level management. Stakeholders can plan and prepare their strategies on the basis of previous year data.
- ***Effective Surveillance***- The portal aims to strengthen online reporting of outbreaks of infectious diseases to detect, identify and respond to outbreaks quickly.
- ***Geo Tagging of each case***- The latitude and longitude of each case is taken and filled online to plot geo position of the outbreak and its spreading over the region.

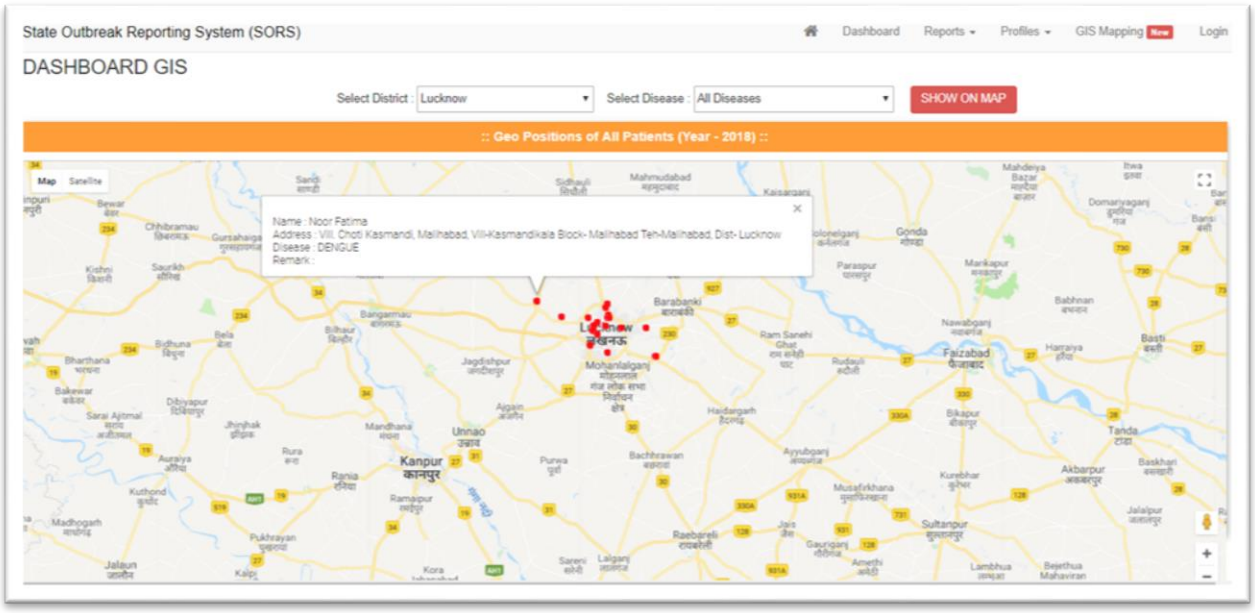
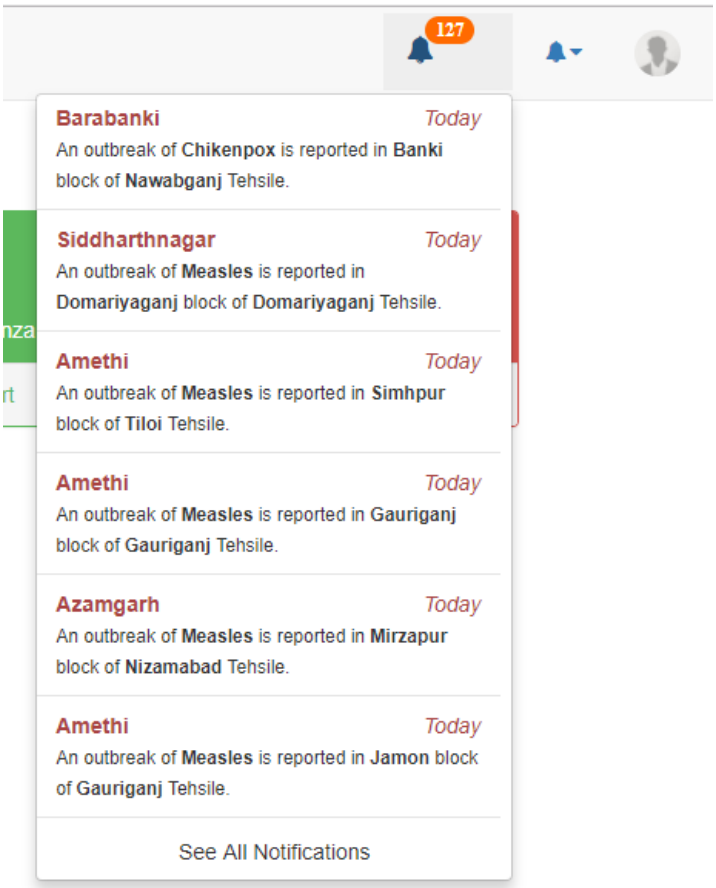


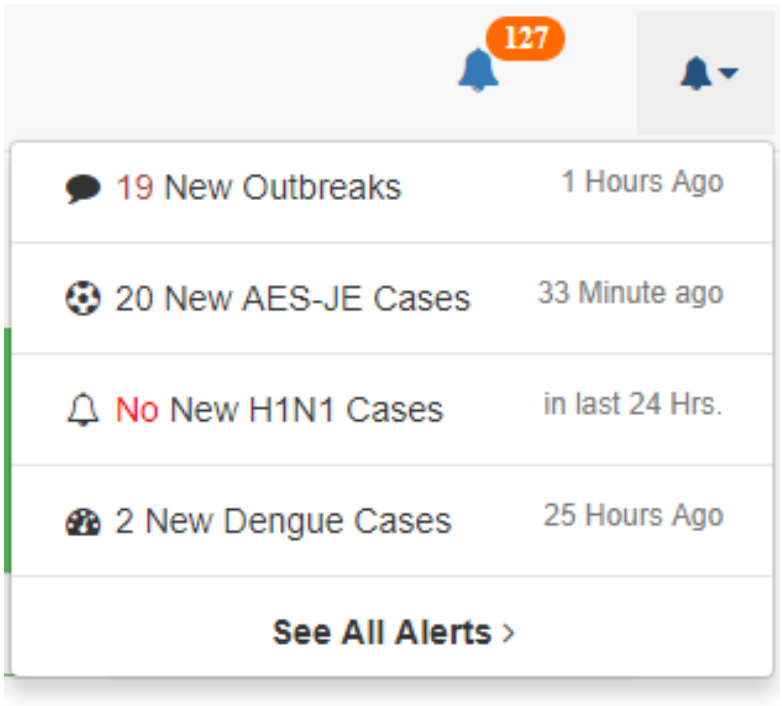
Fig 8- Geographic position of cases in all type of outbreaks in Lucknow.

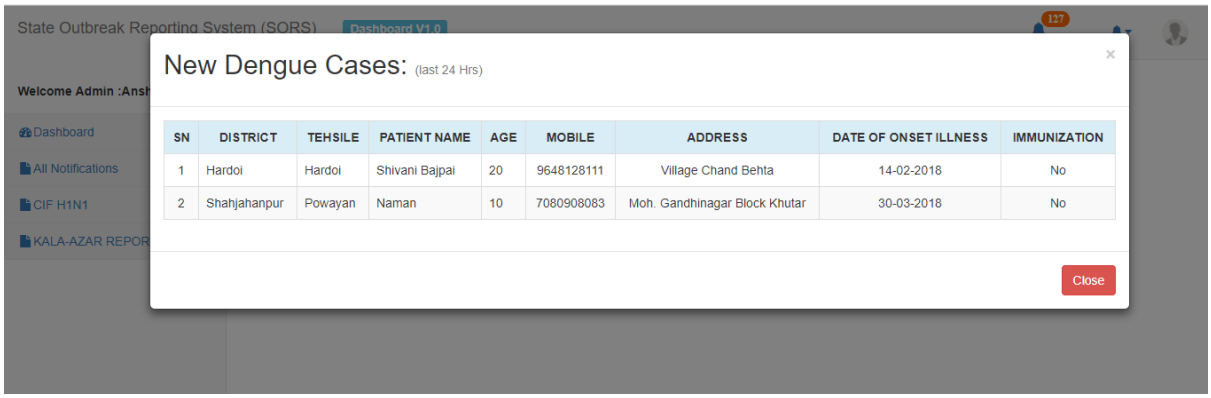
Dashboard

Whenever an outbreak is reported from a District, a **live notification** is flashed on the **admin dashboard**. The State surveillance Unit then immediately takes appropriate action and gets in touch with District Surveillance Unit (DSU) for controlling and managing reported outbreak.



The portal also **sends alerts** to State Surveillance Unit (SSU) about the new cases of H1N1, AES-JE and dengue cases in **Real time**.





Scope of Scalability of SORS –

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- SORS portal is designed on Meta Data and Data Standards (MDDS) using uniform coding of census.
- Integration with National level reporting portal.
- Better planning and effective Management in outbreak control.
- Improve Early warning system.
- Real time reporting of AES-JE, Influenza AH1N1 and Dengue.
- Covers almost all Vector Borne, Water Borne, Air Borne, Zoonotic Disease, Food Borne Disease, Idiopathic and other infectious communicable diseases.
- Detect outbreak prone locality from the data reported on portal.
- Cross reference can be easily done across the states for Influenza A H1N1, Dengue, AES-JE and KALA-AZAR etc. cases.
- Central Database of the all states.

- A step towards Digital India to keep data digital and online. Helps in transparent reporting.
- The whole portal is developed in-house by department, it always has possibilities to adopt and make changes as per user requirements.

So it can easily be integrated with National level reporting portal and be used in all states.

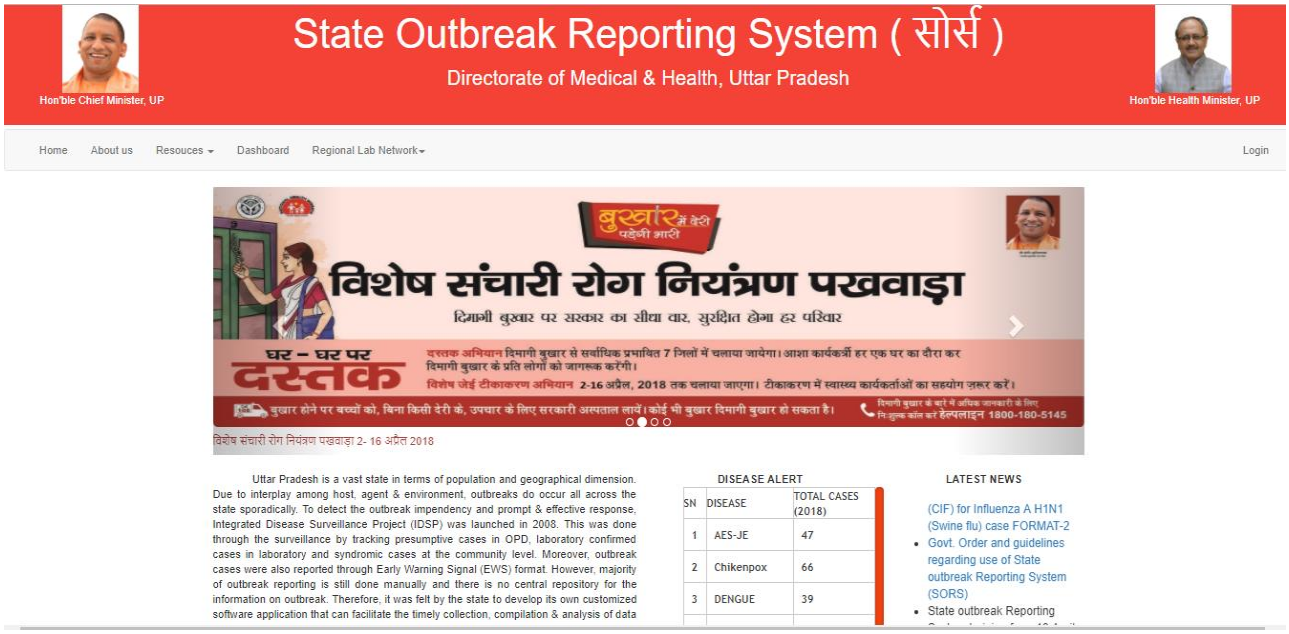


Fig 9- SORS portal Home Page (url- http://sors.uphssp.org.in)

Fig 10- Media and Social Media coverage of SORS portal.

जेई-एईएस पर नियंत्रण को एक्शन प्लान तैयार

राज्य ब्यूरो, लखनऊ : पूर्वांचल के तीन दर्जन से अधिक जिलों में दिमागी बुखार के नाम से पहचानी जाने वाली जानलेवा बीमारी जापानी इंसेफेलाइटिस (जेई) व एक्यूट इंसेफेलाइटिस (एईएस) से बच्चों को बचाने के लिए पहली बार प्रदेश में योजनाबद्ध तरीके से काम शुरू हुआ है। तीन दशकों से नवजातों को मौत के मुंह में धकेल रही इस बीमारी से निपटने के लिए अब तक आकस्मिक और अनियोजित उपाय ही अधिक होते थे लेकिन अब स्वास्थ्य विभाग ने इन बीमारियों पर नियंत्रण के लिए समग्र कार्ययोजना बनाई है और विस्तृत दिशा-निर्देश तैयार किए हैं।

स्वास्थ्य मंत्री सिद्धार्थनाथ सिंह ने बुधवार को जनपथ स्थित विकास भवन में जेई व एईएस के लिए कार्ययोजना व दिशा-निर्देश जारी करते हुए बताया कि अगले महीने जनवरी से लागू होने वाली इस योजना के तहत हर महीने का कैलेंडर तैयार किया गया है कि किस महीने कौन सा लक्ष्य हासिल किया जाना है। सिंह ने बताया कि जून से पूर्वांचल के जिलों में इन बीमारियों का प्रकोप शुरू होता है, इसलिए जनवरी से मई तक योजना के मुताबिक काम करते हुए बीमारी के सिर उठाने से पहले त्वरित उपचार की तैयारी कर ली जाएगी।

मिनी पीकू बनेंगे, बेड भी बढ़ेंगे: दिमागी बुखार की चपेट में आए बच्चों के त्वरित व प्रभावी उपचार के लिए 100 बेड बढ़ाए जा रहे हैं। इसमें पूर्वांचल में नौ जिलों के जिला स्तरीय अस्पतालों में बनाए गए पीडियाट्रिक इंटेसिव केयर यूनिट (पीकू) में पांच-पांच बेड बढ़ाए जा रहे हैं, जबकि कुल 104 इंसेफेलाइटिस ट्रीटमेंट सेंटर (ईटीसी) में से 15 में मिनी पीकू सेंटर भी बनाए जा रहे हैं। स्वास्थ्य मंत्री ने बताया कि प्रत्येक मिनी पीकू में तीन बेड और वेंटीलेटर भी होगा।

पोर्टल से होगी निगरानी: जेई व एईएस पर नियंत्रण के लिए बनाए गए कार्यक्रम की निगरानी और सर्विलांस के लिए भी स्वास्थ्य विभाग ने 'सोर्स' सॉफ्टवेयर के पोर्टल को और ठीक से लागू करने की तैयारी की है।

617 गांवों में चलेगा स्वच्छता अभियान: स्वास्थ्य विभाग ने गोरखपुर व बस्ती मंडल में कुल 617 ऐसे गांव चिह्नित किए हैं, जहां से जेई-एईएस के ज्यादा मामले सामने आए हैं।

जनवरी तक 90 फीसद टीकाकरण का लक्ष्य: स्वास्थ्य मंत्री ने बताया कि पिछले वर्षों में नियमित टीकाकरण का औसत जहां 50 से 60 फीसद के बीच रहता था, वहीं इस बार मिशन इंद्रधनुष के तहत अब तक 87 फीसद बच्चों का टीकाकरण कर उन्हें प्रतिरक्षित किया जा चुका है। मंत्री ने अगले महीने जनवरी में टीकाकरण का औसत 90 फीसद तक पहुंचाने का दावा किया है।

योजना

- स्वास्थ्य विभाग ने मासिक लक्ष्यों के आधार पर बनाया कैलेंडर
- जनवरी से होगा अमल, जून तक दिखेगा प्लान का असर

कम हुई मृत्यु दर (प्रतिशत में)

वर्ष	बीमारी	मृत्यु दर
2016	जेई	19
2017	जेई	12
2016	एईएस	16
2017	एईएस	13

Fig 11- Media, Social Media coverage and IEC of SORS portal.

Sustainability and innovative approach to improve Portal-

- There is a big scope of new innovations in Information technology. An IT team of professional is established by Uttar Pradesh Health System Strengthening Project (UPHSSP) at Directorate department of medical & health to provide technical assistance & support to the department. The portal is upgraded time to time with new ideas and technology by IT team of DRC. The new requirements are generated from department, which are incorporated in the software to facilitate the stakeholders.
- The portal is hosted at State Data Center, where there is team of IT professional to monitor and troubleshoot server and hardware level problems 24X7.
- State Surveillance Unit (SSU) and District Surveillance Unit (DSU) is primary stakeholder. DSU comprises of District Surveillance Officer (DSO), Epidemiologist, Data Manager and Data entry operator of report surveillance and outbreak incidence. This unit is fully equipped with IT infrastructure and large network.

7 Formation of Information, Education, Communication (IEC) Cell

Introduction

Information, Education and Communication (IEC) initiatives are grounded in the concepts of Prevention and primary health care. It is an important component and plays strategic role in the area of public health. It aims to create awareness and disseminate information regarding the benefits available under various schemes/programmes of State Health department and to guide the citizens on how to access them.

Although IEC bureau has been established and functioning in the state, the bureau has not been effectively engaged in IEC activities. Necessary steps are being taken for revival of State IEC Bureau

To face the new challenges and to meet the field needs of health education, an integrated cell has been formulated at UPHSSP to provide technical assistance to the Directorate of Medical Health. The main purpose of the cell is to be the backbone for all the IEC/BCC activities being carried out through the department of Health and its subsidiaries

Vision of the department in formulating a separate the IEC cell

- To connect the programs with the people by educating and mobilizing the masses through Information Education and Communication (IEC)
- To encourage individuals of society to adopt healthy behaviors.
- To disseminate the various activities being carried out by the Health department(state wide and also nationwide) for the benefit of the public
- To help other concurrent programs in creating effective IEC/BCC materials
- To incorporate the concept of Social Behavior Change Communication SBCC for effective rollout of the activities

Various activities being carried out by the IEC/ BCC Cell

The consultants working in the cell are skilled individuals having expertise in Multimedia, Mid media, designing, advocacy and other related activities. Consultants provide support the various on-going activities by the Directorate of Medical Health, and some of the activities being carried out by the cell are enlisted below:

- **Creation of innovative Posters**: Developed various informative posters for creating awareness on Dengue, Malaria, JE/AES , Heatstroke's Swine Flu(H1N1), Bio Medical Waste Management (BMW) etc.

- **Hoarding**: Developed IEC material for hoardings by creating awareness on Hand-washing, Dengue, Malaria

- **Leaflets**: Innovative leaflets on hand-washing, heat-strokes etc were developed

- **Flipbooks**: Created flipbooks for the awareness on dengue for frontline workers

- **Newspaper advertisement**: Taking out newspaper advertisement to announce the various on-going concentrated health care activities by the Directorate of medical Health for the knowledge and benefit of the general population for example when the JE/AES campaign was launched by the Health department in the concentrated 38 districts of the state

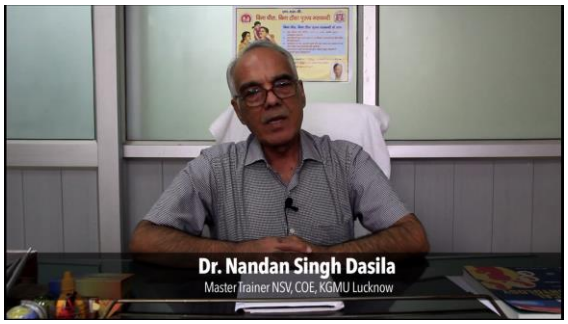
- **Banners:** Innovative and informative banners are created to make people aware of the on-going activity by the government at all stages and levels

- **Short films**: Small films were developed in-house to create awareness on JE/AES, hand washing, Bio Medical waste management, , General waste Management ,Golden hour first respondent project to name a few

- **TVC's and Radio Spots**: Various TVC's and radio spots have been developed to create awareness amongst the general population on Dengue, malaria, heat-strokes, H1N1 etc to name a few

- **Coffee Table** book : Coffee Table book developed for Health department, AES/JEs and revamping of hospitals

- **Short Movies**



A short film on Male Participation in Family Planning (No-Scalpel Vasectomy)

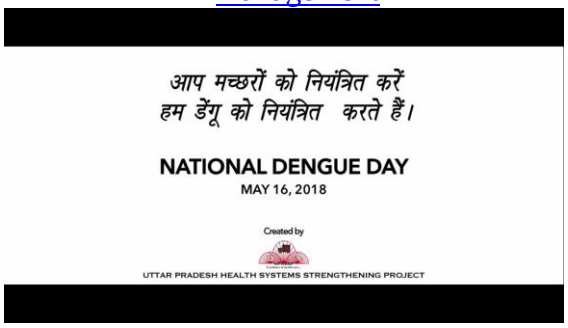
Ayushman Bharat Presentation

A short film of General Waste Management

A thanking video on Doctor's Day

Training video on Bio Medical Waste management

Video on Hand Hygiene Day



A short film on Dengue

A short film on showcasing the public health facilities in Uttar Pradesh

There are other activities also in which the IEC/BCC cell is providing their inputs on like writing articles for newspapers and other in-house circulations highlighting the concentrated efforts by the Directorate of Health and family welfare in disseminating correct information to the last mile.

8 Revamping of District Hospitals: A Cluster Champion Approach

Introduction:

In Uttar Pradesh, the major challenges confronting public hospitals are deficient infrastructure, insufficient manpower, high patient load, vague quality of services and cost burden. Most of the public hospitals in UP are devoid of basic infrastructure, which also includes amenities like water, electricity, beds, medical and paramedical manpower. On the other hand, improper distribution of available infrastructure leads to undermining of merely available resources. Unavailability of any of the resources like water, electricity would render the functioning of existing facilities worthless.

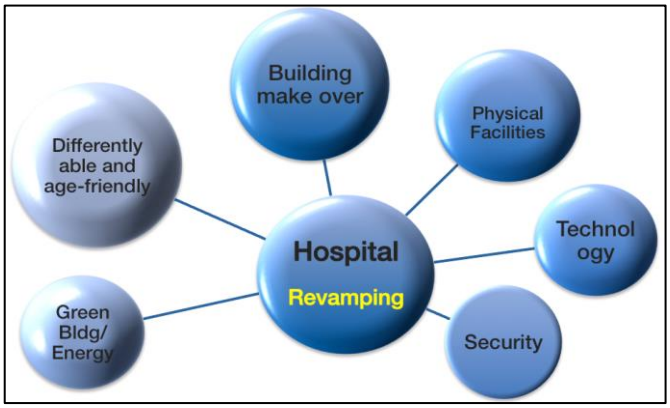
The Uttar Pradesh Health System Strengthening Project (UPHSSP) has taken an initiative of revamping 51 district hospitals in the state of Uttar Pradesh. Under the stewardship of the Honourable Health Minister, Government of Uttar Pradesh, the state has decided not only to improve its services by standardizing its processes as per NABH guidelines, but also to revamp 51 district level hospitals.

In order to fulfill the revamping objectives, a cluster champion approach introduced since November, 2017 to enhance accessibility, efficiency, patients' and staffs' safety, outcome of care and customer satisfaction

Revamping Objectives:

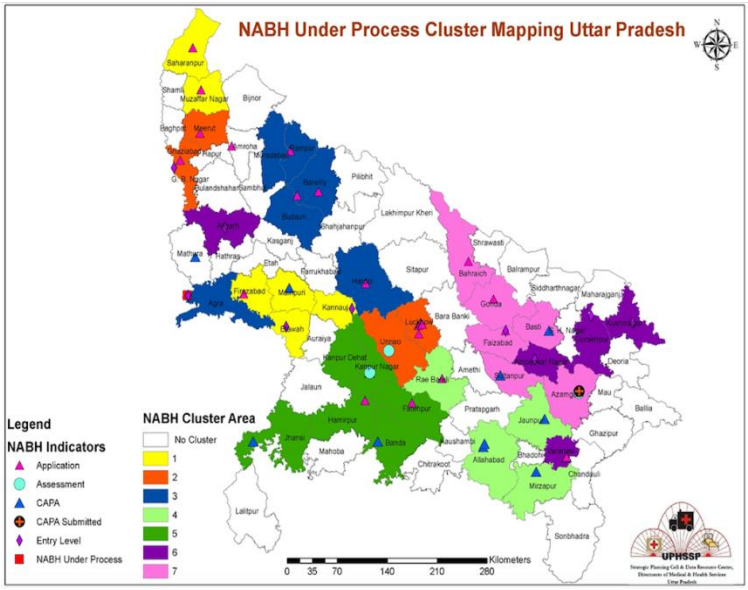
The major objectives of the revamping exercise are:

- Upgrade 41 Hospitals to enable them become Smart Hospitals ensuring patient safety, quality services and patient rights to enhance trust in government services
- Provide Patient Friendly Services by ensuring integrated functional design, physical up gradation, processes redesign and operational improvement to meet the patients and service providers' expectations
- Improve Patient and Service Providers' Satisfaction by focusing on patient centric services and providing conducive working environment



Cluster Champion: Approach

Based on the geographical distribution, 51 district hospitals are divided into 7 clusters. Each cluster caters about 6-7 hospitals. Each cluster is managed by dedicated team and lead by Cluster Champion. The cluster has been assigned a name as **Royal Challengers, The Achievers, Warriors, Silent Killer, the Galvanizers, Renaissance and Phoenix**



A checklist with key performance indicators (KPI), consisting of 109 activities, has been prepared to monitor the revamping work. This checklist reflects status of all major activities envisaged under revamping initiation. All the members of Cluster team, including Cluster Champion oriented about different aspects of the project.

Cluster team is supported by two Management Consulting firm - IMS India Ltd and IIHS. The IMS agency has been hired to support 41 district hospitals for infrastructure assessment of hospitals and complete architure lay out plan for 41 district hospitals by June, 2018. The IIHS is providing support in assessment of infrastructure with process of OPD and ED in 10 district hospitals. The IIHS has started working from December 2017.

Each Cluster has been assigned with nearly 6-7 hospitals; it is mandatory for team members of each team to visit at least two hospitals in a month with one night stay so that every quarter all the six hospitals of their cluster are covered. Cluster Champion approach is linkage between cluster team based at state headquarter and Chief Medical Officer (CMS) and Hospital Manager of the hospitals.

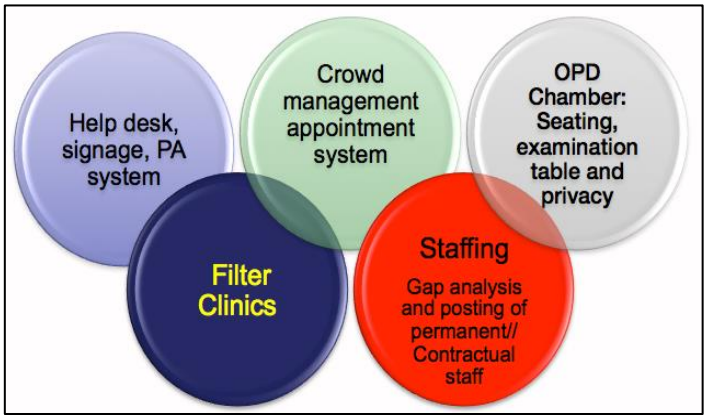
Process:

Building Makeover:

Efforts are being made by each cluster to completely change the look of the selected hospitals. It is expected that after these interventions hospital walls will be well lit, with basic amenities and equipment organized in a patient friendly environment. Some of major task taken by team are- wall painting with wall putty, minor civil work, room refurbishing, patient comfort/physical facilities (toilet, drinking water, cooling system), electrical (load assessment, wiring, safety equipment etc), differently abled/age-friendly facilities (ramp, railing, wheel chair/stretchers' belt, grab bar, railing magnet in toilet doors, alarm bell etc), gardening and landscaping, parking facilities

Out Patient Department (OPD) Revamping

OPD being one of the first point-of-contact of a hospital, The each cluster team is making efforts provide an efficient and patient friendly services in five thrust areas namely i) help desk, ii) filter clinic, iii) crowd management, iv) Re-organization of OPD chambers and v) staffing have been identified under OPD revamping.



The 109 activities mentioned also included IT Solutions(appointment system, CCTV System), directional signage and colour coded way-finding, OT/EMG (zoning, sterilization, infection prevention, scrub area, medical gas), ICU and NICU refurbishing, Labour room standard reforms, Equipment Calibrations, Beds/Dolchi, pans, repair, painting and replacement, inventory management(inventory of equipment, downtime assessment), well-lit gates with glow-sign lights, paediatric unit decoration, bed rails in paediatrics and old-age wards, fire safety measures, mortuary improvements, lead shielding of X-ray and CT rooms, mechanized laundry services, condemnation.

Score Card: Based on list of 109 activities, each activity has been assigned a score as 0 for Non-Starter (non-compliance), 1 for partial compliance (in process), 2 compliance (completed). Responses from each hospital are coded as Good–Green (Compliance), Average- (partial compliance) Yellow and Poor– Red (Non-starter). The progress made on each response is followed from each hospital by Cluster Champion on daily basis.

Supportive supervision: The progress made on 109 revamping activities is being monitored by a committee headed by Project Director and Additional Project Director on daily basis for each cluster. Further, Honourable Health Minister, Govt of Uttar Pradesh review the dashboard of revamping of hospitals once in every month.

Impact

- *Improve in building the capacity of service providers***:** The approach has helped in building the capacity of CMS as well as hospital manager. Now CMS are more aware of their responsibility and actively engage in monitoring key revamping indicators. As a result, there is an improvement in health delivery services in hospitals.

- *Utilisation of Fund:* It was earlier observed that many of hospitals were not optimally utilising the fund for allocated for outsourcing of services including diagnostic, Laundry and cleaning & gardening and Civil work, salaries, training etc. However, due to constant handholding and support to service providers has resulted more than 90 percent in utilising of fund for FY2016-17.

- *Build Trust & Ownership*: The Cluster approach has helped in bringing greater trust among service providers, including the CMS and Hospital Manager. In order to bring stronger bonding among providers, the project has also started organising workshop wherein CMS, Nodal officer–NABH and Hospital Managers share their experience on revamping work. Based on score card of revamping work, the best performing hospital from each cluster are being awarded.

Some Facts……

Condemnation process- The instruments and items which were non-function since many years and have become obsolete, which were grabbing the space of the district hospital were condemned. This Condemnation of equipment helped in creating space and getting more rooms, helped in pest control. One round of condemnation carried out in 51 district hospitals. In some of the hospitals, second round of condemnation carried out.

Mandatory audits- Fire safety and electricity audits are important for hospitals as it ensures safety and security of patients and hospital staff. Cluster champions ensure a systematic fire audit takes place for the, critical appraisal of all potential Fire hazards involving personnel, premises, services & operation method. Fire and electric audit conducted in 51 district hospitals.

Mandatory licences- There are 13 licences required by all district level hospitals. All the hospitals are monitored and assisted on daily basis for procuring them. 13 licences comprises of Bio Medical Waste Authorization, AERB operation license, Air NOC, Water NOC, Narcotics storage NOC from DI, Pharmacy sale license from DI, Fire NOC from CFO, Spirit Storage permit from abkaari vibhag, PCPNDT license, Building Occupancy Certificate from Municipal Corporation, Lift license (only for limited hospitals). More tah 40 hospitals have acquired Narcotics, Pharmacy, Spirit permit, building occupancy, PCPNDT, and BMW authorisation

9 Managing HR Agency

Introduction

Uttar Pradesh Health System Strengthening Project (UPHSSP) is conceived as a strategic initiative to enhance people's access to quality health care services in the state of Uttar Pradesh (UP). The project seeks to strengthen systems and institutions and their capacity to deliver quality services further in a manner that makes them accessible to people in general and to the poor in particular with a focus on women and un-served people in remote areas.

NABH standards are being applied by UPHSSP at 51 District Hospitals. The standards provide framework for quality assurance and quality improvement for hospitals. The standards focus on patient safety and quality of care. To maintain quality of care, minimum essential manpower is required for functional District Hospitals of different bed strengths.

An assessment was done by UPHSSP and required human resource was deployed. Doctors, Hospital Managers, Staff Nurses and 21 type of paramedical were recruited on contractual basis at 51 District level hospitals through an HR service agency, T&M Services Consulting Pvt. Ltd Mumbai selected through NCB.

Service Provider's Bid

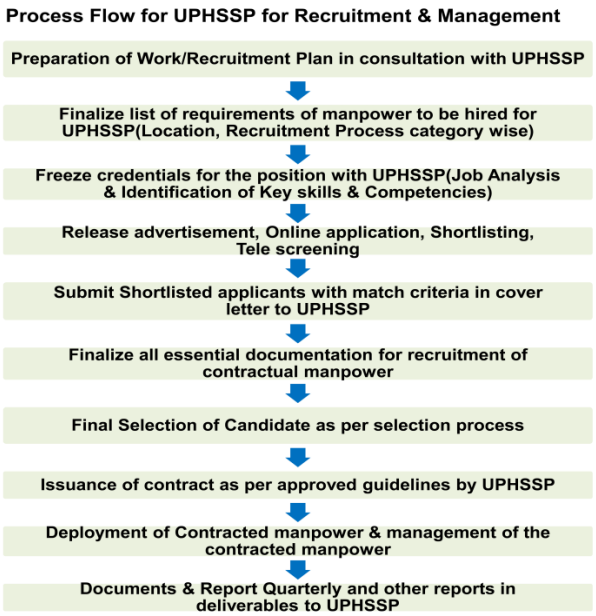
There are two types of contracts with the agency. According to the bidding documents services are offered in accordance with the conditions of Framework Agreement and for the following rates:

Types and Description of Manpower	Type of Contract	Service Charges(Yearly)
Medical/Consultants/Specialists Casualty doctors(EMO)/General Duty doctors, Ophthalmologist, ENT Surgeon, Orthopaedician, General Surgeon, Anesthesiologist, Cardiologist, Skin Specialists, Pathologist, Radilogist, Pediatrician, Gynocologist,Physician, Dental Surgeon, Psychiatrist, Dermatologist, Microbiologist, Public Health Specialist, Managers etc.	Recruitment and direct contract with UPHSSP Contract No. 60/UPHSSP/ HR- RA/ 15-16 Dated 11.06.15	3.99%
Staff Nurse,Dietician, Den. Hyg., OT Tech., Lab Tech., Xray Tech., ECG tech., CSSD Tech., Plumber, Ward aya, Ward boy, Opotometrician, Cook, Physiotherapist, Kahar/Bearer, Reg.Clerk, Store Keeper, MRD Clerk, Mortuary att., Electrician, Pharmacist and audiometrician	Recruitment and Payroll management (Contractual Staff) Contract No. 61/UPHSSP/HR-R& MA/15-16 Dated 13.08.15	1.48%

Scope of the assignment

- The Agency is responsible for strategic recruitment as well as management of Nurses, Paramedical-medical professionals, Computer Operators, Programmers, Gardeners, Plumbers, Electricians etc. at various levels on contractual basis to meet with the requirements of such resource in Government health facilities at the state and district level.
- The agency adopts a transparent, competitive and gender sensitive process. It should also be noted that these posts are contractual nature posts with consolidated pay package including statutory compliances with no other benefits.
- The agency ensures selection of best suitable candidates for the required position, who should be meeting all the eligible criteria as provided by UPHSSP team.
- The manpower deployed by the agency is dedicated full time for this service and shall be retained with that exclusive requirement. To ensure quality, the agency follows an exclusive HR policy in consultation with UPHSSP, describing standards and guidelines for managing the manpower deployed for the purpose. The agency provides services through deployment of suitable manpower, having results orientation, potential to lead a thematic unit and ability to extend quality support to states. The manpower deployed is in accordance with the service requirements of UPHSSP and to be assured of quality of service, the deployment of manpower is with the concurrence Go UP/Directorate/ UPHSSP.
- The composition of manpower deployed by the agency is based on the services assigned to them.
- The activities that agency is performing during the contract period is mostly related to recruitment and management of contractual manpower for filling-up vacancy (as per instructions given by UPHSSP/Department), undertaking HR related trainings/capacity building if required. The scope is quite broad which include preparation of action plan, HRM (Human Resource Management) policy development which lists out recruitment, retention, termination, appraisal, transfer etc. policy.

Process Flow for UPHSSP for Recruitment & Management



Teething problem and its solution:

Payment issue with PF, ESIC and Service Tax: The issue faced by UPHSSP was that a consolidated ECR(Electronic Challan cum Return) was submitted on monthly basis and it was not clear whether employee share and employer share for each employee was submitted with EPFO(Employees' Provident Fund Organisation) or not. This was resolved when the agency was asked to provide one on one mapping of ESIC and EPF challans of all employees at 51 hospitals. Thus it was ensured that service provider will pay the monthly salaries and deposit all the statutory deductions (like PF, ESI etc.) with respective authorities for each resource deployed and then claim the paid amounts as reimbursements from UPHSSP by submitting monthly invoices with relevant supporting documents.

Mode of salary payment: The mode of salary payment was through bank cheques. Many employees faced issues with cheque encashements. UPHSSP was instrumental in ensuring that bank accounts be opened for all employees. The payment of salary to employees is was started through banking mode. The agency was also asked to provide one on one mapping for salary transfer to their respective bank accounts on monthly basis. This ensured transparency in disbursement of employee salary every month.

Timely salary disbursement: The salary was not being transferred on time. To address this issue Human Resource Management System (HRMS) software is developed in-house at UPHSSP. HRMS ensures that all employees fill the attendance of previous month by first working day of the following month and get their attendance verified by verifying authority by third working day. This will ensure timely salary disbursement to all employees.

Human Resource (paramedical) deployed category-wise:

Designation	No. of employees deployed	Designation	No. of employees deployed
Staff Nurse	1688	Kahar/Bearer	34
Dietician	33	Reg.Clerk	180
Den. Hyg.	4	Store Keeper	75
OT Tech.	134	MRD Clerk	65
Lab Tech.	138	Mortuary att.	13
X-ray Tech.	71	Plumber	8
ECG tech.	24	Electrician	20
Physiotherapist	35	Ward aya	325
CSSD Tech.	50	Ward boy	213
Opotometrician	19	Pharmacist	48
Cook	27	Audiometrician	11

Above Data is till March 2018

Human Resource (Doctors) deployed category-wise:

Designation	No. of employees deployed	Designation	No. of employees deployed
General Medicine Sp.	7	Radiologist	4
General Surgery	13	Pathologist	14
Obs and Gyne.	8	Cardiologist	0
Pediatrician	6	Microbiologist	4
Anesthesiologist	17	Chest Physician	6
ENT Surgeon	14	Dermatologist	2
Ophthalmologist	8	EMO	184
Orthopedician	19	Dental Surgeon	13

Above Data is till March 2018

Category of consultants recruited:

The various categories of consultants recruited through the service agency are as follows: Consultant MIS, Consultant Procurement, Assistant Accountant, HR Expert, Junior Engineer (Civil), Programmer HIS, System Administrator, Network Administrator, QA & D Specialist, Programmer HGIS, System Manager, Consultant Environment Management, Consultant Communication & Grievance, Consultant Training & website, Programmer HMIS, Research Officer, QA & D Specialist Hospital, CMSD PIS Finance, Consultant QA, Consultant Knowledge Management Cum Documentation, Consultant QA, Administrator Database, Biomedical Engineer, HR Personal, Consultant Public Health, Consultant Epidemiology, Consultant Planning, Consultant Monitoring and Evaluation, HR Accountant and Legal Expert.

Payments made to T&M year-wise:

Year	Invoice Amount (Rs.)	Payment (Rs.)
2015-2016	20864005	20446725
2016-2017	539388587	528600813
2017-2018	708846417	694854255

Category of Staff engaged by T&M for handling our assignment:

T&M consulting services has employees on following posts to manage the assignment: Recruitment experts, HR managers, Recruitment coordinators, HR Executives, Executive Talent and Acquisition, Executive payroll, payroll managers, Finance manager, accountants, recruitment facilitators, Tele-callers and Office Assistants.

Conclusion:

Both the contracts with T&M Services Consulting Pvt Ltd, Mumbai are being well-managed by UPHSSP. Currently there are 122 specialist doctors, 184 EMO(emergency Medical Officers), 13 Dental Surgeons, 51 Hospital Managers,35 consultants, 1688 Staff Nurses and 1527 paramedical deployed by UPHSSP. Out of which 3215(Staff Nurses and paramedical) are being managed by T&M Consulting Pvt. Ltd., Mumbai.

Other Initiatives

Strategic Planning Cell (SPC) has been actively engaged in supporting the Health Directorate and under taken need-based analytical work and action research to provide necessary evidence for policy decision making. Some of the initiatives taken by Strategic Planning Cell are.

Standard Treatment Approaches: A Standard treatment approaches for 14 commonly occurring diseases/ health conditions for the use by providers at all levels of government health facility was developed. The book was released by Honourable Minister of Health, UP.

Research Study on Non-Communicable Disease: A study titled "Strengthening of district health systems for the management of non-communicable diseases in Uttar Pradesh" is being carried out with technical support from Department of Community Medicine, KGMU. This study is being carried out in 18 selected districts of the state of Uttar Pradesh, using qualitative and quantitative methods. The study involves interviews with various stakeholders and Facility Assessments from District Hospitals, CHC, PHCs, and SC. The data collection work completed in all the districts. The draft report will be ready end of May 2018.

Research Study on Perceived stress and quality of life in community representative population of Uttar Pradesh: The study will help in understanding the stress perceived by people of different age, gender, religion, social strata and occupation. This study will also provide an insight to their quality of life and health. Understanding perceived stress, quality of life and its impact on health will help in identifying potential groups that need stress reduction interventions. Implementation of stress reduction methods and life style modification strategies will help in reducing mental health and physical health morbidities. The study is being carried out collaboration with Department of Psychiatry, KGMU. The draft report will be ready by end of December 2018.

Sustainable Development Vision Document: SDG vision document was prepared and shared with NITI Aayog.

State Infection Prevention Guidelines: The guidelines have been prepared with this perspective defining relevant quality standards to follow in Public Health facility. It will serve as a tool to ensure safer hospitals for all patients and healthcare providers. Infection prevention guidelines will also direct the healthcare providers to follow correct infection prevention and control practices.

Medical Oxygen Policy & Guideline for district level Hospitals: This policy provides the foundational principles for engaging stakeholders in oxygen supply, distribution, administration, and equipment maintenance.

State Action Plan for Trauma Care: Developed State Action Plan for Trauma Care.

Nursing Manual: The manual has been prepared to provide complete guidelines to the nursing staff so that they become aware of proper nursing procedures performed in hospitals and can render quality care to the patients.

Referral Policy: State Referral Policy is being prepared to facilitate patient referral by care provider in response to their inability to provider the type of intervention to the need of patients.

Standard Treatment Guidelines: The guideline have been developed and updated in 11 clinical areas. This guideline will be helpful for medical officers in the state.

Standard Treatment Protocols on Vector-Borne Diseases: Protocols have developed ensure effective & efficient preventive measure along with quality health care provision at all level of Public Health System.

State Trauma Care Policy: The strategic planning cell is leading the work of preparing the 1st Trauma care policy for the State of Uttar Pradesh.
The first draft of the Policy covering pre-hospital and hospital care is ready for the review of State Leadership.

Project Implementation Status

Introduction

Uttar Pradesh Health System Strengthening Project (UPHSSP) was launched in June 07, 2012 with aim to strengthen systems and institutions and their capacity to deliver quality services in a manner that makes them accessible to people, to the poor in particular with a focus on women and underserved people in remote areas. The project has gone through three distinct phases a) Initial phase (2012-2015), b). Performance Phase (2016: 2017) and c). Acceleration Phase (2017-2019)

Challenges during Initial Phase (2012-2015)

There were many challenges faced during initial phase. As a result, the project has not effectively made progress during initial phase. Some of the constraints were-

- **Frequent change in project leadership:** The project was approved on December 20, 2011 and was made effective on May 25, 2012. Since project approval, there had been 9 project directors. The average tenure of the project directors had been for 4-5 months, which affected both decision making and oversight of the project.

- **Delayed decision making:** There was a significant delay in the internal project decision making by the PSU due to change in project leadership, weak oversight of overall project implementation, limited capacity at the PSU and coordination issues with other stakeholders. The average time for any procurement was between 12 to 24 months. Similarly, the administrative decisions on simple issues such as staffing at TAP and PSU had taken as long as 8-12 months. Clearances at the final stage of procurement, such as contract approval and contract signing, from the project steering committee and the project governing board have also had long delays.

- **Long pending decision on Social Accountability, 17 hospitals for accreditation, and outsourcing of nonclinical services:** The project was not able to contract the agency for conducting baseline study under social accountability component, handholding support for 17 hospitals for accreditation, and outsourcing of nonclinical services and HR agency.

Performance Phase (2016: 2017)

The project made progress from mid-2015 due to stability in leadership. The project started implementation of various pending project activities. Most key pending decisions had been made. Number of contracts awarded had significantly increased and for the first time since the start of the project there had been progress in all the activities under the two components and this has translated in the project moving towards achievement of project development and intermediate results targets. The project has also started filling up the position at TAP, directorate cells & PSU.
The Implementation of the project had continued to gain momentum during 2016-17 due longer stability of Project Director. Three out of the six outcome indicators had achieved end-of-project targets while the remaining three were on track. Four of the seven intermediate results indicators have achieved end-of-project targets and two more were on track to achieving the end of the project.

Acceleration Phase (2017-2019)

Keeping the good performance of the project in last two half years, the project got extension for another two years (April-2017- March, 2019). Due to continued leadership, three of the six outcome indicators have surpassed their end-of-project targets and one more is on track to achieve it ahead of time. End-of-project targets have been achieved for all six intermediate results indicators.
The current phase is also witnessing several initiatives taken up by the project. Project has made tremendous efforts in getting NABH accreditation for 12 District Hospitals. The project is looking quality improvements beyond accreditation. These include hiring a revamping the Out-Patient and Emergency Departments starting with 10 hospitals, architectural intervention for hospitals face lifting in remaining 41 hospitals. The project has also started driving initiative such as State Health Policy, Trauma Action Plan, Referral Policy, Standard Treatment Approach, Standard Treatment Guidelines, Nursing Manual, Trauma Action Plan.

Drug Procurement and Monitoring System

Creation of web based software for Drug Procurement and Monitoring System: Government of Uttar Pradesh is making efforts to provide accessible, affordable and quality health care provide services. Under Uttar Pradesh Health System Strengthening Project (UPHSSP), Drug Procurement & Inventory Control System (DPICS), an IT initiative, was developed to ensure in improving drug warehousing and supply chain management in all government hospital in the state. This system covered drug & other item stock maintenance of any facility as well as supply of it. To make this system transparent, availability of medicine of any facility was available in public domain. Rate contracts and Quantity Contracts made by DG were available online. This online application has been developed & hosted by National Informatics Centre. It was available on www.dghealth.up.nic.in website.

Outcomes: The implementation of application of DPICS started in April, 2014 with the pilot run in 50 District Male Hospitals. Budget was provided by the project for purchase of Computer, UPS & printer district hospitals & CMO's. Beside this, the project provided Computer Operators to work on DPICS to support the implementation of application in 22 CMO's offices (where NHM drug warehouse not established) & all district level hospitals. It was mutually agreed and replaced by Drug and Vaccine Distribution Management System (DVDMS) - e-Aushadhi Application (as per DG order received by the letter no 8फ/भंडार.डी.वी .डी/एम.एस/.२०१७ 1115). The DVDMS is now implemented by NHM. E-Aushadhi is a web based supply chain management application that deals with purchase, inventory management and distribution to various district warehouses of State, District Hospitals and their sub-stores like Community Health Centre (CHC) and Primary Health Centre (PHC) to distribute drugs to patients, the final consumers of the supply chain.

Facility Health Report Card

Creation of web based software for Facility Health Report Card: There were no application available in the state to tap the information on different parameters of Human Resources, Equipment, Construction projects, Performance, Immunization , Patients of Epidemic, Deaths reported of Epidemic, Drugs & medicines ,Budget ,Legal cases ,other issues. The Uttar Pradesh Health System Strengthening Project (UPHSSP) developed Facility Health Report Card and it started functioning from April 2013. The objective of the Health Report Card was to present an overview of resources and performance of the district hospital on a sheet for better delivery of services. "Report Card" consisting of information on health outcomes, primary care service coverage and health facility performance (production, productivity and quality) to facilitate regular monitoring at district level (efficiency and accountability).

Outcomes: This was used to keep track of the activities being performed in the hospital and

- Analyses the budget(sanctioned/Previous),
- Monthly availability of resources and performance,
- Cause effect analysis
- Shortage excess of manpower ,
- Functional/ non-functional equipment. Etc.
- Along with other Reporting feature

The facility report card was successfully implemented in state and covered 75 districts (CMO Health Report card) and 169 districts hospitals (District Health Report Card). Later it was mutually agreed and transferred data to UPTSU for development of HMIS.

NABH Accreditation of District Hospitals in Uttar Pradesh.

Hiring of Octova Solutions- Octova Solutions was hired to provide consultancy services to 23 district level hospitals of the Department of Medical & Health through UPHSSP for NABH accreditation. Service provider was to achieve following objectives specifically:

- To assess the current infrastructure, human resource, equipment, processes and outcomes vis-à-vis NABH standards & IPHS and identify the gaps thereof;
- To handhold the facilities to bridge the gaps for conformance to NABH standards and IPHS(wherever needed for getting NABH accreditation) including capacity building and training of all personnel for behavioural changes and adherence to standards in terms of clinical and governance related processes;
- To provide technical support in the process of application of final accreditation of NABH.

Outcomes- Octova Solutions was issued a contract w.e.f. 4th March 2014 for the duration of 36 months. Service provider was to deliver services in 18 months, but could not deliver services in stipulated timeframe. Therefore, contract was closed on mutually agreed terms. Furthermore, Project team started working on these deliverables by appointing Hospital Managers. A considerable progress has been made by the project team achieving pre-set goals.

Hiring for Procurement Agent

Hiring of the Procurement agent:- Accenture Ltd. was hired to act as a procurement agent for all procurement of equipment, goods and service delivery contracts under the project and contract management (except making payments) to achieve value for money, efficiency, transparency, probity and adherence to the agreed procurement arrangement for the project.

Outcomes- Accenture Ltd. was issued a contract w.e.f. 4 March 2014 for the duration of 36 months. Procurement Agent delivered the services during the contract period as per Terms of Reference. Contract expired on its due date. Hereafter, competent authority decided not to extend its contract further. Subsequently, another service provider was hired for undertaking the role of procurement agent. Contract was given 3 months extension as well and expired on 3 May 2017. Contract was amicably closed on mutually agreed terms.

Hiring of Capacity Development Agency

Hiring of Capacity Development Agency: Ernest & Young (E&Y) was hired to find out the systematic weaknesses, capacity gaps and provide technical support to CMSD in strengthening systems, processes, documentations and computerization of CMSD as per the need of the Department/CMSD/ proposed UPMSC and implement the capacity building program in procurement, supply chain management for staff working in Central Medicine Supply Department (CMSD) of the Directorate of Medical & Health, proposed UP Medical Corporation Ltd. (UPMSC), UPNRHM, PSU-UPHSSP & the district level entities associated with the procurement and supply chain management function.

Outcomes: Ernest & Young was issued a contract w.e.f. 4th March 2014 for the duration of 36 months. E&Y reviewed all the systems and did a gap analysis and proposed an action plan. E&Y prepared a procurement manual, bidding documents for goods, drugs & equipment and trained key staff for two years. E&Y prepared new training manuals as well. E&Y run the complete procurement process for mobile medical unit (MMU) and Haemodialysis unit. Thereafter, it did an impact assessment too. E&Y was to train around 1500 district procurement staff too, however, this plan was shelved keeping in the view that Uttar Pradesh Medical Corporation was being formed and these trainings would not have required. Contract was amicably closed on mutually agreed terms.