policy

February 2014

MANUAL FOR DISTRICT AND BLOCK MANAGERS

HEALTH SYSTEM STRENGTHENING AND EFFECTIVE MANAGEMENT FOR JHARKHAND FAMILY PLANNING

This publication was prepared by H. Chokshi, R. Mishra, H. Sethi, and A. Jorgensen of the Health Policy Project.

USAID FROM THE AMERICAN PEOPLE

NATIONAL RURAL HEALTH MISSION

HEALTH POLICY PROJECT

Suggested citation: H. Chokshi, R. Mishra, H. Sethi, and A. Jorgensen. 2014. *Health Systems Strengthening and Effective Management for Jharkhand Family Planning. Manual for District and Block Managers.* Washington, DC: Futures Group, Health Policy Project.

This manual was developed with the support of the Health Policy Project. The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. It is implemented by Futures Group, in collaboration with CEDPA (part of Plan International USA), Futures Institute, Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WRA).

Manual for District and Block Managers

FEBRUARY 2014

This publication was prepared by H. Chokshi, R. Mishra, H. Sethi, and A. Jorgensen for the Health Policy Project.

CONTENTS

ABBREVIATIONS

ACMO	Additional Chief Medical Officer
AHS	Annual Health Survey
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy
BCC	Behaviour-Change Communication
BPMU	Block Programme Management Unit
CBO	Community-Based Organisation
CHC	Community Health Centre
CINI	Child in Need Institute
CMO	Chief Medical Officer
DH	District Hospital
DHAP	District Health Action Plan
DLHS	District-Level Household Survey
DM	District Magistrate
DoHFW	Department of Health and Family Welfare
DQAC	District Quality Assurance Committee
ECP	Emergency Contraceptive Pill
FP	Family Planning
FRU	First-Referral Unit
GOI	Government of India
HMIS	Health Management Information Systems
HPP	Health Policy Project
HR	Human Resource
ICT	Information and Communication Technology
IEC	Information, Education, and Communication
IMR	Infant Mortality Rate
IPC	Interpersonal Communication
IPHS	Indian Public Health Standards
ITAP	Innovations in Family Planning Services (IFPS) Technical Assistance Project
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
LHV	Lady Health Visitor
LAM	Lactational Amenorrhea Method
LTT	Laparoscopic Tubectomy
MD	Mission Director
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MIS	Management Information Systems
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal, and Child Health
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MOIC	Medical Officer In-Charge
MO	Medical Officer
NDCP	National Disease Control Programmes

NFHS	National Family Health Survey
NGO	Nongovernmental Organisation
NHSRC	National Health Systems Resource Centre
NMR	Neonatal Mortality Rate
NRHM	National Rural Health Mission
NSV	Non-scalpel Vasectomy
OCP	Oral Contraceptive Pill
OPD	Out Patient Department
OT	Operation Theatre
PHC	Public Health Centre
PHRN	Public Health Resource Network
PIP	Programme Implementation Plan
PPIUCD	Postpartum Intrauterine Contraceptive Device
PPP	Public-Private-Partnership Program
PRI	Panchayati Raj Institution (village level local self-government)
QA	Quality Assurance
QAC	Quality Assurance Committee
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti (Hospital Management Committee)
RTI	Reproductive Tract Infection
SBS	Skilled Birthing Services
SC	Sub-centre
SN	Staff Nurse
SRH	Sexual and Reproductive Health
SRS	Sample Registration System
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TOT	Training-of-Trainers
VHC	Village Health Committee
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
WCD	Women and Child Development
WHO	World Health Organisation

ACKNOWLEDGEMENTS

The Health Policy Project worked closely with the Government of Jharkhand's Department of Health and Family Welfare (DoHFW) to develop and implement a capacity building and mentoring program to strengthen the management and functional skills of the Family Planning Cell and the district functionaries to effectively implement the Family Planning Strategy in the state. The program included working with the state experts to develop (i) a comprehensive training curriculum to strengthen functional skills, (ii) train functionaries, (iii) provide mentoring and supportive supervision, and (iv) strengthen linkages and partnerships for greater multisectoral coordination. The programme's development was informed by significant stakeholder input, ensuring its effective implementation and subsequent scale-up by the Government of Jharkhand.

The authors would like to acknowledge the main contributors. First, sincere appreciation goes to Smt Aradhana Patnaik and Shri Siddique Aboobakar, (Former Mission Director, National Rural Health Mission (NRHM)–Jharkhand) for initiating the process, facilitating the discussions, and encouraging critical thinking on developing this comprehensive approach. We also thank Dr Manish Ranjan Mission Director, NRHM for recognising the value of the program and scaling up the approach to more priority districts in Jharkhand through the program implementation plan for 2013-2014. We appreciate the directions of the following state officials to implement the program; Dr Sumant Mishra, Director Health, Dr Praveen Chandra, Director in Chief and Dr M.N.Lal, Director FP Cell.

We will like to acknowledge the participation and guidance of the members of FP Taskforce on developing FP Curriculum and leadership in review and monitoring. We would also like to acknowledge the active contributions of staff of FP Cell, experts from civil society organisations for their active participation in the trainings and mentoring.

Finally, we are grateful for the support and technical inputs from the United States Agency for International Development, especially Ms Sheena Chhabra, Team Leader Health Systems Division, Dr Neeta Rao, Senior Advisor Monitoring and Evaluation, and Dr Amit Shah, Senior Advisor Family Planning and Reproductive Child Health.

PREFACE

Jharkhand's 2008 Population and Reproductive and Child Health Policy describes the state's commitment to making high-quality reproductive and child health (RCH) services a priority by following a life-cycle approach to reduce maternal and child mortality, and morbidity (the relative incidence of disease). The policy outlines a broad focus on gender and human rights issues and services to disadvantaged groups and to adolescents, with the aim of eliminating discrimination in the provision of reproductive and child health services at all levels and in all sectors. The state is fully committed to achieving replacement-level fertility and, thereafter, to stabilise population growth by promoting informed choice; widen the available contraceptive choices; empower communities and women; involve all stakeholders from private, public, nongovernmental organisations (NGOs), and industrial sectors; and encourage use of modern contraception, particularly spacing methods.

In 2010, the state formulated the Family Planning Strategy with the overall objectives:

- Reduce the total fertility rate (TFR)—that is, the average number of children a woman can expect to have in her lifetime—from the current estimated level of 3.2 to 2.1 by 2020.
- Increase modern contraceptive prevalence from 31 percent to 54 percent by 2020.

The strategic intervention areas are: focus on adolescent health; promote spacing methods use and other long-acting and permanent methods to limit childbearing; integrate family planning with maternal, neonatal, and child health (MNCH); encourage male engagement; reach out to the rural and urban poor and other disadvantaged populations; increase the involvement of both private and public sectors, and NGOs; coordinate efforts with other government departments; and, develop an effective communication strategy.

In 2010, the Department of Health and Family Welfare (DoHFW) set up the Family Planning Cell to operationalise the FP Strategy and monitor the implementation of the state FP programme. The FP Cell is comprised of five staff members and is headed by the director of FP. The United States Agency for International Development (USAID)-supported Health Policy Project (HPP) is providing technical assistance to strengthen capacities of the FP Cell, and district- and block-level functionaries to improve the FP Strategy implementation.

From 2011–2013, HPP, in partnership with the Government of Jharkhand, developed and rolled out a Health Systems Strengthening (HSS) program to strengthen capacities for improved implementation of the new FP strategy. The capacity-building framework entailed a participatory capacity needs assessment and development of a capacity-building plan. The plan focused on strengthening individual, institutional, and systemic capacities through development of a need-based curriculum, mentoring, and a supportive supervision program. HPP designed a package, including a curriculum, *Training on Systems Strengthening and Effective Management* (Health Policy Project, 2013), and job aids such as the *Manager's Tool* to record data during mentoring and supervisory visits. This *Manual for District and Block Managers* is part of the toolkit.

A State Resource Group (SRG) of 16 experts and professionals from the government and civil society organisations were trained to be master trainers. Implementation and management skills of 65 district and sub-district functionaries were strengthened through a formal training workshop and a mentoring and coaching program. HPP fostered partnerships and linkages between the FP Cell and state-level academic and training institutes to strengthen implementation and improve monitoring, reporting, and analysis of FP data. The outcomes and impact of HPP's efforts in health systems strengthening and effective management to implement the FP Strategy in Jharkhand was measured from the data collected through a *Manager's Tool*. Since the period of implementation was too short to see any impact on FP service

uptake, a trend of change appears to be emerging and while this capacity-strengthening program was developed specifically for Jharkhand, this toolkit and training model may be useful for other states facing similar challenges.

TRAINING AND MANUAL ON HEALTH SYSTEMS STRENGTHENING FOR DISTRICT AND BLOCK PROGRAMME MANAGERS

The training in health systems strengthening and effective management for district and block programme managers is an experiential training that includes leadership and team building, strengthens skills in program management and competencies related to FP, and contraceptive technology.

District Workshop

This district workshop trains health managers and administrators at the district and block levels to plan, implement, and monitor the family planning programme more effectively. The overall goal is to build skills in health systems strengthening and effective management to improve family planning programming.

Participants in the training will

- be familiar with the national and state family planning policies and strategies, contraceptive methods, and reproductive rights-based approach
- understand the key policy processes and the World Health Organisation (WHO) framework for effective health systems and activities which address healthcare need gaps and bring about policy change
- strengthen their analytical skills and ability to use existing data to understand the status of family planning programs, and use this data for effective program decision making
- learn and practice mentoring and management skills
- be able to identify the need for capacity strengthening to improve family planning programming at district and block levels

About the Manual

This manual provides training and guidance to build capacity for a stronger health system that supports family planning programmes. Each session includes

- *Title:* the main topic of the session.
- *Learning objectives:* competencies participants gain during the session that demonstrate increased knowledge, improved skills, or changed attitudes. The trainer writes the learning objectives on a flip chart prior to each session and uses this to open the session.
- *Time:* the planned duration of the session, assuming 12–18 participants.
- *Materials:* the materials required for the session.
- *Handouts:* the respective Annex used as a handout for the session.
- *Session designs:* provide guidance to facilitate each session. The district workshop is built on the four components of the David Kolb's experiential learning cycle (http://academic.regis.edu/ed205/Kolb.pdf), which are important concepts for training-of-trainers: *experience*, *reflection*, *generalisation*, and *application*. The *experience* is an exercise or participatory presentation in which information is presented for discussion and learning. *Reflection* helps participants think about and analyse new information and develop their own

ideas about a topic. *Generalisation* allows participants to draw broad conclusions and lessons learned about the new information. *Application* enables participants to visualise or practice how they may apply their new skills in the future (CEDPA, 1995).

This manual is based on adult-learning principles (Knowles, 1996) as follows:

- Learning is self-directed.
- Training fills an immediate need and is highly participatory.
- Learning is experiential (i.e., the participants and the trainer learn from one another).
- Time is allowed for reflection and corrective feedback.
- A mutually respectful environment is created between the trainer and the participants.
- A safe atmosphere and comfortable environment are provided.
- Participants practice what they have learned in theory in real-life settings.

Training Techniques

The training techniques include the following:

- *Icebreakers and interactive activities:* Informal activities set the climate for the next session, help transition between sessions, energise participants to make them more alert, and provide a break between 'heavy' or difficult sessions.
- *Lectures:* Formal presentations conducted by the facilitator or a resource specialist convey information, theories, or principles.
- *Large and small group discussions:* Participants share experiences and ideas and work together to solve problems.
- *Action planning:* Participants make plans to apply new knowledge and skills.
- *Mini case studies:* Participants use HMIS data and district scenarios to suggest solutions to health system problems.
- *Practicum:* Participants practice what they have learned in theory at a field site with guidance from facilitators.
- *Peer learning, support, and feedback:* Participants provide immediate feedback to one another to strengthen skills and generate new ideas.

TRAINING AGENDA—DISTRICT LEVEL

Session	Participant's Objectives	Materials	Lead Trainer	Co-facilitators/ Resource Persons	Duration (minutes)
Day 1					
Registration and the training assessment form	Register themselves, collect the training package, complete the training assessment tool and submit it.	Training package, training assessment tool (see *Annex G. Training Assessment)*			30
Session 1: Introduction	Become familiar with one another, understand the importance of working in teams, and know the workshop objectives.	PowerPoint presentation #1, projection system Sticky note pads, flip chart and markers			40
Session 2: The Policy Process	Describe the policy process, identify their responsibility to ensure that the last two stages policy implementation, and policy monitoring and evaluation are accomplished and participants are able to recall their roles and responsibilities in implementation and monitoring of policy.	PowerPoint presentation #2, projection system Copies of *Jharkhand Health and Family Planning Policy and Family Planning Strategy* Prepared flip chart for functionaries and roles activity			60
Session 3: Family Planning Policies, Programs, and Strategies	Summarise the family planning programs, strategies, status of family planning and other health indicators. Describe the challenges and opportunities the state has with respect to family planning.	PowerPoint presentation #3, projection system Policy and strategy handouts including: NRHM Policy for FP Jharkhand Population and RCH Policy Jharkhand FP Strategy FP section of the Program Implementation Plan (PIP) 2012–2013 Flip charts, markers, whiteboard			60

Session	Participant's Objectives	Materials	Lead Trainer	Co-facilitators/ Resource Persons	Duration (minutes)
Session 4: Contraceptive Update	Describe the rights of the clients and various contraceptives, their use, benefits and shortcomings	PowerPoint presentation #4, projection system *Contraceptive Update* booklet in Hindi, developed under the IFPS Technical Assistant Project and/or the *Family Planning-A Global Handbook for Providers, 2011 Update* Flip charts, markers			90
Session 5: Health System Components	Summarise the six health system building blocks and describe the health system components within the family planning program	PowerPoint presentation #5 projection system State PIP, health action plans of each district Flip charts, markers, whiteboard			
5a. Health Service Delivery	Understand the various aspects of service delivery including: • FP Services at PHC, CHC, DH, fixed-day approach, FP Camps • Quality Assurance Committee meetings and visits • BCC/IEC activities at community level, health facilities, community level, for improved communication and counselling and other mobile or ICT technology for demand generation and behaviour change • Intersectoral convergence and partnerships	PowerPoint presentation #5A projection system Flip charts, markers, whiteboard			60

Session	Participant's Objectives	Materials	Lead Trainer	Co-facilitators/ Resource Persons	Duration (minutes)
DAY 2					
5b. Health Workforce, Health Information System, and Access to Essential Medicines	Understand the various aspects of: • Health workforce–technical, managerial, community-level human resources, trainings, and capacity strengthening • Health management information system • Access to essential medicines–logistical and supply chain	PowerPoint presentation #5B projection system Flip charts, markers, whiteboard			60
5c. Financing for FP and Leadership and Governance	Understand the various aspects of: • Financing for FP–fund utilisation/vs. approved, and budgeting for District Health Action Plan (DHAP)/State PIP • Leadership and governance–state-level initiatives–FP Cell and Task Force, and community participation–Rogi Kalyan Samiti (RKS), VHSC, and VHC	PowerPoint presentation #5C projection system Flip charts, markers, whiteboard			30
Session 6: Develop a Work Plan	Understand and consolidate the key activities for health system strengthening as identified throughout the training, and reconstruct the plan to include the key person responsible and a proposed timeline for the same.	PowerPoint presentation #6 projection system Plans and templates developed by participants in the earlier sessions			90

Session	Participant's Objectives	Materials	Lead Trainer	Co-facilitators/ Resource Persons	Duration (minutes)
Session 7: Develop a Supportive Supervision Plan	Develop a supportive supervision plan for at least six months using the *Manager's Tool*	PowerPoint presentation #7 projection system Gantt chart for developing the field plan and copies of the *Manager's Tool*			90
Questions and Answer Session **Completion of the training assessment form and feedback form**	Participants ask for clarification on any question, doubt, or uncertainty; provide feedback to the training, and complete the post-training forms. Summarise the four-day workshop	Post-training forms and feedback forms. (see *Annex G. Training Assessment).*			30

SESSION 1. INTRODUCTION

Learning Objectives	By the end of the session, participants will: • Be familiar with one another • Know the workshop objectives
Materials	PowerPoint presentation #1, projection system, sticky note pads, flip chart, and markers
Methodology	Game, presentation, discussion
Duration	40 minutes

Activity 1: Introductions and Expectations

STEP 1

Ask each participant to introduce themselves.

STEP 2

One way to have participants share expectations is to:

- Provide two sticky notes to each participant and ask them to write down their expectations from the workshop in terms of strengthening their competencies. Ask the question, "When you go back, what two things would you want to be able to do in improving the health system at your level?" Give them about five minutes to think and write.
- Invite the participants to read out their responses and stick them on a flip chart.
- Once everyone has shared their expectations, the facilitators can group and categorise the expectations and write the keyword or phrase around that set of expectations.

STEP 3

Summarise participant expectations and share workshop objectives and an overview of the agenda using the PowerPoint presentation or on a flip chart if technology is unavailable.

Activity 2: Establish Workshop Norms

STEP 1

Ask the participants to discuss norms to be followed during the workshop to make it most effective. Write these norms on a flip chart. If they cannot think of any, suggest a few as examples and ensure that the participants understand and agree with them.

- Listen respectfully to every participant's opinion, even if disagree.
- Feel free to voice your opinions positively.
- Be punctual.
- Give all participants an equal opportunity to contribute.
- Put on silent mode or switch off mobile phones; take urgent calls only outside the training room.

STEP 2

Inform the participants about the logistic arrangements during the workshop (lodging, timing, etc.).

Activity 3: Overview of Capacity-Strengthening Plan

STEP 1

Using the PowerPoint (PPT), review the overarching plan for the capacity strengthening in the State, highlighting the stakeholders and the cascading training plan, and the outputs of the district workshop.

STEP 2

Ask participants to reflect on the importance of team work as they participate in this effort. Facilitate a discussion using questions such as,

- Why is teamwork so important to this undertaking?
- How can you support each other as the trainings and activities roll out?
- How will we coordinate on lessons learned so we can make improvements as we go along?

SESSION 2. THE POLICY PROCESS

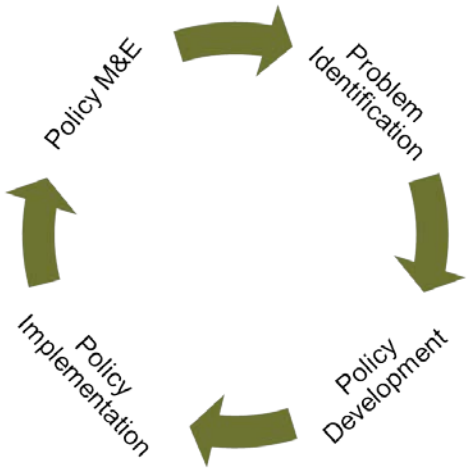
Learning Objectives	By the end of the session, participants will be able to • Describe the policy process. • Recognise their role in the last two stages–policy implementation, and monitoring and evaluation (M&E). • Recall their roles and responsibilities to implement, monitor, and evaluate policy monitoring and evaluation.
Materials	PowerPoint presentation # 2, copies of the *Jharkhand Health and Family Planning Policy and FP Strategy* document, prepared flip chart for functionaries and roles activity
Methods	Presentation and discussion
Duration	60 minutes

Activity 1: Policy Process

STEP 1

- Ask participants what their first thought is on hearing the word *policy* and write on a VIPP card; summarise with a brief discussion of policy.
- Present the policy cycle (see figure) and ask participants to discuss what each stage of the process means.
- Write down the important points on the flip chart. Summarise the information in *Annex A: The Policy Process*

Figure 1: Policy Cycle



Activity 2: Who Makes It Possible?

STEP 1

- Have participants review the tasks under policy implementation and policy monitoring and evaluation (M&E). Ask them which of these functions are the responsibility of the state-, district- and sub-district-level functionaries (see below).
- Ask them to list on the flip chart all functionaries in the health system responsible for ensuring the implementation and monitoring of the Family Planning Strategy. Start with the state, then the district, and finally, the sub-district level. If participants have not listed some of the functionaries and stakeholders shown below, augment the list.
- After naming the functionaries on the flip chart, ask participants to add the role of each functionary in policy implementation and M&E. The facilitator can consolidate the responses and summarise.

Refer to *Annex B. Government Officials—Roles and Responsibilities*

Policy Implementation

- Mobilise resources for dissemination, training, and implementation.
- Plan for health system needs, modifications, resources, and information.
- Disseminate policies and guidance, and provide training.
- Establish communication and M&E mechanisms.
- Manage and coordinate effective/efficient use of resources (human, financial, material, information) to support implementation.
- Steward private sector and NGO participation in implementation.
- Address bottlenecks in implementation and systems.

Policy Monitoring and Evaluation

- Commission periodic reviews of performance indicators.
- Support forums to include feedback.
- Conduct epidemiological analysis, coverage studies, and cost-effectiveness analysis.
- Implement M&E plans.
- Track expenditures.
- Link operations data (Management Information Systems (MIS) to decision making and policy reform.
- Establish feedback mechanisms and forums for public debate and citizen participation.

Policy Functionaries and Stakeholders Flipchart

Level	Position	Policy Implementation	Policy M&E
State			
	MD NRHM		
	Director in-charge		
	FP Cell		
	QA Cell		
	IEC cell		
	Training cell		
	State statistics division		
	State FP task force		
	State Health Systems Resource Centre (SHSRC)		
	NGOs		
District/block			
	District program manager		
	District data manager		
	Block program manager		
	Medical officer in-charge		
	Block data manager		
	District program coordinator		
	RKS		
	VHSCs		
	QA Committee		

SESSION 3. FP POLICIES, PROGRAMMES, AND STRATEGIES

Learning Objectives	By the end of the session, participants will be able to • Summarise the FP policies, programmes and strategies, national, state and district FP and other health indicators.
Materials	PowerPoint presentation #3, projection system Policy and strategy handouts including: • NRHM policy for FP, special programmes, and schemes • Jharkhand population and reproductive and child health (RCH) policy • Jharkhand Family Planning Strategy • Family planning section of the state PIP 2012–2013
Methods	Discussion, group work, and presentations
Duration	60 minutes

Activity 1: Population Policies and Issues

STEP 1

- Deliver PowerPoint presentation #3, FP Issues and Directions (slides 1-41), and facilitate a follow-up discussion on the population of India, the state, and the associated FP issues. Highlight the following:
    - o Population of India and of Jharkhand
    - o Current status of fertility and mortality
    - o Impact of high fertility and other health indicators on social and economic development
    - o Challenges and barriers
    - o Opportunities
    - o Family planning benefits
- Continue with PowerPoint presentation #3, *FP Issues and Directions* (slide 42 onwards) and facilitate a follow-up discussion on the how national and state policies are in line with one another and that state specific modifications have been made to address issues in the state. Highlight the following:
    - o National, state, and district policy and strategy documents that affect FP programme implementation in Jharkhand

Refer to *Annex C. Family Planning Issues and Strategic Directions*

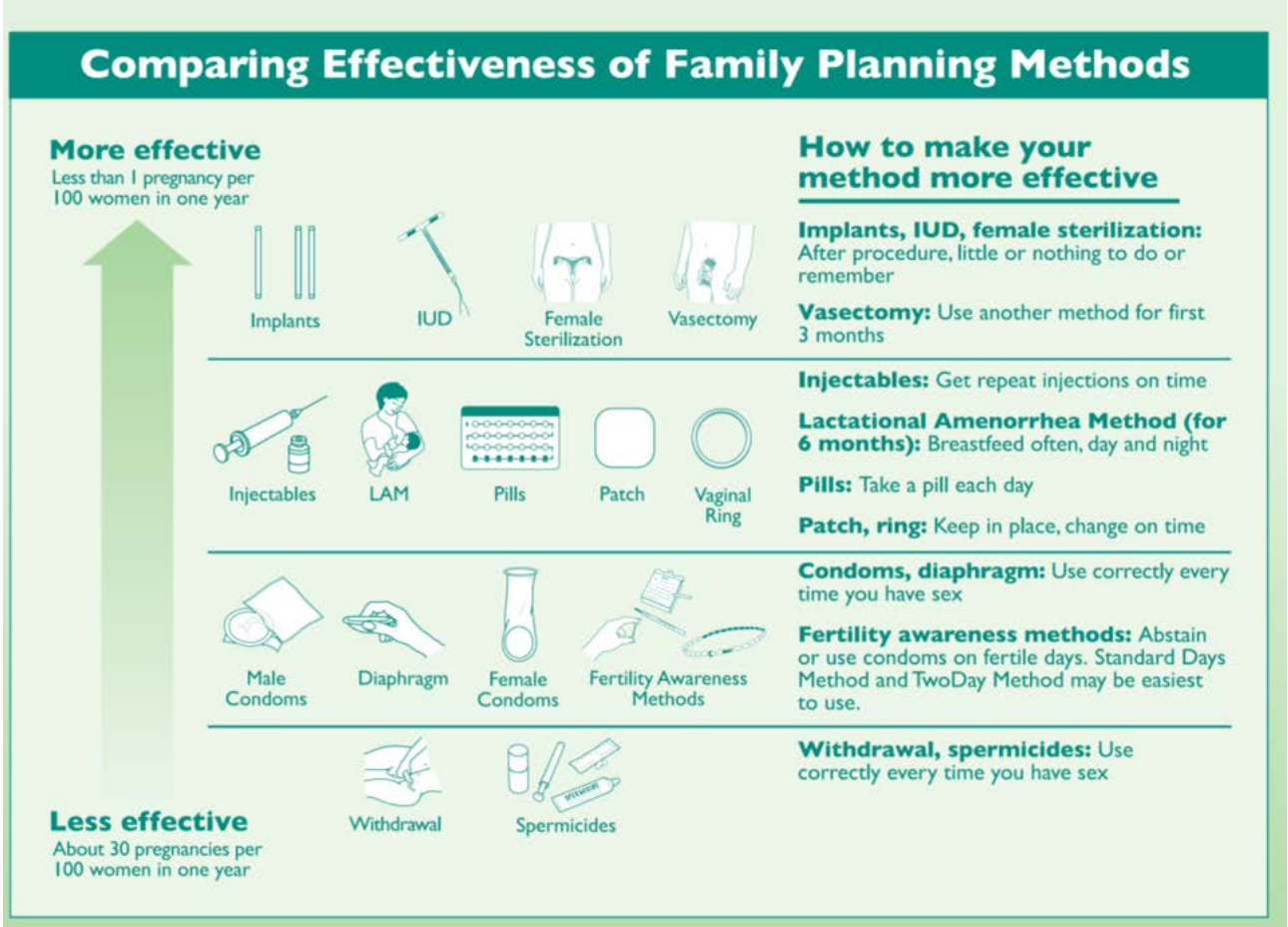
SESSION 4. CONTRACEPTIVE UPDATE

Learning Objectives	By the end of the session, participants will be able to describe the rights of the clients, and various contraceptives—their use, benefits, and shortcomings
Materials	PowerPoint presentation #4, projection system *Contraceptive Update* booklet in Hindi, developed under the IFPS Technical Assistant Project and/or the *Family Planning—A Global Handbook for Providers, 2011 Update* Flip charts, markers, paper, and sticky dots (red and green)
Methods	PowerPoint presentation, small group work, and discussion
Duration	90 minutes

Activity 1: Basket of Contraceptives

STEP 1

- Label three flip charts with a heading in large letters—*highly effective contraceptive method*; *moderately effective contraceptive method*, and *less effective contraceptive method*. Place the charts in different corners of the training room.
- Ask each participant to name a particular contraceptive method and write the method in large letters on a sheet of paper.
- Then ask each of them to stand (with the contraceptive type) in one of the three corners depending on whether they think the method is a highly, moderately, or less effective.
- Open the discussion to the entire group. Ask if they agree with where each of the methods is placed, if not, where they would like to shift it, and why?
- Once the entire group has agreed with the new categorisation, ask them to state if they see commonalities in the methods among each category.
- Open the slide #11 from PowerPoint presentation #4 on Comparing Effectiveness of FP Methods and share more details from the *Family Planning Handbook for Health Providers 2011 Update.*



Source: WHO, 2011.

STEP 2

- Give a copy of the *Family Planning—A Global Handbook for Providers 2011 Update* to all participants.
- Ask each of them or in groups of two or three, to prepare a one-hour update session, on any one method, for auxiliary nurse midwives (ANMs) or accredited social health activists (ASHAs).
- Ask each of them to make a presentation on how they would do the session. Give them 20 minutes to prepare and 10 minutes to present.

Activity 2: Rights and Family Planning

STEP 1

- Ask the participants to share their thoughts or define '*voluntary decision making*' with respect to contraceptive choices.
- List their responses on a flip chart and facilitate a discussion about whether they agree or disagree with the responses.
- Explain that the term *informed and voluntary* decision making (EngenderHealth, 2008) is used to underscore the importance of the decisions that individuals make in every area of sexual and reproductive health (SRH), even when options are limited and their need is urgent. Examples of decisions that people make concerning their SRH include the following:
    - *For FP:* whether to use contraception to delay, space, or end childbearing; which method to use; whether to continue using contraception when side effects occur; whether to switch methods when the current method is unsatisfactory; and whether to involve one's partner(s) in decision making about FP.
    - *For HIV and other sexually transmitted infections (STIs):* whether to use a condom with every act of sexual intercourse; whether to use a dual-protection strategy (to prevent both unintended pregnancy and STIs); whether to limit the number of sexual partners; whether to seek treatment for apparent infection; whether to inform partner(s) if an infection is diagnosed; whether to delay sexual intercourse until the infection is completely treated, and whether to be tested for HIV.
    - *For maternal healthcare:* whether to seek antenatal care during pregnancy, whether to improve one's nutrition during pregnancy; whether and when to have sex during pregnancy; whether and when to go to a healthcare setting for assistance with delivery; whether to breastfeed exclusively and for how long; and whether and when to use contraception after delivery.
    - *For post-abortion care:* when to seek care following signs of spontaneous abortion; whether and when to seek care for complications of abortion; and whether to use contraception to prevent or delay future pregnancies."

STEP 2

- Give each participant 20 green sticky dots and 20 red sticky dots (or use red and green markers if dots are not available)
- Post the list of 19 statements.
- Ask the group to put a red dot on statements they disagree with and a green sticky dot on statements with which they agree.
- When complete, ask the group for observations. For those statements where the response is mixed, ask for volunteers to explain their answers.
- Discuss which are statements of values and which are factually incorrect (i.e. 9, 10, 19)
- Use the following *Survey of Sexual Attitudes* (Solter, 1998). Mention the source of the survey clearly.
- Ask each participant one by one to explain why s/he agrees or disagrees with the statement.

Survey of Sexual Attitudes (Solter, 1998)	
1. Women should be virgins when they marry.	
2. FP should be available for married people only.	
3. The average woman wants sex less often than the average man.	
4. FP goes against this country's tradition.	
5. Vasectomy should not be considered by a man who has only one or two children, or who is under the age of 35.	
6. Most people who contract sexually transmitted diseases (STDs) have had many sexual partners.	
7. The choice of sterilisation should always be voluntary.	
8. Men enjoy sex without love more than women do.	
9. Easy availability of FP encourages sexual activity, especially among young people. Using FP methods is not a good idea before the wife has had her first child.	
10. It is not unusual for people to be in love with more than one person at a time.	
11. Couple should not marry until they have had sexual intercourse.	
12. Parents should not allow their daughters as much sexual freedom as they allow their sons.	
13. Marital infidelity is equally acceptable or unacceptable for both sexes.	
14. A child should be given sex education at school.	
15. Abortion is an acceptable form of FP.	
16. Couples should only be allowed two children.	
17. Prostitutes provide a useful social service.	
18. STDs are more common among poor, illiterate people.	

Summarise the exercise by stating that people's experiences often lead them to different conclusions. We must first of all be aware of our own individual value systems and also to respect the values and beliefs of others with whom we might disagree. It is also important to correct faulty assumptions and misinformation.

STEP 3

Emphasise that the rights-based approach to FP and SRH assumes that health and human rights are inseparable and that individuals have both the right and the capacity to make decisions about their own lives. Basic elements of this approach include: gender equity and equality, rights to sexual and reproductive health (SRH), and client-centred SRH care. The rights-based approach was adopted at the 1994 United Nations-hosted International Conference on Population and Development (ICPD), which was held in Cairo, Egypt. Share the following list of clients' rights:

Clients' Rights (EngenderHealth, 2008)

- *The Rights of Clients Information:* Clients have a right to accurate, appropriate, understandable, and unambiguous information related to reproductive health and sexuality, and to overall health. Educational materials for clients should be made available in all parts of the healthcare facility.
- *Access to services:* Services must be affordable and available at times and places that are convenient to clients, without: physical barriers to the healthcare facility; inappropriate eligibility requirements for services; and without social barriers such as discrimination based on gender, age, marital status, fertility, nationality or ethnicity, belief, social class, caste, or sexual orientation.
- *Informed choice:* A voluntary, well-considered decision that an individual makes on the basis of options, information, and understanding represents his or her informed choice. The decision making process begins in the community, where people get information even before coming to a facility for services. It is he provider's responsibility either to confirm a client's informed choice or to help him or her reach one.
- *Safety of services:* Safe services require skilled providers, attention to infection prevention, and appropriate and effective medical practices. This right also refers to the proper use of service-delivery guidelines, the existence of QA mechanisms within the facility, counselling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.
- *Privacy and confidentiality*: Clients have a right to privacy and confidentiality during delivery of services—for example, during counseling and physical examinations and in the way staff handle clients' medical records and other personal information.
- *Dignity, comfort, and expression of opinion*: All clients have the right to be treated with respect and consideration. Providers must ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, especially when their views differ from those of service providers.
- *Continuity of care:* All clients have a right to continuity of services and supplies, follow up, and referral.

Close the day with a brief recap of the day's activities. Ask participants to share their thoughts on the most important aspects of the day, and what they will take away from the sessions. Encourage participants to share with facilitators any suggestions for improvement.

SESSION 5. HEALTH SYSTEM COMPONENTS

Learning Objective	Participants will be able to summarise the six building blocks of a health system and describe the health system components within the FP programme.
Materials	PowerPoint presentation # 5, projection system State PIP, District Health Action Plans (DHAPs) of each district represented in the district workshop Flip charts, markers, whiteboard
Methods	PowerPoint presentation, small group work, discussion
Duration	150 minutes

Activity 1: Health System Components

STEP 1

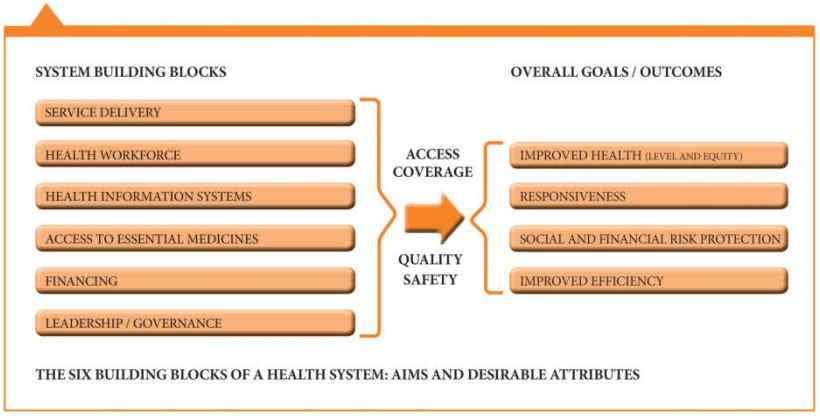
Welcome participants back to the workshop. Explain that participants will get an overview of each building block and have the opportunity to ask questions. Then, in small groups, participants review the building blocks within the context of the district and block plans for family planning, and identify gaps and opportunities to strengthen the system.

STEP 2

- Give the overview presentation (PowerPoint #5) on the World Health Organisation (WHO) building blocks of health systems.
- Ask if there are any general questions prior to moving into more detailed discussions of each building block throughout the day.

See *Annex D. Health System Components*

Figure 2: World Health Organisation (WHO) Health System Building Blocks



Source: WHO, 2007.

Facilitate the sessions for each building block, keeping track of the time so that enough time remains for important small group work at the end of the day.

Health Service Delivery

- FP services at public health centres (PHCs), community health centres (CHCs), and district hospitals (DHs)
- Fixed-day approach
- FP camps
- Quality assurance committee (QAC) meetings
- QA visits
- Behaviour change communication (BCC)/IEC activities at community level
- BCC/IEC display at health facilities
- BCC/IEC display at community level
- BCC/IEC tools for improved communication and counselling
- Helpline and other mobile technology or information and communication technology (ICT) for demand generation and behaviour change
- Intersectoral convergence and partnerships

Health Workforce

- Technical human resources
- Managerial human resources
- Community-level human resources
- Trainings and capacity strengthening

Health Information System

- HMIS

Access to Essential Medicines

- Logistics and supply chain

Financing for FP

- Fund utilisation vs. approved funds
- Budgeting for DHAP/ State PIP

Leadership and Governance

- State initiatives–FP Cell and Task Force
- Community participation rogi kalyan samiti (RKS), village health and sanitation committee (VHSC) and village health committee (VHC)

STEP 3

- Divide the participants into three or four groups and ask them to identify the various components/activities of the FP programme recommended in the respective DHAPs, and national priority for the year as mentioned in the National PIP guidelines. Ask them to identify and write down the current status and need gap, and activities to address the need gap.
- Allow 30 minutes for the small group exercise, and clarify that each group will be given 10 minutes to present its findings.

- The three groups will work on the following aspects:
    1. Health Service Delivery
    2. Health Workforce, Health Information System, and Access to Essential Medicines
    3. Financing for FP, and Leadership and Governance
- Ask the teams to present what they have discussed on chart papers, following the format mentioned in the table below.
- After each presentation, allow time for brief discussion and feedback from other groups.

No	Health Systems	Recommended/ in national PIP guidelines, state PIP and DHAP	Current status and need gaps	Key activities/ tasks required
1.	**Health service delivery**			
	FP services at PHC, CHC, DH			
	Fixed-day approach			
	FP camps			
	Quality assurance committee meetings			
	Quality assurance visits			
	BCC/ IEC activities at community level			
	BCC/IEC display at health facilities			
	BCC/IEC display at community level			
	BCC/IEC tools for improved communication and counselling			
	Helpline and other mobile technology or ICT for demand generation and behaviour change			

No	Health Systems	Recommended/ in national PIP guidelines, state PIP and DHAP	Current status and need gaps	Key activities/ tasks required
2.	**Health workforce**			
	Technical human resources			
	Managerial human resources			
	Community-level human resources			
	Trainings and capacity strengthening			
3.	**Health information system**			
	HMIS			
4.	**Access to essential medicines**			
	Logistics and supply chain			
5.	**Financing for FP**			
	Fund utilisation vs. approved funds			
	Budgeting for DHAP/ State PIP			
6.	**Leadership and governance**			
	State initiatives: FP Cell and Task Force			
	Community participation: RKS, VHSC, and VHC			

SESSION 6. DEVELOP A WORK PLAN

Learning Objectives	By the end of the session, the participants will be able to consolidate the key activities for health system strengthening identified throughout the training, and construct a plan to include the key person responsible, and a proposed timeline for the same.
Materials	Plans and templates developed by the participants in the earlier sessions PowerPoint presentation #6
Methods	Small group work and PPT presentation
Duration	90 minutes

Activity 1: Developing a Work Plan

STEP 1

- Divide the participants into three or four groups. One group will have only district functionaries, the other three groups can be with the block managers.
- Hand over the District Action Plans to the district team(s), state PIP and the national FP focus for the year to the managers.
- Ask the teams to compile their findings and proposed strategies for improving FP programming (system strengthening, reporting, and monitoring) into one consolidated plan in the following template. Ask them to develop a yearly plan and arrive at key activities/tasks required to strengthen the FP programme, the person responsible for completion of the task, and the timeline for completion.
- Ask the teams to present the plans for the state, district and block levels.

No	Health System	Current	Recommended /planned in the state/ district plans	Key activities/ tasks	Responsible person(s)	Timeline
1.	**Health service delivery**					
	FP services at PHC, CHC, DH					
	Fixed-day approach					
	FP Camps					
	Quality assurance committee meetings					
	Quality assurance visits					
	BCC/IEC activities at community level					
	BCC/IEC display at health facilities					
	BCC/IEC display at community level					
	BCC/IEC tools for improved communication and counselling					
	Helpline and other mobile technology or ICT for demand generation and behaviour change					
2.	**Health workforce**					
	Technical human resources					

No	Health System	Current	Recommended /planned in the state/ district plans	Key activities/ tasks	Responsible person(s)	Timeline
	Managerial human resources					
	Community-level human resources					
	Trainings and capacity strengthening					
3.	**Health information system**					
	HMIS					
4.	**Access to essential medicines**					
	Logistical and supply chain					
5.	**Financing for FP**					
	Fund utilisation vs. approved funds					
	Budgeting for DHAP/state PIP					
6.	**Leadership and governance**					
	State-level initiatives: FP Cell and FP Task Force					
	Community participation: RKS, VHSC, and VHC					

SESSION 7. DEVELOP A SUPPORTIVE SUPERVISION PLAN

Learning Objectives	Participants recognise the skills and approaches involved in supportive supervision and develop a supportive supervision plan for at least six months.
Materials	Gantt chart to develop the field plan and a copy of the *Manager's Tool* PowerPoint presentation #7
Methods	Small group work
Duration	90 minutes

Activity 1: Monitoring and Supportive Supervision

Ask the participants to share their views on the following:

- Definition of supervision and important points to remember
- What should an effective supervisor know and do?
- Supervisor's roles and responsibilities
- Qualities and attributes of a good supervisor

Write down their responses on large flip charts and summarise with the PowerPoint presentation #10.

Refer to *Annex E. Supportive Supervision*

Activity 2: Use the *Manager's Tool*

STEP 1

- Introduce the *Manager's Tool* to the participants, and discuss each aspect of the tool, and the appropriate use.

Refer to *Annex F. Manager's Tool*

STEP 2

- If possible, organise a half-day actual field visit to a CHC, FP camp, or village health and nutrition day (VHND) and have the participants practice using the tool to provide supportive supervision and mentoring.
- In the field, if the participants are stuck or unable to conduct the visit and interact as a supportive supervisor or mentor, gently step in and offer a positive model.
- After returning from the field, discuss the experience together with the participants, and get their response on the following:
    - Aspects of the visit that went well, and the ways in which the *Manager's Tool* was useful
    - Difficult aspects of the visit. What were the obstacles or challenges?
    - Aspects of the *Manager's Tool* or supportive supervision where the participants might have questions and want more assistance or clarify any doubts

Activity 3: Develop a field visit plan for mentoring

- Participants (as state- and district-level teams) list the number of facilities they plan to visit, monitor, and supervise each month, the number of meetings or trainings they would attend, and also the opportunities for providing mentoring support. Separate plans can be made for each district.
- Participants use the *Manager's Tool* to record their observations, provide feedback, and take required action for each of the plan's tasks.
- Participants add the number of visits to the specific blocks that they plan to visit, in the blank spaces. The plan, which follows, indicates that Mr. X, district programme manager, will make two PHC visits in the Kolibara block of the Simdega district, Jharkhand. He will also visit these two PHCs in the first week of the next month as follow up.
- A realistic plan for a period of three months should be developed by participants, with as much detail as they can think of—taking into account public holidays, mandated monthly meetings, festivals, along with seasonal phenomena where working may be difficult. The focus of the meetings and visits should be to improve the family planning programme and its related access, demand, and system-related issues, to give attention to the variations between different blocks.

Name: _____

Designation: _____

Location: _____

TASK	Month 1				Month 2			
	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4
Sub-centre visits								
CHC visits								
PHC visits	Two at Kolibara, Simdega				Two at Kolibara, Simdega			
District hospital visits								
RKS meetings								
QA meetings								
VHSC meetings								
VHND with FP services								
District headquarters								
HMIS data quality at district headquarters								
Adolescent Reproductive and Sexual Health (ARSH) Clinics providing counselling on delaying								
Include FP agenda in the VHSC meetings								
FP camps and fixed-day services								
Trainings related to FP								
Others								

REFERENCES

AusAID. 2006. *A Staged Approach to Assess, Plan and Monitor Capacity Building*. Canberra: AusAID.

Bridgman, P and Davis, G. 2003. "What Use is a Policy Cycle? Plenty, If the Aim Is Clear." *The Australian Journal of Public Administration.* 62(3): 98–102.

Solter, C. 1998. Comprehensive Reproductive Health and Family Planning Training Curriculum. *Module 3: Counseling for Family Planning Services*. Watertown, MA: Pathfinder International, Medical Services Unit.

Centre for Development and Population Activities. 1995. The CEDPA Training Manual Series. Volume 1, *Conducting a Workshop in Participatory Training Techniques.* Washington DC: CEDPA.

Children's Vaccine Program at PATH. December 2003. *Guidelines for Implementing Supportive Supervision*. Seattle: PATH.

Cross, Harry, Norine Jewell and Karen Hardee. 2001. Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs. *POLICY Occasional Paper*. No. 7. Washington DC: Futures Group, POLICY Project.

Hardee, K, I. Feranil, J. Boezwinkle and B. Clark. 2004. The Policy Circle. *POLICY Working Paper* No. 11. Washington, DC: Futures Group, POLICY Project.

Hardee, Karen, Lori Ashford, Elisabeth Rottach, Rachel Kiesel and Rima Jolivet. 2012. *The Policy Dimensions of Scaling Up Health Initiatives.* Washington, DC: Futures Group, Health Policy Project.

Howard, C. 2005. "The Policy Cycle: A Model for Post-Machiavellian Policy Making?" *The Australian Journal of Public Administration.* 64(3): 3–13.

IFPS Technical Assistance Project (ITAP). 2010. *Soch Se Amal Tak- State Level Behaviour Change Communication (BCC) Planning Workshop.* Gurgaon, Haryana: IFPS Technical Assistance Project.

International Institute for Population Sciences (IIPS) and Macro International. 2009. *District Level Household and Facility Survey (DLHS-3), 2007-09*: Fact Sheet. Mumbai: IIPS.

International Planned Parenthood Federation. June 2006. *Supportive Supervision for Quality Improvement. Training of Trainers Guide for Health Professionals.* London: IPPF.

Knowles, M. 1996. Adult Learning. In *The ASTD Training and Development Handbook*, edited by Robert L. Craig, 253–264. New York: McGraw-Hill.

Lasswell, Harold D. 1951. "The Policy Orientation." *In The Policy Sciences: Recent Developments in Scope and Method*, edited by Daniel Lerner and Harold D. Lasswell. Stanford: Stanford University Press.

McMahon, R. et al. 1992. *On Being in Charge: A Guide to Management in Primary Health Care.* Geneva: World Health Organisation.

Ministry of Health and Family Welfare (MoHFW). 2006. *Quality Assurance Manual for Sterilization Services*. New Delhi: MoHFW, GOI.

National Family Health Survey (NFHS-3), 2005-6: India: Volume I. Mumbai: IIPS

NRH. 2008. Community Participation for Jharkhand State. New Delhi: NRH.

Office of the Registrar General and Census Commissioner (ORGI), India. 2012. *Annual Health Survey 2011-12: Fact Sheet*, New Delhi: Vital Statistics Division, Office of the Registrar General & Census Commissioner, India.

Office of the Registrar General and Census Commissioner (ORGI), India. 2011. *Provisional Population Totals: Paper 1 of 2011, Series 1*.New Delhi: Office of the Registrar General & Census Commissioner, India.

O'Sullivan, G.A., J. A. Yonkler, W. Morgan, and A. P. Merritt. 2003. *A Field Guide to Designing a Health Communication Strategy.* Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs.

Planning Commission, GOI. 2011. *Report of the Working Group on National Rural Health Mission (NRHM) for the Twelfth Five Year Plan (2012–2017)*. New Delhi: GOI.

POLICY Project. 1999. *Networking for Policy Change: An Advocacy Training Manual*. Washington, DC: Futures Group, POLICY Project.

Ross, John, and Ellen Smith. 2010. *The Family Planning Effort Index: 1999, 2004, and 2009.* Washington, DC: Futures Group, USAID │Health Policy Initiative, Task Order 1.

Sabatier, Paul. 2007. *Theories of the Policy Process*. Boulder, CO: Westview Press.

Sundararaman, T. January 2011. *HMIS Managers' Manual: User Manual for DHIS 2. VOLUME III.* New Delhi: National Health Systems Resource Centre.

EngenderHealth/The ACQUIRE Project. 2008. *Counseling for Effective Use of Family Planning: Participant Handbook.* New York: EngenderHealth/The ACQUIRE Project.

The Population Council. 2010. *Facilitating Provision of Client Centered Family Planning Services through Supportive Supervision: A Guide for Human Resource Management.* Pakistan: Population Council.

UNFPA. 1999. Technical Report..*Planning Population Development Projects with Focus on Decentralization and Quality of Care.*

United States Agency for International Development (USAID). 2000. "Policy Implementation: What USAID Has Learned." Center for Democracy and Governance. Washington, DC: USAID.

Voorhees, R. 2001. "Competency-Based Learning Models: A Necessary Future." *New Directions for Institutional Research.* (110): 5–13.

Walt, G., and L. Gilson. 1994. "Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis." *Health Policy and Planning* 9(4): 353–370.

World Health Organisation (WHO). 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action.* Geneva: WHO.

WHO. 2008. *Training for Mid-level Managers (MLM): Module 4: Supportive Supervision.* Geneva: WHO.

WHO. 2010. *Key Components of a Well-Functioning Health System.* Geneva: WHO.

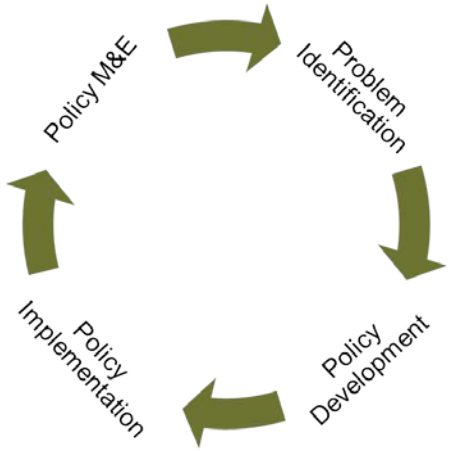
WHO Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project. 2011. *Family Planning: A Global Handbook for Providers 2011 Update*. Baltimore and Geneva: CCP and WHO.

ANNEX A. THE POLICY PROCESS

Source: Jorgensen, A., K. Hardee, E. Rottach, A. Sunseri, M. Kinghorn, A. Bhuyan, and M. Hijazi. 2012. *Capacity Development Framework and Approach for Health Policy, Governance, and Social Participation*. 20–21. Washington, DC: Futures Group, Health Policy Project.

Strengthening the capacities of multiple stakeholders to navigate the complex dynamics of developing and implementing policies requires a substantive understanding of the policy process. A number of theories and frameworks of policy have been developed to describe the process (Sabatier, 2007). The policy process is clearly complex and context-dependent, and includes many feedback loops (Howard, 2005; Hardee et al., 2004). However, this framework makes use of a stages approach first articulated in the 1950s (Laswell, 1951) and still used today to facilitate identifying and defining competencies needed to engage in health policy (Bridgman and Davis, 2003). The four stages of the process are:

Problem identification: The initial step is identifying the problem requiring a policy response to be placed on the policy agenda. The problem may require developing a new policy or changing an existing policy or set of policies. Problems can be identified through various means, for example, studies, assessments, gender analyses, or health surveys, and by a number of stakeholders. Advocacy—by civil society, women's groups, media, healthcare providers, or policymakers—is a common approach for bringing issues to the attention of policy makers. Problem identification is most effectively based on evidence, in order to both determine the extent of the problem and to suggest feasible and cost-effective policy responses.



Policy development: Once the problem has been established, it is framed by diverse stakeholders to determine if it will make it onto the policy-making agenda, and how the policy response will be formulated. Policy development requires attention to policy content (e.g., clear goals, strategic directions, institutional arrangements, resource needs, indicators of success), as well as policy processes (e.g., evidence-based, participatory processes). Different stakeholders play different roles in policy development. Policymakers determine what officially gets on the policy agenda and have official roles in voting for policies. Other stakeholders can and should influence this process by advocating for issues to be placed on the policy agenda and participating in dialogue to determine the content of the proposed policies.

Policy implementation: Implementation of policies is the actual "doing" of the actions outlined. Since policies are often broad statements of intention, they require supplemental documents in the form of strategic plans, implementation plans, and operational policies to ensure that they are carried out (Walt, G., and L Gilson. 1994; Cross, Harry, Norine et al, 2001; USAID, 2000). Policy implementation may involve the scale-up, testing, and rolling out of new or improved services in alignment with policy goals. By establishing operational policy guidelines, reliable funding, and adherence to equity principles, effective scale-up of policies and plans helps to lay the foundation so that services are not provided in an ad hoc, arbitrary, or inconsistent manner (Hardee, Ashford, et al., 2012).

Policy implementation to put policies into practice is generally the purview of technocrats. However, it is best done as a consultative process where policymakers, the private sector, and civil society

representatives alike remain engaged in outlining what, how, who, when, and where resources and efforts are needed. Scale-up and sustainability are achieved when the goals, principles, and operational guidelines of policy directives are normalised and consistently supported as part of the everyday practice of health service planning and provision. Therefore, effective policy implementation requires an understanding of existing institutions and bureaucracies, and the actions needed to create or modify programmes, or remove barriers to implementation.

Policy monitoring and evaluation: Monitoring the implementation efficiency and impact of the new policies is important both to continually improve the policies and practices that support a strong health system, as well as ensuring accountability of the government to its citizens. Therefore, policy monitoring and assessment is of concern for all stakeholders—to identify gaps in implementation or potentially negative consequences of the policy that may require additional policy response. Government leaders have a key role to play in fostering accountability—by guiding policy and programme implementation, harnessing resources, and answering to their citizens for pledged commitments. Civil society must be involved in policy monitoring, by serving as a watchdog to monitor how policies are actually rolling out and affecting communities. Strong civil society networks, such as social watch activities, citizen monitoring systems, and grievance resolution centres, are key to accountability.

ANNEX B. DISTRICT AND BLOCK FUNCTIONARIES—ROLES AND RESPONSIBILITIES

Source: Adapted from NRHM. 2007. *Operational Manual for Preparation and Monitoring of RCH Component II of NRHM State Programme Implementation Plans*. New Delhi: NRHM. Modified by the state department of health and family welfare.

District

District Programme Manager

- Provide managerial inputs from time to time to the district health team including civil surgeon, additional chief medical officer (ACMO), district reproductive and child health officer, and district programme officer for district health action plans, formulating and designing project proposals, district micro plans, monitoring plans.
- Plan and facilitate execution and monitoring all the health action programmes introduced in the state under NRHM, 24x7 first referral unit (FRU) and public health centre operations, Mukhymantri Janani Sishu Swasthya Abhiyan (institutional delivery scheme), routine immunisation (RI), reproductive and child health (RCH)/FP camps, and any other activities as per plan.
- Develop monitoring plans for all public health centres/community health centres in the territory and provide feedback to deputy director (Health), civil surgeon, and state programme manager.
- Ensure uniform and timely submission of reports of all the programmes under NRHM from health sub-centres, public health centres, and community health centres in line with state programme management unit.
- Participate in all the monthly district meetings as well as in other meetings related to NRHM.
- Apprise district health team on the district developments under NRHM.
- Update the chairperson and members of the district health society on the progress in the district under NRHM.
- Establish and monitor district financial procedures as well as in public health centres for smooth functioning.
- Prepare and submit monthly work plan and monthly progress report to deputy director (Health), surgeons and state programme manager.
- Represent the district health team in the monthly meeting at the state headquarters to review the progress of NRHM in the district.
- Ensure proper information flow from public health centres to district headquarters and vice versa.

District IEC Officer (profile being looked after by the additional chief medical officer)

- Identify the need of BCC/IEC activities at the district level.
- Monitor and supervise all BCC activities in the district.
- Develop IEC materials and activities with prior permission of civil surgeons of the district.
- Develop BCC/IEC implementation plan for the district.

District Data Officer

- Assist district accounts manager in managing district health society affairs and document the decisions taken during the district meetings of the society.
- Prepare monthly progress reports on the implementation of various programmes in prescribed formats and with timely submission to state headquarters.
- Assist the district programme manager in developing district work plans.
- Assist the district programme management unit in strengthening the MIS in district and public health centres.
- Assist district and public health centres with computer hardware and software issues.
- Ensure functionality of the routine immunisation management system in the district and generate reports.
- Ensure coordination between public health centres and district headquarters for timely report submission.
- Ensure proper coordination between district and state headquarters for timely report submission.
- Create a data bank at district and public health centres for easy access to any data related to programmes.
- Ensure coordination with the civil surgeon, district programme manager and the state data officer.

Block

Block Programme Manager

- Provide overall leadership to all health programmes under NRHM; develop action plans, monitor development, and suggest mid-course corrections.
- Implement and monitor all programmes under NRHM, 24x7 FRU, and public health centre operations, Mukhyamantri Janani Shishu Swasthya Abhiyan (institutional delivery scheme),, routine immunisation, RCH/FP camps, and/or other activities as per plan coordinated with the district programme management unit.
- Provide managerial inputs to the block health teams including medical officers in-charge, medical officers, and other health staff in the development of Block Health Action Plan and ensure its timely implementation and monitoring.
- Develop a monitoring plan of all the public health centres/health sub-centres in the territory and provide feedback to respective medical officers in-charge and district programme managers.
- Ensure uniformity and timely submission of reports of all the programmes under NRHM from health sub-centres, public health centres and community health centres in line with State Programme Management Unit. Strengthen documentation of the processes at the block level.
- Participate in all the monthly block-level meetings as well as other NRHM-related meetings. Apprise block health teams on the developments under NRHM at the block level.
- Assess the training requirements of the block health personnel to enhance their technical and managerial skills, especially at the community health centre/public health centre levels and develop training plans for them in collaboration with the district programme management unit and state programme management unit and also explore local training opportunities for them.

- Establish and monitor the financial systems and procedures at the block level as well as public health centres and health sub-centres for smooth functioning.
- Prepare and submit monthly work plans and monthly progress reports to the district programme manager and the respective medical officer in-charge.
- Represent block health team in the monthly meetings at the district headquarters to review the progress of NRHM at blocks.
- Ensure proper information flow from health sub-centres/public health centres to block and district headquarters and vice versa.
- Any other specific assignment as per requirement.

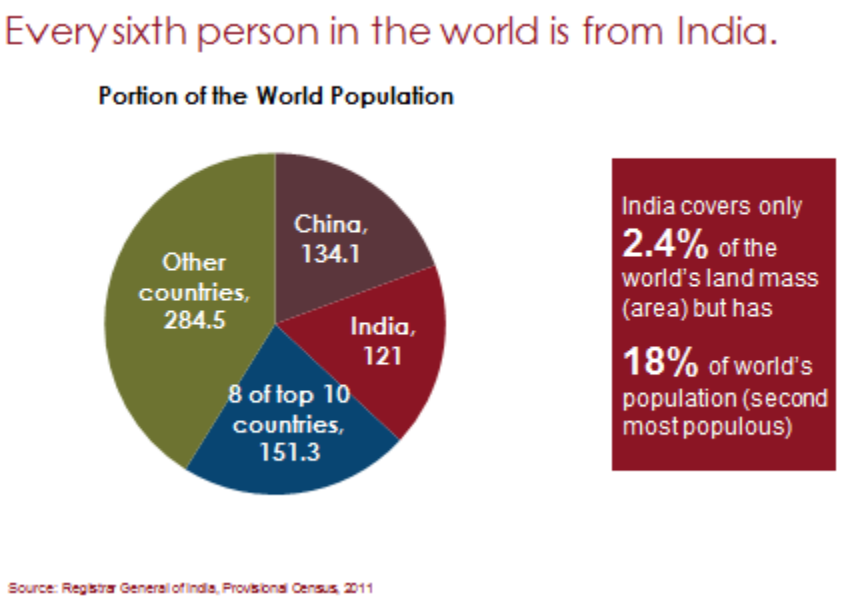
Block Data Manager

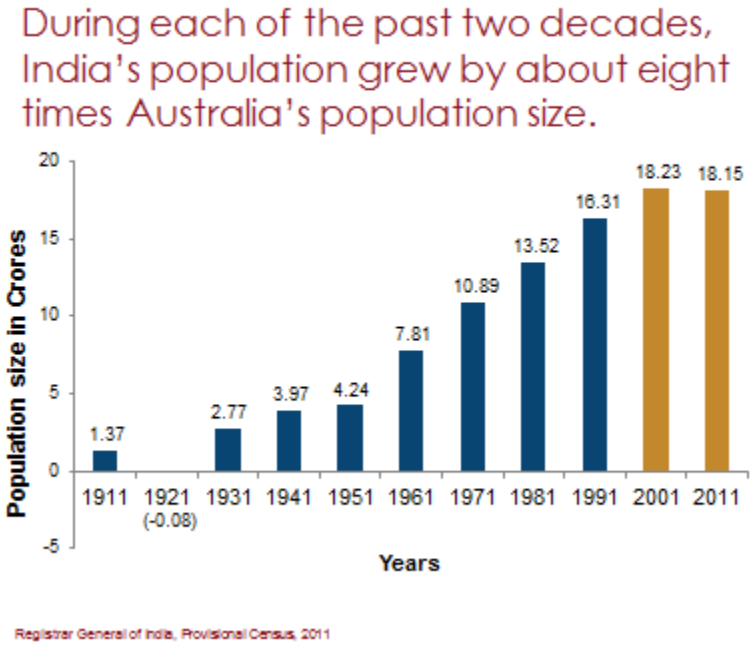
No data manager or data assistant position exists in any of the districts. The block programme manager or block accounts manager is responsible for data compilation.

ANNEX C. FAMILY PLANNING ISSUES AND STRATEGIC DIRECTIONS

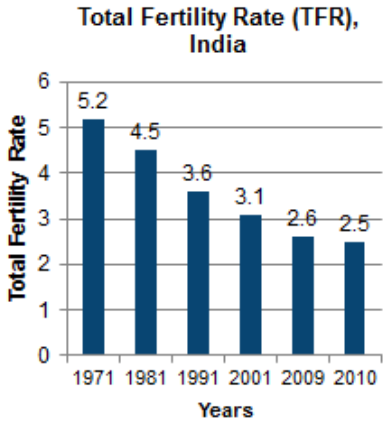
India's Historical and Current Population

India's population has almost doubled from 0.7 billion to 1.2 billion in just 30 years (from 1981 to 2011). The number of people added each decade continues to grow. At this rate, *each year* the population has grown by 21 million people—the equivalent size of Australia's population. With a relatively small land mass, India, and over the last two decades has accommodated a very rapid population growth—the equivalent size of eight Australias—and not without human and financial cost to its social and economic development.



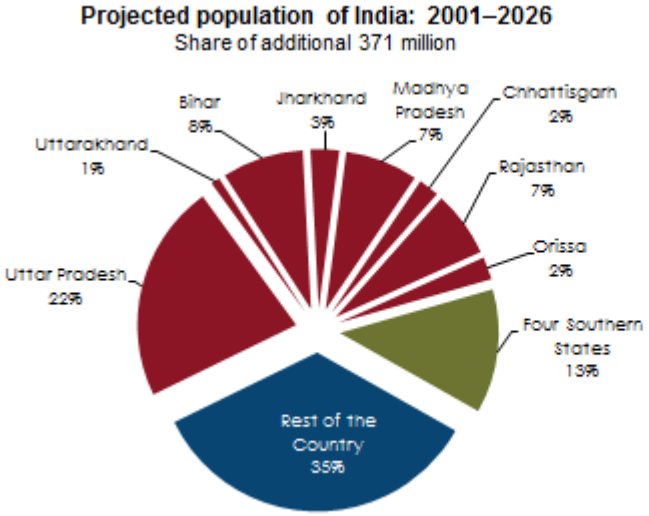


The Good News



- Declining annual population growth rate:
  - 2.16% between 1981–1991
  - 1.97% between 1991–2001
  - 1.64% between 2001–2011
- 20 states/UTs reached TFR 2.1 in 2007
- Urban TFR of 2.1 achieved in 2004

Sources: TFRs are from the Sample Registration System; Population Growth Rate is from Census of India, 2011



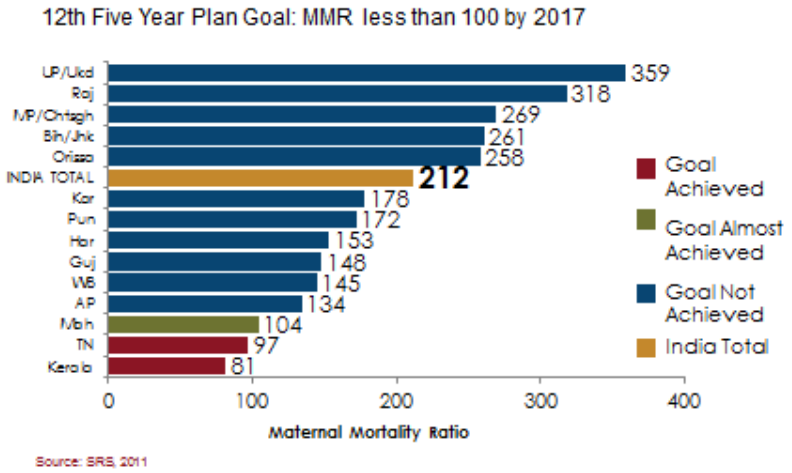
Half (50%) of India's population growth will be in **7 northern states.**

Southern states will contribute only 13% of growth.

Maternal Mortality Ratio

- Maternal Mortality Ratio (MMR) is the number of maternal deaths per 100,000 live births
- 12th Five-Year Plan Goal: MMR less than 100 by 2017

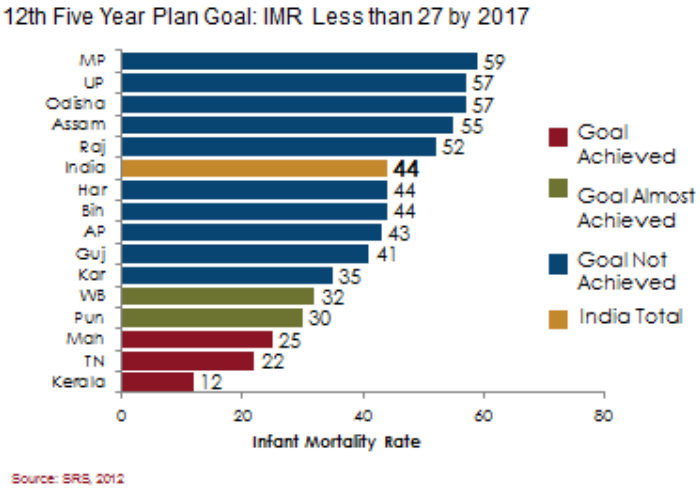
Maternal Mortality Ratio: 2007–2009



Infant Mortality Rate

- **Infant Mortality Rate (IMR):** number of infant deaths per 1,000 live births
- **12th Five-Year Plan Goal:** IMR less than 27 by 2017

Infant Mortality Rate: 2011

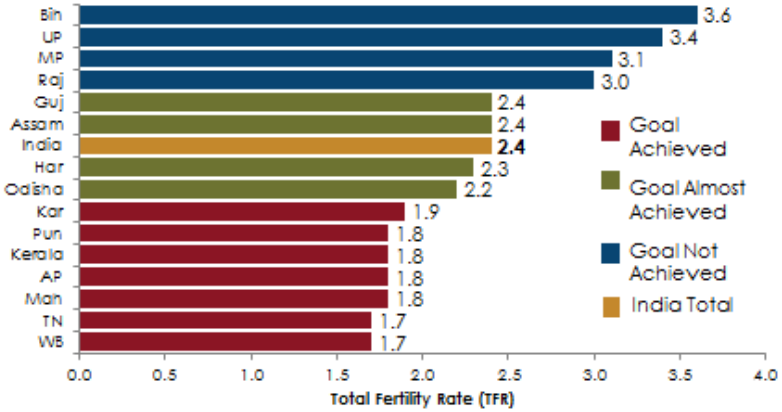


Total Fertility Rate

- **Total Fertility Rate (TFR)**: number of children born per woman
- **12th Five-Year Plan Goal:** reduce TFR to 2.1 by 2017

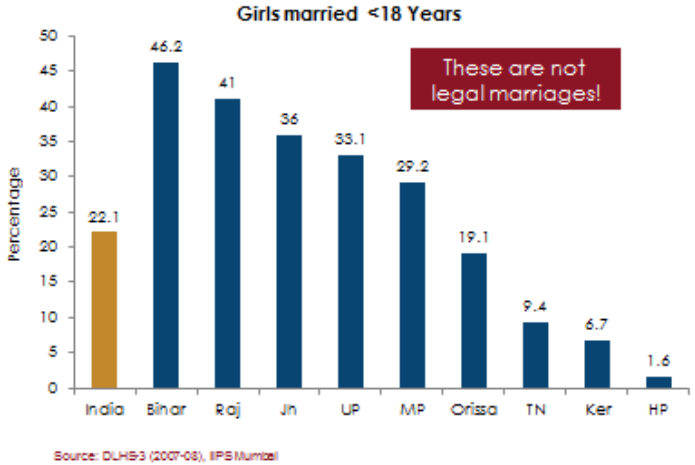
Total Fertility Rate: 2011

12th Five Year Plan Goal: TFR less than 2.1 by 2017



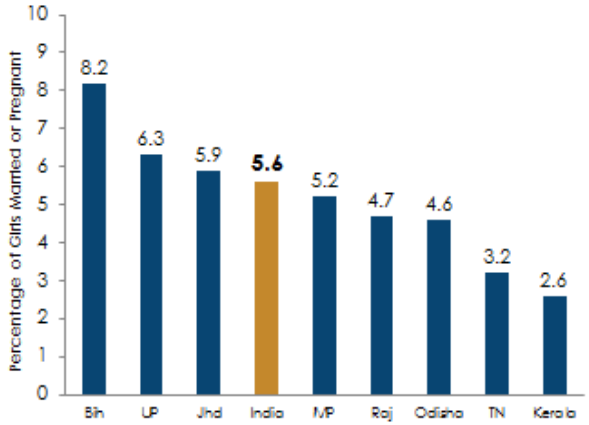
Source: SRS, 2012

Early Age at Marriage Is a Challenge in High-focus States



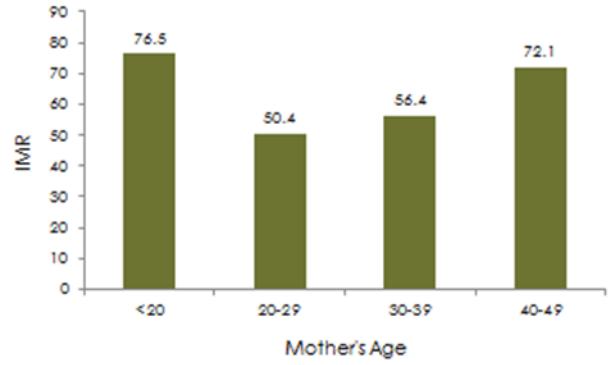
Source: DLHS-3 (2007-08), IIPS Mumbai

Percentage of Teenage Girls Who Are Pregnant or Already Mothers



Higher chance of children dying when:

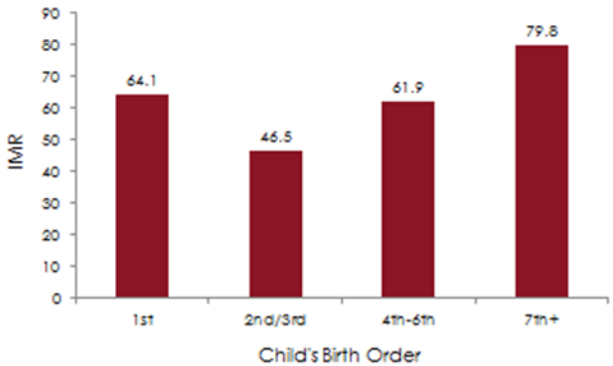
The woman is pregnant before age 20 or after age 40.



Source: DLHS-3 (2007-08), IIPS Mumbai

Higher chance of children dying when:

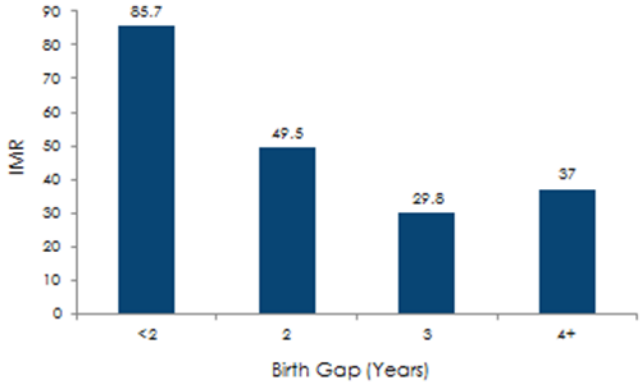
The baby is the first child or fourth and then on.



Source: DLHS-3 (2007-08), IIPS Mumbai

Higher chance of children dying when:

Gap between two births is less than 2 years.

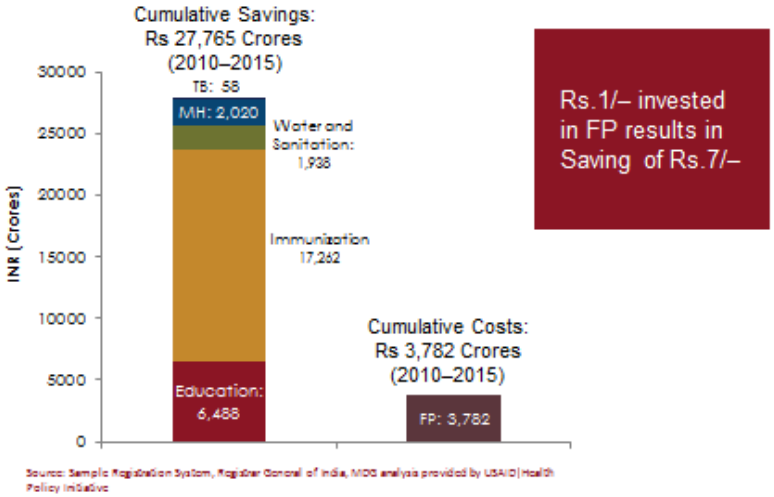


Source: DLHS-3 (2007-08), IIPS Mumbai

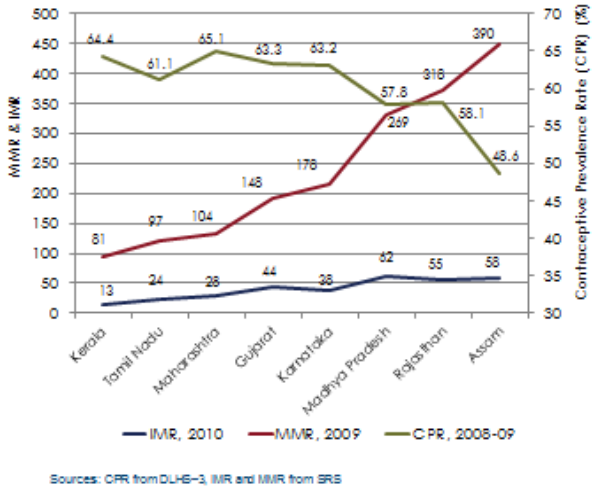
Reproductive Rights are Central to Population

- Reposition family planning
- Reduce infant and (neonatal) mortality
- Increase age at marriage and delay the first child
- Promote better spacing
- Improve access to and quality of the basket of contraceptives and reproductive health services
- End discrimination against the girl child

Social Sector Cost Savings Outweigh Family Planning Costs



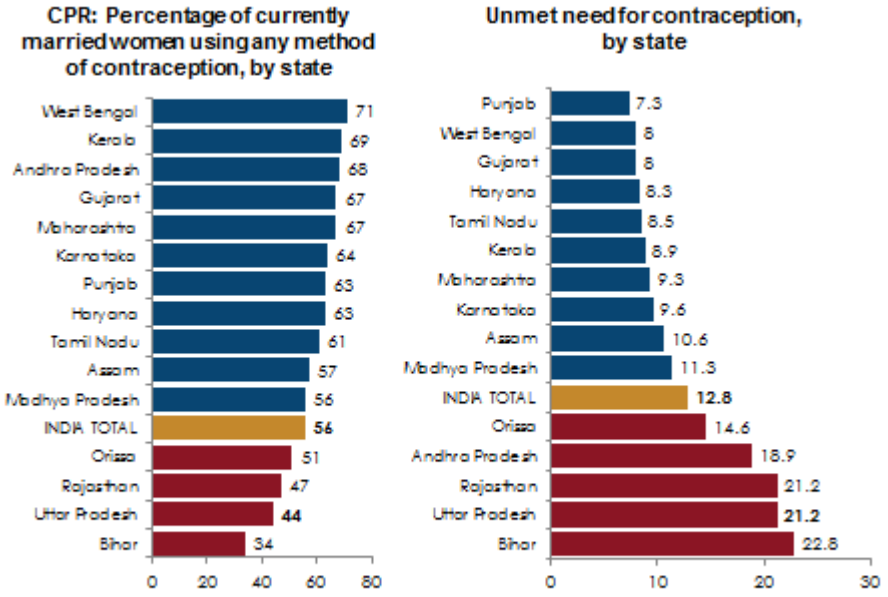
Family Planning Saves Lives



Sources: CPR from DLHS–3, IMR and MMR from SRS

As contraceptive use rises, maternal and infant deaths decline.

By simply supplying the unmet need for contraceptives, states can achieve replacement-level fertility.


CPR: Percentage of currently married women using any method of contraception, by state
West Bengal 71
Kerala 69
Andhra Pradesh 68
Gujarat 67
Maharashtra 67
Karnataka 64
Punjab 63
Haryana 63
Tamil Nadu 61
Assam 57
Madhya Pradesh 56
INDIA TOTAL 56
Orissa 51
Rajasthan 47
Uttar Pradesh 44
Bihar 34
0 20 40 60 80
Unmet need for contraception, by state
Punjab 7.3
West Bengal 8
Gujarat 8
Haryana 8.3
Tamil Nadu 8.5
Kerala 8.9
Maharashtra 9.3
Karnataka 9.6
Assam 10.6
Madhya Pradesh 11.3
INDIA TOTAL 12.8
Orissa 14.6
Andhra Pradesh 18.9
Rajasthan 21.2
Uttar Pradesh 21.2
Bihar 22.8
0 10 20 30
Source: NFHS, 2005-2006

National Family Planning Programme

Mission: "The mission of the National Family Planning Programme is that all women and men (in reproductive age group) in India will have knowledge of and access to comprehensive range of FP services, therefore enabling families to plan and space their children to improve the health of women and children..." (NRHM (2005–2012): Mission, 2005)

The guiding principles are: a target-free approach based on unmet needs for contraception; equal emphasis on spacing and limiting methods; and, a promotion of 'children by choice' in the context of reproductive health.

Strategies for States to Follow

Source: FP Appraisal Form for State PIP 2013–2014

Strengthen spacing methods, including:

- Increasing the number of providers trained in intrauterine contraceptive device (IUCD) 380A
- Strengthening fixed-day IUCD services at facilities
- Introducing the Cu IUCD 375
- Delivering contraceptives to beneficiaries at home in pilot states/districts

Emphasise postpartum FP services by:

- Strengthening postpartum IUCD (PPIUCD) services, at least at district hospitals
- Promoting postpartum sterilisation (PPS)
- Establishing district postpartum centres at women and child hospitals
- Appointing counsellors at high-caseload facilities

Strengthen sterilisation service delivery by:

- Increasing the pool of trained service providers (minilap, lap, and non-scalpel vasectomy)
- Operationalising fixed-day services centres for sterilisation
- Holding FP camps to clear backlog

Strengthen the quality of service delivery by:

- Strengthening QACs for policy monitoring
- Disseminating/following existing protocols, guidelines, and manuals
- Monitoring FP insurance

Develop the BCC/ IEC tools highlighting family planning's benefits, especially with spacing methods.

Focus on using private sector capacity for service delivery, and explore public-private partnership availability.

Strengthen programme management structures by:

- Establishing new structures for monitoring and supporting the programme
- Strengthening programme management support to state and district levels

Twelfth Five-Year Plan Recommendations

Source: Summarised from Planning Commission, GOI. October 2011. *Fast, Sustainable and More Inclusive Growth: An Approach to the Twelfth Five Year Plan (2012–2017).* New Delhi: GOI.

- A different approach among the seven high-fertility states, including Jharkhand, is required to address the need for population stabilisation. Whereas in the other states, the focus is on promotion of spacing measures without reducing the levels of achievement required for sterilisation, in high-fertility states the challenge, by necessity, is to be creative—think unconventionally and from new perspectives.
- Intensification of skill development for government providers, and efforts to recruit and use private providers will focus on both spacing and limiting methods.
- Postpartum contraception will also be promoted. In all states a planned effort will promote spacing methods, especially the intrauterine device (IUD); improve FP counselling services; and motivate and provide incentives for male sterilisation.
- Efforts will be made to introduce injectable contraceptives. Social marketing of contraceptives through ASHAs will be actively promoted and ASHAs will be paid incentives/commissions for their efforts.
- Given the major load in referral medical college hospitals and large district hospitals on account of Janani Suraksha Yojana, efforts to strengthen the district hospitals and increase the number of beds for providing quality antenatal, intranatal, postnatal, and child care to cope with increasing caseloads of pregnant women, newborns, and children, and with a focus on postpartum FP services. Separate maternal and child wings may also be constructed where required to handle the higher caseload.

Population Stabilisation Goals

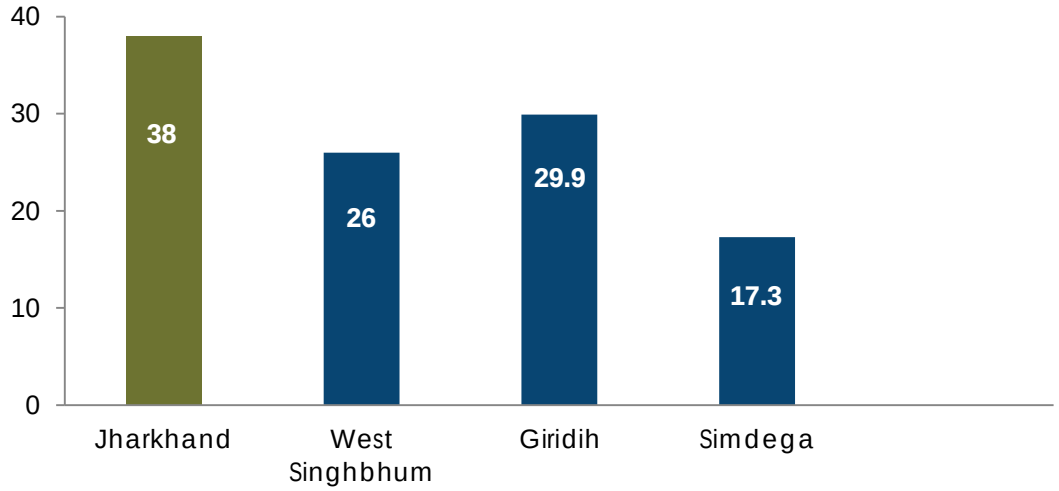
- As per the Twelfth Five-year Plan (2012–2017), the goal is to achieve a total fertility rate (TFR) of 2.1 by 2017 nationally, with state-specific targets set by the states.
- The goal of Jharkhand is to achieve a TFR of 2.1 by 2020, as per the state PIPs.

Current Status of Family Planning in Jharkhand

- District total population of the state is about 3.3 crore (District total: 32,96,623; Males:1,69,31,688; Females:1,60,34,550) (Census of India, 2011)
- According to the NFHS-3, 2005–2006
  - Mean age at marriage in Jharkhand is 16.3
  - Desired fertility rate in the state is 2.1
- According to the Annual Health Survey (2010–2011):
  - Jharkhand's TFR is 3.1, which varies from 2.4 in urban areas to 3.3 in rural areas.
  - Forty percent of births are of higher order (3 and above); 30 percent in urban Jharkhand and 43 percent in rural Jharkhand.
  - Sixty-one percent reported wanting no more children.
  - Median age at first live birth is 21.6 years.
  - Modern contraceptive use is only 38 percent, 35 percent in rural areas, and 47 percent in urban areas.
  - Use of modern spacing methods is low (8.3%).

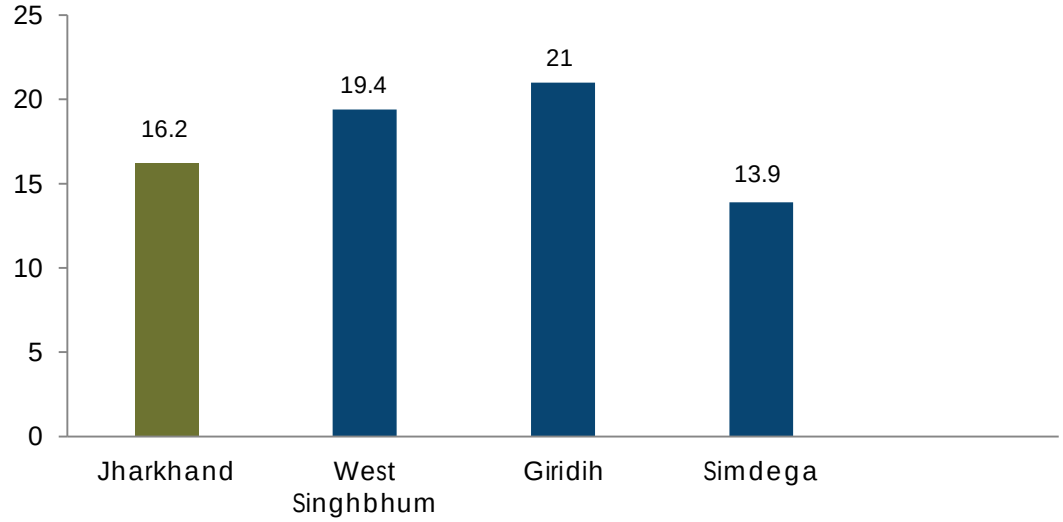
- High unmet need for contraception stands at 31 percent, unmet need for spacing is 16.2 percent and limiting is 14.3 percent.
- Maternal mortality ratio (MMR) is high at 278.
- Infant mortality rate (IMR) is 41/1000 live births; 45/1000 rural and 26/1000 urban.
- Neonatal mortality rate (NMR) is 26/1000 live births; 29/1000 rural and 17/1000 urban.
- Under-five mortality rate is 59/1000 live births; 66/1000 rural and 35/1000 urban.

Figure 3: Contraceptive Prevalence Rate (Modern Method)



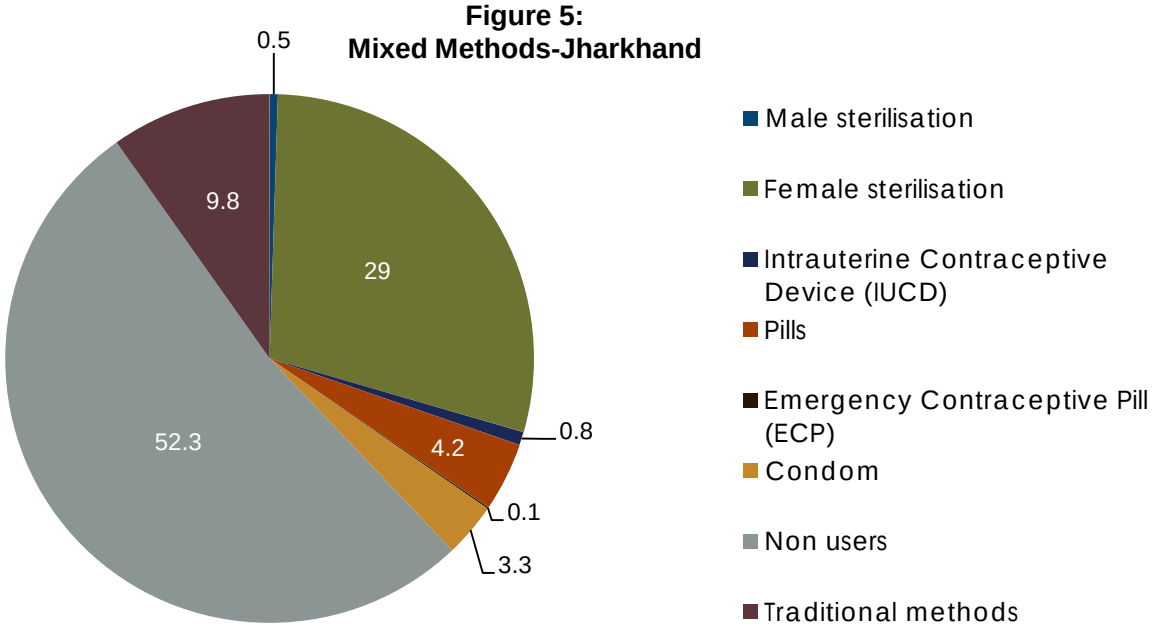
Sources: Jharkhand, W. Singbhum, and Giridih from Office of the Registrar General and Census Commissioner (ORGI), India 2012; AHS 2010–2011; Simdega from DLHS 2007–2008.

Figure 4: Unmet Need for FP: Spacing Method



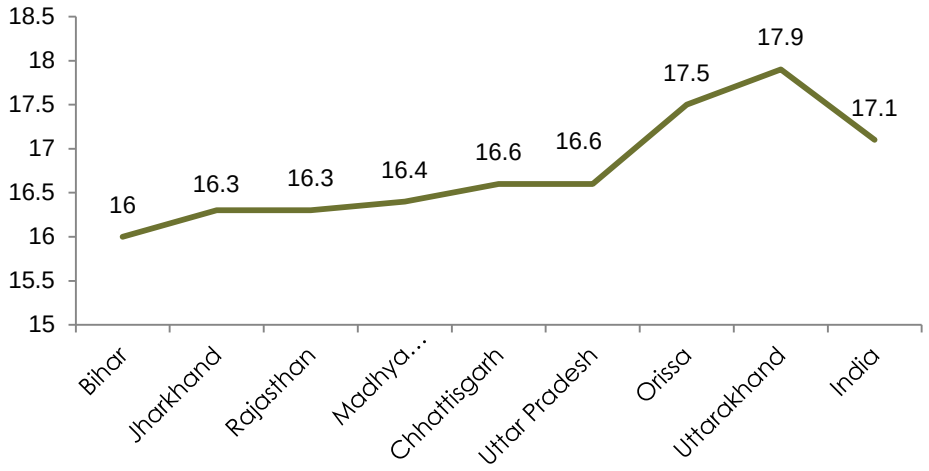
Sources: Jharkhand, W. Singbhum, and Giridih from AHS 2010–2011; Simdega from DLHS 2007–2008

Figure 5:
Mixed Methods-Jharkhand



Source: AHS 2010–2011.

Figure 6: Average Age at Marriage



Source: NFHS–3, 2005-06

Figure 7: Parents want more sons than daughters

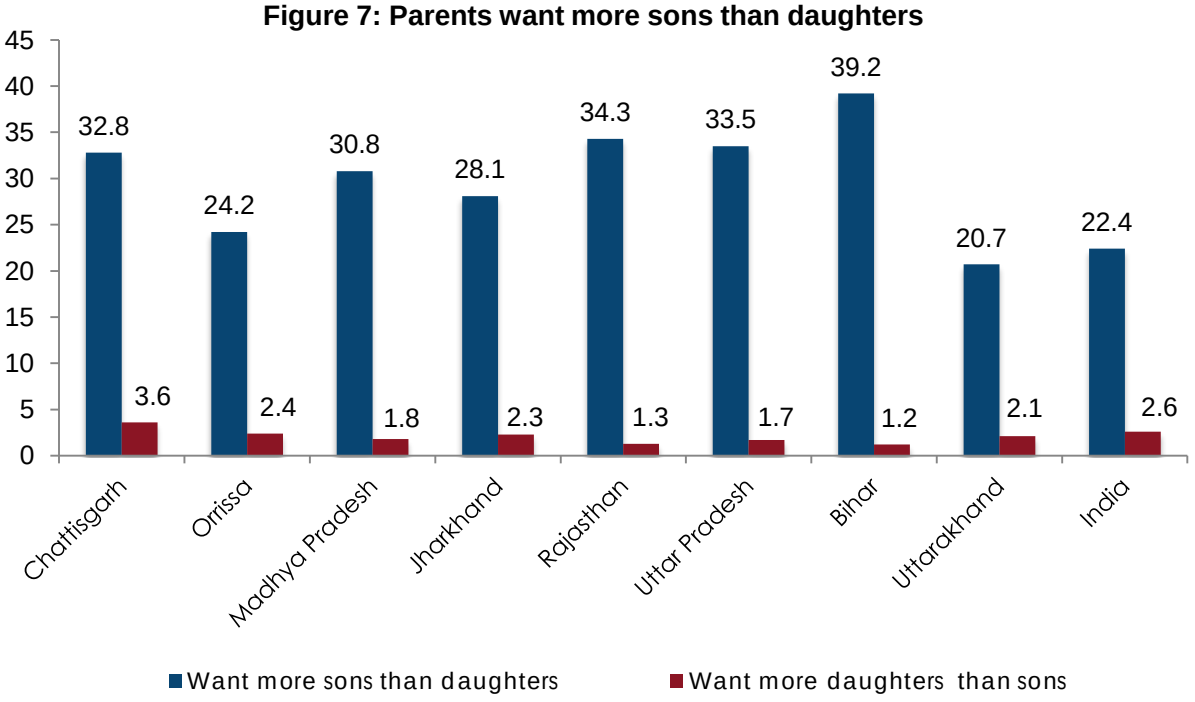


Figure 8: Desired TFR vs Actual TFR

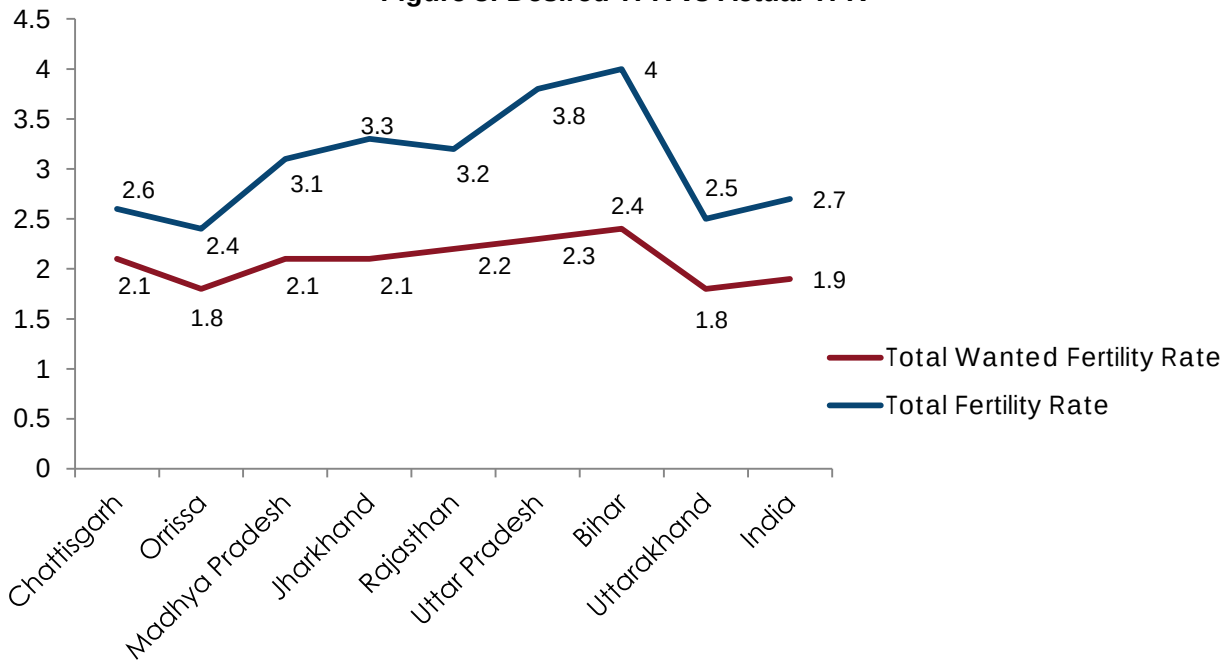


Table 1: Unmet Need for Contraceptives

States/ INDIA	Not using any modern FP method	Unmet need for limiting methods	Unmet need for spacing methods	Total unmet need for FP
Jharkhand	62.0	14.3	16.2	30.5
Bihar	66.1	17.9	21.3	39.2
Orissa	56.0	12.4	10.8	23.2
Madhya Pradesh	43.0	8.6	13.8	22.4
Chhattisgarh	50.5	10.9	15.5	26.4
INDIA	52.7	9.3	5.3	14.6

ANNEX D. HEALTH SYSTEM COMPONENTS

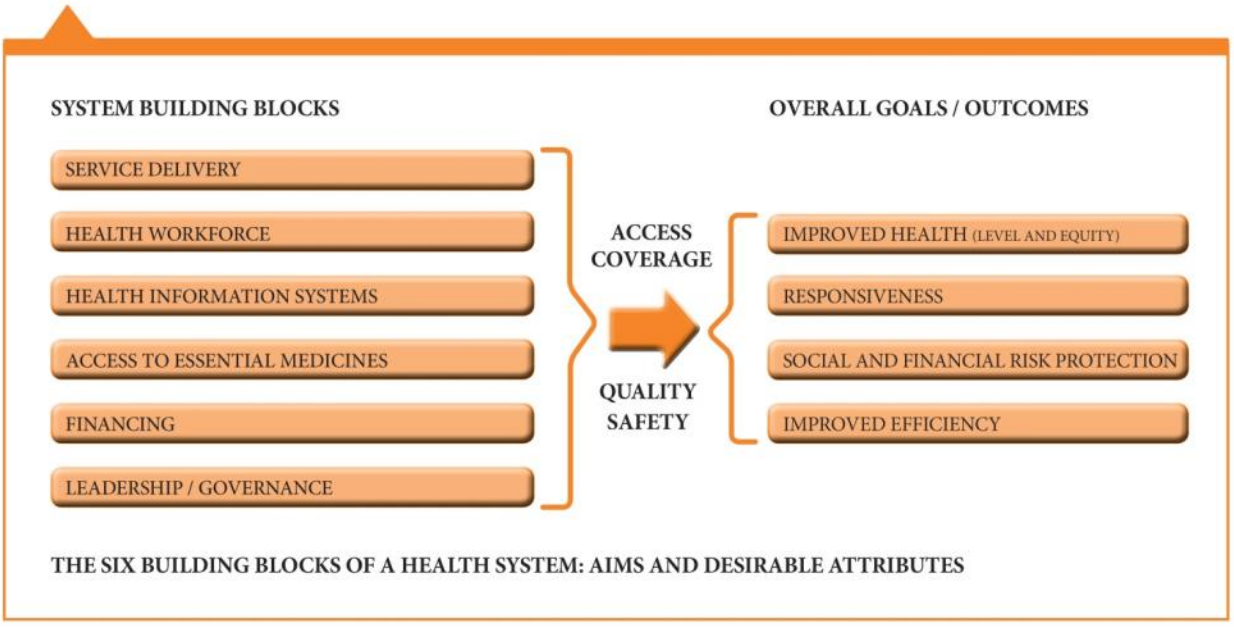
What is a health system?

Source: Adapted from World Health Organisation. 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*. Geneva: WHO.

A health system consists of all organisations, people, and actions whose primary intent is to promote, restore, or maintain health. This includes efforts to influence the factors that promote or determine health, as well as more direct health-improving activities. A health system is more than a complex pyramid of publicly-owned facilities that deliver personal health services. A health system includes–a mother caring for a sick child at home, private providers of health-related goods and services, behaviour-change programmes, vector-control campaigns to prevent disease, health insurance organisations, and legislation for occupational health and safety. It includes intersectoral action by health staff, such as encouraging the Ministry of Education to promote female education, a well-known determinant of better health.

WHO health system building blocks

To achieve their goals, all health systems have to carry out some basic functions, regardless of how they are organised: they have to provide services; develop health workers and other key resources; mobilise and allocate finances; and ensure health system leadership and governance.



Source: WHO, 2007.

1. Good health services deliver effective, safe, high-quality personal and non-personal health interventions to those that need them, when and where needed, and with minimum waste of resources.
2. A well-performing health workforce works in ways that are responsive, fair, and efficient, to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed and they are competent, responsive, and productive).

3. A well-functioning health information system ensures the production, analysis, dissemination, and use of reliable and timely information on health determinants, health system performance, and health status.
4. A well-functioning health system ensures equitable access to essential medical products, vaccines, and technologies of assured quality, safety, efficacy, and cost-effectiveness, and their scientifically sound and cost-effective use.
5. A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.
6. Leadership and governance involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design, and accountability.

Key Health System Concepts

- *Multiple, dynamic relationships.* A health system, like any other system, is a set of interconnected parts that must function together to be effective. Changes in one area have repercussions elsewhere. Improvements in one area cannot be achieved without contributions from the others. Interaction between building blocks is essential to achieve better health outcomes.
- *Health system strengthening* is defined as improving these six health system building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes. It requires both technical and political knowledge and action.
- *Access and coverage.* Since notions of improved access and coverage lie at the heart of this WHO health system-strengthening strategy, there has to be some common understanding of these terms.
- *Is progress being made?* A key concern of governments and others who invest in a health system is how to tell whether and when the desired improvements in health system performance are being achieved. Convincing indicators that can detect changes on the ground are needed.

India's Public Health System

Source: Planning Commission. 2011. *Evaluation Study of National Rural Health Mission (NRHM) in Seven States.* New Delhi: Planning Commission, GOI (pp. 8–9).

India's healthcare system structure:

India being signatory to Alma Ata Declaration is committed to attaining health for all through the primary healthcare approach. The ultimate objective of a healthcare delivery system is that the rich and poor are treated alike, poverty does not become disability, and wealth is not an advantage toward accessibility of healthcare. In order to provide accessible, affordable, and accountable healthcare system to all, especially underprivileged and vulnerable sections of the society, the NRHM has emphasised an improvement in healthcare infrastructure in demographically backward states and districts (NRHM, 2005). Thus, apart from increased budget, through the involvement of people in VHSCs, district health societies, and RKS, the emphasis is on basic health infrastructure improvement with an adequate supply of human resources, material, drugs, equipment, and a viable transport system.

In the hierarchical healthcare system of the GOI, the district hospital (DH) is the apex body, which provides specialised healthcare to the people of a district on subsidised cost. Every district is expected to have at least one DH, but in some cases the medical college hospital or any other subdivisional hospital also serves as DH, where such an institution is not established.

As per norms, district hospitals, first referral units (FRUs), and community health centres (CHCs) need critical inputs such as adequately equipped operation theatres and laboratories, separate aseptic labour room, electricity in all parts of the hospital with backup generator, and overhead tank and pump facility; specialists, such as gynaecologist, surgeon, orthopaedician, obstetrician, paediatrician, anaesthesiologists, and laboratory technicians; and ready availability of all critical drugs/medicines, and equipment. Most of the DHs/FRUs should have direct linkage with the blood bank or blood storage facility. Since FRUs treat emergency cases, they should be well equipped with adequate human resource, materials, drugs, and kits.

The CHC is also the FRU where referral cases are sent from lower-level healthcare facilities. FRUs and CHCs take referral cases from the lower healthcare establishments in addition to providing healthcare activities for the area of their operation.

The PHC provides curative, preventive, and promotive health and family welfare services in any rural area for a population of about 30,000. For effective service delivery a PHC should have essential infrastructure, staff, equipment, and supplies (MoHFW, 2007). Thus, a PHC needs critical infrastructure such as continuous water supply, electricity, labour room, laboratory, telephone, and a functional vehicle. A PHC needs at least one Medical Officer, one laboratory technician, and health assistants both male and female. Critical equipment for a PHC includes a functioning deep freezer; vaccine carrier; blood pressure instrument; autoclave and supply of contraceptives; normal delivery kit/labour room kit; essential obstetric kit; all vaccines; Iron and Folic Acid (IFA) tablets; and Oral Rehydration Solution (ORS) packets. PHCs have the major responsibility of providing both preventive and curative healthcare services in the area. PHCs have limited facilities and expertise; hence they cannot provide complete obstetric care to women. Some of the upgraded PHCs and CHCs have been categorised as FRUs and these facilities have been provided with specialised equipment and kits to provide maternal healthcare, particularly Emergency Obstetric Care (EmOC). Emergency cases can be referred from the sub-centres and PHCs to these FRUs.

FP Health System Components

Looking at the state FP programme from the health system building-blocks point of view, consider the following aspects to help identify areas for improvement.

Component 1. Service Delivery

Service delivery needs to be ensured through:

- Availability of free or low-cost condoms, oral contraceptive pills (OCPs), and emergency contraceptive pills (ECPs)
    - with accredited social health activists (ASHAs)/*Sahiyas* through door-to-door delivery
    - at village health and nutrition days (VHNDs)
    - through social marketing depot holders
    - through pharmacies selling premium and social-marketed brands
- IUCD services provided by trained auxiliary nurse midwives (ANMs)/nurses/doctors at the PHC, CHC, DH fixed-day services, and FP camps.
- PPIUCD provided by trained ANMs/nurses/doctors at select CHCs, FRUs, and DH.
- Sterilisation services for males and females provided by trained surgeons at the CHC, DH fixed-day services, and FP camps.
- Range of clinical FP services provided by private providers, franchised hospitals, trust-run facilities, and corporate social-responsibility initiatives.
- *Helpline*: JSK runs a Helpline (1800-11-6555) to provide reliable and accurate information on issues related to RCH. It specifically caters to adolescents, newly married, and about to be married people from the high-focus states of Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Jharkhand, and Chhattisgarh.

Quality Assurance

Adapted from Ministry of Health and Family Welfare (MoHFW). 2008. *Quality Assurance for District Reproductive and Child Health Services in Public Health System: An Operational Manual.* New Delhi: MoHFW, GOI.

Quality assurance can be defined as a mechanism/process that contributes to defining, designing, assessing, monitoring, and improving the quality of healthcare (MoHFW, 2006). It applies broadly to an entire cycle of assessment, which extends beyond problem identification to:

- Verification of the problem.
- Identification of what is correctable.
- Initiation of interventions/improvements.
- Continual review to ensure that identified problems have been adequately corrected, quality of services improved and no further problems have been engendered in the process.

Nine elements of quality of care (UNFPA, 1999)

1. *Service environment*—appropriate setting with basic amenities for client's comfort and privacy.
2. Client-provider interaction and appropriate information exchanged.
3. *Informed decision making*—relevant information available and accessible, and service providers who facilitate informed choice by clients.

4. Integration of services with links between services and health institutions.
5. Women's participation in management including planning, implementation, and monitoring of reproductive health services.
6. *Access to services*—taking into account location, distance, timing of facility, and affordability (travel cost, loss of wages, and other factors).
7. Availability of standardised equipment in good working order and sufficient supplies.
8. *Professional standards and technical competence*—current guidelines, protocols, and established service standards available, as well as well-trained, competent providers.
9. *Continuity of care*—regular and effective client follow ups, proper management of side effects/complications, proper design and maintenance of management information systems.

Steps to initiate quality assurance (QA)

- Constitution of the state and district QA committees
- Finalisation of QA tools
- Pretesting of QA tools
- District workshop for master trainers from three districts
- Training of QAC members at the district level
- Training of medical officers and other functionaries of the identified institutions
- Organising QA visits
- Compilation of data on the basis of QA visits
- Monitoring of the quality improvements after the quality assessments

Quality Assurance (QA) Cell objectives, Jharkhand (as per standard technical protocol and standards)

- Facilitate improvement of systems and process of service delivery in healthcare facilities.
- Establish and develop high-quality management systems at hospitals, to enhance service quality, and provide QA Cell quality certifications.
- Implement and monitor quality of reproductive health services/MCH services at health facilities and improve service quality by focusing on and addressing the gaps identified during the assessment process.
- Undertake periodic assessment visits through state and district QA Cell/committees using specific tools and based on gaps identified, guide service providers in addressing specific service-quality elements and sub-elements.
- Undertake other GOI/state initiatives entrusted with QAC from time to time, such as maternal death review (MDR) and mother and child tracking system (MCTS).

QA Cell Structure, Jharkhand

Source: NRHM. 2011. *Quality Assurance Cell: Structure and Terms of Reference, Jharkhand*. New Delhi: NRHM.

- Mission director (heads the cell)
- State QA nodal officer
- Full time consultants: MCH, FP, managerial and monitoring
- Data entry operator

Terms of Reference

Members of the state QA Cell, medical legal advisor, and other resource persons operationalise the cell and all state programme officers and consultants to provide technical input and support. To assist the cell, a state working group is constituted with technical experts from various organisations such as Rajendra Institute of Medical Sciences (RIMS), National Health Systems Resource Centre (NHSRC), Jhpiego, UNICEF, Public Health Foundation of India (PHFI) and others.

QA Committee, Jharkhand

Terms of Reference

- Adopt standard protocols in maternal health, child health, and FP in tune with national guidelines.
- Ensure adequate dissemination and monitor standards adherence through a set of quality indicators.
- Sensitise and orient health personnel involved in quality management on quality protocols and tools.
- Formulate strategies with timelines for quality improvement for all levels of facilities and outreach-based programmes.
- Provide technical and managerial guidance to programme officers at the state and in districts to implement measures which improve state service quality.
- Develop and recommend joint field travel plan for undertaking QA visits to districts at regular intervals using checklists. Share the field visit feedback received from teams with all QAC members and recommend concrete, measurable corrective actions with timeline for participants.
- Review reports and recommendations of members, field observations of district quality assurance committee (DQAC), and recommend corrective actions to the chair.
- Meet once every three months.

Quality Assurance Working Group, Jharkhand

Terms of Reference

- Prepare, adopt, and ensure dissemination of standard operating procedures (SOPs), guidelines, and manuals for the facilities.
- Working group holds monthly meetings to review district reports. Members may ask for additional information from the district committees, as needed.
- Review reports of district-level committees received from the regional QAC and present the progress before the state QAC.
- Create a pool of district trainers for disseminating QA concepts, tools, and methodology at district- and subdistrict-levels.
- Make periodic visits to districts, evaluate the QA in districts using a standard format, and give necessary inputs to the regional/district QA teams.
- Visit accredited facilities both public and private providing various health services in the state—under the private-public partnership (PPP) scheme—to ensure implementation of national standards and provide feedback for consideration during accreditation renewal process of facilities.

- Review (desk review/field visit, if required) cases of deaths/complications following sterilisation and cases of conception due to failure of sterilisation in the state.
- Review cases of maternal and infant deaths/any adverse outcomes in MNCH.
- Review and monitor quality of trainings under RCH II/National Disease Control Programmes (NDCP) organised at the state- and district-level and undertake follow up of selected sample of trainees during field visits.

Regional QA Unit

Structure

- Regional deputy director (RDD)–chairperson
- Regional quality consultant–convener
- Members–one RCH Officer from each district of the region, one ACMO or MOIC from each district of the region, one NGO representative, and development partners (UNICEF/CINI)
- Divisional commissioner reviews functioning and progress of the regional QA unit quarterly.

Terms of Reference

- Monitor health facilities and guide district-level teams to ensure high-quality healthcare services.
- Ensure adherence of treatment protocols on public health management and delivery of high-quality healthcare services focusing more on the medical colleges, DHs, and FRUs.
- Plan, control, and manage: the medical staff; demography and biostatistics; research in healthcare; epidemiology and community health; and overall strategy.
- Ensure proper HMIS function and monitoring of medical records, as prescribed.
- Manage health and related services within medical colleges and hospital premises to achieve optimal care by providing necessary staff to manage and treat patients.
- Provide quality of care through monitoring and evaluation (M&E), development of protocols, supervision of staff, and continuing education.
- Review cases of maternal and infant deaths and report cases of adverse outcomes/complications in MNCH.
- Provide technical inputs to medical colleges/DHs/FRUs within the division to improve their functioning.

District Quality Assurance Committee

Structure

- Civil surgeon—chairperson
- District programme manager—convener
- Additional chief medical officer (ACMO)—member secretary (hospital manager to assist)
- Members—district gynaecologist and/or district surgeon and/or district anaesthetist and/or district paediatrician; one NGO representative; district nursing head; district RCH officer/family welfare
- District programme officer—TB, vector-borne diseases , blindness control, and leprosy
- Deputy programme coordinator
- Technical assistance—two health educators
- Secretarial assistance—district M&E officer
- Special invitees—representatives from development partners in the district

Terms of Reference

- Meet once/month.
- Develop half-yearly action plan of district for QA interventions to strengthen infrastructure and services at the facility.
- Provide technical and managerial guidance to blocks on the implementation of action plan to improve service quality in the facilities.
- Monitor quality improvement of programme and track progress based on identified quality indicators at each facility level (sub-centres, PHCs). Also, check whether the facilities are providing the essential service package as per standards and protocols.
- Review cases of maternal and infant deaths and report from cases of adverse outcomes/complications in maternal, neonatal, and child health (MNCH).
- Collect information on all hospitalisation cases related to complications following sterilisation and sterilisation failures.
- Process all cases of failure, complications requiring hospitalisation, and deaths following sterilisation for payment of compensation.
- Review all static institutions—government, and accredited private/NGOs, and selected FP camps providing sterilisation and safe abortion services for quality of care as per established standards, and recommend remedial actions for institutions not adhering to standards.
- Conduct periodical medical audits of all maternal and infant deaths, and deaths related to sterilisations and send reports to the state QAC office.
- Review and monitor the quality of trainings under RCH II/NDCP organised at the state and district level and undertake follow up of a selected sample of trainees during field visits.
- Review the community-based interventions and implementation of schemes under MNCH.
- Plan QAC visits and make necessary preparations for visits to facilities. Use standardised QA checklists to conduct assessments and debrief the facility's MOIC, providing guidance on what action needs to be taken.
- Compile findings during district-level visits and distribute the district summary report and discuss these at monthly meetings with medical officers. Forward the monthly QAC meeting minutes, (including actions to be taken by the concerned officials) to the regional and state QAC.
- Share district visit reports with the state committee monthly and initiate actions based on recommendations from the state committee. To address the state-level actions, the district must take the initiative to contact the state authorities and follow up.
- Keep a record of follow up and actions taken, so that these can be reviewed on subsequent visits to the facility.

Communication for Demand Generation and Behaviour Change

It is important that district- and block-level functionaries of health programmes have conceptual clarity of BCC, as most programme managers focus only on knowledge creation and awareness through IEC rather than on behaviour change. In order to achieve sustainable behaviour change, it is necessary to shift from creating awareness to a focus on changing behaviours.

Compare two methods of communicating a message:

IEC message on a pamphlet at PHC

Small Family, Happy Family

Adopt a contraceptive method today

BCC message from an ASHA to a woman during a home visit

Now that your child is three months old, you need to choose a contraceptive method to delay the next child for three years. You can choose from a range of easy options that are easy to use and effective, and will ensure that you are healthy, your child receives all the required love and attention, you and your husband will have more time for each other and you can save up some money for the entire family. I will help you access your choice of contraceptive.

What is health behaviour?

Source: Soch Se Amal Tak–State Level Behaviour Change Communication (BCC) Planning Workshop. USAID-supported IFPS Technical Assistance Project. 2010.

Behaviour is an action. For example, in Uttar Pradesh, 28 percent of rural women receive three ANC checkups during pregnancy. The behaviour that requires promotion is to receive three ANC checkups. It is not enough to simply tell every pregnant woman "go for three ANC checkups"—district- and block-level workers must follow up to see if the behavioural action occurred after the BCC inputs. One cannot assume that a woman will go for three ANC checkups simply because she was asked to do so. The main work in changing patterns of behaviours is to make sure that the desired behavioural action occurs.

Behaviour is a specific action. Some health-related behaviours/actions include washing hands with soap after defecation, eating iron-rich food daily, using modern FP methods, and taking iron tablets during pregnancy. So, behaviours include small and big actions that can be carried out at individual, household, and community levels. Often it is difficult to carry out these desired actions. For example, if no transportation is available late at night in the village, how can a pregnant woman have a hospital delivery? Therefore, it is important to identify the barriers to behaviour change.

What is Behaviour-Change Communication (BCC)?

It is important to build a common understanding of the term "behaviour-change communication." This process strategically uses a mix of communication media to motivate a specific or targeted audience to adopt specific behaviours. BCC includes *all* the efforts undertaken to motivate people to adopt healthy behaviours—TV and radio spots; posters, flip books, and most important, interpersonal communication (IPC) and the community-based efforts of the ASHAs, ANMs, anganwadi workers (AWWs), and medical officers.

How to send the motivating message?

Before you can decide what materials to produce, you must first decide what communication channels will best reach the intended audience. Health communicators have defined communication channels as modes of transmission that enable messages to be exchanged between "senders" and "receivers."

Communication channels

Interpersonal channels include one-to-one communication, such as between provider and client, spouse to spouse, or peer to peer.

Community-based channels reach a community (a group of people within a distinct geographic area, such as a village or neighbourhood, or a group based on common interests or characteristics, such as ethnicity or occupational status). These channels include:

- Community-based media, such as local newspapers, local radio stations, bulletin boards, and posters.
- Community-based activities, such as health fairs, folk dramas, concerts, rallies, and parades.
- Community mobilisation, a participatory process of communities identifying and taking action on shared concerns.

Mass media channels, which reach a large audience in a short period of time, include

- Television
- Radio
- Newspapers
- Magazines
- Outdoor and transit advertising
- Newsletters
- Internet

Develop a communication strategy

Write down opportunities (or openings) for sending your message during a typical day in the life of your audience (who you are trying to reach).

Research has demonstrated that a multichannel approach has a better chance of changing behaviour than a single channel approach (O'Sullivan, Yonkler, Morgan, and Merritt, 2003). In addition, a multichannel approach—especially an approach that uses mass media—can achieve objectives more quickly. Using several channels enables you not only to reach more people, but to reach people in different environments and with greater frequency. Using several channels creates a synergy to the campaign and gives it more impact. It is important for the primary audience, as well as for secondary and influencing audiences who will likely be exposed to these same messages. This exposure, in turn, helps reinforce support for the campaign.

Select a lead channel and supporting channels, with a rationale for each

Determine which channel will lead and which ones will be supporting channels. Just as a locomotive pulls the other cars on a train, the lead channel is the engine that pulls the other channels with it. Which channel will reach the largest proportion of the intended audience? Which channel will fit the message most appropriately? Which channel will achieve the greatest impact?

Although a mass medium may reach more people, it may not always make sense to choose it as a lead channel. Depending on the objective of your strategy, you may choose from one of the eight strategic communication tools.

Eight strategic communication tools—definitions and examples

1. *Advocacy* creates a shift in public opinion and mobilises the necessary people and resources to support an issue, policy, or constituency.
2. *Advertising* informs and persuades in a controlled setting by means of paid media, such as television, radio, billboards, newspapers, and magazines.
3. *Promotion* provides incentives to encourage the audience to think favourably about a desired behaviour or to take some intermediate action that will lead toward practice of the desired behaviour. Typical incentives are coupons, free samples, contests, sweepstakes, and merchandising.
4. *Interpersonal communication (IPC) enhancement* improves or heightens the value of personal interaction between clients and providers both within and outside the clinic. It includes not only training the information providers, but also enhancing the place where the communication takes place.
5. *Event creation and sponsorship* develops and/or sponsors events for the purpose of calling attention to and promoting a desired behaviour—news conferences, celebrity appearances, grand openings, parades, concerts, award presentations, research presentations, or sporting events.
6. *Community Participation* helps a community to actively support and facilitate the adoption of a desired behaviour.
7. *Publicity* uses nonpaid media communication to help build audience awareness and affect attitudes positively.
8. *Entertainment vehicles*—media such as television or radio programmes, folk dramas, songs, or games provide entertainment, which is combined with an educational message.

Intersectoral convergence and partnerships

Source: Adapted from National Programme Implementation Plan, RCH II, 2005.

Convergence is a process that facilitates various officials/functionaries and members of the community to work together toward efficient service delivery. Networking occurs at the highest levels and then percolates down to various levels. It is important to converge with critical sectors whose actions would lead to joint outcomes.

Benefits

- Save time
- Build rapport
- Increase efficiency
- Reduce workload
- Facilitate idea sharing
- Improve the community health status

Intersectoral convergence is envisaged with

- Ministry of Women and Child Development
- Panchayati raj institutions (PRIs)
- Ministry of Human Resource Development
- Ministry of Urban Development

What does convergence require?

- Leadership and willingness to act
- Supportive policies
- Sharing of common visions and perspective
- Definition of roles and responsibilities
- Identification strategies and activities
- Joint monitoring
- Taking remedial measures in cases of coordination-related issues

Common issues between the health department and Ministry of Women and Child Development

- Link MCH problems with family planning

Synergy between ANMs, ASHAs, and AWWs

- Family planning counselling
    - ANMs, AWWs, and ASHAs can counsel women and men on contraceptive options based on the clients' life stage and desired family size.
- Convergence on village health and nutrition day
    - ANMs and ASHAs can bring all pregnant women to the anganwadi centre (AWC) and counsel on postpartum contraception and the lactational amenorrhea method.
    - ASHAs and pancharati raj institutions can facilitate couples to adopt FP methods.
- Declining sex ratios
    - Counsel women who have two or more girls.
    - AWWs, ASHAs and local women persuade women to have institutional delivery to reduce female infanticide.

How can panchayati raj institutions be engaged?

- Monitor and supervise services related to family planning and its functionaries.
- Sensitise and provide orientation on women and reproductive health issues, child health issues, family planning, and gender.
- Be responsible for the selection of accredited social health activists (ASHAs).
- Guide the village health and sanitation committees (VHSCs).

Convergence with the Education Department

- Include life skills education materials for formal and informal education.
- Involve various agencies and all *zilla saksharata samitis* (District Education Committees) in IEC activities, especially on delaying age at marriage and first child.
- Involve school teachers, health workers, and adolescents in awareness programmes.

Component 2. Health Workforce

Source: Adapted from World Health Organisation (WHO). 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes, WHO's Framework for Action*. Geneva: WHO

"Health workforce includes a host of human capital at the state, district, sub-district and community level. Some of these are health promoters, some technical experts and some managers. It is the responsibility of the state and districts to have all the designated staff in place and ensure that they are skilled to do their jobs well; are provided regular trainings and mentoring to upgrade their skills and knowledge for them to perform to their fullest; are provided an environment conducive to work; and their financial needs and compensation are taken care of."

When district programme managers and block programme managers go on field visits they need to focus on the following:

- *Sahiyas* who counsel, provide condoms and pills, and refer clients for clinical services.
- Auxiliary nurse midwives (ANMs) and lady health visitors (LHVs) who counsel and provide IUCD services.
- Nurses and doctors trained in and providing IUCD, PPIUCD, tubectomy, non-scalpel vasectomy (NSV), and minilap services in a client-friendly manner.
- FP counsellors at selected facilities.

Family planning training programmes planned under NRHM for these staff members are:

- District workshop for IUCD 380A and 375, and training of medical officers, staff nurses, ANMs, and LHVs.
- District workshop for PPIUCD insertion and training of medical officers and staff nurses.
- District workshop on laparoscopic sterilisation and training for service providers (gynaecologists/surgeons).
- District workshop on minilap and training for medical officers and medical students.
- District workshop on non-scalpel vasectomy (NSV) and training for medical officers.
- Contraceptive update trainings for health providers in the districts.
- IPC and community mobilisation family planning training for ASHAs, ANMs, and block trainers teams.
- Training in quality assurance (QA) to state, district, and block quality assurance committees (QACs).
- Orientation of district programme managers, block programme managers, and district programme committees in contraceptive update, programme management, and supportive supervision.
- Orientation of rogi kalyan samitis (RKSs), village health and sanitation committees (VHSCs), VHCs in importance of FP, motivating men in adopting methods and using untied funds for FP promotion.
- District data managers, district programme managers, and block data managers need training on checking and improving the quality of HMIS data. Such trainings have been provided by the centre through NHSRC at state level, however staff still require training on improving data quality (HPP Baseline Assessment, 2012).

Component 3. Health Information System

Sources: World Health Organisation (WHO). 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action.* Geneva: WHO.
MoHFW. 2011b. *HMIS Resource Persons' Manual*, Volume IV. New Delhi: GOI.

A health information system includes a well-functioning system where data are entered, updated, compiled, and analysed on a regular basis with little or no discrepancy. The health management information system (HMIS) is critical for the state and districts to ensure that services are being accessed, stocks are available at all delivery points, equipment for clinical services is available and of good quality, and to analyse and understand trends and occurrences based on which activities can be planned or which problems can be addressed in a timely fashion. (WHO, 2007)

An important aspect of HMIS is supervision and feedback. This is crucial for health workers at all levels—to recognise the value of their contribution to the overall healthcare system, and be accountable in addressing areas for improvement (such as underperformance)—so that capacity-building activities can be planned and implemented.

HMIS data are a reliable source of routine information for use in programme monitoring and management support. Such data are available at district and sub-district levels and provide the only available information source and an effective tool for decentralised district programme management. The following information related to family planning is included in the HMIS (Sundararaman, 2011).

Monthly reporting

On a monthly basis, the following types of cases conducted during the reporting month, are included in the HMIS:

1. Total Number of *non-scalpel/conventional vasectomies* conducted at each of the following facilities: PHCs, CHCs, subdivisional hospitals/DHs, other state-owned public institutions, and private hospitals.
2. Total Number of *laparoscopic sterilisations* conducted at each of the following facilities: PHCs, CHCs, subdivisional hospitals/DHs, other state-owned public institutions, and private hospitals.
3. Total Number of *minilap sterilisations* conducted at each of the following facilities: PHCs, CHCs, subdivisional hospitals/DHs, other state-owned public institutions, and private hospitals.
4. Total Number of *postpartum sterilisations* conducted at each the following facilities: PHCs, CHCs, subdivisional hospitals/DHs, other state-owned public institutions, and private hospitals.
5. Total Number of *IUD insertions* performed at each of the following facilities: sub-centres, PHCs, CHCs, subdivisional hospitals/DHs, other state-owned public institutions, and private hospitals.
6. Total Number of *IUD removals* performed during the reporting month
7. Total Number of *oral contraceptive pills packets* distributed to individual beneficiaries during the reporting month.
8. Total Number of individual *condoms* distributed
9. Total Number of *centchroman weekly oral contraceptive pills* distributed
10. Total Number of *emergency contraceptive pills* distributed

11. *Quality in sterilisation services*
    - *Number of complications following sterilisation*-Total number of cases of complication following NSV/conventional vasectomy reported in the facility during the reporting month for:
      - Male
      - Female
    - *Number of failures following sterilisation*-Total number of cases of failure following NSV/conventional vasectomy reported in the facility during the reporting month for:
      - Male
      - Female
    - *Number of deaths following sterilisation*- Total number of cases of death following NSV/conventional vasectomy reported in the facility during the reporting month for:
      - Male
      - Female
12. Total Number of institutions having *doctors trained in non-scalpel vasectomy*
13. *Monthly inventory.* Family planning methods, in numbers (e.g., number of condoms) for the following: IUD 380As, condoms, OCPs, ECPs, and tubal rings

Quarterly Reporting

On a quarterly basis, the HMIS provides training information on *number of individuals (by profession) trained during the quarter*:

1. *Doctors*, by numbers, trained on specific skills for: NSV, minilap, laparoscopic sterilisation (for specialists), IUD
2. *General nurse midwives/auxiliary nurse midwives (ANM)/lady health visitors (LHV)* trained in: intrauterine device (IUD), contraceptive update training
3. *Trainings undergone by State programme management unit* including: programme managers, accounts/finance managers, MIS/data managers
4. *Trainings undergone by District programme management unit* including: programme managers, accounts/finance managers, MIS/data managers
5. *Trainings undergone by Block programme management unit (BPMU)* including: programme managers, accounts/finance managers, MIS/data managers

Component 4. Access to Essential Access to Essential Medical Products and Services

Source: WHO. 2010. *Key components of a well-functioning health system.* Geneva: WHO

Universal access to healthcare depends heavily on access to affordable essential medicines, vaccines, diagnostics, and health technologies of assured quality, which are used in a scientifically sound and cost-effective way. Economically, medical products are the second largest component of most health budgets (after salaries) and the largest component of private health expenditure in low- and middle-income countries. Key components of a well-functioning system are:

- A medical products regulatory system for medical product procurement and safety monitoring—supported by relevant legislation, enforcement mechanisms, an inspectorate, and access to a medical products quality control laboratory.

- National lists of essential medical products, national diagnostic and treatment protocols, and standardised equipment per levels of care—to guide procurement, reimbursement, and training.
- A supply and distribution system, which ensures universal access to essential medical products and health technologies through public and private channels, with focus on the poor and disadvantaged.
- A national medical products availability and price monitoring system.
- A national programme to promote rational prescription standards.

As per the NRHM drug and supply policy, the recommendations include:

- Implementation of programmes/schemes depends on timely procurement of drugs and equipment.
- Strengthen state-level procurement capacity.
- Procurement management information system is implemented by GOI to automate and overcome challenges of the current procurement system.
- States to standardise and streamline the procurement process.
- Hire trained personnel.
- Develop standard procurement documents and specifications.
- Establish transparent procurement systems.
- Complete all pending procurement at the earliest.

Component 5. Financing

Source: WHO. 2010. *Key components of a well-functioning health system.* Geneva: WHO

Health financing can improve health and reduce health inequalities if its primary objective is to facilitate universal coverage, remove financial barriers to access, as well as prevent financial hardship and catastrophic expenditure for healthcare. These outcomes require a system that:

- Raises sufficient funds for health with fairness.
- Pools financial resources across population groups to share financial risks.
- Has a financing governance system supported by relevant legislation, financial audit, public expenditure reviews, and clear operational rules to ensure efficient use of funds.

The FP programme is funded centrally under the National Rural Health Mission (NRHM) and each year the state budgets a certain sum for FP-related activities under the state programme implementation plan (PIP), which is approved based on cumulative achievements of the previous year, money spent and unspent, and the need for expanded services. The district and block programme managers monitor:

- Transfer of funds approved in the financial year from the state to the districts and from districts to blocks.
- Use of the ‘record of proceedings’ funds for district-level activities as planned in District Health Action Plan (DHAPs).
- Fund allocation for all relevant aspects of programming (i.e., BCC activities, procurement of supplies/equipment, centre operating expenses).
- Use of untied funds at sub-centres, PHCs, and CHCs in consultation with the rogi kalyan samitis (RKSs) and village health and sanitation committees (VHSCs).
- Availability of timely and complete compensation for clinical FP sterilisation services such as compensation for wage loss on the day of the sterilisation procedure, and insurance coverage for cases of either sterilisation procedure failure or of death.

The GOI schemes compensates acceptors of sterilisation procedure for loss of wages: With a view to encourage people to adopt permanent FP methods, GOI has been implementing a centrally sponsored scheme since 1981 to compensate the acceptors of sterilisation for the loss of wages for the day on which he/she attended the medical facility for the operation. Revised in 2007, in public (government) facilities the present compensation for the acceptor is: *vasectomy*–Rs. 1100, and *tubectomy*–Rs. 600 (MoHFW, 2011a).

The *family planning insurance* scheme is another centrally-sponsored initiative launched November, 2005. Policy benefits include:

- Death following sterilisation in hospital (inclusive of death during process of sterilisation operation) or within seven days from the date of discharge from the hospital–Rs. 2 lakh.
- Death following sterilisation within 8–30 days from the date of hospital discharge–Rs. 50,000
- Failure of sterilisation–Rs. 30,000.
- Cost of treatment up to 60 days arising out of complication following sterilisation operation (inclusive of complication during process of sterilisation operation) from the date of discharge—actual, not exceeding Rs. 25,000.
- Indemnity insurance per doctor per facility, but not more than four cases in one year—up to Rs. 2 lakh per claim.

Component 6. Leadership and Governance

Source: WHO. 2010. *Key Components of a Well-functioning Health System.* Geneva: WHO.

Each country's specific context and history shape the way leadership and governance are exercised, but common good practices include that health system authorities take responsibility for *steering the entire health sector*, not merely the public-sector service delivery; and for planning for and coping with future challenges (including unanticipated events or disasters) as well as with current problems. This process includes:

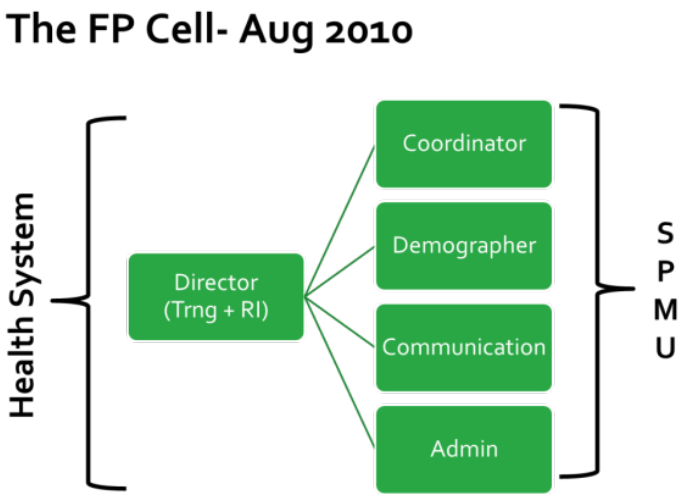
- Defining through transparent and inclusive processes—national health policy, strategy, and planning, which set a clear direction for the health sector, using:
    - India's commitment to the highest, overarching policy goals—healthcare equity, people-centredness, sound public health policy, effective and accountable governance.
    - An implementation strategy for translating these policy goals into its implications for financing, human resources, pharmaceuticals, technology, infrastructure and service delivery, with relevant guidelines, plans and targets.
    - Mechanisms for accountability and adaptation to evolving needs.
    - Effective regulation through a combination of guidelines, mandates, and incentives, backed up by legal measures and enforcement mechanisms.
    - Effective policy dialogue with other sectors.
    - Mechanisms and institutional arrangements to channel donor funding and align it to country priorities.

At the State Level

Source: Adapted from Khalko, Gunjan. "Implementing the Family Planning Strategy: Progress, Achievements, and Challenges." Health Policy Project Presentation, Institute of Public Health Auditorium, Ranchi, Jharkhand, April 11, 2013.

Jharkhand has an FP Cell housed within the health directorate with the members of the cell also a part of the state program management unit. The mandate of the FP Cell is to:

- Oversee the implementation of all approved FP activities at the state/district level.
- Streamline the programme's financial and administrative process:
  - Identify unspent money; monitor utilisation reports; review and streamline flow of funds, develop processes to minimise lapse.
- Periodic situational review—impact, indicators, and gaps.
- Strengthen the M&E process.
- Strengthening the IEC/BCC and integrating them with all FP services and activities.
- Review existing training material for comprehension and applicability; documenting best practices and lessons learned.
- Clinical and nonclinical quality assurance.



The FP Cell is also supported by the *FP task force* which was set up with assistance from the Innovations in Family Planning Services (IFPS) Technical Assistance Project (ITAP) in 2009. The objective of the task force is to review the state FP programme, identify key priorities, provide direction to the establishment of FP Cell and review and provide direction to the development of FP strategy for the state. The task force—currently comprised of ITAP, JHPIEGO, Institute of Reproductive Health, A to Z, Population Foundation of India (PFI), Population Services International (PSI), UNICEF and Vistaar—is chaired by the mission director (MD), NRHM, and officials from DoHFW.

The ITAP project provided assistance to DoHFW to constitute the task force and coordinate the initial meetings and the discussions. After the ITAP project ended, the FP Cell coordinated the task force and has been proactively engaged by the DoHFW for programme planning, state review missions, and other FP-related activities. The task force meets quarterly to review FP HMIS data, QA data, and other issues to arrive at programmatic action. Most task force members also provide technical assistance to the FP Cell and district- and subdistrict-functionaries, as and when, required.

In *subdistricts* the mechanism for governance is through community participation initiatives such as the RKS and the VHSCs that are entrusted with ensuring good governance of the FP programme at the community level.

Rogi Kalyan Samiti (RKS)

Source: Summarised from MoHFW. 2011c. *Model Accounting Handbook for Rogi Kalyan Samitis.* New Delhi: GOI.

For efficient management of health institutions, in 2005 NRHM proposed the RKS at the subdistrict level. This initiative introduced the power and sense of community ownership into running rural hospitals and health centres; it also brings greater accountability and responsibility. Important RKS features include:

- A registered society set up in DHs/sub-DHs, CHCs/FRUs.
- *Composition*—people's representatives (members of Legislative Assembly/members of Parliament); health officials, including ayurveda, yoga, naturopathy, unani, siddha, and homoeopathy (AYUSH) and doctors; local district officials; leading members of community; CHC/FRU in-charge, representative of Indian Medical Association (IMA); members of local bodies and Panchayati Raj Institution representative; leading donors.
- *Functions*
  - Identify problems faced by patients in facility
  - Acquire equipment, furniture, ambulance—through purchase, donation, loans from banks
  - Expand hospital building subject to guidelines by the state government.
  - Arrange maintenance of hospital building.
  - Improve boarding/lodging facilities for patients and attendants.
  - Partner with the private sector for support services, such as facility cleaning and laundry
  - Encourage community participation in maintenance and upkeep of hospital.
- *Governing body*—with district magistrate (DM) as the chairperson, to meet at least once in every quarter.
- *Executive body.*—with medical superintendent of hospital as chairperson, senior medical officer of district hospital as member secretary, meets monthly.
- *Roles*
  - Review outpatient department and inpatient department service performance of hospital in last one month and service delivery targets for next month.
  - Review outreach work performed and planned.
  - Consider reports of monitoring committee for remedial action.

Implementation of Citizens' Charter

Source: National Rural Health Mission (NRHM). 2006. *A Summary of Entitlements and Mechanisms for Community Participation and Ownership for Community Leaders.*

CHCs and PHCS are required to display the Citizens' Charter, which provides a framework to enable individuals/citizens to know what services are available at the facility; how they can avail themselves of these services; and how any complaints regarding services or denial of services will be addressed.

"The objectives of the charter are:

- To make available medical treatment and the related facilities for citizens
- To provide appropriate advice, treatment, and support that would help cure the ailment to the extent medically possible
- To ensure that treatment is best on well considered judgement, is timely, and comprehensive and with the consent of the citizen being treated.

- To ensure just awareness of the nature of the ailment, progress of treatment, duration of the treatment, impact on lives.
- To redress any grievances in this regard"

Village Health and Sanitation Committees

Source: NRHM. 2008. *Community Participation for Jharkhand State.* New Delhi: NRHM.

Under the NRHM, the VHSCs are responsible for the Village Health Plans. This committee is formed at the level of the revenue village. With inputs from the Public Health Resource Network, the national guidelines were modified and adapted by NRHM, Jharkhand, as follows:

National Guidelines	Jharkhand Modifications
Composition and Mandate	
• At least 50 percent members should be women. • Due representation of every hamlet within revenue village. • ANMs, anganwadi workers (AWWs), school teachers (government employees and honorarium-paid staff members). • Representation from self-help groups (SHGs) or other development related community-based organisations (CBOs). • ASHA to be a member and mandatory to make her the member secretary. • Ensure needs of disadvantaged sections (STs, SCs, OBCs) are reflected. • Members to be residents of the village.	• Members above 18 years. • At least two office bearers should be women. • Part of one of the pancharati raj institution standing committees. • All pancharati raj institution members of the village to be members. • Representation of all areas and ethnic groups.
Intent and Purpose	
• Active participation of the community. • Focus on core health issues through people's participation. • Involvement of pancharati raj institution in decision making and meeting Indian Public Health Standards (IPHS). • Ensure accountability, transparency and high-quality service provision. • Maintain register recording significant activities undertaken (may come from household survey and data supplemented from ANM, AWW, ASHA registers). • Maintain record of money received and expenditure for periodic review by health department representative and the panchayat body. Block-level panchayat samiti reviews functioning and progress of VHSCs. District Mission in its meetings periodically collects information on the functioning of VHSCs and issues guidelines to improve their functioning.	• Ensure community participation in assessing health needs, planning and monitoring of health activities. • Fund-raising and fund management where necessary. • Create demand for health services. • Promote healthy and hygienic habits in the community. • Ensure gender equity and women's empowerment.

Management of Untied Funds at Village Health and Sanitation Committees
• District workshop amount of untied funds: Rs. 10000 per annum • Fund transfer from block programme management unit to VHSC's bank account • Bank account in the name of VHSC. • Joint signatories: *Sahiya* and president/treasurer of VHSC • *Sahiya saathi* to collect the cheque and deposit in the account. • Bank records collected and submitted by *Sahiya Saathi* or *Sahiya*. • Report submission: Statement of Expenditure and Utilisation Certificates on quarterly basis. • Reports and vouchers to be submitted to block accounts manager by 28th of every month for verification and certification.
Decision making Process at the VHSC
• Needs assessment: formulation of village Health Plan. • VHSC monthly meeting. • Quorum—minimum of 50 percent members (11–21) must be present when decisions are made and passed, but presence not restricted to members only.
Use of Untied Funds by the Village Health and Sanitation Committee
• As revolving funds for families in emergency and special circumstances. • Cleanliness and environmental sanitation drives. • Anganwadi activities which promote healthy eating habits among children. • Increasing awareness on health issues. • Meeting expenses of village health and nutrition day (VHND) (maximum Rs. 200 per month) related to IEC/BCC activities. • Emergency transportation to nearest facility.

ANNEX E. SUPPORTIVE SUPERVISION

Source: Adapted from The Population Council. 2010. *Facilitating Provision of Client Centered Family Planning Services through Supportive Supervision: A Guide for Human Resource Management.* Pakistan: Population Council (p. 19, 22, 25, 26).

Supervision is the activity carried out by supervisors to oversee the productivity and progress of employees. This function leads to better coordination in helping others to accomplish the mission, aims, and objectives of a programme or organisation. The main mission of the health system is to care for the clients in a manner that fully satisfies the client. Listening is more important than speaking or talking, and providing feedback is essential for improving staff performance.

Supervision is "...a way of ensuring staff competence, effectiveness, and efficiency through observation, discussion, support and guidance" (McMahon, 1992, p 472).

In short, supervision ensures that staff are performing to the best of their abilities those tasks assigned to them and achieving the results with the least amount of resources. Supervisors achieve this by guiding and supporting their staff.

These points are important to remember:

- A good supervisor must always be accessible and approachable.
- To model accessibility, a supervisor should avoid using two words—*inspection* and *checking*.
- A good supervisor demonstrates patience.

Supervision is a process not a task. For each staff member, a supervisor must understand the individual's roles and responsibilities, and ensure that training, facilities, and equipment are provided to support the staff member in doing the job. It is important that that staff work is valued, appreciated, and recognised—pick the positive points and anything for which the staff can be praised (for example, a neat and clean *Sahiya* health house).and that staff's defined problems are solved.

Dos:

- Listen attentively to staff's problems, show respect, and encourage staff to identify problems as well as solutions to the problems.
- Provide on-the-spot guidance.
- Clearly talk about what is expected from the staff.(task clarification).

Don'ts:

- Supervision should not be carried out in a manner that is:
  - *Autocratic*—checking or inspecting things in an authoritative manner according to the supervisor's whim.
  - *Superficial*—not going into the depth of finding out what is working and what is not working.
  - *Erratic or Irregular*—such as conducting infrequent, one-time, or irregular visits.
  - *Checklist oriented*—focusing on a checklist rather than in an in-depth manner.
  - *One-way*—discouraging input from staff.

Supervisors must never:

- Scold a supervisee in the presence of others including family members or clients.
- Show favouritism towards certain employees.
- Blame an employee for the supervisor's own mistakes.

- Unnecessarily focus on the personal matters of employees, especially if the staff member is reluctant to discuss these matters.
- Gossip with one staff member about another.
- Discourage initiative by being overly critical.
- Constantly highlight the negative aspects.
- Make unfair comparisons between employees.
- Become inaccessible to staff, for instance, by visiting infrequently.
- Deny appreciation even on occasions when it is due.
- Fail to highlight staff achievements to higher authorities such as district coordinator of the national programme.

Roles of a supervisor:

- *Lead*—inspire, persuade, and encourage staff/supervisees to be innovative, think up new ideas, and work with others collaboratively.
- *Plan*—creatively develop joint plans with the lady health visitor's (LHV) to achieving programme goals.
- *Solve problems* in a timely manner.
- *Organise*—get things organised through good planning.
- *Coordinate and control*—work as a team and be assertive when necessary.
- *Communicate*—be clear-headed and articulate.
- *Practice diplomacy*—handle sensitive issues delicately without being hurtful.
- *Motivate*—inspire a passion in others to work optimally<<by modelling that behaviour
- *Counsel*—provide thoughtful advice.
- *Show appreciation*—administer rewards appropriately.
- *Be a change agent*—think innovatively out of the box<<.
- *Coach*—guide and help.
- *Team build*—model the behaviour you want to instill, take everyone along, and work collaboratively.
- *Manage conflict*—tactfully help to resolve issues.
- *Advocate* for staff's rights and needs.

Attributes of a supervisor:

- Listens patiently.
- Perseveres, remains calm, and does not lose temper.
- Empathises.
- Is sensitive.
- Handles grievances appropriately.
- Maintains discipline.
- Has good negotiation skills.
- Is a good teacher.
- Manages time effectively.
- Maintains trust.
- Is fair and impartial.

ANNEX F. MANAGER'S TOOL

What is the Manager's Tool?

The USAID-funded Health Policy Project supported the state to develop the *Manager's Tool* as an aid for health managers to check critical aspects of the health system during their field visits to health facilities, to note their observations and the issues discussed and resolved together with health centre staff. The tool also serves as a means to address issues in quality assurance (QA) meetings and family planning (FP)-related trainings.

This tool is useful for managers at all levels. State-level managers may include members of the FP Cell and state programme managers. District-level managers may include: district programme managers; civil surgeons; additional chief medical officers (ACMOs); reproductive and child health (RCH) officers; district programme coordinators; district programme officers; information, education and communication (IEC) officers; and district data officers. Block managers may include programme managers, data managers, and development officers.

Managers use this monitoring tool to inform decisionmakers of progress being made in each block or district, and identify the issues that need to be addressed to strengthen the health system and improve health service delivery.

Managers should use separate tools for each district.

The tool has the following sections, each of which corresponds to functions that district- and block-level healthcare managers typically engage in or are responsible for.

- Details of each block
- Sub-centre visit
- Primary health centre visit
- Community health centre visit
- Family planning camps
- Trainings
- Contraceptive updates
- Private hospitals accredited
- Empanelment of doctors
- Community monitoring meetings
- Quality assurance meetings
- Transport and referral
- Meetings at state level
- Meetings at district level

Manager's Tool Basics

For each section in the *Manager's Tool*, add the details in the top portion under 1, 2, 3, 4, or 5 rows. Continue using the same row to add other details.

The example here is of a visit to the sub-centre in Bano block of Simdega district in Jharkhand, and the details about basic infrastructure are filled in the first row, in the next section.

SubCentre Visit					
No.	Date	Sub Centre	Block	Village	In-charge
1	12-Dec-12	Bano	Bano	NA	Dr. Minz
2					

No.	Labour Room hygenic	Electricty/telephone	Toilet facility	Water supply	ANM Staying	ANM Trained	Male Health Worker	Contractual Safai Karmachari to assist ANM
1	2	1	1	2	2	1	2	2
2								
3								

Step 1

When the State/District/Block Programme Manager visits a health facility or a meeting, first s/he informs the facility level staff that the visit's purpose is to understand the functioning of the centre or meeting, which aspects are doing well, which areas need strengthening. S/he assures the staff that this is neither a test nor a record for punitive action. Rather, the purpose of this visit is to improve the overall health system and health service delivery to the community and to jointly, arrive at possible solutions to address existing issues. Invite one person to show you around, and share relevant documents. S/he may ask questions to add in the *Manager's Tool*, the required information but only exactly what is asked for, rather than delving into the details of why things are done a certain way. Also, ask the health facility staff to give a few minutes (not more than 15–20 minutes) to share and discuss things 30–40 minutes, after making observations.

Step 2

The manager records the observations as '1' (for present or yes), and '2' (for absent or no). For example, during a sub-centre visit, under the equipment and supplies section, record information on whether electricity and telephone is present or absent. Similarly for water supply, auxiliary nurse midwife (ANM) staying at the centre, whether the ANMs are trained as suggested by the Indian Public Health Standards (IPHS), and record the information as above.

In addition to recording observations, the manager asks the staff to share relevant documents and notes this information. For example, the manager can request the supply register to verify whether all the sections are current and complete. The register is checked against the available stock of supplies to see if it matches. No feedback is given at the recording stage—the manager waits to ask questions about why it is or is not updated. Comments are made during the follow-up discussion.

SubCentre Visit							
No.	Date	Sub Centre	Block	Village	In-charge		LEGEND
1	12-Dec-12	Bano	Bano	NA	Dr. Minz		Present/ Yes= 1
2							Absent/ No= 2
3							Reason in words
4							
5							
No.	Labour Room hygenic	Electricty/telephone	Toilet facility	Water supply	ANM Staying	ANM Trained	Male Health Worker
1	2	1	1	2	2	1	2

Step 3

When all the sections are filled out, the manager meets with the key staff to, discuss things that are going well, that need strengthening and gather more information on the health facility and its functioning. Begin with a discussion on all the positive aspects observed during the visit. S/he can then look at all the areas marked '2' and discuss all these issues with the relevant staff in a group discussion.

This is a good opportunity for the entire staff to look at the positives and negatives, the resources they have and those that they can maximise; recognise and accept the issues or problem areas; and think together about options to address the issues at hand and find innovative solutions.

Step 4

No.	Key issues Disucssed	With	Solutions Offered	Next Steps		
				Action	Who is responsible	Due date for action
1	ANM not staying; MIS incomplete and not qulaity	Dr. Minz	ANM is not from block- so not possible to stay; BPM to receive training by DPM during next visit	ANM issue to be raised with ACMO/CS; BPM to receive training by DPM during next visit	DPM	Jan 2nd week

The next step is to develop specific actions with both a timeframe and assigned responsibility to address particular issues. Be realistic with timelines and responsibilities to assure that problems are addressed in a timely fashion and that the relevant people are informed about the needs, requirements, and changes.

The manager may also assign some responsibility to himself/herself. Some issues do not have an obvious solution, and may require a human resource or policy decision from the district or state. In this case the manager adopts the appropriate chain of command, communicates with the responsible person, and keeps the relevant staff informed of communication and follow up for all policy actions.

For example, a manager may learn that the supply of emergency contraceptive pills (ECPs) has been depleted for the last three months. Since ECPs are procured at the centre and contracted out to a manufacturer, if the manufacturer has delayed supply to the state or the district, the sub-centre staff cannot be held responsible. In such a case, the district programme manager should inform the state programme manager, the state FP Cell, or the procurement officer to remedy the problem—or short-term solutions can be explored. One option is to check whether unused or excess ECP stocks exist in other districts, facilities, or in the state repository and can be shared with the sub-centre. Simultaneously, take steps to ensure that clients are advised to use ECPs available in the private sector.

Managers should use a separate *Manager's Tool* for different districts.

Step 5

The manager should thank the health facility staff for their time, and sharing their ideas and thoughts for improvement. Wherever relevant the manager should commend the staff for the good work they are doing towards improving the health of the community. The manager should also inform them about the next visit.

By following the five steps mentioned above, program managers can ensure the following:

1. The staff does not get a sense of approval or disapproval of their functioning, and do not get defensive or biased right at the beginning. This way they may not tend to influence the remaining parts of your visit/presence.
2. In cases where the centre is under-staffed or has irregular supplies, and the staff feel that they are dealing with many problems, they start in a negative mode and come up with a long list of complaints at the onset of the visit. This may also take up a lot of time. In such cases the staff members fail to see the positives, placing too much importance on the problems, without focusing on coming up with solutions.
3. In some cases, the meetings with the staff also have a positive team building effect, helping the entire team look at their strengths, weaknesses and also the opportunities available.
4. The visits also help the staff recognise that the managers or 'bosses' are not just interested in fault finding, but are genuinely interested in bringing a positive change. This acts as a motivating factor, and in the long run the staff tend to respect the managers and are responsive to future requests.
5. Setting realistic action points and timelines, and sharing responsibilities encourages the team to enhance its working in the given restricted resource settings available to them.
6. In order to assess areas of strengthening required by the staff, the managers need to: provide examples of innovative solutions that they can apply to other centres or districts; take opportunities to appreciate people who are doing commendable work; and iron out any pending issues in a timely fashion.

ANNEX G. TRAINING ASSESSMENT

Print this form for each participant. The same form is used both before and after the training.

Pre-training ☐ Post-training ☐

Name: _____

Date: _____

Designation: _____

Block/District/State: _____

# of years of experience in health sector: _____

Contact Number: _____

Write the correct answer (*a/b/c/d/e*) in the next column	Answer
1. The four stages of the Policy process are- Problem Identification, Policy Development, Policy Implementation and Policy M & E a. True b. False	
2. The National Population Policy 2000 aimed to reach a TFR of 2.1 by the year: a. 2010 b. 2015 c. 2020 d. 2050	
3. Health is a state subject: states are responsible to implement the health programs and policies established by Government of India a. True b. False	
4. The population of India is so large that a. Every 3rd person is an Indian b. Every 6th person is an Indian c. Every 10th person is an Indian d. Every 16th person is an Indian e. None of the above	
5. According to the 12th Five year Plan a. Achieve a total fertility rate (TFR) of 2.1 by 2017 b. focus is on promotion of spacing and Post-partum contraception c. intensify training of service providers in FP d. deploying private providers e. all of the above	
6. According to the Annual Health Survey (2010-11) Jharkhand's family planning data is: a. TFR is 3.1; varies from 2.4 in urban areas to 3.3 in rural areas b. TFR is 2.1; varies from 2.1 in urban areas to 3.1 in rural areas c. None of the above	

Write the correct answer (*a/b/c/d/e*) in the next column	Answer
7. The most adopted contraceptive method in Jharkhand is a. Female Sterilisation b. NSV c. Condoms d. Emergency Contraceptive Pill	
8. The six building blocks health systems are service delivery, health workforce, health information systems, access to essential medicines, financing and leader ship and governance a. True b. False	
9. Free or low-cost condoms, oral contraceptive pills (OCPs) and emergency contraceptive pills (ECPs) are available: a. With ASHAs/Sahiyas through the door-to-door delivery. b. At VHNDs. c. Through social marketing organisation depot holders. d. Through pharmacies selling premium and social-marketed brands. e. All of the above	
10. Quality Assurance (QA) is defined by MoHFW (2006) as: a. a mechanism/process that contributes to defining and designing the quality of healthcare. b. a mechanism/process that contributes to assessing and monitoring the quality of healthcare. c. a mechanism/process that contributes to defining, designing, assessing, monitoring, and improving the quality of healthcare. d. None of the above	
11. At the District level the DQAC should meet at least a. Twice a month b. Once a month c. Once a quarter d. Once a year e. Anytime, as required	
12. IEC BCC should be planned for a. Mass media b. Community level display and activities c. Health facility level display and activities d. Interpersonal Communication e. All of the above	
13. Jharkhand has an FP Cell, housed within the health directorate, is mandated oversee the implementation of all approved FP activities at the state/district level a. True b. False	
14. Data quality can be ensured by a. compare the data with other survey data that is available b. compare the data with previous month data c. discussions with program managers on data elements and indicators that are found to be unreliable, unrealistic d. Visit facilities, blocks and HMIS office to check data e. All of the above	

Write the correct answer (*a*/*b*/*c*/*d*/*e*) in the next column	Answer
15. Ensuring data quality means a. Data correctness b. Data consistency c. Data Linkages established between related indicators d. None of the above e. All of the above	
16. According to McMahon (1992), supportive supervision is "A way of ensuring staff competence, effectiveness, and efficiency through observation, discussion, support and guidance." a. True b. False	
17. A good supervisor should: a. Show appreciation and encouragement. b. Listen attentively to supervisee's problems, encourage in identifying supervisee's problems and identifying solutions. c. Show respect. d. Provide on-the-spot guidance. e. All of the above.	
18. In India's public family planning program these are the contraceptive choices available: a. Sterilisation, condoms, oral contraceptive pills, emergency contraceptive pills, and Copper T (or IUCD) b. Sterilisation, condoms, implants, injectables, pills, and diaphragms c. Sterilisation, condoms, oral contraceptive pills, implants, and Copper T (or IUCD) d. All of the above combinations	
19. The main supply side issues w.r.t. family planning program are: a. Fewer contraceptives in the basket b. Inadequate supply, especially to the last mile c. Supply chain management d. Option a. and c. e. All of the above	
20. The main demand side issues w.r.t. family planning program are: a. Improper counselling of men and women about family planning choices b. Focus on sterilisation is high from the ASHAs (community health workers) c. Range of myths and misconceptions among health workers about certain FP methods d. Option a. and b. e. All of the above	

REFERENCES

AusAID. 2006. *A Staged Approach to Assess, Plan and Monitor Capacity Building*. Canberra: AusAID.

Bridgman, P and Davis, G. 2003. "What Use is a Policy Cycle? Plenty, If the Aim Is Clear." *The* Australian *Journal of Public Administration*. 62(3): 98–102.

Centre for Development and Population Activities (CEDPA). 1995. *The CEDPA Training Manual Series. Volume 1, Conducting a Workshop in Participatory Training Techniques*. Washington DC: CEDPA.

Cross, Harry, Norine Jewell and Karen Hardee. 2001. *Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs.* POLICY Occasional Paper. No. 7. Washington DC: Futures Group, POLICY Project.

EngenderHealth/The ACQUIRE Project. 2008. *Counseling for Effective use of Family Planning. Participant Handbook*. NewYork: EngenderHealth/The ACQUIRE Project.

Hardee, K., I. Feranil, J. Boezwinkle and B. Clark. 2004. *The Policy Circle*. POLICY Working Paper No. 11. Washington, DC: Futures Group, POLICY Project.

Hardee, Karen, Lori Ashford, Elisabeth Rottach, Rachel Kiesel and Rima Jolivet. 2012. *The Policy Dimensions of Scaling Up Health Initiatives.* Washington, DC: Futures Group, Health Policy Project.

Howard, C. 2005. "The Policy Cycle: A Model for Post-Machiavellian Policy Making?" *The Australian Journal of Public Administration*. 64(3): 3–13.

International Planned Parenthood Federation (IPPF). 2006. *Supportive Supervision for Quality Improvement. Training of Trainers Guide for Health Professionals.* London: IPPF.

Knowles, M. 1996. "Adult Learning," in Robert L. Craig, ed., *The ASTD Training and Development Handbook* (pp. 253–264). New York: McGraw-Hill.

Lasswell, Harold D. 1951. "The Policy Orientation," in Daniel Lerner and Harold D. Lasswell, eds., *The Policy Sciences: Recent Developments in Scope and Method,* Stanford: Stanford University Press.

McMahon, R. et al. 1992. *On Being in Charge: A Guide to Management in Primary Health Care*. Geneva: World Health Organisation.

Ministry of Health and Family Welfare (MoHFW). 2006. Quality Assurance Manual for Sterilisation Services, Research Studies and Standards Division. New Delhi: MoHFW, GOI.

MoHFW. 2011a. *Annual Report 2010–2011.* New Delhi: MoHFW.

MoHFW. 2011b. *HMIS Resource Persons' Manual*, Volume IV. New Delhi: GOI.

MoHFW. 2011c. *Model Accounting Handbook for Rogi Kalyan Samitis.* New Delhi: GOI.

NRHM. 2008. *Community Participation for Jharkhand State.* New Delhi: NRHM.

NRHM. 2011. *Report of the Working Group on National Rural Health Mission (NRHM) for the Twelfth Five Year Plan (2012–2017).* New Delhi: NRHM.

O'Sullivan, G.A., Yonkler, J.A., Morgan, W., and Merritt, A.P. 2003. *A Field Guide to Designing a Health Communication Strategy*. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs.

PATH. 2003. *Guidelines for Implementing Supportive Supervision.* Seattle: PATH.

Ross, John, and Ellen Smith. 2010. *The Family Planning Effort Index: 1999, 2004, and 2009.* Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Sabatier, Paul. 2007. *Theories of the Policy Process.* Boulder, CO: Westview Press.

Sundararaman, T. 2011. *HMIS Managers' Manual–User Manual for DHIS 2*. VOLUME III. New Delhi: National Health Systems Resource Centre.

Population Council. 2010. *Facilitating Provision of Client Centered Family Planning Services through Supportive Supervision. A Guide for Human Resource Management.* Islamabad: Population Council.

UNFPA. 1999. *Planning Population Development Projects with Focus on Decentralization and Quality of Care* Technical Report. New Delhi: UNFPA.

Voorhees, R. 2001. "Competency-Based Learning Models: A Necessary Future." *New Directions for Institutional Research* 110.

Walt, G., and L. Gilson. 1994. "Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis." *Health Policy and Planning* 9(4): 353–370.

World Health Organisation. 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action.* Geneva: WHO.

WHO. 2008. *Training for Mid-level Managers (MLM). Module 4: Supportive Supervision*. Geneva: WHO.

WHO Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project. 2011. *Family Planning: A Global Handbook for Providers 2011 Update*. Baltimore and Geneva: CCP and WHO.

For more information, contact:

Health Policy Project
Futures Group
One Thomas Circle NW, Suite 200
Washington, DC 20005
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@futuresgroup.com
www.healthpolicyproject.com