GOVERNMENT OF KERALA

Abstract

Health and Family Welfare Dept - Health Needs of Extreme Poor - Guidelines approved - Orders issued.

HEALTH AND FAMILY WELFARE (M) DEPARTMENT

G.O.(Rt)No.2205/2022/H&FWD Dated,Thiruvananthapuram, 11-09-2022

---

1 G.O (MS) No.146/2022/LSGD dated, 08.07.2022.

Read

2 D.O Letter No. IA1/52/2022/LSGD dated, 27/08/2022

ORDER

As per the Government Order read as 1st paper above, the Local Self Government Department has issued guidelines for microplans for the alleviation of extreme poverty in the state. As per the letter read as 2nd paper above, the Additional Chief Secretary, LSG Department has requested to issue necessary instructions to field functionaries to enable them for immediate action to combat extreme poverty.

Government have examined the matter in detail and are pleased to issue guidelines as annexed to this order.

(By order of the Governor)
TINKU BISWAL
PRINCIPAL SECRETARY

To:

The Director of Health Services, Thiruvananthapuram.
The Director of Medical Education, Thiruvananthapuram
Members of State Level Executive Committee, Aardram Mission
CEO, Mental Health Authority, Thiruvananthapuram
Local Self (IA) Department
State Mission Director, National Health Mission

G.O.(Rt)No.2205/2022/H&FWD

The Executive Director, State Health Agency
The Executive Director, State Health Systems Resources Centre
The Executive Director, Kudumbasree
Informations & Public Relations Department.
Stock File/Office Copy

Forwarded /By order

Signed by Hari G S
Date: 13-09-2022 12:22:32
Section Officer

Department of Health & Family Welfare / Ayush, Govt. of Kerala

Guidelines for addressing the health needs of extremely poor families identified under the Extreme Poverty Eradication Mission

Ref: G.O.(Ms) No. 146 / 2022 / LSGD dated 08.07.2022

Background

Poverty is a state in which a person lacks the usual or socially acceptable resources (money or material possessions) to provide for the basic necessities of life (food, clean water, shelter and clothing) - a state which may be harmful to both individuals and society. The 2030 agenda of the United Nations known as Sustainable Development Goals (SDG) propose to end poverty and deprivation in all forms, leaving no one behind while making development economically, socially and environmentally sustainable. This has special reference to SDG Goal 1 which focuses on ending poverty in all its forms everywhere.

The first step in tackling poverty is the identification and elimination of the existing extreme poverty. Extreme poverty is a multidimensional phenomenon in which there are simultaneous deprivations in multiple functions such as attainment of health, education and living standards. Extreme poverty ravages the lives of one in four persons in the developing world.[1] Two-thirds of financial catastrophe leading to poverty is due to out-of-pocket expenditure (OOPE) for health. High OOPE can push households into poverty and make them vulnerable to catastrophic health expenditures.[2]

Many of the SDGs adopted by India have already been achieved by Kerala; hence, the State of Kerala has committed itself to achieve state-specific SDG goals. As part of achieving the Kerala-specific SDG Goal 1, the Local Self Governments (LSGs) of Kerala have conducted a baseline assessment of all families and enlisted those in extreme poverty. The Government of Kerala is determined to provide free services for such families to help them break the vicious cycle of “poverty reproducing poverty” and introduced a targeted programme for extreme poverty eradication. The Health and Family Welfare Department, Government of Kerala aims at preventing and reducing the incidence and intensity of impoverishment due to health care expenditures.

The purpose of this guideline is to standardise the approaches and to assist the heads of health institutions across the State to streamline, direct and ensure health-related services for extremely poor families.

Micro plan for Service Delivery

Step 1: Preparatory activities

- Each Local Self Government (LSG) has compiled a ward-wise list of extremely poor families under their jurisdiction. The families included in the list shall also be included in the list of vulnerable families for priority visits during the regular duty of ASHA, JPHN, JHI and MLSP. The head of the institutions shall collect the list related to their jurisdiction and distribute them to the concerned sub-centre teams for further action.

- The sub-centre team shall consist of the Junior Health Inspector (JHI), Junior Public Health Nurse (JPHN) and Mid-Level Service Provider (MLSP). In the absence of MLSP / when the number of MLSP is insufficient to finish the activity on time, the head of the institution shall assign a Staff Nurse along with JHI and JPHN for house visits. The presence of an MLSP / Staff Nurse in the team is essential for the proper collection of clinical and treatment data of any patients in such families and also to do a preliminary clinical assessment wherever needed.
- In cases where there is a disproportionate distribution of extremely poor families between sub-centres, the head of institutions can pool/redistribute staff from sub-centres with low load to those with high load for the timely completion of the activity. Similarly, redeployment of existing staff can also be done within the block/ district by the Block Medical Officer / District Medical Officer respectively based on the beneficiary load so that the data collection process may run smoothly across the district.
- To cover the beneficiaries in the urban areas (Municipality/Corporation), a similar team shall be constituted under the LSG Urban Health Services and the process shall be monitored by the concerned urban local body.

Step 2: House visits by the Sub-centre team

The Sub-centre team shall visit the residence of each beneficiary family to collect baseline information and conduct a preliminary health assessment of the family members. If any family member is not present at the time of the visit, their details shall be collected during the subsequent visit which shall be planned in consultation with the family to ensure completion. The ASHA shall accompany and aid the team in data collection. The general information of the family and baseline data of each family member shall be collected in Format I and II respectively attached as Annexures.

During data collection, special attention shall be given to those who are at risk of diseases but not screened for such diseases as non-communicable diseases, diseases of familial or genetic origin and communicable diseases. These families shall be given priority in all screening programmes.

Step 3: Registration of beneficiaries

The head of the institution shall co-ordinate with the LSG to ensure the following:

1. All the beneficiaries are registered under the extreme poverty eradication programme and are issued an identification/beneficiary card.
2. All the beneficiaries are registered under e-health and KASP (Karunya Arogya Suraksha Padhathi).
3. Special registrations under various health schemes (eg: Hridyam, Arogyakiranam, etc) as per need are done with the help of concerned health institution.
4. Registration for support schemes by other departments (an indicative list is attached to this guideline), if eligible, are done with the support of the LSG.
5. If any member of the extremely poor family is in need of a disability certificate / other medical certificates, the case shall be given top priority by the concerned medical boards / officers.

Step 4: Health Need Assessment

Based on the information obtained from Step 2, the health needs of each of the family members and the family shall be listed by the head of the institution of the preferred system of medicine. For those opting for modern medicine, the sub-centre team shall do the health needs assessment under the guidance of the Medical Officer. For those preferring other systems, the Medical Officer of the concerned system shall do the health need assessment of the family with the support of the sub-centre team. The health needs can be categorised as given in Format III attached as Annexure.

Following analysis of the collected data, the Medical Officer shall give a recommendation note on the measures to be taken for correcting social and environmental determinants of health prevailing in the concerned families to the LSG. (For example, if firewood is being used as fuel in a COPD patient's house, measures to provide alternate fuel shall be suggested in the note. Similar suggestions can be given in the relevant areas like drinking water, sanitation, housing, etc.)

Step 5: Linkage to existing programmes

The listed services identified shall be linked to the existing programmes. LSG shall link the beneficiaries to the existing programmes of different departments with the help of the concerned institution. A tentative list of available programmes is given in Format IV attached as Annexure.

Step 6: Gap identification in free service delivery

Those services which are not available for free or not attached to any government schemes shall be identified. The most common cause of OOPE is for diagnostic tests and for buying medicines - hence any cost incurred for testing, treatment, transportation and rehabilitation services shall be identified. The following instructions shall be followed for bridging the gaps:

1. Priority shall be given to extremely poor families in providing already existing services like laboratory diagnostics, treatment and transportation. National and State health programme benefits also shall be prioritised for them. (For example: When there is a possibility of drug shortage under a programme, priority in drug distribution shall be given to those with extreme poverty).
2. All laboratory tests shall be provided free for the extremely poor families identified. The 15th finance commission grants provide ample funds for strengthening laboratories. These funds shall therefore be utilised for the purchase of reagents and other laboratory consumables.
3. The beneficiary families shall be prioritised for drug dispensing from health institutions, especially when stocks are likely to be insufficient.
4. Medicines purchased under LSG funds for extremely poor families shall be used only when there are no sufficient stocks in the general pool. These drugs shall not be utilised for other patients under any circumstances. In case any of these drugs are nearing expiry and are not likely to be utilised for these beneficiaries within the date of expiry, the LSG can analyse the situation and permit using these in the general pool under special circumstances. This option shall be used judiciously and with extreme caution.

5. Certain medicines / laboratory tests which are needed under special circumstances might not be available in the regular supply and also cannot be purchased/provided using LSG funds. An MoU shall be entered into with local pharmacies or labs for the supply of such drugs/tests in special instances, through a competitive process so that needs of the extremely poor families can be met for free. In institutions where there is an authorised supplier identified by a competitive process (for KASP or other schemes), the same supplier may be used for this scheme too. In case no such supplier has been engaged, the procedures adopted under the KASP scheme may be used for this purpose. While outsourcing priority shall be given to Government-run stores like Jan Oushadi, Neethi medicals, Karunya pharmacy etc.
6. When implemented, the hub and spoke model laboratory network shall be utilized for laboratory tests and priority shall be given to extremely poor families.
7. As far as possible, bedridden patients under the scheme requiring long-term drugs and other services shall be provided with the same at home through the palliative care team and the Vaathilpadi services of the LSG. Other patients on long-term drugs can be provided with the same as close to home as possible – such as through sub-centres, thereby reducing the need to visit PHC / FHC to the minimum.
8. Beneficiaries when admitted to hospitals shall be supplied with a double diet free of cost to meet the nutritional requirements of both the patient and the caretaker.
9. In case patients do not have anyone to stay with them during hospital admissions, the matter shall be informed to LSG by the Medical Officer. The LSG shall arrange a bystander through Kudumbasree / Social Justice department schemes for social support.
10. 108 ambulances shall be used to transport patients from these families on a priority basis. In cases where the health institution or the LSG has an ambulance, the same also shall be made available free to these families when needed. Inter-facility transfer also shall be provided free. 108 ambulances and all hospital, LSG and other government ambulances may be used for providing free transportation from one facility to another in case of need. In cases where such facilities are not available, or a vehicle other than an ambulance is needed, a scheme shall be put in place under the LSG project for outsourcing transportation of these patients free of cost to the health facility. LSG shall bear the responsibility of transporting the beneficiaries to meet their needs.
11. All the existing schemes of health as well as other departments shall be used for the benefit of these families. For example, if the beneficiaries belong to scheduled tribe groups, the existing tribal schemes for transportation/medicine purchase/ laboratory tests shall be used. Only when such schemes are not available shall the LSG project funds be used
12. An emergency team shall be formed at the ward and LSG level for coordinating emergency transportation of these beneficiaries when needed.
13. Persons suffering from mental illness shall be rehabilitated either at home or in institutions if required through existing schemes.

Step 7: Budgeting

LSG projects shall be prepared compulsorily for bridging the gaps identified in Step 6. Projects shall be prepared in such a way that these are continued every year with necessary modifications based on the need assessment. The project shall include funds for meeting the

emergency needs also. LSG project for the families with extreme poverty shall cover all the health needs of the family, including but not restricted to:

1. Diagnostic Tests: screening and diagnostic tests
2. Treatment: Drugs and other consumables
3. Rehabilitation: support devices, aids and rehabilitation measures to make the person self-reliant.
4. Transportation- including ambulance services.

In case of non-availability / delay in implementing the LSG projects, the HMC fund shall be utilised for providing free-of-cost testing/treatment/transportation to the beneficiaries. Even the subsidised rate for BPL families shall not be charged from these beneficiaries under any circumstances. The HMC has the full responsibility of providing completely free hospital services to the extremely poor. The HMC shall utilise any funds at its disposal for providing free service to these patients including the HMC fund, KASP fund, donations, grants or awards received in HMC funds. Such an amount spent from the HMC fund shall be recouped from the LSG project at the earliest.

In addition to this, every LSG and the concerned health institution shall keep an imprest amount exclusively to meet the unforeseen expenditures of the extremely poor families. The quantum of imprest amount to be kept in an institution shall be decided by the HMC committee. The items procured through LSG project for extremely poor families shall not be used for others unless and until the items reaches near expiry. In such cases, the procedures detailed under section 4 of Step 6 shall be followed.

A separate guideline will be released for making the services free for the beneficiaries seeking care from higher level institutions like Medical Colleges, Cancer care centres, outside the State etc.

Step 8: Follow-up visits

At least one member from the sub-centre team (JPHN / JHI / MLSP) shall conduct monthly follow-up visits to the families to update the initially collected data and to look for any special needs.

The ASHA shall visit these families at least twice a month. The ASHA shall keep in constant touch with these families through telephone and through volunteers to ensure that any health need of the family comes to the notice of the ASHA immediately. The ASHA in consultation with the sub-centre team shall take necessary steps to provide free health services in all such cases.

ASHAs and the Sub- Centre team will be monitored and supported by the concerned supervisors.

Step 9: Team building

Monthly or more frequent (if needed) review meetings of the programme shall be conducted at LSG level. This will help in liaison and proper linking with the existing or newer programmes across various departments. Inter departmental co-ordination and resource utilisation will be

more efficient and duplication of works can be avoided. Convergence at the LSG level shall be the responsibility of the LSG Nodal Officer. Head of the institutions shall attend the meetings without any fail.

Emergency team shall be formulated at the ward and LSGD level with the ward member and Chairperson of the LSG respectively as the responsible persons for emergency responses.

All concerned officials shall incorporate the dissemination of extreme poverty eradication mission in the programmes run by Government so that this programme will receive wider publicity and spirit.

Step 10: Expanding the programme

For eradication of poverty, it is essential that free services are also available to other poor families not included in the present list. Hence, once the data collection and planning for the scheme is completed, the same process shall be repeated for all families registered under the Ashraya scheme. In this phase, it shall be ensured that all Ashraya beneficiaries are also provided completely free services as in the case of extremely poor families. The same programme may be replicated for those registered under the Ashraya scheme.

References

1.https://www.oecd-ilibrary.org/ DAC Guidelines- Poverty Eradication

2.Health Policy and Planning2012;27:213–221doi:10.1093/heapol/czr029213

ANNEXURES

Annexure I- Formats for data collection

Format I- General information of the family

1.	KASP Enrolment number.
2.	KASP validity ends on.
3.	Any family member not included under KASP?
4.	Name of the family member not included under KASP.
5.	Which is your nearest government hospital?
6.	What is the distance of the nearest government hospital from your residence?
7.	Which is the health facility most commonly accessed by your family?
8.	What is the usual mode of conveyance to hospital?
9.	Which health facility will you approach first in case of emergencies?
10.	What is the distance of the emergency care hospital from your residence?
11.	Do your residence have electricity?
12.	What is the source of drinking water?
13.	What facility are you using for storing water?
14.	Do you have toilet facility at your residence?
15.	What kind of latrine are your family using?
16.	What method is used to dispose solid waste?
17.	What method is used to dispose sullage?
18.	What is the type of house?
19.	What type of flooring is used at your residence?
20.	What is the type of roofing used?
21.	What kind of cooking fuel is used?
22.	Any kind of water collection noticed in the vicinity which is potential to breed mosquito?
23.	Do you have any domestic/pet animal?

Format II- Individual Details (One for each member)

A. **Baseline information**

1.	Name of the person
2.	Contact number
3.	Age
4.	Gender
5.	Body Height in cm
6.	Body Weight in Kg
7.	Body Mass Index*
8.	Physiological status
9.	Do you belong to any special category like physically disabled/ differently abled /migrant/ destitute ?
10.	Do you have any addictions?

11.	Brief details of present illness**(Diagnosis, investigations, treatment, hospitals, cost incurred)
12.	Past history of illness or surgery***
13.	Vaccination status
14.	Educational status
15.	Employment status

*BMI= weight in Kg/ (height in cm)^2

**Present illness- It includes major Communicable diseases such as Tuberculosis, Hepatitis B/C, Filariasis, Leprosy, Malaria, AIDS and Non-Communicable diseases such as Hypertension, Diabetes Mellitus, Cancer, Cardiovascular diseases, Mental illness, Chronic liver and kidney diseases. Familial or genetic disorders such as Hemophilia, Colour Blindness, Phenylketonuria, Cystic fibrosis etc.

***Past history of illness or surgery- It includes previous history of Tuberculosis, Malaria, Leprosy, Cancer, Mental illness etc and surgeries done if any.

B. Health needs of the individual

Services	**Health Needs***	**Details****
Promotive care		
Nutrition		
Sanitation		
Drinking water		
Clean fuel		
Housing		
Health Education		
Income generation		
Preventive care		
Vaccination		
Screening for the diseases		
Curative services		
OP consultations		
Emergency medical care		
Organ donation		
Referral services		
Supply of drugs		
Rehabilitative services		
De-addiction services		
Differently abled		
Supportive aids		
Vocational rehabilitation		
Endosulphan victims		
Palliative care		
Financial assistance		
Home delivery of drugs		
Home care		
Secondary care		
Vulnerable group services		

Pregnancy care		
Childbirth		
Newborn care		
Postpartum care		
Under 5 services		
Mental health care		
Elderly care		
Women		
Transgender		
Miscellaneous		
Transportation		
Ambulance services		

*Tick the relevant cells.

** Give the details of appropriate services needed for the individual

Annexure II

Indicative list of programmes available for the purpose of health service linkage

Health Needs	Programmes
Promotive care	
Nutrition	PDS, ICDS, Hunger free city, padheyam
Sanitation	Swachh Bharat Mission
Drinking water	Jal jeevan mission, Jalanidhi
Clean fuel	Ujjwala yojana, sahaj scheme
Housing	Life mission, PM Awaas Yojana
Health Education	ICDS
Income generation	MGNREGA, sahayahastham
Preventive care	
Vaccination	UIP
Screening for the diseases	NCD screening, Annual Health Check up, Shalabham programme,
Curative services	
OP consultations	RBSK, Cancer Suraksha, Amrutham arogyam
Emergency medical care	KEMP 108service
Organ donation	Mrithasanjeevani
Referral services	DEIC(upto 6years)
Supply of drugs	Vaathilppadi sevanam
Rehabilitative services	
De-addiction services	Vimukthi, Subodham
Differently abled	Vaathilppadi sevanam, Shreshtam,Sahajeevanam, Snehayanam, Niramaya health insurance, Athijeevanam, Pariraksha, Swasraya,Vidyajyothi, Vidyakiranam, Anuyatra
Supportive aids	Sruthitharangam
Vocational rehabilitation	Kaivalya
Endosulfan victims	Sneha Santhwanam
Palliative care	
Financial assistance	Aaswasakiranam
Home delivery of drugs	Vathilppadi sevanam
Home care	Palliative care project
Secondary care	
Vulnerable group services	
Pregnancy care	Ammamanasu, Sneha
Childbirth	JSY, JSSK
Newborn care	Shalabham, Amma thottil,
Postpartum care	Ammamanasu
Child care	Hridyam(CHD) ,Thalolam, Mittayi, Arogyakiranam(upto 18 years), Operation valsalya,
Mental health care	Aaswasam
Elderly care	Vaathilppadi sevanam, Vayoraksha, vayomithram, vayomadhuram, vayoamrutham, Mandahasam, Sayamprabha
Women	Bhoomika, Nirbhaya, Snehasparsham, Saranya, Kaithangu
Transgender	Saphalam, Financial assistance programmes