Learning Practice of Health Management Through Existing Health Action Plans Under National Health Mission (NHM)

The Indian medical graduates coming out of medical colleges be familiar with the basic factors which are essential for the implementation of national health programs and acquire basic management skills in the area of human resources, material and resource management related to health care delivery system, general and hospital management, principal inventory skills and counseling. They must be able to identify community health problems and learn to resolve these by designing, instituting corrective steps, and evaluating the outcome of such measures (MCI 2018).[1]

It is widely recognized that training in health management, by and large, has been neglected and consequently the managerial functions of the health system are being neglected.[2] Teaching/learning management skills by the didactic method are high and dry and quite boring for teachers and students alike. Participatory methods such as case studies, observation, interaction, and demonstration could be most useful. Most textbooks do not cover health management topics adequately and adhere to purely theoretical concepts.[3] Some of the participatory methods of learning about health management are being presented hereunder for their adoption and wider application in the existing training program of UGs.

**Process of Planning under National Health Mission (NHM): Village Health Action Plan (VHAP)**

For planning the delivery of comprehensive primary health care and secondary care services in the district, health services need assessment is the first vital step. Health planning and needs assessment should begin at the village/ward level with the community. The objective of VHAP is to ensure equitable access to health services to all target groups with priority to the neediest. The village/urban census ward is the basic unit of planning in India to map the diversity. Over 5.5 lakhs of village/urban health sanitation and nutrition committees (VHSNC/UHSNC) have been constituted. ASHA is the member secretary and convenor of VHSNC. These committees meet once a month wherein all sectors participate. Every VHSNC maintains public services register wherein it records access to various services like health, school/education, safe drinking water, sanitation and latrines, anganwadis, mid-day meal, ration from the public distribution system, and work under Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA). This makes it a pre-eminent platform for convergent action on social determinants of health. Every VHSNC is entitled to an annual untied grant of Rs. 10,000/- for local community level actions predominantly related to sanitation, vector control, and garbage disposal. Village health and sanitation day is organized once a month at anganwadi center by this committee for the delivery of a package of health services closer to the community. Formulation of VHAP is the responsibility of VHSNC. VHAP is based on the felt health needs of the community. The committee maintains a village health register depicting the total population, number of households, and below poverty line (BPL) families, and it monitors and oversees the functioning of village-level workers (ASHAs, AWWs, ANMs, primary school teachers, and development workers). All the ministries converge at the level of the village. The concept of village health action planning and convergence of different sectors sustained contacts with the community, and community participation can be learned by participatory observation on village health and nutrition day on the 15th of every month and the day of its monthly meeting. The faculty of community medicine should not miss this golden opportunity.

**District Health Action Plan (DHAP)**

Decentralized DHAP is the principal instrument for planning, implementation, and monitoring of comprehensive primary health care services. DHAP is the bottom-up planning process. Every district should have a district health action plan with health facilities identified and mapped. It should assess specific health needs of the community and the burden of disease in the district based on local epidemiology situation. Under the NHM program management units at state, district, and block levels have been set up to supplement the building of management and public health skills in the existing workforce. A program management unit at the district level consists of a district program manager with a master of business administration qualification, district accounts manager, and a district monitoring and evaluation officer to ensure improved program management and preparation of DHAP under the guidance of district health society. Medical college faculty (departments of community medicine) in the country were involved as a mentor to facilitate the preparation of DHAP. Under the revised Indian public health standards (IPHS) 2022, all CHCs at the block headquarter level are to be developed as block public health units to promote decentralized planning and preparation of block health plan that feeds into DHAP.

The DHAP is an aggregate of village, sub-health centers, primary health centers, and block health action plans. At the village level, VHSNC holds the responsibility of preparing VHAP with the help of ASHA, ANM, and AWWs under the guidance of a medical officer. The sub-health center team
collates the village plans to constitute a sub-health center action plan. Aggregation of these plans leads to a primary health center action plan which converges to form a block health action plan. The block plans eventually converge into DHAPs. Each level adds on service utilization data, surveillance data, and vital events in the action plans so prepared.

**Situational Analysis**

Each district undertakes a detailed situational analysis by conducting the facility and household surveys (HHS) and using data from national health programs, compiled service utilization statistics, and secondary data such as NFHS. The availability of this information enables the district in providing a snapshot of where the district stands with respect to key program indicators. This apart from the exercise provides an overview of the other resources (human, material, financial, and community resources).

**Outcomes**

Formulation of annual DHAP essentially helps in developing epidemiological skills of data collection from various sources, analysis, and interpretation of data to generate information for action at various levels. It also provides an opportunity to learn various management skills.

**IPHS and Facility Surveys**

Since the last revision of IPHS in 2012, several new initiatives, interventions, and programs have been introduced in the public health system of India. The introduction of comprehensive primary health care through 1.15 lakhs upgraded sub-centers and their PHCs (now known as health and wellness centers) and similarly in urban areas, Urban health and wellness centers have been planned—one center for 15,000–20,000 population and specialty polyclinics—one for 2.5–3 lakhs population. These are some of the new additions. Since then, seven key policy shifts have been proposed under National Health Policy 2017 for public health care delivery system. IPHS have been developed for sub-health centers, PHCs, CHCs, and district hospitals. The prescription of IPHS marks one of the most important core strategies of NHM. Once the norms or standards are in place, the challenge lies in identifying facility-wise gaps in physical infrastructure, human resources, equipments, drugs, supplies, and above all service outcomes. The facility surveys are conducted to identify these gaps and funding is directed to closing the critical gaps so identified. IPHS now specifies what essential and desirable services would be delivered, what physical infrastructure is needed, what manpower is required, and what equipments and essential drugs and materials are needed. These standards thus help monitor progress and improve the quality of services and functioning of the facility/system. IPHS have been worked out based on population norms, patient load per day, level of utilization of services, bed occupancy rate, and coverage level of health services.[4]

**Household Surveys**

Annual HHS and their regular updating in the rural and urban wards is a unique feature of the health care delivery system. The primary objective of HHS is to assess the health service needs of each individual in the family and household. This apart HHS helps in mapping resources and determinants of health and generates community participation in health planning and delivery of services. One-time HHS are not enough, these need to be updated regularly by continuous registration of marriages, pregnancy, births, deaths, and migration. HHS are conducted by ASHAs, AWWs, and ANMs at the village/ward level. It helps in preparing the village/ward health register. It generates information on the total number of households/families, population, high-risk families, BPL households, and target population for services such as eligible couples, antenatals, young children, adolescents, their health-seeking behavior, nutritional status of young children, and common communicable and non-communicable diseases and disabilities. Listing of HHS has been expanded to include persons over 30 years of age. Under non-communicable disease program, ASHAs prepare a family folder and enumerate all households and individuals in the catchment area. Information on household amenities include the type of household, type of latrine, source of drinking water, cooking fuel, electricity, and common household assets. Individual health records on common non-communicable diseases and three common cancers are being maintained for health action and promotion of healthy lifestyles apart from the screening of NCDs and common cancers by using community-based assessment checklist.

**Outcomes**

HHS enhance learning mapping resources and identify high-risk families needing priority for health services. IPHS facilitates learning of standards for quality of health services besides monitoring and supervision.

**Preparation of Decentralized Sub-Health Center: Health and Wellness Center (HWC) Action Plan**

The objective of SHC action plan is to provide equitable comprehensive health care which includes essential and desirable promotive, preventive, and basic curative health services to the assigned population with high level of coverage and quality as per IPHS. Having assessed the service needs through HHS and facility surveys, health workers plan their activities to be carried out in a specified frame indicating resource requirements, timetable, and place of each activity apart from setting norms for each activity. The health action plan is prepared in a format prescribed by the health system for estimation of service needs and resources required. However, costing of activities at the level of sub-health center team is beyond their capacity which is a function of a higher level.
Based on the last year’s performance, the planned performance for the current year for each service package is drawn up along with stock position and additional quantity requirement of drugs, contraceptives, equipments, and other materials including manpower. The action plan provides the basis for determining the service requirements of the population of sub-health center area. It addresses local problems with assured community participation.[5]

Implementation Plan (IP)
In addition to the health action plan, an implementation plan is prepared. IP essentially displays the planned activities those need to be carried out for achieving the objective of the program set for a specified time span. A fixed work plan/schedule of activities and visits is prepared. This schedule displays day-wise and village-wise, ASHA/AWW-wise activities to cover the total population of 5000/3000 in all the villages/urban wards by organizing outreach sessions and village health, sanitation, and nutrition day. The IP illustrates clearly who will do what activity, at what time and at which place, and with what resources/support apart from the time of initiation and completion of activity. One day is kept as an open day to cover the left-out activity. The fixed work schedule is a matter of policy by each state. At the national level, Wednesday is fixed for universal immunization as an outreach session in rural and urban areas. Similarly, one day is fixed for screening of NCDs and one day is devoted to RMNCH outreach activities. Campaign days for deworming in February and August are fixed at the National/State level. One of the two ANMs of sub-health center stays at sub-center every day to provide services at the facility. The health supervisors and medical officers help/support workers in preparing an efficient work schedule.[6]

Outcomes
IP illustrates how to convert strategies into activities, planning and timing of activities and assigning responsibility for each activity. IPs are observed to learn modes of delivery of health services and activities performed by different team members to learn their job descriptions. These observations are recorded by the students in their logbook for discussion with faculty.

Health Management Information System (HMIS)
The HMIS is organized around key indicators that measure a program’s progress toward its goal. It serves as an important management tool that supports the management to make sound decisions. An integrated village-wise RCH register (RCH Portal) is a step forward to an integrated health information platform. Recently, an updated version of mother and child tracking system has been rolled out called as RCH Portal to track every women and child by name throughout their reproductive life span and life cycle. A formal system of work reporting has been established in the health care delivery system. Every month a service delivery monthly progress report from the lowest level, that is, HWC-SHC and at the village level by AWW, ASHA is processed and transmitted to higher level HWC-PHC. The revised monthly HMIS format version 2.0 for HWC-SHC consists of three parts: Part A covers reproductive child health services, Part B covers health facility services, and Part C covers mortality statistics besides the stock position of essential medicine and equipments and their functional status. The monthly progress report essentially provides information on inputs, processes, outputs, effects, and impacts indicators. The most important outputs of comprehensive primary health care are the utilization of services expressed as simple counts/number of persons served during the month. A due list of beneficiaries is prepared well in advance (every week) for providing services and its effectiveness is measured by dividing the actual performance by numbers who are due/eligible for that service to assess coverage levels.[7]

Outcomes
A monthly progress report of SHC-HWC can be used to learn various monitoring indicators of HMIS. Actual performance of health worker is compared with standard performance. Performance standards have been set for various national health programs and more recently by IPHS 2022. This way the difference between actual and standard performance (performance gap) can be derived for corrective action. The health workers are provided feedback on their performance gap every month on monthly review meeting day. Root causes of performance gaps are analyzed, and appropriate actions are undertaken to improve their performance.

Conclusion
Village and census ward level health action plans besides SHC, PHC, and CHC health action plans are effective instruments to learn the total planning process of the health care delivery system in India. Household and facility survey data collected by ASHAs, AWWs, and ANMs can be used effectively to learn the basis of health services/care needs assessment of the community. Routine service statistic data of health facility and records of vital events—births and deaths—provides information on disease burden and indicates the priority health needs of the community. IPHS and DHAP can be a stimulus to learn the whole of epidemiology and practice of health management in terms of organization of health services, planning, implementing, monitoring, and evaluation of health services in real-life situation. This real-life situation must be used maximally for UGs and PGs training program to develop management skills/competencies. The medical education must be integrated with the health care delivery system for learning the practice of health management.

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