

**Internship  
at  
National Health System Resource Centre,  
New Delhi**

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## Acknowledgement

“The Journey is more important than the destination; Excellence is a journey not a destination”.

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## **Internship Report**

## **1. Organisation Profile**

### **1.1 Introduction**

National Health Systems Resource Centre (NHSRC) has been set up under the National Rural Health Mission (NRHM) of Government of India to serve as an apex body for technical assistance.

Established in 2007, the National Health Systems Resource Centre's mandate is to assist in policy and strategy development in the provision and mobilisation of technical assistance to the states and in capacity building for the Ministry of Health and Family Welfare (MoHFW) at the centre and in the states. The goal of this institution is to improve health outcomes by facilitating governance reform, health systems innovations and improved information sharing among all stake holders at the national, state, district and sub-district levels through specific capacity development and convergence models.

It has a 21 member Governing Board, chaired by the Secretary, MoHFW, Government of India with the Mission Director, NRHM as the Vice Chairperson of the board and the Chairperson of its Executive Committee. of the 21 members, 11 are ex-officio senior health administrators, four from the states. 10 are public health experts from academics and civil society. The Executive Director, NHSRC is the Member Secretary of both the board and the Executive Committee. NHSRC's annual governing board meet sanctions its work agenda and its budget.

The NHSRC currently consists of eight divisions – Community Processes, Public Health Planning, Human Resources for Health, Quality Improvement in Healthcare, Healthcare Financing, Healthcare Technology, Health Informatics and Public Health Administration.

The NHSRC has a regional office in the north-east region of India. The North East Regional Resource Centre (NE RRC) has functional autonomy and implements a similar range of activities.

### **1.2 Vision**

NHSRC committed to facilitate the attainment of universal access to equitable, affordable and quality healthcare, which is accountable and responsive to the needs of the people.

### **1.3 Mission**

Technical support and capacity building for strengthening public health systems.

### **1.4 Policy Statement**

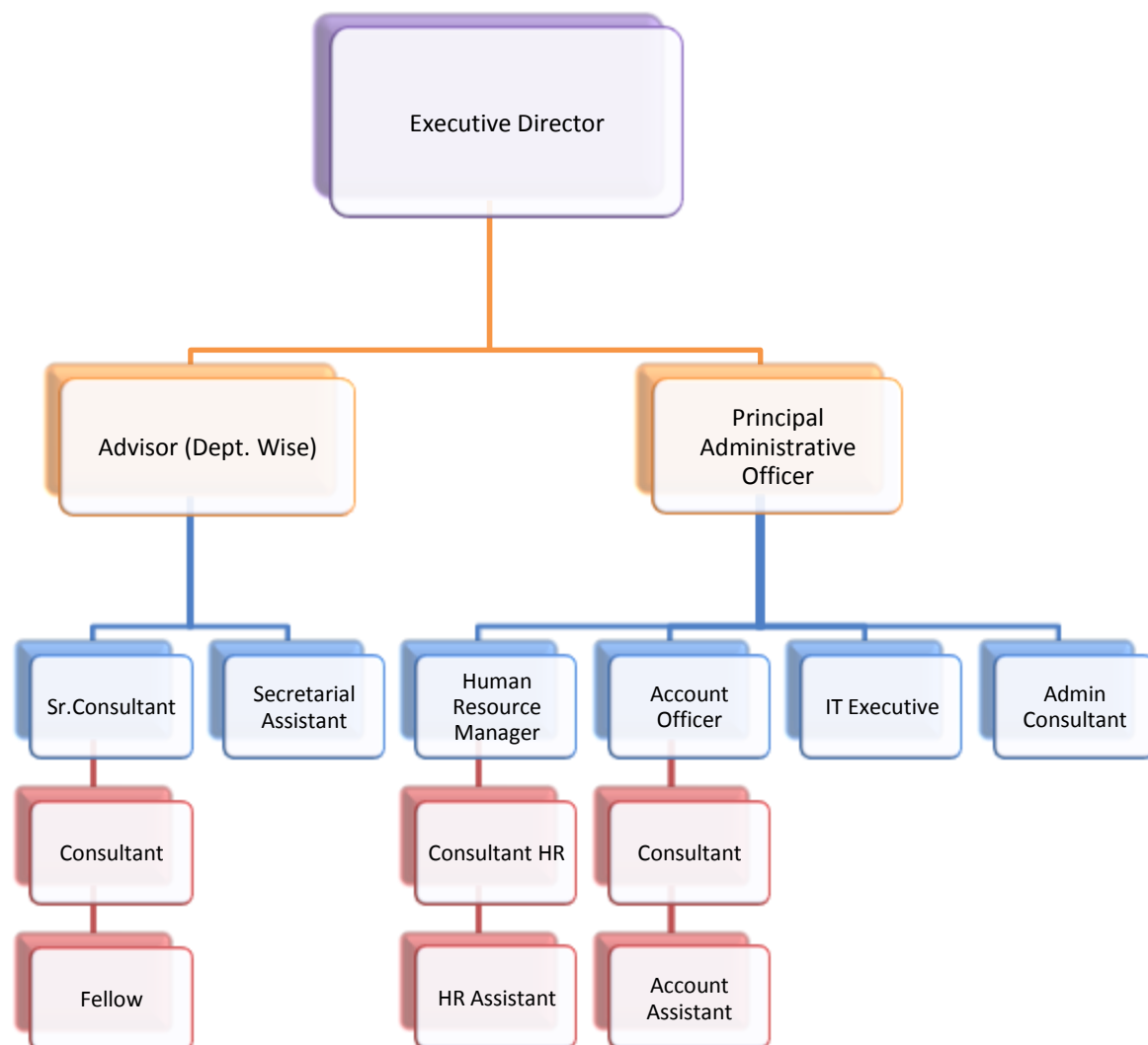
NHSRC is committed to lead as professionally managed technical support organization to strengthen public health system and facilitate creative and innovative solutions to address the challenges that this task faces.

In the above process, NHSRC shall build extensive partnerships and network with all those organizations and individuals who share the common values of health equity, decentralization and quality of care to achieve its goals.

NHSRC is set to provide the knowledge – centered technical support by continually improving its processes, people and management practices.

## 2. Organogram of organization

Figure 2.1



### 3. Departments of NHSRC

The NHSRC currently consists of eight divisions –

- Community Processes
- Public Health Planning
- Human Resources for Health
- Healthcare Financing
- Healthcare Technology
- Health Informatics
- Public Health Administration
- Quality Improvement in Healthcare

#### 3.1 Community Processes

The National Rural Health Mission (NRHM) promised an architectural correction of the health system which included “communitisation” as one of its key anchors and to enable the community and community based organisations to become equal partners in the planning process. Key components of NRHM that strengthen the community processes and promote public participation include:

- The village based female community health worker called ASHA and her support network at village, block, district and state levels.
- The Village Health and Sanitation Committee (VHSC).
- Public Participation in District Health Societies and the district planning process as well as in Rogi Kalyan Samitis (RKSs).
- Community Monitoring Programme.
- Programmes for involving NGOs in the NRHM.

In one of the world’s largest community health worker programmes, 8, 25,525 ASHAs have been selected, trained and deployed across the country, and 488,012 VHSCs have been set up. One of NHSRC’s major responsibilities is to provide technical assistance to the centre and states in the implementation of these two large programmes.

##### 3.1.1 Key Contributions

- Developed operational guidelines for ASHA and her supervisory cadre, and built capacity in states to manage this programme.
- Developed a competency- based training module that provides her the skills to fulfil the roles expected for her.
- Developed capacity in identified training organisations and individuals at state level to transact the competency based training modules.

- Has done a detailed programme evaluation of the ASHA programme in over 11 states- and this has been used to improve both programme management and policy.
- Built up a system of regular programme monitoring, and the summary of findings is published as a six monthly ASHA update.
- Provide assistance to states in identifying constraints and seeking joint solutions.
- Building partnerships with civil society at both state and national level to expand the technical capacity available to implement this programme.

### **3.2 Public Health Planning**

One of the core strategies of NRHM as outlined in the National Framework for Implementation document is the preparation and implementation of integrated District Health Action Plans (DHAP) and village health action plans. District Planning has been conceived by NRHM as a tool of decentralisation. Understanding, documentation and dissemination of experience of these plans across states helps cross learning of best practices and innovations. These are then contextualised and integrated into their state and district Programme Implementation Plans (PIPs) making the planning process an idiom of strategy development and effective implementation. Much of the work of NHSRC has been geared towards making the planning process in districts and states more effective, ensuring their implementation and supportive supervision. At the national level, it is focused on gathering evidence that can support development of strategies and guidelines. The team also works on development of guidelines, tools and manuals that improve quality of planning. A continuous effort towards building institutional capacities at state level to provide technical assistance for ongoing planning process is one of NHSRC's primary roles.

#### **3.2.1 Key Contributions**

- Built up the capacity in states and districts to make annual project implementation plans for implementing NRHM. Also jointly with a civil society network and an open university developed a training programme with 18 modules for capacity building for district health planning.
- Main coordinator of common review missions of the NRHM as well as a number of other programme evaluations and studies of NRHM components.
- Quarterly monitoring report on progress against approved project implementation plan, made by all states.
- Building up of State Health Systems Resource Centres (SHSRC) or equivalent bodies.
- Developing policy notes- especially as related to health systems strengthening and reproductive and child health, reviewing evidence from multiple sources- including studies, best practices and institutional memory of past efforts.

### **3.3 Health Informatics**

NRHM envisaged a fully functional health information system facilitating smooth flow of information for effective decision making. Lack of indicators and local health needs

assessment were identified as constraints for effective decentralisation. Almost 50% of the monitoring and evaluation cost was envisaged to be expended at the district level and below. All this requires a robust health management information system that can provide good quality information which would be essential for decentralised health planning.

### **3.3.1 Key Contributions**

- Rationalisation and choice of data elements and indicators.
- Building and maintaining systems of data collection, flow, management, processing and analysis to improve data quality. Establishing regular reporting from all 640 districts in the country.
- Building capacity and systems for use of information for planning and programme management at district, state and national level.
- Assessing state preparedness and data quality and assisting states in improving data quality.
- Building state capacity to manage the Health Management Information System (HMIS).
- Development of other areas of use of health information-GIS, Hospital Management Information Systems, Human Resources Information Systems, M-Health, and Name-based Tracking Systems.

## **3.4 Human Resource for Health**

One of the major areas of NRHM intervention has been in the development of human resources for health. Across the states, over 1, 06,949 additional skilled personnel have been added to public health system by NRHM. It has also undertaken a number of programmes leading to skill up-gradation of those already in service and innovations that lead to retention of skilled professionals in rural areas. NHSRC's contribution is for sustained evidence based strategies for bridging the HR gaps. NHSRC also identifies and documents and shares interesting experiences from the states in regard to recruitment and retention of work force and performance improvements of the health workers especially in underserved areas. It also contributes by assisting states for systematic studies and then in formulating state specific plans to address the human resource situation.

### **3.4.1 Key Contributions**

- Support to states and MoHFW in designing human resource (HR) strategies through evidence based policy making.
- Studies leading to policy support for approaches to attraction and retention of skilled health care work force in remote and rural areas.
- Support development of curriculum/material/training strategies for capacity building of health care providers.

### 3.5 Healthcare Financing

The key objectives of NRHM, with respect to allocation of financial resources to the health sector by government (centre and state) were to increase the public expenditure on health (centre and state combined) to 3% of the GDP, by the end of the XI Plan, i.e. 2012. NRHM funds at the state level were to be shared between the central and state governments in the ratio of 85-15%. In order to ensure that the additional funds for the health sector are efficiently utilised for achieving the public health goals, NRHM adopts strategies such as: Flexible Financing, Public-Private Partnership (PPP) and Social Protection for Health.

#### 3.5.1 Key Contributions

- Expenditure Studies- - development of tools and building capacity for budget tracking at national, state and district levels and for improving absorption of funds and making financing responsive to local needs.
- Procurement and infrastructure audits in select states.
- Studies of Public-Private-Partnerships (PPPs) and alternative financing schemes – including insurance schemes especially the dial 108 scheme, the dial 104 scheme and RSBY and contracting out of primary care facilities.
- Capacity building at the state and district levels on health financing, financial management, PPP, contracts management etc.

### 3.6 Public Health Administration

The implementation framework and plan of action of NRHM emphasize making the public health delivery system fully functional and accountable so that health indicators improve. The state capacity to plan, and implement the plan is limited, especially in the High Focus states of Bihar and UP that are expected to benefit the most from NRHM. PHA division supports the High Focus states, especially Bihar in planning and implementing the state plans. The division responds to requests from the State or Centre. This division also helps with development of guidelines, and pursuant administrative orders to support implementation and is responsive to requests for assistance from the divisions of MoHFW, Govt. of India.

#### 3.6.1 Key Contributions

- Support to states; especially Bihar and Uttar Pradesh for facilitating implementation of NRHM. Working to strengthen directorates and mission in programme monitoring and review.
- Supporting MoHFW in implementation of Maternal Death Review in the States by way of development of guidelines, conducting workshops, stakeholder engagement etc.
- Supporting implementation of supportive supervision in Public Health Institutions.
- Assisting in the development of guidelines and orders for support to public health administration for appropriate orders, and orientation for implementation of key programmes.

- Supporting MoHFW in Implementation of Clinical Establishments Act by way of drafting of rules, stakeholder consultation, engagement with States, supporting National Council for preparation of Minimum standards for Clinical Establishments in India.

### **3.7 Quality Improvement Division**

Universal access to care under NRHM implies universal access to quality care. The Quality Improvement at the Public Health facilities looks into organisation of the work processes critical to health care delivery, which helps in ensuring that investments made in term of money, material and human resources are optimally used to realise expected outcomes. It helps in delivering quality services those are safe and satisfying to users leading better utilization of facilities. NHSRC's mandate is to make quality improvement an inherent part of service delivery at public health facilities. The NHSRC has implemented pilot programmes that build an approach for ensuring that every public health facility would have a quality assurance program in place. In such an approach every facility is assessed and scored against explicit quality standards and after achieving a certain benchmark gets certified by an external agency. Given the nation's diversity in both health systems development and subjective readiness for assuring quality of care, the quality approach needs to ensure essential norms for facility management, regulatory compliances, clinical protocols & guidelines but at the same time be flexible enough to accommodate variable (essential & Desirable) standards of quality certification objectively and provide scope for innovations. The essential features of a Quality Management System is as shown on the next page –

#### **3.7.1 Key Contributions**

- Development of parameters, tools, techniques and guidebooks for assessing and improving quality in public health facilities.
- Successfully achieved ISO9001:2008 certification of over 80 public health facilities and process ongoing in about 448 more facilities. Evaluation shows both positive gaps and concerns that need to be addresses when scaling up.
- Support for policy and strategy development for quality in public health services, and for improving hospital management and RKS function.
- Development and piloting quality standards and models for various specific areas like SNCU, State Health Societies, RKS and Emergency Response System etc.
- Training and capacity building of states on quality and Hospital administration related issues. National Rural Health Mission Ministry of Health & Family Welfare Government of India National Rural

#### **3.7.2 Learning objectives in department of Quality Improvement Division**

- To gain knowledge about Operational Guideline for Quality Assurance in Public Health Facilities.
- To be aware of departmental checklist tool for assessment
- To have training of internal assessment for quality assurance programme.

### 3.7.3 Worked done

- Worked on 30 key performance indicator, PHC checklist, zero drafting Universal Health Programme, data collection for Standard Treatment Guideline,
- Attended and participated in internal assessment training at Panchkula, Haryana.
- Certification of internal assessment training for Quality Assurance Programme.
- Worked as National monitor for Indradhanush Programme round 1 in Pilibhit District, UP
- Working to state of Bihar for co-ordination of ongoing QA program in the state