NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

11th COMMON REVIEW MISSION

REPORT 2017

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This report has been synthesized and published on behalf of the National Health Mission by its technical support institution; National Health Systems Resource Centre (NHSRC) located at NIHFW campus, Baba Gangnath Marg, New Delhi-110067.

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Jagat Prakash Nadda

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Message

The 11th Common Review Mission (CRM) comes at a time when India is decisively moving towards Universal Health Coverage. Efforts towards financial protection are now in forefront under 'Ayushman Bharat' with provision of comprehensive primary health care (built on health & wellness centres) and National Health Protection Scheme. Previous CRMs have played an important role in reminding us the concerns and consequences related to Out-of-pocket expenditure (OOPE). It is good to see steady progress on various schemes launched by the Government of India to specifically reduce OOPE, eg. National Free Drugs and the Free Diagnostics Service Initiative. The Pradhan Mantri National Dialysis Programme has already served more than two lac patients with End-stage kidney disease, since its launch.

2. CRM has established itself as a key evaluation mechanism under the National Health Mission. However, the observations on diseases targeted for elimination, like leprosy and kala-azar, would need to be more comprehensive. In particular, challenges like the scourge of Drug-Resistant Tuberculosis (DR-TB), and Anti-Microbial Resistance in general, need urgent attention. It would be important for National Health Mission to prioritise advocacy for Anti-Microbial Resistance (AMR) related issues. Public health facilities continue to show increased utilisation on year-on-year basis.

3. However, the range of specialist services at many District Hospitals does not include the minimum core specialities. I am happy to note that some States are adopting innovative approaches to engage specialists and improve range of core specialist services at the district hospital.

4. Moving forward, such initiatives within the National Health Mission will help in strengthening secondary care services and integrate primary and higher services. The Health and Wellness Centres would be a key platform for such integration. Information available through the 11th CRM States would help this Ministry to establish a baseline and make any necessary early amends.

5. I thank all experts for participating in the 11th Common Review Mission.

(Jagat Prakash Nadda)

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Government of India
Department of Health and Family Welfare
Ministry of Health & Family Welfare

Dated 28th March, 2018

Message

A specific strength of Common Review Mission has been the multidisciplinary teams that bring forth different perspectives from ground. Another strength is that a sample of public institutions across all levels get evaluated, thus helping in building a comprehensive overview of the health care service delivery in public sector. However, given the percentage of population seeking care from private providers, it would be pertinent that the review mission also reaches some private institutions to comment on the opportunities and challenges there.

It is encouraging to note that 11th Common Review Mission has reported multiple positive observations, especially from EAG states. These observations range from Bihar's effort to improve quality of construction through external monitoring to use of District Mineral Funds in Odisha for sourcing-in specialist services. At the same time some of the challenges that spurred the origin of National Health Mission, such as malnutrition, the lack of assured care to emergency obstetric care, other surgical services and assured availability of blood services persist. Though the review missions have been able to identify issues of concern, they have often not able to study the issue at length. Given the human resource that we mobilize for this vast exercise, it would be prudent for us to identify certain key issues for in-depth understanding. Further, owing to its annual frequency, the mission invariably assesses certain newly launched initiatives, beyond the launch. For such initiatives, the mission's objective should be report on preparedness by States for ensuring a robust launch- rather than to report on implementation.

An important component of the National Health Mission has been the urban component. Previous Common Review Missions have highlighted bottlenecks in NUHM implementation and some of them continue being reported. For instance, the vulnerability mapping is yet to be initiated across many States, and of the sixteen States that were assessed in 11th CRM, only two (Meghalaya and Telangana) reported to have implemented the exercise. It is expected that States would take cognizance of 11th CRM observations and initiate necessary steps.

ASHAs continue to play a significant role in steering care at village level and States have begun training them for their future role in Comprehensive Primary Health Care. Moving forward National Health Mission will continue supporting the ASHA strengthening initiatives across states.

11th Common Review Mission has been most useful in bringing forth implementation challenges from filed and I thank all the experts who participated in the mission.

(Preeti Sudan)

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Message

The country now has, for the first time, State level data on epidemiological transitions. Indeed, we are nations within a nation. Over the course of last ten Common Review Missions, a steady improvement in public health infrastructure has been reported. We have a comprehensive health systems approach, and evidence of District hospital strengthening, with 98% CHCs, 92% PHCs and 68% SHCs now operating from government buildings and increasing foot-falls in public health facilities. These investments definitely have had significant impact on healthcare access and outcomes. We would continue supporting States in future on infrastructure front, as long as such investments bring care closer to people.

Despite a significant burden of care shifting towards private sector, public hospitals continue to be a preferred provider in most rural geographies; particularly so for the poorer quintiles. Catering the needs of the poorest will remain at the forefront of National Health Mission. I am happy to note that the 11th Common Review Mission has reported year on year increases in OPDs and IPDs at most public institutions.

However, bridging the quality chasm is a continuing challenge. Only 21 public hospitals are NQAS certified, much lesser than the numbers we would like to see. Nonetheless, efforts towards state certification must continue. Kayakalp awards have spurred a movement towards ensuring hygiene and cleanliness at health centres and this momentum of the Swachh Bharat Abhiyan would need to be sustained.

Establishment of corporations for procurements of drugs and consumables have eased out procurement challenges in EAG as well non-EAG States. However, we will need to address this issue in North Eastern States, particularly in Nagaland and Meghalaya as they continue reporting inadequacy of supplies and consequent Out-of-Pocket-Expenditures.

Innovations have been promoted by the National Health Mission and I am happy to observe that many State reports have captured innovative and best practices. Call centre based ambulance services and IT based supply chain management systems for drugs etc were good practices that were promoted under NHM and have got rolled out nationally. Such best practices held the mission in prioritizing its funding and Common Review Mission(s) helped in highlighting these district level interventions.

Moving forward the Common Review Mission would perhaps need to realign itself with the emerging health priorities related to NCDs and comprehensive primary care. I am sure that the States would find the observations useful vis a vis, their implementation priorities, and I thank the members for enriching us with their observations.

(Manoj Jhalani)


RADIENT WARMER-II
37.9
27.5

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Abbreviations

AGCA	Advisory Group on Community Action
AMTSL	Active Management of Third Stage of Labour
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ANMTC Centre	Auxiliary Nurse Midwife Training
APHC	Additional Primary Health Centre
API	Annual Parasite Index
ARC	ASHA Resource Centre
ART	Anti retroviral Treatment
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric & Neonatal Care
BMO	Block Medical Officer
BMWM	Bio-Medical Waste Management
BPHC	Block PHC
BPM	Block Programme Manager
BPMU	Block Programme Management Unit
BPL	Below Poverty Line
CAH	Community Action for Health
CBOs	Community Based Organizations
CEmONC	Comprehensive Emergency Obstetric & Neonatal Care
CHC	Community Health Centre
CMO	Chief Medical Officer
CMOH	Chief Medical Officer Health
CRM	Common Review Mission
CT	Scan Computed Tomography Scan
DH	District Hospital
DHAP	District Health Action Plan
DLHS	District Level Household Survey
DOTS	Direct Observation Therapy - Shortcourse
DPM	District Programme Manager
DPMU	District Programme Manager Unit
DTC	District Training Centre
DWCD	Department Women & Child Development
EDL	Essential Drug List
EmONC	Emergency Obstetric & Neonatal Care
EMRI	Emergency Management and Research Institute
FMG	Financial Management Group
FP	Family Planning
FRU	First Referral Unit
GNM	General Nursing Midwife

HMIS	Health Management Information System
HMRI	Health Management & Research Institute
HR	Human Resource
HRD	Human Resource Development
HRIS	Human Resource Information System
HSC	Health Sub-centre
ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centre
IDSP	Integrated Disease Surveillance Project
IEC	Information Education Communication
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPD	In Patient Department
IPHS	Indian Public Health Standards
ISO	International Organization for Standardization
IUCD	Intra-uterine Contraceptive Device
JE	Japanese Encephalitis
JPHN	Junior Public Health Nurse
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
LLIN	Long Lasting Insecticide Treated Nets
LR	Labour Room
LSAS	Life Saving Anaesthesia Skills
LT	Laboratory Technician
MB	Multi-bacillary cases
MCTS	Mother and Child Tracking System
MDR	Multi-drug Resistant (TB)
MIS	Management Information System
MHW	Male Health Worker
MMR	Maternal Mortality Ratio
MMU	Mobile Medical Unit
MO	Medical Officer
MoHFW	Ministry of Health & Family Welfare
MOIC	Medical Officer In-charge
MoU	Memorandum of Understanding
MPW	Multi-purpose Worker
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NGO	Non-Government Organisation
NHSRC	National Health Systems Resource Centre
NICU	Neonatal Intensive Care Unit
NIHFW	National Institute of Health & Family Welfare
NIPI	Norway India Partnership Initiative
NPCB	National Programme for Control of Blindness
NLEP	National Leprosy Eradication Programme
NRC	Nutritional Rehabilitation Centre
NRHM	National Rural Health Mission
NSSK	Navjat Shishu Suraksha Karyakram
NSV	Non-scalpel Vasectomy
NUHM	National Urban Health Mission
NVBDCP	National Vector Borne Disease Control Programme
OPD	Out Patient Department
PCPNDT	Pre-Conception and Pre Natal Diagnostic Techniques (Prohibition of Sex-selection) Act - 1994
PHC	Primary Health Centre
PHN	Public Health Nurse
PIP	Programme Implementation Plan
PMU	Programme Management Unit

PPP	Public Private Partnership
PRI	Panchayati Raj Institutions
PWD	Public Works Department
RCH	Reproductive and Child Health
RDK	Rapid Diagnostic Kit
RHFWTC	Regional Health & Family Welfare Training Centre
RHP	Rural Health Practitioner
RKS	Rogi Kalyan Samiti
RKSK	Rastriya Kishor Swasthya Karyakram
RMP	Rural Medical Practioner
RMSCL	Rajasthan Medical Services Corporation Limited
RNTCP	Revised National Tuberculosis Control Programme
RSBY	Rashtriya Swasthya Bima Yojana
SBA	Skilled Birth Attendant
SDH	Sub Divisional Hospital
SHC	Sub Health Centre
SHSRC	State Health Systems Resource Centre
SIHFW	State Institute of Health and Family Welfare
SIMS	Softline Intelligent Micro Systems
SNCU	Special Newborn Care Unit
SPMU	State Programme Management Unit
STG	Standard Treatment Guideline
TB	Tuberculosis
TNMSC	Tamil Nadu Medical Services Corporation Limited
VHND	Village Health and Nutrition Day
VHSNC	Village Health and Sanitation and Nutrition Committee

Executive Summary

The 11th Common Review Mission covered sixteen states, of which six were in the High Focus States (Bihar, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, and Uttar Pradesh), four were in the North East (Assam, Manipur, Meghalaya, and Nagaland) and six were Non-High Focus States (Haryana, Karnataka, Maharashtra, Punjab, Telangana, and West Bengal).

The 261 members of the 11th Common Review Mission included senior officials of MoHFW, Public Health experts from Civil Societies and Academic Institutes, Development Partners and officials from related development sectors of the government. These members divided into 16 state teams, each being led by a senior officer of the MoHFW, tasked to carry out study visits to the allotted states. The team members were briefed on the objectives and methodology of conducting the 11th CRM, which was conducted from the 3rd to 10th of November 2017.

The broad objective of each Terms of Reference (TOR) has been to assess the process, outcome and impact of relevant interventions being carried out under the NHM, using the lens of equitable healthcare. The TORs for 11th CRM were developed by the MoHFW involving different stakeholders and technical experts from the Programme divisions and covered various dimensions of NHM ranging from service delivery to governance issues. The 12 TORs focused on implementation status of new initiatives and guidelines issued by MoHFW, assessment of the organization of services, appraisal of health system preparedness, evaluation mechanisms in place for secondary and tertiary care referrals, reviewing linkages with social protection schemes and Public Private Partnerships, and to determine the status of institutional capacity in strengthening programme management. Documentation of best practices, innovations and lessons learned and following up on recommendations of past CRMs were additional objectives.

This National CRM 11th report is based on the findings of different state teams and their State CRM reports. It includes the observations and suggestions made by the representatives of the state governments and development partners during the course of discussion and presentations of the preliminary CRM findings at the district and state level.

KEY FINDINGS

TOR 1: Service Delivery: Expanding Access and Ensuring Quality

- 98% CHCs, 92% PHCs and 68% SHCs now operate from government buildings. In terms of improvement, this translates into 41% more SHCs, 18% PHCs and 7% more CHCs functioning in government buildings (as compared to the year 2005). A reason of continued concern has been the slow pace of construction.
- With the new initiatives of population-based screening for Non-communicable diseases

and referrals of acute illnesses from peripheral centres; the high-risk patients are now reaching the district hospitals. The discourse on district hospitals needs to shift from hospitals catering to 'maximum burden of case loads' to hospitals with 'assured emergency services'.

- While most government health facilities have reported increased utilization and foot-falls, year on year, assured availability of the eight core specialist services is yet to saturate at the level of the district hospitals. Undue referrals from peripheral institutions also continue to be reported from most states.
- States now report dedicated corporations for procurement and supply of drugs and consumables. Outsourcing bulk procurement to PSUs has also been attempted (Maharashtra). However, issues around drug procurement for smaller North-Eastern states persist and patients incur significant out-of-pocket-expenditure (OOPE) for buying medicines.
- All CRM states have notified the free diagnostics policy. However, it is yet to translate to availability of expected range of diagnostics at the peripheral institutions, to eventually reduce out-of-pocket-expenses.
- While mapping of equipment has been completed by all states, challenges relate to availability of a common toll-free number for registering breakdown complaints and persisting time-lag between registration and redressal.

- Considering the burden of renal disease in India, dialysis services continues to reach a fraction of those who need it. Under the NHM, Pradhan Mantri National Dialysis Programme supports states for provision of free dialysis services to poor. Guidelines with a model RFP have been issued for PPP model. States do have the flexibility to adopt either PPP model or provide this service in-house.
- There is effort towards increasing the network of blood banks and BSUs. However, inadequate access to blood services were reported from Bihar (where only 20% of blood banks are licensed, 41% BSUs are functional, 18.7% of demand is met), Karnataka (20% of sanctioned blood banks functional), Uttar Pradesh (8% BSUs functional), Chhattisgarh, Assam, Manipur, Jharkhand, Telangana (instances of OOPE also reported). Lack of human resources and non-functionality of equipment (Bihar, Uttar Pradesh, Nagaland) have been reported as major reason for non-operationalization of Blood banks.
- A degree of dis-engagement is seen emerging in the field, with the launch of National AYUSH Mission (NAM). For instance, in many states, the procurement of AYUSH drugs is now being shifted to NAM. The perception of AYUSH practitioners being a 'side-kick' in various NHM initiatives is also being felt. While NHM has provided a platform for engaging AYUSH professionals in various health programs, it has not been able to increase demand or access to AYUSH services.
- As per the MIS report of 2017 currently there are 8718 (Dial 102), 603 (Dial 104), 8680 (Dial 108) and 5859 (other) ambulances. In addition there are 11,305 patient transport ambulances,

such as Janani Express, Mahtari express etc. However, states such as Bihar, Gujarat, Madhya Pradesh, Punjab, Sikkim, Tripura and Telangana report shortage of ambulances as per the population norms (one BLS ambulance per 1 lakh population and one ALS ambulance per five lakh population).

- MMUs in their current state are largely acting as sporadic providers, of very limited range of care. Some geographies continue to be missed by MMUs as well as the health centres. Moving forward, such pockets would need to mapped and prioritized for MMU services.

TOR 2: RMNCH+A

- Under the RMNCH+A strategy, states have taken the effort to ensure the availability of drugs increased at all levels including sub-centres and with ASHAs. However, due to the lack of a robust supply chain mechanism; interruptions and inappropriate supplies continue be barriers in some states (especially the North East). Many states have focused on operationalization of delivery points to improve access to healthcare. However, the number of delivery points need to be adjusted as the per population norms.

- The CRM observed that states were using Family planning as a reliable method to prevent maternal and child mortality, by focusing on preventing teenage pregnancies, delaying pregnancies after marriage and birth-spacing between children. Availability of FP commodities are reported to have improved in all the states, and a basket of FP choices, ranging from the traditional OCP, condoms to newly introduced non-steroidal contraceptive pills and Inj. DMPA (Antara), are now available.
- IUCD insertion remained the top preferred choice, among the various spacing methods, though PPIUCD acceptance has also increased, over the years. Among the total deliveries at various public institutions across India, 11.74% women accepted PPIUCD insertion. Very few states reported providing Post-abortion IUCD (PAIUCD) insertion services.
- Women continue to bear an uneven burden of the terminal methods of family planning and sterilization. As per HMIS in 2017-18 (till October), of the total 14,73,418 sterilization procedures, only 6.8% were male sterilization operations and an overwhelming 93.1% were female operations. Family Planning Indemnity Scheme (FPIS) was available in all states, though service providers and the community were not very aware about this scheme.
- States have focused on providing quality ANC services to pregnant women through early registration of pregnancies, which has marginally improved to 70%, who received 3 or more ANC visits, newer initiatives like provision of Folic Acid, 180 IFA, calcium supplementation and deworming in pregnancy.
- With the launch of Pradhan Mantri Surkshit Matritva Abhiyan (PMSMA) high risk identification in pregnancy has improved

significantly. Several states have collaborated with private health/non- health organizations (as part of Corporate Social Responsibility) Lions and Rotary Clubs, private nursing colleges and other departments to provide services to PMSMA beneficiaries. In a short span of 18 months, more than ten million antenatal check-ups have been conducted under the programme across 12800 facilities. In response to the clarion call of the Prime Minister, more than 4800 private sector doctors have come forward to volunteer for the programme.

- High risk pregnancies due to severe anaemia (Hb<7) remains persistent across the states, and about 5% severe anaemia has been reported among the registered pregnancies. Many states have adopted provision of Inj. Iron Sucrose as an important step towards treating severe anaemia. However, as per HMIS data, only 37% severe anaemic received treatment. Line listing and follow-up of high risk pregnancies remains missing in most states.

- Delivery care at the facilities showed improvement in terms of being organized, well maintained, well equipped labour rooms, 24 hours water supply and power back-up and ensuring privacy for mothers. However, few high focus states still lack in terms of maintaining labour room protocols such as use of partograph, Oxytocin storage and maintainence of labour registers.

- Important skills like Active Management of Third Stage of Labour, Neonatal resuscitation, Maternal complication identification and management were lacking among the nursing staff in many states like Jharkhand, Nagaland, Manipur, Meghalaya and Bihar. These training programmes are stagnating due to lack of institutional capacity. The trainings rely on ad hoc arrangements with poor institutional linkages and are not sustained which in turn, affects the skill of service providers.

- JSSK has helped foster the perception of health care as an entitlement within the public system. Further, it has also enabled a goalpost shift from mere withdrawal of user fees, to active elimination of out-of-pocket-expenditure. While Out-of-Pocket-expenditures have declined, a few states reported OOP being higher where surgeries or more complex diagnostics are involved. Provider and managerial perceptions are slow to change, and this is reflected in the continuing practice of outside prescriptions, which are the main source of out-of-pocket-expenditures. The absence of policy articulation on free drugs and diagnostics at the state level, contributes to slow and uneven progress.

- Newborn services show remarkable improvement and essential newborn care is operational in many states. Newborns get vaccinated before discharge from most of the facilities, after initiation of MAA (Mother's Absolute Affection) Programme more focus is given on early initiation of breast feeding, counselling is provided to mothers for exclusive breast feeding and complementary feeding.

- At the community level, Home-based Newborn Care yielded good results in identifying and referring the sick newborns. HBNC can further improved through effective supportive supervision. At the facility level, many states have well established SNCU, NBSU and NBCC to cater the sick newborns.

- Many states have initiated the practice of Kangaroo Mother care for Low Birth Weight babies; some states like Telangana, Maharashtra and Uttar Pradesh have KMC units to promote the practice. Few states report poor utilization of KMC units in the SNCU premises, where Low birth weight babies who can breastfed were crowding in the SNCU.
- All states reported improvements in immunization, with no reports on gaps in cold chain or availability of vaccines. Micro plans, due lists were available with the ANM however documentation was major concern.
- In the continuum of care approach, Adolescents emerged as neglected, in most of the states. Rashtriya Kishori Swasth Karyakram (RKSK) was implemented in only a few states. The Adolescent Friendly Health Clinics (AFHC), if initiated, were mostly non-functional or poorly utilized. Supplementation of Weekly Iron Folic Acid (WIFS) in schools has gathered pace in many states. However, sinceinterdepartmental coordination between Health, Education and WCD is still lacking, this results in poor reporting under WIFS program.

TOR 3: Comprehensive Primary Health Care

- Public health systems strengthening under the NHM, has laid the groundwork for an important shift from delivering selective to comprehensive primary health care services. The initiative aims to provide assured, free, comprehensive primary health care services, for a package of 12 services that cover reproductive, maternal, child and adolescent health, communicable and non-communicable diseases, management of acute simple illnesses, enabling continuum of care for chronic illnesses, including care for the elderly.
- “Health and Wellness Centres” (HWCs) developed at the HSC or PHC level are envisioned as the first port of call to deliver the wider package of comprehensive primary health care. Other measures to be implemented include- population enumeration, a health card for every family linking them to primary care facility and making them eligible to avail care, placement of trained Mid- Level Health Care Providers (Nurses/Ayurveda Practitioners),

multiskilling of frontline functionaries and PHC staff, effective logistics support system, building IT platforms to support care delivery and referral backup.

- A positive sign that emerges from all state reports is that states have begun planning and to roll out comprehensive primary health care through Health and Wellness Centres. Fourteen states confirmed receipt of funds. Identification of Sub Centres to serve as Health and Wellness centres has been completed in all 14 states except Punjab and West Bengal.

- Synergistic planning noted across a majority of the states except Odisha, Haryana and Nagaland is the roll out of Universal Screening, prevention and management of NCDs, in sub centres to be strengthened as PHC, indicating an incremental approach to rolling out the 12 packages, and also addressing the risk factors and those disease conditions that account for a high proportion of morbidity and mortality on a priority basis.

- A majority of the states have also prioritized recruitment of Mid-Level Health Care Providers and process of enrolment for the Bridge Programme in Community Health is underway in the majority of the states (barring Assam, Chhattisgarh and Maharashtra which are using alternate training strategies). However, rationale to select centres, phasing, models of implementation and type of Mid-Level Health Care Providers chosen, vary from state to state. In Chhattisgarh and Assam, the state is deploying Rural Medical Assistants and Rural Health Practitioners trained in a three year curriculum and in Maharashtra the state is training Ayurvedic practitioners to manage Health and Wellness Centres.

- Only a few states have planned referral linkages for HWC with PHC and other health facilities. Since the programme is in early stages of implementation, there is a variable progress observed with respect to other activities such as population enumeration, strengthening infrastructure support, building IT mechanisms and ensuring necessary drug or diagnostic support.

- There is limited understanding at all levels in all states visited of the overall concept of comprehensive primary health care, with the emphasis on enabling universal population enumeration, establishing a mechanism for continuum of care and enabling two-way linkages with facility and community, with H&WC being the hub.

TOR 4: Communicable Disease Control Programmes

- **Disease Burden:** Infectious and associated diseases are reducing in most of the states, but remain prevalent in many parts of India. Trend reversal has been achieved in incidence and prevalence of TB in India and the declining trend is continuing. The burden of malaria has plateaued in India, and the number of deaths due to malaria has shown a declining trend. The country faces newer challenges, like drug resistance- especially for Tuberculosis and Malaria.

  Kala azar and Lymphatic filariasis which are aimed at elimination by 2017, have shown a declining trend. The emergence and subsequent increasing trend of Dengue and Chikungunya burden in the country is a cause of concern.

  The country achieved the goal of elimination of leprosy as a public health problem in 2005, however, some states have reported an increase in cases of disability, due to Leprosy.

Some of the key observations and recommendations of the CRM teams can be summarized as follows:

- **Surveillance:** Surveillance activities including outbreak reporting and investigation has been reported to be regular under IDSP in most of the states visited. However, quality of data was not reliable. Further, the data was not being used for planning activities.
- **Human Resource:** Insufficient Human Resource (HR) and sub-optimal HR capacity were cited to be limiting factor by most of the disease control programs- IDSP, NLEP, NVBDCP & RNTCP in most of the states.
- **Logistics:** Drug and diagnostics' availability was reported to be adequate for most of the disease control programs in most of the states, except shortage of Anti Tubercular drugs reported from Telangana and UP.

  LLINs under NVBDCP have been distributed to the GFATM supported states. Acceptable coverage was reported from Chhattisgarh. However, gaps in distribution and usage were reported from Telangana and Odisha respectively.
- **Newer Initiatives:** In 2016, RNTCP expanded TB care services and made landmark changes in the strategy of diagnosis and treatment of TB.
  - CBNAAT machines were installed to expand the rapid molecular diagnostic facilities.
  - A new drug Bedaquiline was introduced for treatment of MDR-TB at identified sites.
  - Single window delivery of HIV-TB services was expanded at all Anti-Retroviral Treatment (ART) centres in the country.
  - Along with it, ICT enabled treatment adherence support system (99 DOTS) was also extended for HIV-TB patients.

These newer initiatives under RNTCP are being adopted by the states but at a slow pace.

TOR 5: Non-Communicable Disease Control Programme

- The Global Burden of Diseases 2015 highlighted that Ischemic Heart Diseases, COPD and cerebro-vascular diseases are the top three reasons for mortality due to NCDs in India. As observed, under NPCDCS programme, the prime focus of the states is on screening and treatment of Hypertension and Diabetes. Few states have initiated screening of common (cervical) cancers with Visual Inspection via acetic acid (VIA). Encouraging initiatives like dedicated clinics (Sampoorna clinics- Uttar Pradesh) for screening women for common cancers and involving private specialists (Cancer warriors- Maharashtra) were reported. While shortage in HR persisted across the states, population-based screening for NCDs showed substantial progress in most states.
- Mental, neurological and substance use disorders (MNSUDs) exact a high toll of 12.3% of Disability Adjusted Life Years (DALYs) in India (India State-level disease burden ICMR report 2017). A total of 45 million people in the nation are suffering from depression (Mental Health Survey of India-2015-16). However, implementation of district mental health Programme at the health facility in terms of dedicated clinic and community level in terms of screening and identification was found to be weak. Moreover, recruitment and training of available HR, ambiguity in fund allocation and poor screening and outreach activities were other factors impeding the progress. Despite the roadblocks, few states like Maharashtra and Karnataka reported state specific initiatives such as dedicating a specific day in a week and linking of patients with mental health institutes (NIMHANS) to avail specialist services.
- Under National Programme for Control of Blindness most of the states visited reported good progress in cataract surgery, screening of refractive error, free distribution of spectacles and eye donation.
- Key positions are still lying vacant under National Programme for Prevention and control of Deafness.
- Progress in service delivery was found to be sluggish in almost all the states under National Iodine deficiency disorder control Programme, Palliative care and Oral health programme.

TOR 6: Human Resources for Health and Training

- There is a significant shortage of skilled human resources in most states – a number of sanctioned posts still remain vacant, especially for specialists and Medical Officers.
- Irrational deployment of the workforce resulted in inefficient use of existing human resources. For example, specialist doctors are often placed in administrative posts with limited or no opportunity to practice their speciality. In many instances, surgeons and gynaecologists are posted at secondary care facilities where there is no anaesthetist and vice-versa. The scarce availability of specialists is further depleted due to these reasons.
- Providing additional training and support to allow service providers to work across vertical programmes that require similar skills (e.g. Laboratory Technicians and Counsellors) has been introduced in only a few states. Many of these staff members do not have heavy case loads but the silos of vertical national programmes prevent them from working in other related areas, adding to further inefficiency within the system. This has also made it more difficult to implement salary rationalization for service providers.
- The majority of states do not have a comprehensive HR policy for contractual NHM staff. This has hampered the streamlining of workforce management for regular and contractual service providers.
- The implementation of a systematic Human Resource Management Information System (HRMIS) has either been delayed or only partially implemented (with only a few parameters entered on to the system). This has made it difficult for states to maintain an accurate record of its workforce and their administration.
- There have been no substantive efforts to establish a Public Health Cadre in the states reviewed in the CRM.

- The conduct of NHM Record of Proceedings (RoP) approved in-service training has been slow and states have either not developed or followed a systematic training calendar.

TOR 7: Community Processes

- Overall the findings from the Eleventh CRM, acknowledge the ASHAs as a critical frontline worker who has enabled improved access to health care services and facilitated behaviour change at the individual and family level. Most reports applaud ASHA's agency and high levels of motivation, who do not hesitate to use their own resources as required to support the community.
- In the current backdrop of strengthening the delivery of primary care services closer to the community, ASHAs are being viewed as a key member of the primary health care team at the Sub centre level. With the launch of universal screening of Non-Communicable diseases, ASHAs have also been trained in selected districts to conduct enumeration, risk assessment, mobilize community for screening and support treatment compliance. Preliminary reports from states where field level activities have been initiated, indicate the high potential of ASHAs and ANMs working as a team to deliver these services. However, a key concern that is likely to affect training for NCDs is related to the slow pace and variable quality of training of ASHAs. This would need to be addressed as a pre-requisite to achieve this potential.
- Though selection of ASHAs is near completion against the set target (over 95%) in majority

of states, it remains a challenge in few states, especially in areas difficult due to geographic dispersion or high proportion of marginalized population.

- Regarding support structures of ASHA, it was observed that, IT applications designed for ASHA facilitators (ASHA Sangini app in Kaushambi) and BCMs have emerged as useful tools to facilitate the mentoring support being provided to ASHAs in state of UP. In Bihar, Jarkhand and Odisha, ASHA facilitators continue to function as ASHAs and, this dual responsibility has affected their performance in both the roles.
- It was observed across the states that access to marginalized has improved with the continuous efforts of ASHAs. Moreover, ASHAs are serving their role as community resource person in fields other than health. E.g. active involvement of ASHAs in the Prerna initiative in Maharashtra, to help and support farmers in distress to address the issue of farmer's suicide and in Beti Bachaoo Beti Padhaao campaign and PCPNDT related campaigns in Haryana.
- The average daily time spent on ASHA work (as per existing work load) ranged from, 5-7 hours per day in Assam and Uttar Pradesh to 3-4 hours in Haryana, Karnataka, Maharashtra, Odisha, and Uttrakhand and 2-3 hours in Nagaland. These findings are largely in synergy with the guideline recommendations.
- Though convergence at field level has been documented across states through the

individual efforts of ASHAs, ANMs and AWWs, primarily in organizing VHNDs, none of the states (except UP) have reported a systemic mechanism of team building among the three key frontline functionaries. No mechanism of promoting convergence between different departments has been reported at state, district and block level except in states of Chhattisgarh and Maharashtra.

- Despite several initiatives taken in the recent years to address delay in payment of incentives, the issue is yet to be fully resolved especially for payment of incentives under NVBDCP and RNTCP. Stock out of drugs/equipment with ASHAs and limited availability of safety measures for ASHAs are also few critical components of the programme that continue to affect the performance of ASHAs.
- Review of mechanisms for ensuring gender equality within the health system show low levels of preparedness and warrant for much more concerted efforts at all levels. With regards to the community-based platforms of VHSNCs, CAH, MAS and convergence, slow pace of implementation is noted across states with varied status of implementation. Except for few states which have invested in building

capacities of these platforms and where ASHAs play a leadership role, the progress made is far from satisfactory and highlight the need for a comprehensive review.

- Some good practices observed in CP were, online payment portal, refresher training through Satellite mode/SATCO, and SMS alerts to ASHAs about incentives and new updates through Mobile portal in Karnataka, ASHA help desks, annual ASHA diwas in Meghalaya and ASHA Kantha – a public notification and message writing wall used for updating information related to health services and health messaging in every VHSNC in Odisha.

TOR 8: Information and Knowledge

- This CRM reveals that all Indian states are well into the information age. Though availability of the relevant, timely and accurate health care data will remain an ongoing challenge, there is enough health data today, for good public health decision-making. The Healthcare Information and Management System is one powerful tool available, with 2,05,691(95%) facilities reporting on the HMIS portal across India.
- The remarkable developments and scaling up of other add-on Information technology tools such as medical e-records, telemedicine services, E-raktkosh, E-Aushadhi and Mera Aspataal have also promoted transparency, accountability and easy remote access to the information from the state level to primary care level.
- Other e-initiatives, including health information and logistics management softwares, are the scaled-up Electronics Vaccine Intelligence Network (eVIN) and the Drug and Vaccine Distribution Management System (e-Aushadhi) and the newer National Identification Number to Health Facilities of India (NIN-to-HFI), E- Arogya, E-Hospital and E-laj clinics (in Karnataka), Health advice call centre (in Maharashtra), E-UPCHAR (in Haryana). However, many of these softwares work in isolation and are often not interoperable.
- This plethora of health applications demonstrates the innovativeness and strength of the Indian IT sector. Excessive information, unused data elements, missing data and discrete unconnected information apps are the concerns that were revealed in this CRM round. State level coordination between mission directorates and the NRHM state programme management unit and state health society continue to be sub-optimal. SHSRCs and support institutions at the state level could help develop the institutional memory and knowledge base.

TOR 9: Healthcare Financing

- The issue of shortage in finance and accounts staff seems to be resolved in most of the states visited. This could be seen as a major achievement, as the issue was highlighted in all the previous CRM reports. However, it is still a challenge for Chhattisgarh and Uttar Pradesh.
- Certain good practices observed during the CRM visits which could be implemented in other states are: simultaneous release of central and state share under NHM to the SHS in Chhattisgarh; a mandatory test on financial guidelines and Government Financial Rules (GFR) for all the Finance staff to ensure thorough knowledge of all rules and regulations in Assam; use of a new software called ASHA-Soft payments of ASHA incentives, which helps in accurate identification of activity wise incentives and implementation of a group health insurance scheme for all the contractual staff working for various state departments in West Bengal.
- Household Out-of-Pocket-Expenditures (OOPE) still remains a major concern. Despite implementation of various schemes such as free drugs and diagnostics in government hospitals, instances of high OOPE were reported in most of the states visited. Patient/beneficiary interactions during state visits show high OOPE on drugs for chronic diseases such as diabetes and hypertension in Assam and Uttar Pradesh; on diagnostics and lab tests in Telangana and Uttar Pradesh; OOPE by JSSK beneficiaries in Nagaland and informal payments to hospital staff for patient care and transportation in Uttar Pradesh.
- Delay in transfer of funds from State treasury to State Health Societies (SHS) continues to be a major problem for most states visited. Delays of 20-21 days in Odisha, 30-33 days in Jharkhand and Chhattisgarh, 30-45 days in Telangana, 60 days in Bihar, 65-164 days in Karnataka, 31-238 days in Punjab, 50-100 days in West Bengal, 90-100 days in Uttar Pradesh, and 256 days in Maharashtra were noted.
- The dissemination of 'district RoPs' was reported only in few States such as Assam, Chhattisgarh, Jharkhand, Maharashtra, and Punjab. However, district RoPs are not being disseminated as per State RoP format with the result that the districts are not aware of approvals for activities where the payment/ administration is from the state, such as Referral transport, civil works, dialysis services etc. This leads to poor monitoring at the district level. In the absence of district RoPs fund allocation to the lower facilities becomes difficult and leads to delay in fund transfers, which ultimately leads to lower utilization of funds by CHCs and PHCs. Utilization of funds was reported low in the first two quarters of FY 2017-18 in most of the states visited.
- States such as Bihar, Chhattisgarh, Meghalaya and Telangana were found to have allocated additional funds (at least 30% per capita) for HPDs; the remaining States have either allocated additional funds/additional (but not following the norms) or have allocated based on utilization in the previous years.
- As regards untied grants, despite the issue of guidelines for differential allocation of untied grants, none of the CRM states have reported adoption of differential financing of untied grants. Poor utilization of untied grants is still an area of concern.
- Non-compliance with statutory obligations also seems to be a prominent issue in many states. Bihar, Maharashtra and West Bengal were the only states that have complied with all the statutory obligations. The statutory Audits for 2016-17 were observed to complete in most CRM States but the final report was still awaited. However, compliance with concurrent audit was found to be poor across all the states.

TOR 10: Quality Assurance

Significant progress has been made under NQAP in past one year and the number of National quality certified facilities has tripled from 13 to 59 in one year (2016-2017). Also, there are 286 State certified public health facilities. Following are the key findings as observed during 11th CRM:

- **Organizational structure for quality assurance:** State Quality Assurance Committees have been formulated in every state but District level committees are yet to be formulated at Bihar, Karnataka and Manipur. However, Regular meetings of the committees were reported only at 3 states (Maharashtra, Haryana and Uttar Pradesh).In terms of Human resource for Quality, adequate numbers are available in states of Haryana, Uttar Pradesh, Odisha and West Bengal. However; Bihar, Punjab, Jharkhand and Meghalaya are still under HR recruitment phase.

- **Trainings and Skill Building:** In current year, trainings have been conducted in all the states visited during the CRM. Overall 73 trainings (Quality Assurance and Kayakalp) have been undertaken nationwide with NHSRC's support.

- **Assessment and Certification:** In comparison to last year, baseline assessment of the facilities has been initiated in all states visited during CRM (Telangana and Nagaland did their assessment for first time this year).

  National and State certifications have increased; and significant progress has been made by Haryana, Punjab, Meghalaya and Maharashtra. However, West Bengal, Uttar Pradesh, Bihar, Uttarakhand, Manipur, Assam, Jharkhand and Chhattisgarh lag behind.

- **Measures ensuring quality services at facility:** Standard Operating Procedures (SOPs): Among the states visited during CRM no SOPs were available at facilities of Manipur, Nagaland and Uttarakhand. However, Assam, Jharkhand, Punjab and Haryana reportedly have SOPs for labour room, SNCU and infection control.

  Patient grievance redressal (conducting Patient Satisfaction Surveys and integration with "Mera Aspataal").

  Patient Satisfaction Surveys (PSS) is being carried out in few of the facilities of Jharkhand, Haryana, Punjab and Karnataka. No PSS is conducted at facilities of Manipur, Maharashtra, Nagaland, Chhattisgarh, Bihar and Odisha. Assessment by "Mera Aspataal" has been initiated in few facilities of Bihar, Chhattisgarh and Haryana.

- **Measurement of Key Performance indicators (KPI):** In comparison to last year, numbers of facilities capturing indicators has increased. Uttar Pradesh, Haryana, Orissa, Uttarakhand, Punjab are regularly monitoring the indicators. West Bengal has taken an appreciable initiative by creating an online portal through which KPIs are captured.

- **Statutory and Legal Compliance:** Majorly it was found that statutory compliance to fire safety and radiation safety was missing in all the state facilities visited under CRM. Also, authorisation for BMW management (Nagaland) and PCPNDT (Manipur) was not found in few of the visited facilities.

- **Bio Medical Waste Management and Infection Control:** Health facilities of Punjab and Haryana are complying with BMW protocols. However, Assam, Maharashtra, Nagaland, Jharkhand and Uttar Pradesh are not complying with segregation and disposal protocols. As a general finding staff lacks awareness, knowledge and motivation for waste management and infection control.

- **Kayakalp:** States have shown tremendous interest in this program. In all the states visited during CRM; state and district level Kayakalp committees have been formulated. States are undertaking assessments and shall be declaring the results by December'17. Till now Assam and Chhattisgarh have declared results in CRM visited states. However, slow progress was observed in Manipur and Bihar.

- **Swachh Swasth Sarwatra:** States have initiated the process of identification of ODF blocks and are getting funds approved for the initiation of program. However, no awareness about Programme was seen at Bihar and Nagaland, also disbursement of funds is taking longer time.

- **Quality Assurance Under NUHM (National Urban Health Mission):** In the financial year 2016-17, baseline assessments as per DLI target were achieved well in time and by the end of financial year it surpassed the set target i.e. 50% of selected UPHCs in defined 15 States. Baseline assessment as per NQAS has been done in Bihar, Haryana, Odisha, Karnataka, Delhi, Chhattisgarh, Nagaland & Uttar Pradesh.

- **Free Drug Service Initiative:** FDSI scheme has been formally initiated in Assam, Jharkhand, Karnataka, Maharashtra, Odisha, Punjab and Telangana. Central procurement board is present at Chhattisgarh, Haryana, Jharkhand, Karnataka, Odisha and Telangana. However, Uttar Pradesh, West Bengal, Uttarakhand, Nagaland, Manipur and Meghalaya have yet to centralize the system.EDL was available at Chhattisgarh, Jharkhand, Haryana, Karnataka, Punjab and Maharashtra. While Bihar, Nagaland and Assam yet have to formulate their facility wise EDL.

TOR 11: National Urban Health Mission

- **Planning and Mapping:** GIS mapping of most of the states is under progress except for Punjab, Haryana and Meghalaya where it is complete. However, it has not been initiated in Assam, Bihar, Jharkhand, Manipur and Uttarakhand. Most of the states have done slum and facility mapping while vulnerability assessment for almost all the states has not been initiated, except Meghalaya and Telangana, where it is 61% complete.

- **Institutional arrangement and Programme management:** Most states have strengthened their institutional arrangement systems like State, district and city PMUs. Key positions under the Programme management units are largely filled except for Assam, Jharkhand, Uttarakhand, Telangana and DPMU in Haryana and city Programme management units at Maharashtra. Convergence with WCD was satisfactory in almost all the states while involvement of ULBs was limited. Odisha, Chhattisgarh and Karnataka demonstrate good convergence with the ULBs or corporations. More efforts on strengthening is needed in the states of Bihar, Jharkhand, Manipur, Punjab, UP, Uttarakhand and Maharashtra.

- **Infrastructure:** Most States have established the UPHCs and UCHCs as per the population norms while the new constructions and renovation of the facilities was underway in most of the states. Acquiring land in congested urban areas remains a challenge for the States and is quoted as the main reason of delay in identifying the sites for construction of the new UPHCs.

- **Human Resource:** High attrition rates especially the clinical staff was observed almost across all the states and their availability remains a challenge. Main reasons quoted by the states are low remuneration and more competition for clinical posts in urban localities. The availability of paramedical staff was also a challenge for most states like Bihar, Chhattisgarh, Telangana and West Bengal, where more than 50% positions were lying vacant.

- **Service Delivery:** Besides the routine OPD, services provided in UPHCs across all states are largely RCH centric and occassional opportunistic screening of NCD cases. Assured population-based NCD screening has not been initiated yet, while integration with National Health programs was found missing in all the States. Some states like Chhattisgarh, UP and Assam had a few designated facilities as delivery points and they were functioning well. Karnataka and Odisha have done well in organizing fixed day specialist clinics at the UPHCs, which include specialties like skin, medicine, OBGYN, pediatric and dental.

- **Outreach Services:** Percentage of UHNDs conducted across all States show a stark variation. While UP has conducted 97% of the sanctioned UHNDs, West Bengal has been able to conduct only 2.5% of the total sanctioned. States like Assam and Bihar have not initiated the UHNDs, which is a serious concern. Rest of the states are performing regular UHND in varying percentages. However, the percentage of special outreach against the sanctioned was found less as compared to its counterpart. This was largely due to unavailability and non-willingness of specialists to engage in this activity.

- **Community Processes:** Status of selection and training of ASHA was found satisfactory across all states. States like Odisha, Punjab, Haryana and Meghalaya have almost achieved their targets as far as number of ASHAs is concerned, however the training in module 6&7 is under progress. Further the ASHA payments are being done through PFMS largely across the States. Most states have achieved the target of MAS formation and orientation in their districts. Accounts for MAS have also been opened for most of them except for Bihar.

- **Quality:** States that have constituted committees for Quality Assurance and started the baseline assessment of UPHCs are Assam, Karnataka, Telangana, Odisha, Punjab and Haryana. States which have not incorporated any quality measures are Bihar, Jharkhand, West Bengal, UP, Uttarakhand and Maharashtra. Compliance to BMW was not found satisfactory in most of the States, also the waste segregation practices were found compromised. Patient feedback mechanism or grievance redressal mechanism was found missing at most places.

- **PPP and Innovation:** In Uttarakhand, there was outsourcing of the complete UPHC for services, HR and management in the PPP modeand in part, at some UPHCs of Odisha and Telangana.

- **Finance:** Low fund expenditure was common to all the States due to various different reasons. States like Jharkhand, West Bengal, Uttarakhand and Maharashtra are still struggling on the formation of RKS. Further the states where RKS are formed, either have not opened their accounts or have not transferred untied funds in their accounts.

TOR 12: Governance and Management

- States and UTs have reported establishment of SPMUs, DPMUs or associated structure in states such as Assam, Karnataka, Odisha, Uttar Pradesh, Uttarakhand, Nagaland, Haryana and West Bengal. However, the Programme management structure remains relatively weaker at the block level.

- Decentralized planning process is a core system strengthening instrument of NHM, and has been initiated in a few states such as Assam, Bihar, Chhattisgarh, Nagaland and Odisha.

- Coordination with urban local bodies remains a challenge, while Punjab, Chhattisgarh and Karnataka have established collaboration with their ULBs. In all visited states, the role of SIHFW is largely not defined and limited to in-service capacity building which is also not happening at full pace due to lack of adequate and competent faculty.

- Intra-sectoral convergence is limited to WCD and Education department for RBSK and WIFS programme in states like Assam, Bihar, Chhattisgarh, Karnataka, Odisha, Nagaland, Uttarakhand and Punjab. Uttarakhand reported integration of ASHA, AWW and ANMs at Village level meetings like VHSNC but it is limited to meetings only no further

action taken or documentation work available in the field.

- All the visited states reported working 104 health helplinesexcept at Meghalaya and Haryana.Notably, Bihar is the only state where state government has passed Act on grievance redressal namely "Lok Sikayat Nirvachan Adhiniyam 2016" in the Bihar assembly.
- Registration of grievances is very low due to inadequate IEC in most of the states. In most of the states, time bound escalation and resolution is also lacking. Chhattisgarh and Nagaland are the only states where the PC&PNDT has not been implemented yet.

RECOMMENDATIONS

TOR 1: Service Delivery: Expanding Access and Ensuring Equity

- **Adequacy of Health Facilities:** Dedicated cells/ units/autonomous bodies should be considered (within states) to monitor pace of all public constructions, including hospitals, perhaps with penalty clauses. An annual report of this cell should be presented in the state assembly. To further the idea of bringing care closer to where people stay - and Health and Wellness centres- establishment of new Sub-centres need continued priority.
- **Utilization and Continuum of Care:** Measures such as 'bidding' for specialist are still ad-hoc at best and would need to be supported through policy reforms in the area of human resources. Those who chose to stay, must be provided with an option of being absorbed in State's specialist cadre. Where such cadres do not exist, these innovative initiatives should be used as a trigger rather than a solution. Dedicated initiatives/programmes on technology driven CMEs for peripheral providers and tele-consultations of patients at SHCs should be considered to address the issues related to undue referrals.
- **District Hospital Strengthening:** States must be incentivized to propose general ICUs, and High-dependency units for every 10-lac population (could be considered at 5-lac for hilly and NE region). This would ensure an emergency infrastructure- at first, shared by 2 or 3 districts- within the government system. Use of district hospitals as training sites has been reported by 4 out of 15 CRM states. Sourcing-in faculty from nearby government and credible private medical colleges should be considered to meet the demand of trainers. NHM should also be looking at possibilities of supporting credible not-for-profit missionary/trust hospitals for acting as training sites. Many such hospitals currently act as training sites and if provided sufficient autonomy, may agree to partner with government.
- **Procurement and availability of drugs:** Disruptive solutions –such as bulk procurement by centre or prioritizing access to drugs as a special measure in broader agenda of NE development under the Act East policy may be needed. Other areas for continued focus are encouraging generic prescriptions, increasing general awareness on use of antibiotics, and scaling up prescription audits.
- **Free Diagnostics:** Strengthening Block PHCs/ Sector PHCs as hubs is required to ease the burden on higher facilities.
- Use of vaccine carriers as lab sample carriers could be proposed with additional incentives. States who have opted for private partnerships in provision of lab services, now need to move towards assessing the outcomes of these partnerships, with support from NHSRC and other such institutions.
- **Biomedical equipment maintenance:** Specific support will be needed by states to recruit biomedical engineers for the Programme to be implemented.
- **National Dialysis Program:** In Stateswith both models of PPP and In-house schemes, the drugs and diagnostics related to dialysis, should be provided free of cost to all beneficiaries. National dialysis Programme should be linked to Free diagnostics initiative and drugs should be enlisted in EDL directory.

- **Access to blood:** Here the recommendation is to bring sanctioning and licensing under a single department of MoHFW and increasing demand for blood and linking it to non-surgical care. This would involve better identification and assured transfusions for cases of severe anaemia and haemoglobinopathies. Also, forming guidelines on use of Unbanked Direct Blood Transfers for states that have made minimal progress (e.g. Nagaland) could be explored for improving access to blood.
- **AYUSH:** Moving forward, inter-ministerial collaboration to ease out apprehensions related to bridge course for AYUSH and to promote AYUSH systems through NHM would be required.
- **Ambulances and MMUs:** There is a need for ensuring uniformity in trainings of providers, scaling up emergency response teams, and solving the last-mile concerns in hilly and difficult regions. Support would be needed by states to foster local experiments in patient transfer from remote regions. Asystems-level thinking is perhaps required, to move beyond the innovative ideas of bike ambulances and similar suggestions.

TOR 2: Reproductive, Maternal, Newborn, Child and Adolescent Health

States need to prepare roadmap for establishing Delivery points as per population norms and as per geographical reach for the population. Delivery points need to ensure the entire range of RCH services, as appropriate to that level (MTP, family planning and care for the newborn and sick child) and not just midwifery services.

- Quality of clinical care for maternal and child health can improve through better training to prioritized service providers, better logistics to ensure uninterrupted drug supplies, and good quality supportive supervision.
- An urgent need to engage specialists in most of the states, Bijapur model in Chhattisgarh can be used for filling the gaps. Also, a non-rotation policy for trained labour room staff is advisable, so that quality services be consistent. Mapping of trained Family Planning providers and their performance review need to be initiated, as many FP providers are not used for providing FP services. Implementation of "each one train one policy" for PPIUCD services. IEC in the hospital or community level about the FPIS scheme is required for its better utilization.
- There is a need to strengthen the NBSU and NBCC to prevent irrational referral to SNCU. All facilities conducting deliveries should be ensured a functional newborn care corner. The staff of SNCU/NBSU/NBCC need to be trained in NSSK and the follow up of discharge cases need to be ensured.
- States that have established facility-based care for the sick newborns must focus on building the capacity at a faster pace and strengthen the referral link between home-based and facility-based newborn care.
- Nutrition Rehabilitation Centres require support for effective operationalization especially in states of high need, forward and backward linkages including children with severe acute malnutrition and follow up on discharge.
- District Early Intervention Center (DEIC) under RBSK Programme needs to be set up in all states on priority basis as it will better referral practices, patient management and follow ups.
- Implementation of peer educator programme under RKSK requires selection and training of PEs. Madhya Pradesh has implemented PE Programme very well and other states may use this as a working example.

TOR 3: Comprehensive Primary Healthcare

- As states progress towards the selection and training of Mid- Level Health Care Providers and staffing of H&WC, they need to address issues of gaps in drugs and logistic support to operationalize HWCs. This is particularly urgent for states such as Jharkhand, Karnataka, Odisha, Uttarakhand, Uttar-Pradesh, and Telangana where a significant pool of Mid- Level Health Care Providers will

be ready to provide operationalize H&WC for providing services by January 2018. Specific assessments could be planned for identifying systemic challenges for procurement/ distribution system and remedial measures should be ensured at the outset of rolling CPHC interventions.

- Early roll out of measures such as training of providers on CPHC package, resource mapping, population enumeration, initiation of IT platforms and digital tools or baseline assessments in states such as Chhattisgarh, Jharkhand, Karnataka and Uttar Pradesh could be facilitated by technical support from state level public health agencies/NGOs.
- States should also plan to build district and block level capacities in programme management and supportive supervision to ensure necessary change management for the delivery of CPHC services.
- States should plan to develop state specific road map for the next three to five years that is specific to the state's needs and challenges- in terms of infrastructure, human resources and diseases burden.

TOR 4: Communicable Disease Control Programmes

- Involvement of front line workers needs to be enhanced by ensuring timely and appropriate payment (especially for malaria workers)
- Utilization of data in picking up increasing trends of diseases, proper documentation of the investigation, and identification of particular pathogens needs to be emphasized.
- District Surveillance Units need to do better data analysis at their level instead of expecting the state to do it. Regular feedback should be given to the PHCs.
- Capturing cases from the private sector, specially RNTCP has been an issue in most states. However, reporting from private sector has shown an increasing trend in Chhattisgarh, Nagaland and Jharkhand.
- To tackle the emerging issues of Dengue and Chikungunya, inter sectoral convergence with the municipal corporations needs to be emphasized by the states.
- Good progress towards Kala azar elimination was observed specially with the involvement of development partners. Similar collaborations may be considered for Lymphatic Filariasis elimination, to make the gains in reducing disease burden more sustainable and provide the final thrust.
- Provision of a communicable disease worker for providing services at the field level for all the communicable diseases may be considered. A field level worker dedicated to the communicable diseases will ensure implementation of the vertical Programme interventions and provision of services to the last man. Treatment adherence and follow up of cases may also be feasible with the availability of a field level worker.

TOR 5: Non-Communicable Disease Programmes

- Training and rational deployment of HR need to be expedited. Partnering with local level NGOs and CBOs should be encouraged in dedicated issues like mental health.
- Availability of technology should be nurtured; newer initiatives like telemedicine and tele consultation need to be promoted to avail easy high-end services from experts/specialists.
- Public awareness on availability of services need to be improved through appropriate and effective IEC.
- Review, supportive supervision and feedback from the state-district-health facility need to be strengthen to ensure effective service delivery in the state.
- Referral linkages for cases requiring secondary and tertiary care services should be strengthened.
- Release of funds for implementing programme activities need to be streamlined.

TOR 6: Human Resources for Health

- There is a critical need to fill vacancies against sanctioned posts by adopting a variety of measures such as walk-in interviews, campus recruitments and the use of separate committees to hasten approval for new posts and their recruitment (as adopted by some states).
- The financial flexibilities offered through NHM should be used to fill existing vacancies for human resources, especially for difficult areas and for medical officers and specialists. Examples of good practices from other States should be considered, e.g. 'Your quote, our post' as used in Karnataka and nearby Uttar Pradesh. Here clinical service providers are asked to quote their desired salary against available vacancies and candidates are then chosen from the pool of applicants based on their suitability and salaries quoted. This has shown early success in filling up vacancies for specialist posts.
- Specialists should be optimally utilized by ensuring that they are posted rationally. Gynaecologists, Surgeons and Orthopaedic Surgeons should only be posted to a facility with an Anaesthetist or an LSAS doctor (who is competent and confident in practicing this skill); Gynaecologists and Paediatricians should be posted together wherever possible. The creation of a specialist cadre will support effective rationalization as will a regular and periodic exercise to map specialists against vacancies and need.
- Integration of service delivery for staff working across programemes where related skills are required (e.g. laboratory technicians and counsellors) should be expedited. This will decrease inefficiencies in the system by optimally utilizing the limited HR available and also boost staff competency by providing them the opportunity to practice a wider range of skills.
- Postings of clinical service providers should be made against IPHS standards and case-loads; not against the criteria of vertical progammes. This health systems approach to HR will ensure better integration of service delivery across facilities.
- An HR policy for contractual staff under NHM should be developed and adopted. This should address the necessary job requirements and terms and conditions for staff through the life cycle of employment, including the process of selection and appointment, their training and capacity building, employee management (including performance appraisal, contract management and grievance redressal), pay/ compensation and other issues related to workforce management.
- The implementation of a functional and effective HRMIS needs to be expedited across states. This should include work force management for both regular and contractual staff and training needs should also be integrated with HRMIS (as the Training Management Information System or TMIS).
- The State should consider the establishment of a Public Health Cadre. While a working group for this may be constituted to take this forward, technical support for this is available through the GoI. As a beginning, it is important that all staff in administrative/management positions are identified and provided public health training (appropriate to their needs) to ensure effective and efficient delivery of their designated public health functions.
- Trainings approved in the annual Record of Proceedings need to be expedited so that all sanctioned training can be delivered in this financial year.

TOR 7: Community Processes

- As the current policy discourse positions ASHAs as a key member of the primary health care team to jointly deliver an expanded package of services, closer to the community, it is essential that the systemic challenges of slow and varied quality of training, delays in payments, stock out of drug and equipment kits, are resolved.
- With the changing role of ASHAs, the capacities of the support structures also need to be strengthened simultaneously to enable effective on the job mentoring support for ASHAs.

- In urban areas, the issue of high attrition rate due to high level of migration and better employment opportunities highlights the need to design urban context-based tasks linked with new incentives to facilitate retention of ASHAs. Extension of all existing programme components v.i.z, training, non-monetary incentives and support measures to urban ASHAs needs to be prioritized.
- Lack of efforts at the state level in implementing measures for ensuring gender equality is a major concern that needs to be addressed on urgent basis. This was noted even in the slow progress made by states in operationalizing grievance redressal mechanisms and creating rest rooms for ASHAs.
- The untapped potential of VHSNCs, RKS and MAS in most states on account of limited capacity building initiatives, have highlighted gaps in utilizing these community-based platforms to address social determinants and take collective community actions. Strategies such as proactive engagement with NGOs and building capacities of support structures to effectively supervise VHSNCs, RKS and MAS could be adopted to bridge this gap.

TOR 8: Information & Knowledge

- There is an urgent need to promote communication and collaboration with multi-disciplinary experts to integrate the existing information silos, multiple e-portals and set up integrated knowledge frameworks for managing health problems better.
- To move to Public Health knowledge management and Informatics by using data and information will require strategic planning. Only then can states use data to assess their performance, enable mid-course corrections to steer towards improving their health system needs.
- Using the Subnational Global burden of disease (GBD) data available for each India state and incorporating it into the 2018-2019 PIPs is an example of improved use of knowledge.

TOR 9: Healthcare Financing

- States should ensure timely release of funds from Treasury to the State Health Society Accounts along with the State share for effective utilization of funds. Similarly, the SHS should also release funds to District Health Societies (DHS) in a timely manner.
- In order to address high OOPE, States should strengthen the implementation of programs such as free Drugs and Diagnostic Schemes and the JSSK scheme.
- States should ensure timely dissemination of RoPs and District Health Action Plans for better planning, rational allocation and timely release of funds.
- States need to ensure that the flexibility in the diversion of funds between pools is used only when it is necessary and not make it a regular practice by ensuring better planning and use of resources. Further, diverted funds should be settled within the same financial year and permanent diversion of funds should be strictly avoided.
- States should adhere to the banking guidelines prescribed by the MoHFW and implement it at the state and district level and not carry out transactions through a single account.
- States have to address the issue of bank integration and ensure synchronization to avoid transaction delays.
- The Northeastern States and Hilly States should liaise with Nationalized banks to increase the number of branches in areas with no banking facilities.
- The States facing problems in Internet connectivity should also liaise with the concerned Government departments to address the issue.
- Settlement of long-standing advances and unspent balances needs to be addressed by States to avoid differences between the balances shown in books of district and sub-district level accounts.

- The states should ensure higher allocations to High Priority Districts as per the GoI norms.

TOR 10: Quality Assurance

- **Organizational structure for quality assurance:** States should expedite the formulation of DQAC where ever they have not been formed yet. Apart from this, they need to operationalize the already constituted state and district quality assurance committees and units. State should regular monitor and mentor available QA HR for Quality Improvement and Certification of Health Facilities. Periodical Field visits by the State QA Unit and trained personal (eg. people with Quality certification from TISS) to district Health Facilities for support & mentoring are required.
- **Training and skill building:** States should utilize their trained human resource to train and conduct refreshers trainings at their level. Trained resource should participate in conducting internal assessments and should prepare their facility for certification by striving hard for certification.
- **Assessment and certification:** Since the implementation of the NQAP growth has been seen as number of state and national certified facilities have increased but after these assessments no action planning for gap closure is undertaken in majority of the facilities. Hence it is recommended that leadership at state should monitor and ensure gap closure with in the set timeline.
- **Facility wise Standard Operating Procedures (SOPs):** States should initiate the process of formulation of SOP at state level which may then be modified as per the facility needs. However, it is also recommended to involve the process owners for creation of SOP. Apart from the formulation of SOP trainings and orientation of SOP should be ensured at the facility level.
- **Patient grievance redressal (conducting Patient Satisfaction Surveys (PSS) and integration of "Mera Aspataal"):** States should ensure formulation of patient grievance committee at each facility and should ensure periodical conductance of PSS. Apart from this state should expedite the enrollment of facilities with "Mera Aspataal". Also, it becomes equally important to analyze and undertake action to close gaps as per the analysis report.
- **Measurement of KPI:** State should ensure periodical collection and analysis of facility wise KPI. A facility wise state level monitoring dashboard may also be considered for same (online reporting) and take necessary actions for the closure of such gaps.
- **Bio medical waste management and Infection control:** State should ensure that each facility should tie up with nearest CWTF or should have proper disposal pits (after proper authorization).
- Ensure proper supply of consumables as required for waste disposal.
- Ensure regular training of staff as per BMW management rules 2016 and for infection control protocols and constitute infection control committees.
- **Swachh Swasth Sarvatra:** The states are advised to expedite the whole process of selection of Health facilities in ODF declared facilities and disbursement of funds to initiate the process of Kayakalp implementation.
- **Free Drug Service Initiative (FDSI):** A centralized procurement body may be constituted to ensure transperancy and uniform system of drug procurement. States where facility wise EDL are not present should make and display them in each facility. IT enabled inventory and procurement system should be developed in states, preferably till the level of SC. State must empanel with lab for quality testing of drugs. Patient's grievance redressal forums and prescription audits should also be implemented at states.

TOR 11: National Urban Health Mission

- All types of mapping including spatial GIS, facility and slum mapping and vulnerability assessment of the identified slums areas should be completed on priority.

- States should make sure that all the key positions under the State, district and city Programme management units are filled and functional.
- State level meetings for strengthening convergence with ULBs and other concerned departments should be organized regularly and roles and responsibilities of various departments under NUHM should be clearly identified and communicated among all stake holders.
- All vacant positions under management and service providers should be filled and state should focus on rational deployment of HR under all category. NUHM trainings under the training module developed by GoI should be completed for officials at all levels of implementation including Secretary, MDs, DHS, SPMUs DPMUs, CPMUs and service providers.
- UPHCs across the states should be made as hubs for providing comprehensive primary health care which incorporates range of services including NCDs and National health programs and not just limited to RCH services.
- Improving ambience and client friendly environment at the facilities need to be prioritized at UPHCs and UCHCs.
- States should make sure that all the UPHCs have registered RKS and release of untied funds to their individual accounts must be expedited. There should be clear understanding over the utilization and dissemination of untied funds by the CPMs and MOs.
- Process of drug procurement should be streamlined to ensure assured drug availability at all the UPHCs.
- There is a need to reinforce coordination among ANM, ASHA and MAS through regular meetings of ANMs with all ASHAs & MAS of their catchment area. There should be special emphasis on their catchment areas, work profiles and level-wise monitoring.
- All the urban health nodal officers in states and districts should be oriented and engaged in quality assurance committee. States should further expedite the process of baseline assessment of UPHCs in developing a practical "action-plan" for prioritization of gaps and closure action for meeting the standard of UPHCs.
- Under the PPP arrangements, the MoU must clearly define the responsibility of private partner and develop a framework to monitor performance of PPPs in terms of defined time bound deliverables and measurable outcomes.

TOR 12: Governance and Management

- Activate District Health Mission and leverage the existing structure to contribute to the mission objectives. Each issue and action taken should have a person responsible and it needs to be pursued till the time it is implemented/ resolved.
- Meeting of state and district health mission needs to be undertaken regularly with focus on policy decisions and required actions to improve accountability and outcome under NHM.
- Systematic exercise may be undertaken to conduct a gap analysis of availability of infrastructure in public health facilities and gaps filled up to ensure compliance to IPHS norms over a period of time. State may set targets of number of new health facilities to be made compliant to IPHS norms while ensuring continuity to IPHS compliance of existing IPHS compliant facilities.
- States may include of district and block PMU in every step of planning and implementation. They should agree on plans and jointly monitor. VHSN Committee may be involved in planning process.
- Operationalize SIHFW urgently by adequate staff strengthening & transparent selection of high quality faculty. The state also needs to plan for exposure visit to other better performing states for the PMU staff.
- Enhance more collaboration across departments. E.g. encourage Medical colleges

to take a lead role in NUHM, engage with Skill India Initiative to train and get technician, physiotherapists etc. The State may strengthen joint reviews and monitoring with all allied departments (e.g. WCD, Education, PRI etc.) which would provide better insights and suggestions and improve performance in the long term.

- HMIS reports needs to be verified by MOIC before uploading on HMIS portal.
- There should be a strong supportive supervision from District level for proper implantation of NHM Programmes. Targets for visit and time bound ATR need to be given & monitored at every level.
- State and District health societies should invite all concerned within the department and among various departments so that decision taken has wider acceptability, avoid duplication and has better ownership. This helps in implementation.
- Decentralized health action plan involving Panchayats, Block and District should be initiated on priority.
- There is no record of medicines prescribed to a patient. As such there is no control system for dispensing of drugs. A proper system should be evolved whereby the drugs distributed may be checked against prescription. System of prescription audit may be institutionalized.
- Social Audit and Jan Sunwais should be institutionalized at all the levels, especially at the district level.
- PCPNDT committee may take action to zero down on the blocks where the sex ratio is below average. Interdepartmental and interstate coordination meetings need to be more frequent.
- Regulatory acts in the line of Clinical Establishment Act need to be enacted as soon as possible in order to provide the poor people a quality medical service with minimum OOP expenditure and harassment.
- State needs to have a transparent transfer and recruitment policy with a defined timeline of posting at various levels. Tenure of service shall be fixed for specialist in any facilities for example 3 years for specialist in hard to reach areas with incentive and 5 years for soft areas. The transfer policy should be innovative and based on pointing system so that the chances of interference would be minimum.
- DISHA committee should be formed for better inter-sectoral and inter-departmental convergence with different departments and elected representatives of District like MPs and MLAs.

Recommendations pertaining to the North Eastern states:

- Identifications of most vulnerable SCs and provide additional incentives, house rent, etc. to Staff staying there.
- Tenure based transfer posting policy for MOs and other key staff working in difficult and remote locations in order to maintain the morale and improve efficiency and delivery of services.
- Issue of mobile/internet connectivity in these remote areas need to be taken up with Department of Tele-communications, GoI at the senior most level from the State Government.
- Issue of non-opening of zero balance bank accounts and delay in opening of bank accounts for beneficiaries need to be taken up with the Department of Financial Services, GoI at the senior most level to facilitate PFMS/DBT transactions.

MANDATE AND METHODOLOGY OF THE 11th COMMON REVIEW MISSION

Mandate and Methodology of the 11th Common Review Mission

I. Background

The 11th Common Review Mission (CRM) was completed between November 03 and November 10, 2017, to review implementation progress of the National Health Mission in sixteen states. The focus of the CRM was to undertake a rapid assessment of the implementation status of NHM and its key strategies and priority areas, analyze strengths and challenges with respect to strengthening health systems, identify trends in progress of key indicators, particularly relating to coverage, equity and affordability, document innovations and best practices, evaluate the readiness of the state to undertake implementation of new initiatives, and review the progress and coordination mechanisms with various partners in the context of High Priority Districts (HPDs) and Left Wing Extremism (LWE) Affected Districts. Of particular focus during the assessment was to assess interventions/strategies undertaken at state, district and sub district levels to address equity, issues of social exclusion and reaching the marginalized in urban and rural areas.

II. Objectives

1. Assess the organization of services at district and sub district levels and ascertain the extent to which continuum and quality of care is enabled for community/outreach, primary and secondary health care services.
2. Appraise the extent to which the health system is prepared to address persistent challenges related to RMNCH and infectious diseases and address newer challenges related to non-communicable diseases.
3. Evaluate the mechanisms in place for secondary and tertiary care referrals, (including linkages with social protection schemes) with respect to access, equity and afford ability.
4. Comment on the adequacy of strategies adopted by the state to reduce Out of Pocket expenditures related to primary and secondary care services.
5. Review current Public Private Partnerships and comment on their functionality, outcomes and regulatory structures.
6. Identify areas of progress in NUHM and the key challenges facing scaling up of NUHM in respect of infrastructure, Human Resources, Primary Health Care models, community mobilization, and convergence with Urban Local Bodies.
7. Assess improvements in creating institutional capacity for strengthening programme management, review and monitoring systems and building partnerships for capacity building, training, and research.
8. Review the extent to which equity is considered in policy and programmatic actions, record progress, and identify challenges to social inclusion.
9. Document best practices, innovations and lessons from scaling up best practices.
10. Assess progress towards conditionalities and follow up on recommendations of past CRMs.

III. Terms of Reference of the 11th CRM

1. Service Delivery: Expanding access and Ensuring equity
2. Reproductive, Maternal, Newborn, Child and Adolescent Health Services
3. Comprehensive Primary Health Care
4. Communicable Disease Programmes
5. Non- communicable Disease Programmes
6. Human Resources for Health and Training
7. Community Processes, Gender and Convergence
8. Information and Knowledge
9. Healthcare Financing
10. Quality Assurance
11. National Urban Health Mission
12. Governance and Management

IV. Geographical Coverage of 11th CRM

The 11th CRM covered sixteen states. Six of these were in the High Focus States category: (Bihar, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, and Uttar Pradesh), four were in the North East: (Assam, Manipur, Meghalaya, and Nagaland), and six were Non-High Focus States: (Haryana, Karnataka, Maharashtra, Punjab, Telangana, and West Bengal).

V. Composition of teams for 11th CRM

Each State was visited by a 15-20 member team comprising a mix of the following:

i. Government Officials

a) Officials of the MoHFW, GoI

b) Representatives of State Governments (Health Secretary/Mission Director/Director of Health)

c) Regional Directors of Health & Family Welfare

d) Officers from other Central Ministries and Niti Aayog

ii. Public Health Experts

a) Non-official member of Mission Steering Group of NHM

b) Non-official member of Empowered Programme Committee of NHM

c) Public Health Experts from the National Health Systems Resource Centre (NHSRC), National Institute of Health & Family Welfare (NIHFW), Public Health Foundation of India (PHFI), other credible institutions including Medical Colleges and Schools of Public Health and Non-Governmental Organizations

iii. Representatives of Development Partners

iv. Representatives of Civil Society (from amongst the following)

a) Representatives of Advisory Group on Community Action

b) Representatives of National ASHA Mentoring Group

v. Consultants from various divisions of the Ministry

(Details of the team members are in the Annexure)

S. No.	State/UT	District 1	District 2
1	Assam	Goalpara	Nalbari
2	Bihar	Madhepura	Bhojpur
3	Chhattisgarh	Dhamtari	Bijapur
4	Haryana	Bhiwani	Gurgaon
5	Jharkhand	East Singhbhum (Jamshedpur)	Pakur
6	Karnataka	Raichur	Chitradurga
7	Maharashtra	Wardha	Parbhani
8	Manipur	Imphal West	Tamenglong
9	Meghalaya	East Khasi Hills	South Garo Hills
10	Nagaland	Kiphrie	Wokha
11	Odisha	Malkangiri	Keonjhar
12	Punjab	Kapurthala	Ludhiana
13	Telangana	Khamman	Siddipet
14	Uttar Pradesh	Kanpur (Dehat)	Kaushambi
15	Uttarakhand	Champawat (Kumaon)	Udham Singh Nagar (Kumaon)
16	West Bengal	Dakshin Dinajpur	Paschim Medinipur

TERMS OF REFERENCE

TOR 1

SERVICE DELIVERY

Expanding Access and Ensuring Equity

Objectives

- To review the adequacy and functionality of health infrastructure in terms of population norms, their accessibility as per time to care norms (hilly and desert areas), progress of infrastructure works and utilization in terms of service delivery
- To oversee the health system strengthening components with a focus on drugs, diagnostic services, blood services – Blood Banks/BSUs, dialysis services, inventory mapping and comprehensive maintenance of bio medical equipment, integration with the AYUSH services, ambulance services, Mobile Medical Units, public and PPP mechanisms if any.
- To review the extent, reach, quality, visibility, availability and effectiveness of IEC material and their use, use of IT based IEC/BCC initiatives such as SMS, pre-recorded voice calls, Interactive Voice Response System, m-health.

National Overview

A significant investment in infrastructure has been made through the National Health Mission. When compared with the year 2005, these investments are reflected in an increased number of Sub Centres by 6.2%, Primary Health Centres by 9.2% and Community Health Centres by 64.7% (Rural Health Statistics 2016). Further, the number of health facilities running in government buildings have increased over time. For instance, percentage of Sub-Centres, Primary Health Centres, and Community Health Centres functioning in the Government buildings have increased from 49.7% (in 2005) to 67.6% (in 2016), 78% to 91.5 and 91.6% to 97.7% in 2016 respectively (RHS 2016). However, state level variations are observed. For instance, the number of SHCs have stayed constant at 20,521 in Uttar Pradesh and have increased by 3 in West Bengal during the period between 2005 to 2016 (RHS 2016). During the same period a decrease in number of functional SHCs has been observed in few states such as Andhra Pradesh, Arunachal Pradesh, Bihar, Jharkhand and Kerala. Chhattisgarh, Odisha and Rajasthan have reported the most number of additions to their functional sub-health centres. Overall, despite the significant increases in number of health facilities, shortages in SHC (20%), PHCs (22%) and CHCs (30%) continue to be reported across various states.

The Key Performance Indicator analysis (for the year 2016-17), based on Health Management Information System (HMIS) portal data, indicate that the number of OPDs and IPDs have increased over the previous year. However, large scale surveys such as NSSO indicate that the public sector in the country is ceding space to the private sector.

For instance, analysis of NSSO 71st round data for 12 (of 16) states that were part of current CRM indicated that in most states, barring Odisha and Assam, the private sector dominates as the provider of curative care. A bright spot perhaps is that the institutional delivery services, where the public sector has shown impressive gains, is now a significant provider (52.2% in NFHS 4 as compared to 18% in NFHS 3). However, there remain inter-state variations wherein the private sector is a dominant provider of this service too. Services such as immunization continue to remain predominantly with public sector. Skewing of care provision towards private sector is of critical significance in view of the fact that 71% care is financed by households (of which 67% is through out-of-pocket-expenditure) (NHA Estimates for India, October 2017). There is also a case for learning from the experiences of those states where public sector, despite competition from private providers, has been able to maintain significant presence in the provision of inpatient care in urban areas (e.g. Odisha).

With the availability of state level disease burden, it is possible to sharpen the priorities further. For instance, seven states in the current CRM (Assam, Bihar, Chhattisgarh, Jharkhand, Meghalaya, Odisha and Uttar Pradesh) fall under the lowest Epidemiological Transition Level (ETL) as per the India State Level Burden of Disease Initiative report. This indicates the challenges these, and other ETL states face in terms of double burden of Communicable, Maternal, Neonatal and Nutritional diseases (CMNNDs) along-with non-communicable diseases (NCDs). For such states the financial and human resources allocations to competing Programme priorities would be a challenge.

In most states District Hospitals are considered as providers of assured secondary care services. However, the available range and quality of services do not meet the secondary care health need in most instances. Further, they remain the only FRUs in some districts of states like Jharkhand and Uttarakhand. Given the caseloads that District hospitals manage, it is possible to use this an opportunity for further strengthening them as a training hub. However, a basic infrastructure (physical as well as clinical) needs to be in place before these institutions can be upgraded. States have been encouraged to propose for such basic infrastructure development related support. While DH strengthening guidelines have been shared on many occasions with the States but none of the states have prepared any road map nor plan for this. Observations from the 32 odd district hospitals visited as part of 11th CRM indicate a) continued burdening of these institutions from undue OPD and IPD referrals, and b) inadequacy of human resources to manage caseloads. DH strengthening has a potential to address both these challenges. DH strengthening initiative aims at developing clinical, ancillary and training capacities (including conducting DNB courses) of district hospitals. However, most teams have reported largely on the plans related to DNB/other training courses only.

Ensuring adequate availability of banked blood has been persistent challenge. Multiplicity of controls, with licensing being under the Drug Controller General of India, policy under National/State Blood Transfusion Councils and implementation with the States[1] has also posed difficulties. The Lancet Commission on Global Surgery recommends at least 15 units/1000 people/year.[2] Promotion of voluntary donation is recognized as a key strategy to achieve blood security. According to 2015 WHO data, the median blood donation rate in Low Income

1. http://naco.gov.in/access-safe-blood accessed on 2/01/2018
2. Meara JG, Leather AJ, Hagander L, et al. Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development. *Int J Obstet Anesth* 2016;25:75–8

Countries is 3.9/1000 people/year[3]. In India, about four units of blood are donated per 1000 people/year[4]. Further, there are rural-urban disparities in blood supply with an urban skewness. Factors such as relatively higher deferral rates of 11.6%[5] also limit voluntary donation. Through NHM efforts have been made to increase blood supply in rural areas through operationalizing Blood Storage Units. However, as reports from CRM states suggest, their functionality remains a challenge.

National Health Mission has supported mainstreaming of AYUSH through co-location of these services. A total of 15,543 health facilities have co-located AYUSH services till date. Of these health facilities 54 percent are in high focus states. Further, 27,792 AYUSH doctors have been appointed under NHM. Of these 56 percent are working as MOs in RBSK. There is now a National AYUSH Mission which is implemented through the Ministry of AYUSH. This mission further aims to strengthen the AYUSH services through upgrading AYUSH Hospitals and Dispensaries, co-location of AYUSH facilities at Primary Health Centres (PHCs), Community Health Centres (CHCs) and District Hospitals (DHs) and upgrading AYUSH educational institutions.

Ambulance services have seen continuous growth under NHM and as per MIS report 2017 currently we have 8718 (Dial 102), 603 (Dial 104), 8680 (Dial 108) and 5859 (others) ambulances. In addition, there are 11,305 patient transport ambulances (such as Janani Express, Mahtari express, NISHCHAY Yan) across various states. However, states such as Bihar, Gujarat, Madhya Pradesh, Punjab, Sikkim, Tripura and Telangana are short of ambulances as per the population norms (one BLS ambulance per 1 lakh population and one ALS ambulance per five lakh population).

3. World Health Organization. Blood safety and availability. (Fact sheet #279).

4 Kralievits K, Raykar N, Shrime M, et al. The lancet commission on global surgery appendix 2.6: blood: an estimation of optimal blood donation rate and a review of the blood supply literature. *The Lancet* 2015:51–76.

5 Access to safe blood in low-income and middle-income countries: lessons from India. Hillary E Jenny, Saurabh Saluja, Rachita Sood, Nakul Raykar, Raman Kataria, Ravindranath Tongaonkar, Nobhojit Roy. BMJ Global Health May 2017, 2 (2) bmjgh-2016-000167; DOI: 10.1136/bmjgh-2016-000167

Mobile Medical Units (MMUs) have continued to be an important mode of service delivery in difficult topographies. Amongst the oldest initiatives under the National Health Mission, there are now 1336 MMUs/Mobile Medical Vans (MMVs) operational under the rural component of NHM and 24 under the urban health mission. Of these 42% are in 18 High Focus States and 47% in High Priority Districts (10th CRM reported 45% of the MMUs to be operational in high priority districts). As the number of High Priority Districts have been revised to 209 (of which 61 are newly identified), it would be important for States to identify the need of mechanisms such as MMU in these districts. Nine (of 16) CRM states have reported PPPs for operationalizing MMUs. These include, Bihar, Karnataka, West Bengal, Chhattisgarh, Assam, Jharkhand, Manipur, Punjab and Telangana. The 10th CRM recognized lack of robust planning as a key concern in some States and this challenge is reported to persist in some those states (e.g Nagaland) in 11th CRM too. In addition, stagnation in range of services provided through MMUs (in most states) and inconsistent follow-ups are also key challenges.

Inadequate monitoring of Biomedical Equipment Maintenance and Management Programme was highlighted as one of the key challenges in prior CRM reports. In this regard, consultative meetings at national level have been done with all the focal persons of States to develop the Standard operating protocol for maintenance monitoring. Deliverables tools have been developed to boost the monitoring process and already disseminated to all the States where programs have been implemented and these are part of tender where tender is in progress. More than 10000 historical dysfunctional equipment have been rectified in State under CRM where Programme is rolled out.

National Free Diagnostic Initiative was designed to ensure the availability of better range of diagnostic and imaging services. In financial year 2017-18, financial support through NHM has been provided to all States for in-house strengthening of diagnostic services as well as for outsourcing models. Maharashtra, Assam and Meghalaya have opted for public private partnership model. In these states a list of 53 tests at District Hospitals, 36 tests at Community Health Centres and 17 tests

at Primary Health Centre level are available for all beneficiaries. Further, in Assam X-ray services are being provided through Tele-radiology and CT scan services have been outsourced as per NHM guidelines. Uttar Pradesh has notified Free Diagnostics Services, however, it is yet to be scaled up across all districts. Further, the state has recently outsourced their CT scan services however the services are yet to commence. Haryana has notified free diagnostics for all the citizens. This includes a list of laboratory tests up to the level of PHC, X-rays up to the level of CHC and 73 laboratory tests with CT Scan & MRI Services at District level. Jharkhand has notified free diagnostic for BPL patients at all level of health facilities (in public private partnership) and the reimbursements to the service provider are done on CGHS rate per test. Bihar is providing radiology (X-ray and Ultrasound) services from PHC up-to DH level in public private partnership. However, none of the facilities complied to statutory requirements. Significant utilization of services have been reported under the FDSI. For instance, in Maharashtra, 943,613 patients have been served and a total of 2,214,195 tests were done in this year 2017. Similarly, in Assam, under the radiology services, 206778 X-ray cases and 52857 CT scans were performed in last one year. Similarly, a mix of PPP and in-house models for operationalizing free dialysis services have been reported from various CRM states.

Key Findings

Adequacy of Health Facilities and Reach

Infrastructure: Support through NHM has helped high focus states to reduce the shortfalls in infrastructure. For instance, against a shortfall of

216 PHCs (26%) in pre-NHM Assam, the state now has no shortage in number of PHCs. Further, the state has also made progress in operationalizing 24X7 PHCs. Compared to 37% PHCs being 24X7 in 2005, the state now has 56% of its PHCs operational on 24X7 basis. In general, well-kept and clean health facilities were observed in states of Karnataka, Uttarakhand, West Bengal, Maharashtra and Punjab. Punjab and West Bengal also reported adequate display of information on drugs, diagnostic tests, citizen charter at its health facilities. To ensure quality in construction work, Bihar has initiated regular monitoring of its constructions. This process includes testing of material at NIT/accredited labs, and third party inspection for projects above 50 Lac by NIT/other Engineering Colleges & Accredited labs.

While there are positives, some challenges continue to be reported. For e.g., shortfalls in desired number of CHCs (Bihar, Karnataka, Chhattisgarh, Assam), PHCs (Punjab, Maharashtra) and SHCs (Uttarakhand, Punjab, Maharashtra, Meghalaya, Nagaland) have been reported. As high as 73% SHCs are reported to be running in rented buildings in Telangana. In hilly and tribal areas, the number of functional health Centres continue to remain short of the desired norms (Karnataka), or are situated at long distances (Uttarakhand, Meghalaya) leading to OOPE on transport in these states.

Planning of new health Centres has been reported to be centralized in Bihar and Assam. This is leading to poor say of districts in planning of new infrastructure. Districts in Assam reported

non-provision of details such as lay out, finalized design and the timelines by state headquarters. This leaves very little scope of monitoring at the district level. Pace of construction of MCH wings is reported to be slow in Bihar (of 11 sanctioned in 2012-13, only 1 is complete), and Karnataka (of 18 sanctioned, 6 are functional so far). Where such wings are complete, their operationalization continues to remain a challenge owing to non-availability of human resources (e.g. Uttar Pradesh, where both CRM districts reported construction of 100 bedded MCH wings). Annual maintenance plan of health infrastructure was observed to be lacking in most states. This has affected the long-term durability of infrastructure.

Access to services: Innovative measures like 'bidding' for specialists has improved access to specialty services in Karnataka. For instance, the 100 bedded General Hospital at Deodurga (Raichur district) - which had only one MO in position for long, is now equipped with four specialists (1 each for Obstetrics, Anaesthesia, Surgery and Medicine). To reach out to particularly vulnerable districts such as Bijapur, Chhattisgarh has rolled out health Tents *(canopies)* at local Haats. Alternative source(s) of funds, such as the District Mineral Fund (DMF), is also being utilized in states such as Chhattisgarh and Odisha to improve access to services. Chhattisgarh has used these funds to operationalize MMUs. Odisha on the hand has reported using these funds for a telemedicine initiative – 'digital dispensary'. Specialist consultations are provided through 'digital dispensary'. In addition, DMF has been used to provide super specialist services in Cardiology, Nephrology and Oncology at District Hospital Keonjhar (Odisha). However, access to surgical care continues to remain a concern in Uttar Pradesh (56% of FRUs functional), Bihar (66% FRUs functional), Manipur, Jharkhand and Telangana. In most instances District Hospitals are the only FRU in districts. Referral linkages between secondary and tertiary care institutions were observed to be limited in states like Bihar, Uttarakhand, and Jharkhand. Patients were observed to be seeking care in neighbouring districts or private sector, increasing instances of OOPE.

Utilization, Range of Services and Continuum of Care

All states reported an increase in utilization of OPD and IPD services as compared to last year. However, instances of decreased utilization of OPD and IPD services at district level have also been reported. Compared to previous year, a decrease in number of surgeries was reported from Kaushambi district of Uttar Pradesh and Gurugram district of Haryana. Karnataka has reported a decreasing trend in full immunization coverage, which has dropped from 89% in 2014-15 to 78% in 2016-17.

Prioritizing operationalization of well-connected health Centres has led to improved access to services. For example, in Uttar Pradesh strengthening of sub-Centres having road connectivity has made them operational as institutional delivery points. Based on the current range of services few SHCs in Haryana and Maharashtra have potential to be developed into Health and Wellness Centres. Services for endemic conditions (such as Kala Azar in Bihar) was also reported at PHC level in some States. However, most states report continued skewing of services towards MCH care and lesser focus on other diseases and programs.

Most 'well performing states' such as Punjab, Haryana and West Bengal seem to be prioritizing strengthening of SDH and above level health facilities in terms of increasing range of services, ensuring adequate infrastructure and manpower. Peripheral facilities in these states at block and sub-block level reported provision of basic consultation for common ailments (mostly at PHCs), maternal and child health care-including immunization services (at SHCs) and preventive care related to disease control programmes of Malaria, Leprosy and Tuberculosis. However, in all these states multiple instances of use of DH/SDH for primary care and follow-up consultations was observed. There is perhaps a need to delegate follow-up care to PHCs in these states. EAG states like Bihar and Assam on the other hand have reported undue referrals to higher Centres largely due to lack of assured care at peripheral health Centres. Referral and follow-up of high risk pregnancies, SNCU discharged children, and those requiring multiple follow-ups (e.g. NCD cases) were reported to be

a cause of concern in States like Uttar Pradesh and Haryana.

Performance of institutions continue to be heavily affected by few well-performing individuals and often their transfers directly affect institutional output. Documentation of service provision continues to remain tedious at the lowest levels, without consequent improvements in ensuring patient follow-up. Outreach services in States like Uttar Pradesh are limited to VHND and immunization.

Significant amount of Out-of-Pocket-expenditure (ranging between ₹5000-10,000) has been reported from Telangana on transport and USG services. Lack of medicines at public hospitals was reported as reason for OOPE in Manipur.

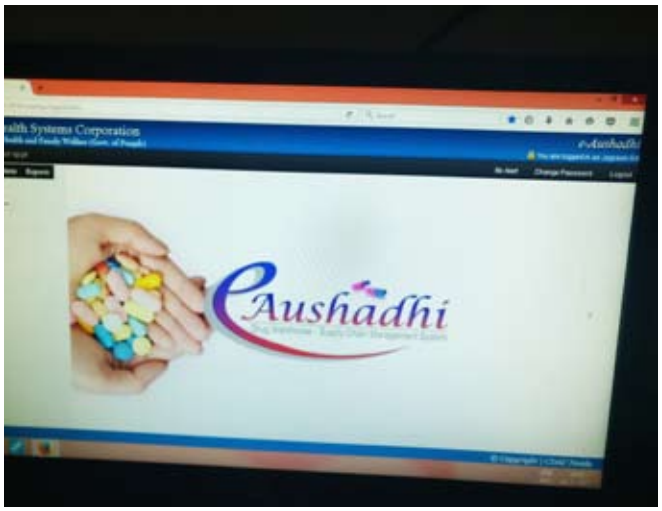
District Hospital Strengthening

There is no systematic approach for an organized critical care services and functional OT, general and obstetric HDU, ICU, PICU, accidents and emergency services in the hospitals visited in this CRM. In some states like Haryana, Punjab only fragmented and unorganized services were available in these areas. Support services like CSSD, mechanized laundry, modern kitchen are also almost completely missing, barring a few facilities e.g. Sector 15 DH Gurugram (Haryana) and Bijapur district hospital (Chhattisgarh) and currently many states have no plans for it.

None of the District Hospital visited were providing services as per IPHS standards. Most of the district hospitals visited were not even providing services in 8 core specialities as per DHH guidelines. The states conducting medical and paramedical/ nursing courses are Maharashtra (CPS course), and Karnataka, Telangana, Punjab (DNB course). None of the other states have initiated these courses. States like Haryana and Uttar Pradesh are planning to roll out such courses in next financial year.

Drugs and Supply Chain Management

Free drug policy is reportedly implemented in almost all CRM states. However, in Nagaland, Manipur and Meghalaya the free drugs initiative is yet to percolate down to the district level. EDLs for various levels of health facilities were observed in states of Assam, Chhattisgarh, Karnataka, Odisha,



Uttar Pradesh, Haryana, West Bengal, Maharashtra, Bihar and Punjab. Manipur has finalized its EDL recently, while in Meghalaya the EDL is under approval.

Odisha, Assam, Chhattisgarh, Karnataka, Jharkhand, Punjab, Haryana and Telangana have reported dedicated corporations as the nodal agency for purchasing and supplying drugs and consumables. Maharashtra has recently outsourced the procurement of drugs to a PSU (Haffkine Institute). In case of need, the Odisha State Medical Corporation Limited is empowered to purchase costly drugs outside its EDL. West Bengal has empowered the district and medical colleges to purchase drugs as per their needs through rate contract. Purchase of drugs at district level was reported from Bihar too. The flexibility to purchase medicine was given to Medical officers in few states, in case of an

urgent demand. However, procurement in states of Uttarakhand and Manipur is being done either through centralized procurement policy or through the constituting of a procurement committee. Uttar Pradesh has completed the tender process in 2016-17 but is yet to select a procurement agency. Procurement related challenges continue to persist in Nagaland.

Indent management via e-Ausadhi was observed in the state of Bihar, Jharkhand, Punjab and Telangana and via e-nirmaya (up to CHC level) in Odisha. IT enabled procurement and management was observed in Karnataka (up to PHC level) Chhattisgarh, Uttar Pradesh (up to district level) and Assam.

The mechanism for quality check of drugs is varying from state to state. For example, Drug Regulatory Authority does quality checks in Telangana; Drug Control Department in Karnataka and CGMSC ensures quality of drugs in Chhattisgarh. In Haryana and Maharashtra, quality testing for each batch was done at both warehouses and medicines were released to health facilities only after being quality certified.

Maharashtra has initiated process for implementation of prescription audits. Other states also need to expedite the process of prescription audit to ensure that generic drugs are prescribed. OOPE on drugs was reported from Bihar, Odisha, Nagaland and Jharkhand. In Jharkhand doctors were observed to be prescribing medicines which are not part of EDL. In Nagaland, the EDL was not available at any of health facilities that were visited.

National Free Diagnostic Services Initiative (FDSI)

All CRM States have notified free diagnostics initiative. However, user charges are applicable for APL beneficiaries in State of Uttarakhand, Chhattisgarh and Jharkhand. Limited number of tests are provided in the State in-house laboratory, and the services are not uniform at the periphery centres as per NHM free diagnostic guidelines. The service delivery under public private mode was up and running in the states of Assam and Maharashtra. Real time dashboard was also available for monitoring the services. The state of Punjab is providing 50 tests at DH level with external quality assurance scheme in place. Haryana is planning to establish a comprehensive diagnostic hub through a collaboration between Municipal Corporation Gurugram (which will provide the building), Department of Health and Family Welfare and Hindustan Level Ltd. (as part of CSR initiative, will set up the lab and provide human resources). The services at this proposed hub are envisaged to be free for BPL populations and at CGHS rates for others. Telangana has initiated free diagnosis

services in all public health facilities in all 31 districts. 7 tests at SHCs, 12 at PHCs, 16 at CHCs and 28 tests at DH are provided in the state. Haryana is also planning for an in-house Hub and Scope model. All the medical college and District hospitals are proposed as Hubs for high-end tests. Radiology services were not available uniformly across same level of health facilities in States. Further, facilities providing radiology services were not compliant to statutory requirements of the Atomic Energy Regulatory Board (AERB) in many instances. In Nagaland, it was observed that certain districts were provided free diagnostics and while in other districts, user fees were charged.

There were no quality assurance mechanism in place for the labs at District level as well as at the periphery level in States under CRM. The labs were neither NABL accredited nor enrolled for any External Quality Assurance Scheme (EQAS). In most states, detailed inventory of consumable and reagents were not available at the facility level as well as State level. No online channel was available for stock out as well as gap in supply chain management at periphery level. However, lab equipment were well maintained and infection control protocols were being adhered for providing various tests in State of Odisha.

Pradhan Mantri National Dialysis Program

West Bengal, Uttarakhand, Uttar Pradesh, Bihar (17 districts) and Haryana (14 districts) are delivering the services in public private partnership model. Assam, Chhattisgarh, Manipur, Meghalaya, Nagaland, Odisha are in process of hiring the service provider through open tendering process. Maharashtra on the other hand is delivering the dialysis services in-house at 30 centres in 24 districts and a total of 41,825 dialysis sessions have been done from April, 2017 to till date.

Real time dashboards are not available for in-house and State PPP-model for service delivery. As per the National guidelines, the selected service provider captures real time patient data along with the diagnostics details like viral marker etc for all beneficiaries. The details on dialysis session were not available uniformly across state where the mode of service delivery is not as per NHM guidelines.

Blood Services

Relatively better access to blood services was reported in Uttarakhand, Haryana, Odisha, Punjab and Haryana. Blood component separation units were functional in Uttarakhand and West Bengal. Free blood services to BPL patients and JSSK beneficiaries have been reported from all states. Free services are also provided to sickle cell anaemia, thalassemia, and haemophilia patients in Uttarakhand, Odisha, Assam (for thalassemia), and Telangana. Chhattisgarh (Bijapur district) has used WhatsApp for on-call pooling of voluntary donors (including CRPF personnel) at the level of district hospital. This has increased the pool of voluntary donors.

States reporting inadequate access to blood services include Bihar (where only 20% of blood banks are licensed, 41% BSUs are functional, 18.7% of demand is met), Karnataka (20% of sanctioned blood banks functional), Uttar Pradesh (8% BSUs functional), Chhattisgarh, Assam, Manipur, Jharkhand, Telangana (instances of OOPE also reported). Lack of human resources and non-functionality of equipment (Bihar, Uttar Pradesh, Nagaland) have been reported as major reason for non-operationalization of Blood banks. Voluntary donation is the major source of blood in Bihar, Karnataka, Uttarakhand, West Bengal, Odisha and Punjab. However, significant collection through replacement units was observed in Uttar Pradesh (Kanpur Dehat), Assam, and Manipur. In Meghalaya both the CRM districts reported lack of Blood Storage Units despite several (functional) delivery points.

AYUSH

Karnataka has reported specialist panchkarma centres (13) under NHM. The state has also operationalized Yoga and naturopathy centres through PPP arrangements. Haryana has operationalized district AYUSH centres at its district hospitals. Cross referrals were observed to be made at these centres from the DH. Relatively better utilization of AYUSH services was observed in Haryana, Punjab and West Bengal. Per day OPD at DH/SDH level ranged between 90-150 footfalls in these states. Manipur has reported training AYUSH providers in SBA, PPIUCD, RTI/STI. The widest range of involvement of AYUSH doctors was observed in Odisha. AYUSH MOs were a part of RBSK, NDCPs and immunization programme. They were also observed conducting deliveries and performing IUCD insertions. In addition, their services were utilized for supervision of programs, monitoring of VHND and GKS along with attending ICDS meetings. Few providers reported to be trained in NSSK too. In Maharashtra, the procurement of AYUSH drugs was being done through e-Aushadhi and procurement of equipment is done through Infrastructure Development Unit of NHM. In Meghalaya, AYUSH facilities were observed to be well established in co-located facilities across the districts visited. Supply of AYUSH drugs was observed to be erratic in Bihar, Uttar Pradesh, Uttarakhand, Chhattisgarh, Jharkhand and Telangana. In Assam, there was reportedly no provurement and supply of AYUSH drugs since three years, and AYUSH doctors were conducting OPDs without drugs. These are affecting the uptake of AYUSH services in these states. AYUSH MOs at co-located health facilities were observed to be providing allopathic medicines in Bihar, Karnataka, Uttar Pradesh, and Assam. Lack of pay parity was reported as a concern in Bihar and Karnataka.

Ambulances and Referral Services

Incremental improvements in service uptake of ambulance service have been reported particularly by pregnant women, in Uttar Pradesh, Maharashtra, West Bengal and Odisha. Data provided by State reports reveals that on an average 100-200 km are covered by each ambulance per day. On an average one ambulance makes 3-8 trips per day. Training of EMTs have been reported by Uttarakhand, Haryana and Bihar. However, the reports have also indicated the need for regular refresher trainings. Availability of Hearse vans has been reported from Telangana and of bike ambulances for Trauma care and Road accidents in Karnataka. Some concerns reported by the CRM includes high call-drop rate (Maharashtra), lack of basic life support equipment (Nagaland), and lack of GPS in ambulances (Meghalaya).

Mobile Medical Units

Average daily OPD consultations by MMUs is reported to be in range of 100-150 per MMU and average number of trips by MMUs is 20-25 trips/month/MMUs. However, the number of trips in North-eastern States (Assam, Manipur, Meghalaya, Nagaland) range between 9-12 trips per MMU per month. Better range of services through MMUs was reported from Karnataka and Chhattisgarh, where the MMUs reported provision of care for chronic ailments such as diabetes, hypertension, asthma and arthritis. MCH and FP services, promotion of institutional deliveries, counselling and referral services were also provided. In Chhattisgarh, the MMUs were observed to be providing screening services for malnutrition, malaria, tuberculosis and leprosy too. Odisha and West Bengal have also reported good utilization of MMU services.

While Odisha has roped in services of AYUSH MOs, West Bengal has reported that MMUs provided nearly 12% of total OPD and 14% of total diagnostics carried out in the blocks where they are functional. West Bengal has also developed a mobile based application for MMU services to have the real-time information and continued monitoring of the services. Robust referral linkages of MMU services were observed in Maharashtra and ASHA is playing important role in mobilization of people at the time of MMU visit which leads to better utilization of MMU services. States like Uttar Pradesh are planning to propose for MMUs in next financial year. Challenges related to payment of MMUs was reported from Bihar, Uttarakhand and Assam.

Biomedical Equipment Maintenance and Management Program

A pre-requisite of Biomedical Equipment Maintenance and Management Programme implementation is the mapping of all medical device installed public health facilities across State, which has been already executed in all CRM States. The Programme has been implemented in State of Jharkhand, Telangana, Nagaland, Maharashtra, Punjab, Maharashtra and Meghalaya. Assam, Karnataka, Haryana and Chhattisgarh have concluded their tendering process and are in the phase of implementation. There is no progress in the State of Bihar, West Bengal, Uttarakhand, Manipur, Uttar Pradesh and Odisha on Programme implementation. The centralised toll-free numbers and real time dashboard are available where Programme is implemented. For instance, in Punjab the end users are aware about the Programme components and logging individual breakdown calls using toll free number provided by the service provider. Similarly, 6168 non-functional equipment will become functional by the end of December in Telangana. However, in state of Nagaland even though the biomedical maintenance and management Programme is implemented, equipment are dysfunctional, as there is little awareness about the Toll-Free number.

High non-functionality rate of equipment was found in States where the Programme has not been initiated and there is no mechanism for breakdown call management, as seen during the visit to these states. The number of equipment lying unused/ uninstalled were also reported to be high. Further, the numbers of Biomedical engineers were not adequate where maintenance activities are in-house, the turnaround time for breakdown call management was more than a week. Standard operating procedure for maintenance activities were also not in place at facility levels, where Programme has not been implemented.

IEC/BCC

Karnataka and Punjab have reported use of folk shows for improving awareness on health programs. In Chhattisgarh, a special IEC plan for 85 tribal blocks has been prepared. Strategies under this plan include use of local artists in health promotion, wall painting in local languages, and special workshops for panchayat representative. The state also undertook innovative initiatives like celebration of *Rakhi* festival with leprosy patients. Uttar Pradesh undertook extensive mid-media campaign through village level shows in local language. This has helped improve the awareness on availability of free ambulance services in the state. Beneficiaries in Uttarakhand demonstrated satisfactory knowledge on JSY, JSSK and emergency transport schemes. Other innovative initiatives include 'IEC Wall' initiative of Maharashtra. Under this initiative a wall nearby the Gram Sabha building is used for documenting various schemes and generating

awareness. Punjab undertook a month long 'Sehat Jagrukta Muhim' with an objective to a) disseminate information on Govt. run Schemes/ Free Services and b) generate awareness on key health issues and their determinants. IEC material such as posters and wall paintings in local language was observed in Odisha, Telangana, and Chhattisgarh.

However, across CRM states, the display of IEC was skewed towards RMNCH+A when compared with other programs. Consequently, awareness on other programs was observed to be limited. For instance, recall of information on the vector-borne, communicable and non-communicable disease was limited in beneficiaries in Uttar Pradesh. Citizen charters, which inform beneficiaries on entitlements, were not displayed at many health centres in Chhattisgarh. Interpersonal communication (IPC) is a relatively neglected area in states when compared with use of posters/pamphlets/wall paintings. Lack of a comprehensive IEC plan is reported from West Bengal. Impact assessment of most IEC/BCC strategies is lacking in states. Potential initiatives such as 'Know your health facility', which is a web portal aiming to locate the nearest health centre in Uttar Pradesh, were observed to be non-functional.

Recommendations

- States need to prioritize infrastructure development in tribal and remote geographies. GIS mapping of vulnerable populations should be considered by States and infrastructure plans should be linked to such mapping.
- Districts must be involved in the planning of new infrastructure.
- Mapping of all health facilities should be done to decide the nearest referral point with specialists and necessary drugs and equipment, instead of following the hierarchical referral points.
- Strengthening of peripheral primary care facilities need continued attention.
- States need to assess their District Hospitals and plan to improve the quality and range of services with ultimate goal to meet the IPHS standard.
- Basic nursing teaching and training for Labour room, SNCU, OT and Lab should be initiated, especially at health facilities with large caseloads.
- Some of the selected DHs should initiate paramedical courses also. To being with courses identified under Ministry of Skill Development in partnership with MOHFW can be initiated.
- All horizontal expansion of district hospitals/ CHCs should be restricted and a hospital planner should be hired for developing a prospective vertical plan.
- Work on mission mode needs to be initiated for improving ambience for providing client friendly environment.
- Critical care areas like OT, LR, general and obstetric HDU/ICU, assured emergency services should be available at all DHs.
- Every DH must have basic support services like CSSD, Mechanised laundry, modern Kitchen, ETP etc.
- A scoring method for assessing the DH strengthening should include assessing availability of 8 core specialty services.
- States which have notified free diagnostics initiative need to go for an assessment of available services. The number of tests notified

at various level of health facilities are not available due to scarcity of consumable and reagents, equipment and manpower. Gap analysis of these components are mandatory. Online dashboard is advised to be developed for electronic record of services delivered and monitoring purposes. It will also assist in stock out linkage with supply chain management of requirements.

- All high end low volume diagnostics tests, CT scans, MRI services are needed to be procured under service model. The free diagnostics guidelines contain model tender documents for procurement of services which may be utilised by the state. A Programme unit should also be set up for monitoring of services for in-house and outsource model of service delivery.
- State with in-house service delivery may be advised to enrol under various quality assurance scheme for quality service delivery in phase wise manner. Compliance to mandatory requirements for radiation emitting devices needs to be expedited as per Atomic Energy Regulatory Board norms.
- All states facing issues in shortage of reagents, X-ray films, Ultrasound/ECG gels may undertake rate contract for all frequently used reagents, X-ray films, Ultrasound/ECG gels.
- A policy on Unbanked Direct Blood Transfusions for remote and difficult areas should be considered.
- AYUSH staff posted in areas like the labour room should be considered for relevant trainings.
- EDLs related to AYUSH drugs and availability linked to EDL needs strengthening.
- There is an immediate need to ensure quality emergency care in Advanced Life Support ambulances and building the capacities of emergency medical technicians.
- Ambulance services available under different schemes (central and state funded) can be merged to optimize services and management at the State level including having a single centralized toll-free number.
- The ambulances which are running under Public-Private Partnership, need to enter a clause of mid-term evaluation and audit, and the monitoring of performance built into their Memorandum of Understanding (MoU).
- Line listing of the complicated cases and high-risk pregnancies should be done and requires urgent attention. This information can be shared to referral facilities in advance through 104 Integrated Call Centre to avoid any delay and further complication.
- All states need to move towards a centralized, free emergency transport system at the earliest for non-MCH emergencies.
- States must ensure that MMU routes are planned to cover areas where service delivery is unreachable either through health Centres or outreach sessions. Further there is a need for robust monitoring mechanisms for review of range of services provided through MMUs.
- Effort should be made by state to assess referral linkages for care provided through MMUs.
- Adequate number of technical manpower needs to be positioned across state to monitor the program. State which have Biomedical engineers in position have better technology management to keep checks and balance of biomedical maintenance and management program, hence it may be replicated in all states. Programme management unit is essential at State head quarter for overall monitoring of technology intensive program.
- In states where Programme is implemented there is a need to increase awareness or publicity (IEC) of toll free number for biomedical maintenance and management Programme among all healthcare professionals. IPC material supply to peripheral workers should include information on communicable and non-communicable diseases. Targeted IEC to address local myths, misconceptions and stigma related to various disease conditions should be prioritized. Use of social media platforms should be considered by states.

State Findings

BIHAR

- In Madhepura, PHC is the nodal health facility at the block level and is at the average distance of 10-15 kms from the district head quarters, catering to the population ranging from 1.63-2.3 lakh/PHC (IPHS norm @30,000/PHC).
- Bihar has lowest number of beds in government hospitals vis-à-vis the population. In Bihar there is one bed for 8645 population whereas all India average is 1: 2046 (CBHI)
- 8.71% of drugs in govt. supply is not of standard quality (National Drug Survey 14-16)
- Bihar has the highest OOPE on drugs in public health facilities i.e. 1808 per person against national average of 291.
- Most patients who could be managed at a primary health facility were being referred to higher facilities and medical colleges, thereby increasing patient load at secondary and tertiary care settings.
- Facility-wise Essential Drug List has not been developed in the state as yet. Overall, there was a huge shortage of drugs and patients reported spending money on drugs, even for entitlements under JSSK in Bhojpur. No quality assurance mechanism was in place for the drugs being procured at the district level.
- Free Diagnostic Services are to be provided in all the public health facilities. In one of the visited facilities it was observed that the slides prepared for testing were neither named nor coded to identify the patient to whom it belonged.
- Lack of HR and non-functional equipment are the major hindrance in effective functioning of blood banks in the state.
- There is huge gap between demand and supplies of blood in the state, where the requirement is around 8 lakh units while the collection is only 1.5 lakh units per year. There is also a huge burden of anaemia, thalassemia and haemophilia in the state. No action has been initiated for Haemoglobinopathies, as yet. It is suggested that state should start antenatal screening of mothers for early detection of these Haemoglobinopathies.
- With the population of 24 lakh, availability of ambulance service in the district is not as per IPHS norm (1 per lakh population). 108 ambulance services were outsourced in PPP mode from the state but is lying defunct due to non-payment issues.
- Telemedicine services were outsourced to Norton on PPP mode in 4 out of 13 blocks of the district.
- Biomedical Equipment Maintenance Programme (BMEMP) is yet to be initiated in the state.
- AYUSH medical officer from the adjoining APHC are providing ad-hoc services to ensure 24*7 availability of MO at the PHC.
- Bihar has a total of 1384 AYUSH Doctors (Ayurvedic–704, Unani–252 and Homeopathic–428) and 26 co-located (Ayurvedic, Unani & Homeopathic) dispensaries in 26 out of 38 districts of the state.
- MMUs services are lying defunct for last 2 years. The services were outsourced in PPP mode at the state and due to non-payment issues the services were discontinued.
- Display of IEC on National Health Programs was minimally visible at all the health facilities visited.

KARNATAKA

- Overall the state has adequate numbers of SC and PHCs in the rural areas, but there is a shortfall of 120 CHCs. In the state, 5.61% live in the tribal areas and as per tribal population norms there is shortfall of 822 SCs, 107 PHCs and 35 CHCs in the tribal areas.
- To meet the shortage of Specialists, the State under funding from NHM has initiated the process to start DNB Courses (Medicine, Surgery, O&G, Paediatrics, Anaesthesia & Orthopaedics) at 8 District Hospitals and 2 General Hospitals.

- The State is in the process of adopting the GOIs free drugs services initiative. Essential Drug List (EDL) for Public Health Facilities is available for the State. State has facility wise EDL – for PHC 452, CHC – 572 and DH 737 drugs and the consumables have been listed.
- The National Free Drugs and Diagnostics Service is yet to be fully operationalised. Under NFDS the State has planned for free lab services from PHC to DH.
- Apart from NHM supported ambulances, Karnataka has 180 Nagu Magu drop-back ambulances 200 and Bike Ambulances "Platinum Ten Minutes" for Trauma Care and Road Accidents 30.
- Over 85% of the equipment procured are installed and functioning and only 7.6% were not working, 1.3% not in use, 5% were to be condemned and 0.6% not installed.
- A comprehensive communication plan, based on health concerns in different regions, including capacity building of ASHAs/ANMs for interpersonal communication would yield better results in the state.
- Raichur and Chitardurga districts have good health infrastructure, road connectivity and time to care reach of health facilities. Overall the health facilities in the districts were well maintained, clean and signage was prominently displayed.
- The State's strategy of hiring services of specialists through bidding is beginning to improve service availability in some of the districts. For example, the Taluka general hospital at Deodurga, Raichur district, a 100-bedded hospital, which had only one MO in position has now hired services of six specialists through bidding, of which four have joined the hospital and are providing speciality care in Obstetrics, Anaesthesia, Surgery and General medicine since the past four months.
- E-aushadi is functional in the state, and the reported time for delivery is within 15 days following receipt of request from health facilities.
- In Karnataka, about 650 AYUSH doctors are posted at 24X7 PHCs and CHCs against the vacant posts of MBBS doctors.
- 64 MMUs are functional in state and provides basic clinical examination, diagnosis, treatment and minimum lab investigations, medicines, screening and drugs for chronic ailments such as diabetes, hypertension, asthma and arthritis. MCH and FP services, promotion of institutional deliveries, counselling and referral services.
- The development partners working in the State have developed several innovative practices for IEC and IPC such as Mobile Academy and Kilkari.
- 24x7 PHC conducting more than 10 deliveries per month has come down from 469 (2014-15) to 399 (2016-17).
- Overall hospital delivery against estimated delivery has marginally decreased from 76.3% (2014-15) to 75.6% (2016-17) whereas in Public Health facilities it has decreased from 51.6% (2014-15). to 46.8% (2016-17). Discharge within 48 hours of deliveries against total reported Institutional Deliveries (public) has decreased from 19% (2014-15) to 12.2% (2016-17).
- There is a decreasing trend in full immunization coverage, which has dropped from 89% in 2014-15 to 78% in 2016-17.
- Continuum of care was missing in both districts, particularly from the facility to community of discharged high risk pregnant women, babies from the SNCU and Nutrition Rehabilitation Center (NRC).
- The State has one of the highest number of medical colleges in the country (59, government 16 and private 36) and many district hospitals have been upgraded to medical college hospitals, but the state continues to have large number of vacancies of MBBS doctors and specialists.
- There are no empanelled laboratories in the districts and no NABL accredited aboratories for drug testing.

- It was observed that most women however, incurred out of pocket expenditure for investigations during the ANC period as majority sought antenatal check-up and diagnostics services at private facilities.
- Out of 200 sanctioned blood banks, only 41 are made functional by the government. 23 BSU are non-functional due to delay in Infrastructure establishment, training and licensing.

UTTAR PRADESH

- The state has not yet proposed any district hospital for upgradation as per DH strengthening guidelines. However, the state has identified 7 district hospitals for strengthening of comprehensive secondary care services.
- State has online Drug Procurement and Inventory Contract System (DPICS) functional up to district level.
- High end laboratory tests are being provided under the PPP mode at 52 District Hospitals, with the NABH accreditation Programme through UPHSSP.
- The standalone AYUSH facility in the state are supported by State, National AYUSH Mission under Ministry of AYUSH, U.P. through various Directorates of AYUSH (viz. Ayurveda, Unani & Homeopathy Directorate), but the coordination with NHM supported facility is limited.
- The State do not have mobile medical units (MMUs, but given the shortage of health facilities the state plans to implement mobile medical units.
- The Kaushambi district has applied innovative thinking for better use of sub centres, in Keneli CHC jurisdiction, the strengthening of Sub centres which are connected with habitation and access to road and transportation are showing outstanding performance in terms of conducting deliveries, two sub-centres of the 19 in Kaushambi district which have better access are conducting about 15-20 deliveries in a month.
- All the visited health facilities had defined EDL and most of the drugs against EDL were available.
- The involvement of AYUSH in modern medicine practice was observed, even the AYUSH LMO posted in labor room and emergency department at district level has never been trained either under SBA, DAKSHTA or skill lab.
- Overall, there is incremental improvement in service uptake of ambulance service in last 2 years.
- *Sehat Sandesh Vahini,* it is a Kanpur specific IEC using mass media that visit one village in a day and work for 20 days in a month, though the initiative is designed well.
- As per population norms, there is a shortfall of 41% CHCs, 34% PHCs and 38% HSCs in the state.
- State has identified a need of 420 FRUs, but there are only 238 functional FRUs covering the entire population.
- Batch wise certification of drug testing were not available neither randomized sampling is being done.
- Labs at the peripheral level facilities are either not functional or are providing limited number of tests and the staff available was highly underutilised. Hence, they have to refer the cases to private sector or to higher level health facility that leads to loss to follow up.
- None of the Radiology units were AERB certified and even TLD badges, lead coated separators were not available.
- High out of pocket expenses on USGs, CT scan and other specialized diagnostic tests including some of the biochemistry and haematology tests at the peripheral level.
- None of the FRUs visited had a functional blood storage unit. The reason for non-functionality was due to non-availability of human resource and completion of licencing process.
- The interaction and coordination between the blood bank and collection centre is very weak,

similarly, no records where available to see the supply of blood units from district hospital to other FRUs.

- Most of the unopened equipment in the store are supplied during 2011 and 2012, and few of them are even un opened from last 10 years. Systematic approach to create the log of available medical equipment that will help in better planning in future.
- It was observed that the IEC material is not placed in the appropriate place which is relevant to audience and for the service provider. For example, the placement of PPIUCD related protocols are not placed in labour room and OT, however they were found in other areas as well, similarly, the IEC material was develop using English which might not be relevant to the beneficiary who local language.

UTTARAKHAND

- The concept of establishing State allopathic dispensary in hard-to-reach areas in entire Uttarakhand is a good one and could also help reduce the travel time and Out of Pocket expenditure by the community.
- Plans are afoot to train AYUSH doctors in the Bridge course as Mid-Level Providers.
- IEC material was well displayed in most institutions in both districts visited. The extent, reach, quality and visibility and availability of IEC materials are also satisfactory especially the ongoing programmes such as breastfeeding, MR vaccination.
- Uttarakhand started the Free Diagnostics Services which currently comprises of 30 free tests at district, and sub district hospitals and 28 free tests at the CHC level.
- Healthcare services remain inadequate with severe human resource crunch in both districts visited leading to patients travelling long distances to access healthcare. The number of SCs (600) in Uttarakhand is less due to the non-availability of human resources and MMUs (the contract expired in June 2017). This affects the coverage of vulnerable groups and hard to reach areas
- Secondary care facilities are under-utilized and their full potential is untapped due to lack of appropriate HR, erratic drug supply, high user fees and in some cases difficult location away from habitation.
- The provision for handling and stabilizing emergency and complicated cases at secondary level (both District Hospitals and Sub-district Hospitals visited) is minimal.
- The work under DH strengthening has not yet started as the RFP has not been received from facilities and State has not made any work plan to execute the programme or activity.
- The pace of completing construction, renovation and upgradation of infrastructure is slow. Various activities which are based on demand from the district level, such as strengthening of the SDH, construction of new drug warehouse, setting up of emergency ward, establishing Blood storage units have been completed up to 30% of work sanctioned.
- The display of essential drugs was not found in most of the facilities visited. In the few facilities where the EDL was displayed, no grievance redressal mechanism was in place.
- The condition of the referral vehicles and ambulances is poor. Since 2008, no maintenance services have been provided due to which the ambulances remain 15 days off the road and there is no night duty. State ambulances are generally used for loading and unloading the drugs and vaccines from the drug warehouse to the designated facility.
- 10% mapping of the equipment has been done and around 21% of the equipment was found lying non-functional.

WEST BENGAL

- West Bengal has 11,709 facilities notified with a total of 83,859 beds available under State health department *('Health on March 2015-16' report of State Government),* i.e 9 beds/10000 population.
- Public-private partnership (PPP) was seen across the State to increase and improve

service delivery ranging from provision of diet to operationalization of Mobile Units or provision of surgical care for congenital heart diseases.

- At State level, no specific plans have been seen for strengthening DHs for assured multi-specialty services or developing DHs as knowledge hubs.
- An effort to expand the basket of health care services in the public domain was seen at the district and sub-district levels with addition of specialties, critical care units (one at Medinipur Medical College Hospital and another at SDH Ghatal in P.Medinipur) and dialysis facilities.
- State of West Bengal has recently expanded its Essential Drug List to provide for a total of 450 drugs free of cost at public health facilities. This includes select NCD drugs, psychiatric and psychotropic drugs.
- Store Management Information System (SMIS), an online drug procurement mechanism developed in house, has been functional at district stores and has been used for indenting, and processing payments by district drug stores and large hospitals (as per rate contracts entered into by the State).
- State has been providing transportation service to pregnant women and sick newborn through NISHCHAY Yan – a scheme of empanelled vehicles.
- The MMU visited by CRM team was using a mobile based application developed by the agency for daily reporting on service delivery. This has enabled real time information sharing with the district officials and continued monitoring of their services.
- IEC materials (posters, information board) were available and displayed at all the facilities visited in both districts. Content of such materials included – family planning, ORS & Zinc, sanitation and hygiene. Leaflets on institutional delivery, leprosy, dengue, ORS & Zinc were also found during field visit. Along with printed materials, wall paintings were seen in health facilities.
- Further, no systematic referral (referral out and referral in) and follow-up was observed across facilities, even for chronic conditions.
- OOPE on drugs was reported only in case of high end antibiotics which were prescribed by doctor at Mobile Medical Unit after prolonged disease condition. However, in D. Dinajpur, stock-outs as well as OOPE on drugs was noted during beneficiary interactions.
- Free Diagnostic Policy not notified and defined package of free diagnostics be assured at each level of facilities was not available
- Dedicated ambulance services for emergency care have not been made available in the State.

CHHATTISGARH

- Drug Procurement is done through a central procurement agency, i.e. Chhattisgarh Medical Services Corporation (CGMSC). IT enabled procurement & inventory management system has been developed by the state through an agency - Broad Line System. State level indenting of drugs is done through IT enabled inventory management system i.e. DVDMS.
- HLLFPPT has completed the mapping exercise of all Biomedical equipment in the state. Districts would then take steps to repair or condemn non-functional equipment.
- There is a WhatsApp group of voluntary blood donors who are always available for on call donation in DH Bijapur. They also have a micro plan of blood donation camps planned in the different areas of Bijapur district, including CRPF camps.
- In Chhattisgarh out of 146 blocks, 85 blocks come under tribal belts, for which special IEC plans for all programs have been made.
- Awareness of Health Programme to Panchayat Representatives daily in Hamar Chhattisgarh Yojna of Panchayat Department.
- Celebration of Rakhi festival with leprosy people at State Level.
- Advertisement given on Print Media & Electronic Media for Iodine Day celebration, Elderly

Day, Deworming Day, Swine flu awareness campaign, Eye donation, Population control fortnight & Leprosy day.

- Number of existing Health Facilities is lesser than required as per the IPHS norms in both the districts.
- 30% of the Bijapur district is inaccessible to the public health services.
- Irrational use of Antibiotics is found in all the facilities when prescription audits were done.
- Assured referral is absent as patients are being referred to higher facilities without stabilization and referral slip. Higher Centres are not informed about the referred patients in advance.
- There is no AMC or mechanism for the Biomedical equipment repair maintenance.

ASSAM

- The State has created many 'Model hospitals' in the recent years. While the initiative to have 'models hospitals' is appreciable, their location (close to DH/other facility) and lay out designs of critical service areas (e.g. OT) require better planning.
- None of the Civil Hospitals (Nalbari and Goalpara) have been proposed DH strengthening.
- Considerable efforts have been made by State to close the gap with regard to adequacy of physical infrastructure. The State has been able to close the Primacy Health Centre (PHC) shortfall in the State. Against a shortfall of 216 PHCs (26%) pre-NHM, the State has now 1014 functional PHCs.
- Despite approval given for 280 ALS and demarcation by State as ALS and BLS, the State does not have a single functional ALS ambulances in the State.
- To provide access to the underserved and unreached areas, State has operationalized Mobile Medical Units (MMUs) through an outsourced model. The State has recently finalized new agreement for running these MMU to provide comprehensive primary health care services along with diagnostics facilities other than X-ray (provided earlier). State has 130 operational MMUs with 71 operating in Tea Garden areas and 11 in non-tea garden areas on outsourcing basis through M/s Hindustan Latex Family Planning Promotion Trust (HLFPPT). The average reported OPD is 45-50 OPD per day.
- For communities residing in the remote riverine areas and river islands (Char/Saporis) access to basic healthcare services is through Boat clinics focused mainly on MCH services. Currently, 15 Boat Clinics are functioning in 13 Districts. Despite approval given for 280 ALS and demarcation by State as ALS and BLS, the State does not have a single functional ALS ambulance in the State.
- The range of services provided by the facilities was not commensurate with the level of facility and the number of HR in position. Almost all the facilities, DH, CHC, State Dispensary, PHC were largely focused on MCH and disease control programs.
- The shortcomings of the PPP –hub and spoke model put in place by Assam has the following shortcomings: Improper planning has led to existing LTs being underutilised. Since sample collection is done till 2 PM everyday by the PPP partner, any patient arriving after OPD is not able to access. The idea of PPP arrangements is to improve and expand access and not replicate the existing government lab functioning of sample collection of only upto OPD hours While test reports can be given the next day sample collection should be 24x7 so that the patient does not have to make another trip to the hospitals or get pushed to private labs. Some tests including routine test are not covered under the PPP arrangement for which facilities are levying user charges.
- Although the State has ensured availability of most of the drugs and its provision free of cost, drug dispensing is a critical weak link in the chain with no mechanism put in place by the State at facility level to ensure patients are getting the drugs as per need. Despite availability of more than adequate drugs in the system, the State was not able to put in place an effective drugs dispensing system.

The OPD patient load does not match with the drug dispensing register.

- The practice of kitting of drugs is not only leading to wastages but not required as State has put in procurement and logistics system that should be in a position to forecast and indent as per requirement. The State has not prepared facility wise EDL.
- Patients and ASHAs reveal that the homes to facility services are poor for most patients including pregnant women. They reported incurring expenditure of about ₹ 500 to 750 for transport.

ODISHA

- State has developed IT platform for supply chain and drug inventory management called e-Niramaya that is available up to the CHC level.
- The investigations facility was available at the facilities, but user fee was being charged for various tests and the fund was allocated to RKS. Inadequate utilization of the funds was seen in relation to patient centric activities.
- State has prepared a detailed road map along with budgetary allocation to strengthen Blood Bank services in the State and to provide safe Blood to the patients. The major features include Quality Assurance measures with the support of National Institute of Biologicals in Blood Services, ensuring supply of blood & blood products to multiple transfused patients like Thalassemia, Sickle cell, Haemophilia & immune deficiency disorders, Promotion of Voluntary Blood Donation Camps.
- The provision of reimbursement of transportation cost to pregnant women from home to nearest motorable road to be implemented in designated difficult villages as notified by district collector. The cost decided is 1000/- per pregnant woman for institutional delivery.
- State started with the Mobile Health Units (MHU)/Arogya plus with detailed micro-planning to ensure maximum coverage in terms of terrain and outreach.
- State has also developed Maternal Waiting Homes (MWH) Maa-Gruha to provide support for institutional delivery for High Risk Mother, for Pregnant women living in difficult and most difficult blocks. Adequate services are being provided at the gruha to the beneficiaries from far flung areas identified by the ASHA/ANM.
- The cold storage supply chain was robust in the districts especially after the implementation of eVIN. Digital temperature loggers were functional with most of the units and were being regularly monitored and manual monitoring was also in place.
- The AYUSH doctors were being trained for providing screening under RBSK, conducting deliveries, NSSK, IUCD insertion and they were also involved in supervision of various activities.
- Comprehensive Primary Healthcare System being weak in the districts has led to over loaded SDH and DHs and low performing PHCs.
- District Hospitals have drug warehouses. There was no temperature control mechanism for the District drug warehouse. There was a lack of power back up in a few of the premises. There were no measures taken to control rodents as well as fire safety measures.
- Patient's registration is a manual process giving picture of chaos leading to increased waiting time with no crowd management procedures in place.
- No central mechanism for grievance redressal in the state, but a facility had displayed the details for contacting the MO for any grievance.
- Private drug stores are present in public health premises and patients visiting public health facilities were buying medicines from these stores. This was incurring OOP to the patients.
- The ambulances were not in good condition. Even the siren was not functioning properly as it requires a separate maintenance procedure.

MANIPUR

- The state is planning to increase the number of health facilities as per the population ratio after taking due approval from the state cabinet.

- The state is in the process of implementing DVDMS with the help of CDAC.
- Blood was procured from NACO division @ ₹ 300 per unit.
- Jana Aushadhi is present and all the generic drugs are available.
- Free Diagnostics Services has been initiated under NHM. In-house Free Diagnostic Initiated in 2 Medical Colleges, 7 District Hospitals, 17 CHCs and 57 PHCs. The state has also processed e-tender for PPP model.
- The state, currently, does not have a free drug policy. However, interactions with the state officials revealed formation of a state level committee and their plan to finalise and implement a new free drugs list.

JHARKHAND

- State is yet to initiate DNB courses, establishing Knowledge Hubs, and integrated training for paramedical staff.
- There are no adequate drug warehouses in Jharkhand. There are seven existing warehouses in Ranchi out of which two are assigned for JMHIDPCL and the rest are being used for national supplies such as vaccines, contraceptives, TB drugs, and IEC materials.
- The state has completed the development of C-DAC eAushadi DVDMS for inventory management, but it is not rolled out in the state.
- The facility had a well functional in-house laboratory which provided all routine diagnostic tests free of charge to patients. High end diagnostic tests were outsourced to M/S Medall Laboratories.
- Ambulance and referral services are provided either through "Mamta Vahan" or State/Hospital owned ambulance vehicles.
- The utilization of inpatient services in DH, CHC was sub-optimal. Bed occupancy was ~50% in East Singhbum district in these facilities.
- The primary health centre is a neglected entity in the Jharkhand health system. These facilities are understaffed and underutilized. A large number of PHCs are run by ANMs and as a result, services such as laboratory and pharmacy remain unutilized.
- No Mainstreaming of AYUSH and there are no AYUSH practitioners at PHC, CHC or SDH. AYUSH doctors are not involved in national health programs.

PUNJAB

- As per RHS Bulletin, there is a shortfall of SCs-15% (518 SCs) and PHCs-25% (146 PHCs).
- State has implemented National Free Diagnostics Service Initiative in phase wise manner but yet to be fully operationalised
- State has taken initiative of providing free treatment including all diagnostics expenses for first 24 hours of admission for all patients.
- The State has a separate Directorate for AYUSH and Homeopathy. The whole of the State is covered through 111 Regular Govt. Homoeopathic Dispensaries and 104 Homoeopathic Dispensaries running under NRHM.
- The State has adopted GoI's free drugs services initiative. The state has Punjab Health System Corporation (PHSC) through which Drugs are purchased and supplied through DVDMS (E-Aushadhi).
- Free Annual Preventive Health Check Up initiative is undergoing in the State for 30 plus population which is state initiative. It is taking place at the CHC level on a fixed day, beneficiaries being mobilized by the ASHA workers and tests are being done for Sugar, BP and Hb.
- State of Punjab has initiated free dialysis services.
- A 30 days comprehensive health awareness campaign-cum-person to person contact programme titled *'Sehat Jagrukta Muhim'* was launched in Punjab state from 5th November to 5th December 2016 with the objective to reach out to the masses for dissemination of

information regarding the Govt. run Schemes/ Free Services & Facilities and general awareness on key health issues and their determinants.

- The health institutions in the periphery need to be made optimally functional to decongest the DH which should be only for secondary and tertiary level care.

HARYANA

- Better LSCS rates are observed at Gurugram as compared to Bhiwani.
- In Bhiwani, the ANMs were observed to keep record of the members of high risk pregnancies, including pregnant mothers of severe anaemia.
- Both the districts were observed to have a 24X7 emergency and trauma care services.
- Basic amenities (drinking water, lift, chairs in waiting area etc.) was observed to be inadequate at Sector 10 DH Gurugram, SDH Sohna, and DH Bhiwani.
- Quality testing for each batch was observed at both warehouses and medicines were released to health facilities only after being quality certified.
- Owing to a good road network the travel time to district hospital is within an hour from most parts of Gurugram.
- Siwani SDH has an excellent infrastructure for operating as a SDH to provide full range of services.
- Both SHCs as well as PHCs in Gurugram have potential to be developed into Health and Wellness Centres with capacity for provision of a wider range of services.
- Due to inappropriate HR status, DH Bhiwani has huge OPD load with 1:400 to 1:500 Doctor: Patient Ratio per day.
- Bhiwani has reported an increase in number of Major surgeries.
- The RBSK AYUSH MO is not allowed to use AYUSH medicines for treating even simple ailments, which in turn is diminishing their skills.
- Availability of specialist care at sub-district levels remain another area of concern with both the districts reporting no specialists at the CHC level.

MAHARASHTRA

- LSCS rates in Public facilities were observed to be satisfactory i.e. within the range of 10% to 15% as per WHO norms.
- Rate of BEMP is 5.87%, which is one of the lowest in country.
- OOPE for APL families observed at Trauma care unit of Wardha Hospital was 776/- during 2016 and is 878/- up to October 2017.
- In SDH Gangakhed and RH Palam, there were no links to lower centres thus instances of infants who were not given '0' dose due to non-availability of vaccine were not being followed up or there were no community linkages to ensure that they were given vaccination at other centre.

NAGALAND

- Call centres for Dial -102 service not available and 102 ambulances were not working.
- The DH at Wadha was constructed in the year 1964 and the premises were neat, clean and well maintained.
- The cold chain was maintained and the power back-up for maintaining the cold chain was also available in the hospital.
- Expired drugs in Kiphire DH were being burned.
- The entire district of Kiphire did not have proper BMW mechanism in place. Burying wastes in pits or burning was the common practice.
- DH follows direct collection and transfusion practices, which is not the standard practice.

MEGHALAYA

- The number health facilities in the State are quite adequate in number as far as the

population is concerned except a Sub-center having shortfall of nearly 42% as per Rural Health Statistics, 2016.

- Blood services are found to be chargeable to pregnant women and expenditure should not be incurred under JSSK at East Khasi Hills.
- In East Khasi Hills, from the records of October'17, the average trips per day per ambulance is 6 with average 9.10 Km travelled per day.
- Annual rate decided for the BMMP services is 7.9% of total asset value, for 5 years without escalation.
- There is one state drug warehouse where receipt of stock is recorded on delivery and stock is physically verified before stored in the warehouse and dispatched to the district warehouses.
- Due to lack of diagnostics like X-ray, ECG, USG, inadequate medicines, weak referral transport and non-functional blood bank/BSU in the South Garo Hills district have made people travel to Tura district to avail health services leading to high out of pocket expenditure.

TELANGANA

- There were no separate toilets and wards for Male and female patients in most of the visited facilities.
- No bed nets provided in the facility, even though there are high chances of dengue and malaria.
- State has adopted GOI guidelines on free drugs initiative and following e-aushadhi for strengthening Drugs and logistics procurement system.
- Good emergency referral transport facilities were available in both Adilabad & Khammam districts.
- Uniform IEC material was displayed everywhere for RMNCH+A activities, which was centrally developed by the state with the technical support by UNICEF.

TOR 2

REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH

Objectives

- To assess the planning of RMNCH+A, alignment with RMNCH+A 5x5 Matrix based upon gap analysis and prioritization for continuum of care based upon utilization and delivery points.
- To review delivery and quality of PPIUD services, JSY & JSSK entitlements, establishment and functioning of SNCUs, NBSUs, NBCCs, NRCs, RBSK screening, immunization, Alternate Vaccine Delivery arrangements, Maternal and Child Death Review, organization of AFHS .
- To oversee community level care arrangements for Home based new born care, safe delivery at home through SBA, advance distribution of Misoprostol, Iron Supplementations, Adolescent Health Days, Peer Educator and AH counseling etc.
- To review the preparedness for implementation of Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)

National Overview

Implementation of RMNCH+A Strategy

RMNCH+A strategy was launched in 2013 with the aim to address major causes of mortality among women and children, through the continuum of care approach. In order to streamline the efforts, certain priority interventions under each thematic area have been identified and States are expected to plan service delivery keeping in view a systems approach for RMNCH+A care.

The states have made a special effort to ensure focused provision of RMNCH+A services in all their facilities, as reflected in the availability of essential commodities as per RMNCH+A 5*5 matrix, effective cold chain management system, adherence to Labour room protocols and availability of SBA trained Staff at delivery points. Access to C-sections has improved in government facilities which has reduced OOPE. Keeping the life cycle approach in mind, the states needs bolster their adolescent health Programme including the young undernourished/ underweight girls becoming mothers, especially in the smarginalized population.

The Status of Various Components of RMNCH+A

Reproductive Health

Spacing services are provided through facility and community-based interventions. Facility based interventions includes Interval IUCD, Postpartum IUCD, Post Abortion IUCD, provision of condoms, OC pills and newly introduced non-steroidal contraceptive pills and Inj. DMPA (Antara).

Community interventions include provision of contraceptives and ECP through ASHAs.

IUCD insertion is a priority area under spacing services. The national HMIS data for 2017-2018 (till October) reports a total of 21,22,983 IUCD insertions (excluding PPIUCD and PAIUCD). The percentage of insertions that public and private institutions reported were 93.11% and 7.4% respectively. Rural health facilities have reported inserting more IUCD than urban facilities (86.5% and 13.4% at rural and urban facilities respectively).

Promotion of PPIUCD insertion has been an important intervention under the family planning program. 11.74% of all women delivering in various public institutions across India, accepted PPIUCD insertion. 8 States/UTs namely West Bengal (26.7%), Karnataka (21.4), Tamil Nadu (19.6%), Madhya Pradesh (16.8%), Delhi (16.3%), Andaman and Nicobar Islands (13.7%), Rajasthan (13.7) and Punjab (13%) reported higher percentage of PPIUCD insertions, as compared to the national average.

Women continue to bear an uneven burden of sterilization. In 2017-18 (till October,2017) of all 14,73,418 sterilization procedures, only 6.8% were male sterilization operations and 93.1% were female operations.

Maternal Health

The concerns about quality and accessibility of ANC services remain, with a slight improvement (from 60% to 62% as per HMIS data for 2017-18-till October'17) in the percentage of pregnant women who received ANC in first trimester. 70% of pregnant women received 3 or more ANC visits. However, only a third of the mothers received postpartum check-up within 48 hours of delivery. 62% of women who delivered, received a postpartum check-up between 48 hours and 14 days.

Health facilities need to be strengthened for providing safe abortion services in terms of infrastructure, trained manpower and drugs and consumables. As per HMIS estimates for 2017-18 (till October'17), total number of reported abortions

were 687,784 of which 45% were spontaneous abortions. 70% of the abortions were conducted at public institutions.

High risk pregnancies due to severe anaemia (Hb<7) is persistent across the states. Line listing and follow-up of high risk pregnancies were found to be lacking in all states. Of the total 16,583,181 ANC registrations, the pregnant women identified as severe anaemic (Hb<7) were 7,62,377 (5%), which is an underestimate. Of these, only 2,83,698 (2%) received treatment as per HMIS estimates 2017-18 (till October'17).

HMIS estimates for 2017-18 (till October'17) report a total of 2053 deaths reviewed at the community level. 1345 deaths were reviewed by the collectors and 2729 deaths were reviewed by the CMO. Facility based review of maternal deaths to understand the systemic gaps in service delivery is lacking in most of the states visited.

Newborn Health

As per NFHS IV report, the national average for early initiation of breastfeeding within one hour of birth was reported to be at 41.6%. However, it

varied from the 4.4% (lowest) in Puducherry to 73.3% (highest) in Goa.

Effective round the clock services to sick newborns can reduce the neonatal mortality of the country. To achieve the target of NMR and to provide effective health services to all sick newborns, 712 Special Newborn Care Units (SNCUs) have been set up in district hospitals and Medical Colleges, while 2329 Newborn Stabilization units (NBSU) and 18283 Newborn care corners (NBCC) are operating to provide services for the newborns. As per 2017-2018 estimates (till September'17) 4.5 lakh babies were treated at SNCUs. SNCU online reporting system has been introduced in 28 states and more than 600 facilities (i.e 90%) are reporting SNCU services online.

Child Health

The recent trends as per NFHS IV reveals that 62% of the children aged 12-23 months are fully immunized (BCG, measles, and 3 doses each of polio and DPT). There has been an increase of 18.5 points from NFHS 3 to NFHS 4 (43.5% to 62%) in the number of fully immunized children. However, the coverage differs in urban and rural context with 63.9% and 61.3% respectively. Full immunization coverage was reported to be highest in Puducherry 91.3% and the lowest in Nagaland i.e. 35.7%.

The RBSK screening and follow up mechanisms are well laid down across India as compared to the previous CRM reports. The estimates from HMIS a for 2017-18 (till October'17) shows that 1,390,421 newborns have been screened for defects at birth (as per RBSK). The number of children identified with disease are 1,821,943, of which 50.7% were males and 49.3% were females. Whereas, the number of children identified with deficiencies are 487,115, out of which 47.1% were male and 52.8% were female.

Unfortunately, the services for management of Diarrhoea is still inadequate. The NFHS IV report estimates that the percentage of children with diarrhoea who received oral rehydration salts (ORS) and zinc is 50.6% and 20.3% respectively. Data however, shows improvement as compared to NFHS 3 data, which reported 26% children received ORS.

Adolescent Health

Through Adolescent Friendly health clinics (AFHCs), counselling and curative services are provided at primary, secondary and tertiary levels of care on fixed days with due referral linkages. The total number of Adolescents registered for Adolescent Friendly Health Clinic (AFHC) was 3,296,428 (HMIS 2017-18 till October '17). Of the total registered 70% of them have received clinical services and 77.5% have received counselling.

Key Findings

Reproductive Health

Adequacy and quality of family planning services: Supplies related to spacing methods, particularly condoms and OCPs were found adequate in most of the states except in Jharkhand, Manipur, Meghalaya and Nagaland. All states reported availability of Pregnancy Test Kits (PTKs) at sub-health centres.

Most of the states preferred IUCD insertion as method of choice for spacing. In the states of Chhattisgarh, West Bengal and Haryana PPIUCD insertion and IUCD insertion were found to quite prevalent, desired by the community and suitably trained HR, which is in sync with the national program. Only Chhattisgarh reported insertion of PAIUCD. Few states reported taking verbal consent for PPIUCD on the delivery table which is an inappropriate protocol under service provision.

Haryana has a three-day strategy for home distribution of contraceptives by ASHAs, and is undertaken on Saturday(s), IUCD services are available on Tuesday(s) and sterilization operations are undertaken on Thursday(s) at designated operating centres in various districts.

Sterilization services

Women continue to bear the burden of terminal methods of contraception. Fixed day static sterilization services have been reported in most of states except in Uttarakhand, Jharkhand, Nagaland and Manipur. However, these are available only at District Hospitals. In Uttarakhand, due to the lack of specialists, the family planning services, especially female sterilizations, have declined. Chhattisgarh has initiated Enhanced Compensation Scheme for sterilization and is being followed appropriately, as per GOI Guidelines. The Non-Scalpel Vasectomy (NSV) services were reported to be provided in very few facilities and uptake of NSV is negligible in all CRM states.

Newer Initiatives like Mission Parivar Vikas promoting the Injectable MPA (Antara Program) has not yet been initiated in most states. Only Chhattisgarh reported distributing MPA in 10 districts and District hospitals

in Haryana and Maharashtra have recently started the Medroxyprogesterone acetate (MPA) injectable service. ANTARA (Injectables) & CHHAYA, launched in the West Bengal, services were available only at Medical Colleges, with trainings still due at the district level.

Counselling services need to be more robust in Karnataka, Assam and Bihar. RMNCH+A Counsellors or ANMs were found to be providing counselling for FP. IEC and audio-visual material was displayed in the waiting area and kangaroo care rooms in Karnataka. The supply of expanded basket of choices of contraceptives at the facilities needs to be ensured and offered during family planning counselling.

There was minimal involvement of ASHAs in home distribution of contraceptives in the majority of states, except for Chhattisgarh, Odisha, Telangana, Uttar Pradesh, West Bengal and Haryana. Ensuring spacing at birth scheme (ESB scheme) was implemented in most of the CRM states, but home-based delivery of contraceptives by ASHA was restricted only to condoms and there were few takers for Oral Contraceptive pills. Odisha reported that ASHAs through diligent community based Family Planning advocacy for young women, created opportunities during VHSND, HBNC visits and small group meetings with women. ASHAs in most of the states did not have Emergency Contraceptive Pill for distribution.

The awareness among the Hospital Staff & Community on Family Planning Indemnity scheme

was very poor. There was no IEC nor campaigning about FPIS scheme at the hospital or community level.

Maternal Health

Quality ANC services are provided in the State of Tamil Nadu. Jharkhand, Gujarat, Chandigarh, Kerala and Andhra Pradesh reported maintaining line listing of high risk pregnancies and severe anemia. In most other States antenatal care, particularly at the level of Sub Health Centres, was deficient, in terms of range of services (Tripura, Nagaland, Kerala, Chandigarh, Jharkhand), identification and line listing of high risk pregnancies (Nagaland, Delhi, Tripura, Uttar Pradesh, Himachal Pradesh, Bihar, Arunachal Pradesh) and orientation on newer guidelines - such as those on Gestational Diabetes Management, Calcium supplementation, deworming during Pregnancy, Screening for Syphilis/HIV- and other protocols (Andhra Pradesh, Arunachal Pradesh, Himachal Pradesh, Kerala and Nagaland). Missing records in MCP cards were observed in Uttar Pradesh and Nagaland,

Intrapartum and PNC services were affected in most of the CRM states, due to lack of infrastructure (ANC ward, PNC ward, Labour room) in most of the facilities, inadequate number of labour tables in relation to the delivery load in the facilities. CRM states also reported that Postnatal stay ranged from 6 hours to 24 hrs. PNC vital parameters not monitored in many states.

Labour Rooms were found organized, well-equipped, well-maintained with 24x7 water supplies, power backup, separate toilets in states of Assam, Chhattisgarh, Haryana, Karnataka, Maharashtra, Manipur, Meghalaya, Odisha, Punjab and Telangana. However, labour room protocols such as use of partograph, Oxytocin storage, maintaining of labour registers were still lacking in Bihar and Jharkhand.

Many states reported that majority of their nurses/ANMs conducting delivery were not SBA trained and that SBA training institutes were unavailable in the states. The skills for AMTSL, neonatal resuscitation, complication identification and management and IMEP were prominently lacking in states like Jharkhand, Nagaland, Manipur, Meghalaya and Bihar.

A few states like Chhattisgarh and Assam have convenient sterile delivery kits with a sterile gown, patient drape, gloves cap, mask, protective eye wear and foot wear to ensure aseptic conditions during delivery.

A Partograph to monitor labour is now available in many states, however the quality of partograph use calls for improvement. State CRM reports indicate, that birth companion initiative is being practiced by a few states like Chhattisgarh, Odisha and Telangana. Bio Medical waste Management practices were lacking in the labour rooms of Bihar, Chhattisgarh, Haryana and Punjab. Emergency Management protocols like PPH management and Eclampsia management were limited to secondary and tertiary care settings. Below DH level, emergency management or even timely referral was lacking in most of the CRM states.

In all states, beneficiaries were aware about the JSY schemes, and most of the beneficiaries had bank accounts. The ASHAs were helping beneficiaries to open bank accounts. Most of the states followed DBT as mode of payment for JSY benefits. States like Assam, Bihar, Chhattisgarh, Jharkhand, Punjab and Uttar Pradesh reported delays in JSY payments.

Under JSSK scheme, beneficiaries do get free drugs, diet and diagnostics (except Ultrasonography which was not free in

most states). There were issues as regards referral services in many states. West Bengal has an MoU with private service providers for ambulance services. These vehicles named as "Nishchay Yaan" which improves their referral and transport system.

In Chhattisgarh, women delivering in Public health facilities are provided Poshtik Aahar (Energy dense High Protein Diet) every day for 3 days. The diet is according to local traditions, as it is believed to enhance milk production and clear the uterus of any retained blood clots.

Comprehensive Abortion Care (CAC) facilities were found only at DH level in most of the CRM states. The provision of CAC at peripheral facilities was largely absent. MMA drug kits were not available in most facilities. The knowledge and awareness about safe abortions and MTP Act was very poor among the staff and in the community. Most of the cases at the District Hospitals are reported as 'spontaneous abortion or incomplete abortions'. Abortion cases with more than 12 weeks pregnancy are largely admitted in the facilities.

Identification of high risk pregnancies and line listing remains low in most of the CRM states and it is limited mainly to anaemia. However, the ANMs were aware of signs and symptoms of high risk pregnancies and also have adequate skills for basic investigations in ANC like Haemoglobin, blood pressure, abdominal examination and a urine test. However, majority of ANMs use Hb estimation strips over Sahli's haemoglobinometer which is inaccurate. Routine tests for ANCs are being conducted, however tests such as thyroid profile, screening for HIV, GDM are not (adequately) available below DH mainly due to lack of training of ANMs in these skills or the non-availability of equipment or kits. In the facility, although a register is maintained for recording high risk pregnancies, but there is no mention of "criteria for inclusion" under high-risk category. Similarly, no record was found on follow up of these HRP except verbal/telephonic communications, as ascertained by the service provider. The same observation stands true at the community level. This was further substantiated by the cause of maternal deaths attributed to delays in referral and where high risk pregnancies were delivered at CHC level, with no specialists.

PMSMA is implemented in all the states though they adopt different implementation models. The range of services include USG in most of the states, but only at the district hospital. In Maharashtra, under this initiative, USG services are being provisioned free of cost to pregnant women in partnership with private providers. In Uttarakhand "Samman Divas" is being conducted on every Monday throughout the State. The outreach activities and the ANC services are delivered by the ANMs through this platform. PMSMA runs as a routine ANC programme every week.

In the states like Karnataka, Assam, Odisha, Uttarakhand, Manipur, Punjab and Telangana, there was low voluntary participation of private providers. In Uttar Pradesh, planning for PMSMA need to be done as per GOI operational guidelines, priority should be given to high volume facilities for inclusion in PMSMA. In West Bengal, PMSMA has not been officially launched by the State and there is no involvement/enrolment of private practitioners in PMSMA. In Bihar Full complement of PMSMA is not being given even basic tests like Haemoglobin estimation was not being done in Bhojpur District.

Maternal Death and Maternal near miss (MNM) review has not been implemented in most of the CRM states. However, MDR emphasized only on clinical analysis of the cause of death and it was not a systematic review, even in the Medical Colleges. No major corrective actions followed the review.

There was gross under reporting of maternal deaths in many states like Uttar Pradesh, Bihar and Chhattisgarh. In Uttar Pradesh, a new incentive has been adopted by the state to improve maternal death reporting in the community, where the first reporter of a maternal death is given an incentive of ₹ 1000. Most of the states did not receive the GoI Guidelines on MDSR and MNMs at district or sub district level and the capacity of the staff in conducting maternal death reviews was inadequate.

In West Bengal, MDR was very well established. Mentoring and supervision by Obstetric Mentor Group has been established. All maternal deaths are duly informed to all in hierarchy by SMS system following which facility based, as well as community based MDR is carried out.

The newer initiatives under Maternal health are use of antenatal corticosteroids, universal screening of HIV, Syphilis, GDM, calcium supplementation and maternal death/maternal near miss review guidelines have been implemented at the District hospital level. These services are not available at the peripheral facilities due to lack of trained ANMs or lack of equipment and supply.

Revised guidelines on IFA consumption are being followed in most of the states. Home-based distribution of Misoprostol is yet to be implemented in the states where home delivery rates are high primarily due to lack of awareness and training among the staff. Supply of Albendazole is available for deworming in pregnancy but the coverage is inadequate, Calcium is also available in the field, however consumption of IFA and Calcium in PNC period is still low due to poor awareness among service providers.

Newborn & Child Health

Kangaroo mother care practice and the establishment of Kangaroo mother care (KMC) unit was observed in almost all state health facilities, except in West Bengal, Jharkhand, Meghalaya, Nagaland and Manipur. The State of West Bengal has disseminated the guideline to the health facilities but no model KMC unit nor KMC practice was found at any health facilities visited. Uttar Pradesh has implemented it as a best practice in the state and KMC is operational in 13 CHCs of four districts and 42 district women hospitals across the state. The KMC room is available in SNCU premises in Haryana, but it was not being utilized.

Kangaroo mother care unit with adequate infrastructure was observed in Telangana, Maharashtra and Uttar Pradesh. Inadequate infrastructure and display of IEC materials were observed in Bihar and Punjab. Separate room for KMC at the health facility was reported from Bihar, UP and Telangana.

Knowledge and Awareness level among Delivery room staff about KMC was good in Assam, but not so in Uttarakhand.

Sick Newborn Care Unit/Newborn Stabilization Unit & Newborn Care Corner are available, but its utilization varies from state to state. The SNCU facility is available and functional at District and Sub district level in all the states except Manipur, Nagaland and Uttarakhand. Majority of SNCU admission are Birth Asphyxia, Low Birth weight, Sepsis except in Karnataka where 16% SNCU admission are due to jaundice cases and in Chhattisgarh which reported Birth Asphyxia and Jaundice. The inborn admission is higher in all facilities than out born admissions except in UP (Kausambi district) where it is 50-50.

The training of SNCU staff remains an issue in Assam, Bihar, Chhattisgarh, Jharkhand and Punjab.

However, in Uttar Pradesh and Telangana they were better trained. Bihar reported a lack of Medical officer in the SNCU. An adequate follow up of the cases was found to be an issue in all the states.

The process of establishing NBSU up to CHC and PHC level has been started in the state of Assam, Chhattisgarh, Karnataka, Odisha, Uttar Pradesh, Uttarakhand, and Jharkhand. However, the taluka level NBSU in the state of Karnataka is non-functional as Medical officers are unavailable.

ASHAs/ANMs were aware of benefits of IYCF/ MAA (Mother's Absolute Affection) and exclusive breast-feeding. There was an adequate display of IEC materials on breastfeeding at facilities and sub centres. However, providers were unaware about the MAA initiative in the districts, ASHAs were oriented on MAA programme in monthly block meetings and were provided with ASHA info-kit and flip charts for MAA programme. ASHAs utilized VHND platform to conducted meetings with the mothers for breastfeeding promotion in villages.

The IYCF and MAA programme has initiated in the state of Assam, Bihar, Odisha, Uttar Pradesh, Maharashtra, Telangana, Meghalaya and West Bengal. However, the awareness level among service providers need to be strengthened in these states. The practice of exclusive breastfeeding observed in almost all facilities visited by CRM team. However, delay in breastfeeding from 1.00 to 1.15 hours was observed in both the District hospitals of Assam. The overall IEC activities on exclusive breastfeeding was poor in West Bengal.

The Home Based Newborn Care (HBNC) is implemented in all the states. Supportive supervision is an issue in almost all states for effective implementation of HBNC programme. Uttar Pradesh has developed an android-based application which helps in monitoring and generation of real time reporting mechanism on ASHA-HBNC performance and provides support for training and capacity building. However, block level programme managers would like a more responsive supportive supervision to reduce gaps in loss to follow up. In addition, replenishment of ASHA kit is an issue in Maharashtra and in Haryana, as is the follow up with those mothers who are discharged from the health facility.

Nutrition Rehabilitation Centres (NRCs) are available in Assam, Bihar (under Public Private Partnership mode), Chhattisgarh, Haryana, Maharashtra, Karnataka, Odisha, Uttar Pradesh, Uttarakhand, Meghalaya and West Bengal. However, there is no follow up or feedback process. The bed occupancy rate is varying from state to state and within state, district to district. The bed occupancy was reported to be 57% in Chhattisgarh, 60% in Karnataka, 45% in Uttar Pradesh and 30% in Uttarakhand. A good discharge rate is observed in the state of Maharashtra. The trend shows that many NRCs are under-utilized. In Chhattisgarh, only 60-70% NRCs are functional due to lack of staff nurse. ANMs are placed in NRCs in place of staff nurse in Chhattisgarh. Self-referral is high in Karnataka, while referral from community is high in Odisha.

The performance under Integrated Diarrhoea and Pneumonia control programme varies in content and coverage in different states, with Assam, Chhattisgarh, Maharashtra, Meghalaya, Haryana, Karnataka, Uttar Pradesh and West Bengal reporting better coverage under service provision. Non-availability of Zinc is reported from Bihar, Uttar Pradesh, and Manipur.

The Rashtriya Bal Swasthya Karyakram (RBSK) is in place and micro plan is available at all the states. However, the District Early Intervention Centre (DEIC) was set up only in the states of Haryana, Maharashtra, Odisha, Manipur, Punjab and in a few districts of Meghalaya. West Bengal has MOU with

one of the private tertiary level facilities in Kolkata, where all confirmed cases of Congenital Heart Diseases are being operated free of cost. Screening and follow up mechanisms are well established in almost all states except Uttar Pradesh and Jharkhand where programme needs strengthening. Screening is also poor Nagaland where AWW centres are not functional. While screening and follow up mechanism is good in Odisha, there is no referral transport available. Similarly, in Bihar, referrals are not being attended at the District Hospital.

Child Death Review (CDR) is being conducted in the states of Assam, Bihar, Nagaland, Haryana and Maharashtra. However, audit is missing from the CDR report of Assam and in Bihar, and more than 60% deaths were not reviewed. Haryana has developed MIDRS software to capture child death.

Health systems for Immunization is well established with the effective implementation of task force in most of the CRM states. All vaccines and consumables were found to be available in all immunization and cold chain points in all states. Birth doses of BCG, Hep B and OPV are given in most of the CRM states at facilities where delivery took place.

At all the cold chain points, cold chain equipment were functional with temperature maintained and a functional power backup. Also, protocols/job aids on cold chain management were well displayed at all the cold chain points.

Micro plan along with due lists are available with ANMs, but all details are not captured in micro plan and many dropouts were observed. MCP cards are available with immunization counter foils and immunization status is well recorded in the MCP cards. All the counter foils were found to be updated and maintained at session sites in the tickler bag at the visited HSC. AEFI is reported as per the protocol.

Alternate Vaccine Delivery System was well in place. Cold chain technician was available at the district. The ANM had adequate knowledge on vaccination schedule and 4 important key messages. ASHAs were aware about the incentives linked to mobilization for routine immunization.

Adolescent Health

RKSK is implemented with essential commodities in the visited CRM states like Assam, Jharkhand, Karnataka, Telangana, Uttarakhand, Uttar Pradesh and West Bengal. There is the complete lack of focus on adolescent health which has a significant impact on maternal and child health and missing a crucial stage of life cycle. In Uttar Pradesh- 'Meri Sehat, Mera Nirnay' programme has been initiated which aims to impart knowledge to adolescents on the age of marriage, family planning and their health.

The Adolescent Friendly Health Clinics were operational in Uttarakhand, West Bengal, Telangana, Odisha, Jharkhand and Karnataka but not in Assam. In states like West Bengal AFHCs are called as 'Anvesha clinic' while in Odisha and Karnataka it is called 'Shraddha Clinic' and 'Sneha clinic' respectively. In Punjab, the clinic is known as 'UMANG clinic'. In most of the facilities there are no separate clinics or dedicated counsellors for AFHCs and ICT counsellors are providing selective counselling services. There are no outreach activities by these counsellors.

Weekly Iron Folic Acid Supplementation (WIFS) to children was observed in Assam, Telangana, West Bengal, Chhattisgarh, Punjab, Odisha and Uttarakhand. However, WIFS has not yet been procured in Bihar and Jharkhand, while the coverage of WIFS in Chhattisgarh and Uttar Pradesh is 30% and 24% respectively. No records were available

in Assam, Odisha and WIFS not being provided to out-of-school children at AWC in Manipur. Major gap identified under WIFS Programme in UP was supply of wrong colour medicines in the schools. Inter-departmental coordination between Health, Education and WCD is still lacking which results in poor reporting under WIFS Programme which is a major challenge for most of the CRM states.

Menstrual Hygiene Scheme and the provision of Sanitary Napkins is not well operationalized in visited CRM states. The quality and accessibility of services vary from state to state as Assam, Telangana, Jharkhand, Punjab and Uttarakhand has major gaps and the Programme needs to be revived.

In Chhattisgarh, the sanitary napkins were provided from Rajiv Gandhi Swasth Yojana Scheme and in Odisha Kushi napkins were distributed even to the students of tribal schools. In Assam, adolescent girls still use the traditional cloth during menses.

There is progress in Peer Education Programme in states like Bihar, Karnataka, Telangana and West Bengal while Chhattisgarh, Assam, Jharkhand, Odisha and Punjab are yet to recruit peer educators.

Key Recommendations

- An urgent need to engage specialists in most of the states, Bijapur model in Chhattisgarh can be used for filling the gaps.
- Capacity building, supportive supervision of ANM and ASHA is required to improve quality of services.
- Non-rotation policy for labour room staff needs to be in place so that quality services can be provided to beneficiary.
- Chhattisgarh is using Sterile Disposable delivery kit, other states can adopt this model for infection prevention.
- JSSK entitlements for children need to be included in all communication material.
- HBNC kit needs to be provided to Mitanins in Chhattisgarh.
- Blue IFA supplies and reporting must be streamlined in coordination with other stakeholder departments.
- Implementation of peer educator programme-selection and training of PEs to be undertaken at the earliest in most of the states. Madhya Pradesh has implemented PE Programme very well, states can take guidance from MP for implementing PE program.
- Mapping of trained Family Planning providers and their performance review need to be initiated. FP providers at the state are not used for providing FP services.
- Implementation of “each one train one policy” for PPIUCD services.
- Prioritize introduction of Injectable contraceptive (Antara) across the state
- There is a need to strengthen NBSU and NBCC to prevent irrational referral to SNCU. All facilities conducting deliveries should be ensured functional newborn care corner. The staff of SNCU/NBSU/NBCC need to be trained in NSSK etc. and the follow up of discharge cases need to be ensured.
- DEIC needs to be set up in all states on priority basis. Functionalize the DEIC for better referral, patient management and follow up.
- Adequate supply of Zinc to all districts should be ensured.
- CDR need to be initiated in all states.

State Findings

ASSAM

- Access to C-sections has improved in Government facilities and consequently, we expect reduced OOPE.
- Postnatal stay is between 6 hours to 24hrs and in some Nalbari FRUs few patients who stayed for 48 hours.
- Use of pre-packed sterile delivery kit is a good practice for infection control but does waste a few drugs. There is adequate supply of RMNCH+A drugs. However, Inj Gentamycin, IUCD-375 and Calcium which was unavailable at Nalbari for last two years. Most of the SNs/ANMs posted in
- PMSMA day was observed at various facilities in visited districts. But there was a low level of awareness in the community about the initiative.
- In Nalbari, despite availability of ultrasound machine and radiologist, ultrasound is being done through private providers. Some of the routine blood tests and other diagnostics are also being done through private providers.
- Though state has initiated steps towards online payment of JSY incentives, progress is relatively slow. Awareness about JSY incentives was low in Goalpara, while beneficiaries in Nalbari were more aware. Payments are being done through PFMS in batches of 10-20 at Nalbari, whereas in Goalpara there were delays in payment to the beneficiary.
- In the Janani Shishu Suraksha Karyakram program, diet was provided only at CHC and DH level facilities, with poorly assured home to facility transport.
- The Out of pocket expenditure by beneficiaries were for Ultrasonography, laboratory tests, food and transport.
- State is in the initial stage to yet to implement the Dakshata program, and also the home based distribution of Misoprostol.
- Maternal death reporting (FBMDR) is being conducted but the major causes are recorded as “Others”.
- ART for ANC was not available and the delivery room staff need to be oriented on administration of Syrup Nevirapine.
- Comprehensive Abortion Care services and syphilis screening for pregnant women is available only at the district hospital at Nalbari.
- There are high numbers of home delivery – 942 in Golpara and 203 in Nalbari between April to September 2017 conducted by non-SBA. Particularly, in Char areas of the Brahmaputra basin, institutional delivery is abysmally low. None of the mothers visit the health facility and await the monthly visit of the Boat Clinic.
- Though the ASHAs have information of all pregnant women, line listing of the high risk pregnant women is not done.
- Pre-Service Nursing Education Programme has only seen the establishment of National Nodal Centre (NNC) at Guwahati. The Director of Medical Education Assam, objected to conduct other trainings at the College apart from normal classes.
- Adequate essential commodities were available except Salbutamol Nebulizing solution. Model unit of Kangaroo mother care (KMC) not found in the facilities visited.
- Initiation of breastfeeding is between 1 to 1.5 hours in Goalpara and Nalbari.
- Bed occupancy is very good in Nalbari and with a 76% discharge rate. Out-born admission in the SNCU is around 30% and the SNCU at Nalbari caters to the nearby districts as well.
- The cold chain management at all levels in Goalpara was better than in Nalbari.
- In Nalbari, the NBC is functional but its use is suboptimal. The staff posted in NBSU are not trained and it’s utlization minimal. The equipment in the facility are being condemned due to non-use.
- Zinc is available at facilities, but they have not been provided the ASHA kit.

- The use of antenatal Corticosteroids in preterm labour and use of Gentamicin by ANMs for management of sepsis as well as implementing them at district and sub-district level was not observed.
- In Nalbari, the RBSK team was mostly focused on information collection and screening protocol of head-to-toe approach was not being followed.
- DEIC is not operational, though the state has engaged the DEIC human resources.
- Only 23 cases of CDR was done out of the 67 child deaths by the block Medical Officers and the audit report was missing.
- The CRM team observed improvements in Routine Immunization (RI) across all districts, with increase in use of IT enabled platforms such as eVIN.
- In many areas of Nalbari and in the Char areas, Only BCG is given as birth-dose . For rest of the doses, in Char areas, there are gaps in immunization with missed doses.
- JSSK entitlements of free diet and assured free transport from home to facility has been repeatedly pointed out by last three CRM reports continue to remain unaddressed.
- While display of IEC for RCH component was found, they were not in local language and the placement was improper
- Adolescent health component is totally missing from the State's radar leading to vicious cycle of anaemic mothers giving birth to LBW babies and other associated problems

BIHAR

- Bio-medical Waste segregation at source was carried out by colour coded bins in the labour room. Displays for NSSK regimens and hand-washing steps found to be placed in labour rooms.
- ANC was incomplete with no blood pressure nor haemoglobin in the ANC records carried in past month.
- There was no provision of 180 IFA tablets (as per new guidelines) and with no printed records in the health facilities.
- MCP cards were incomplete (Hb, BP and urine albumin were lacking) with poor awareness on identification criteria for high risk mothers (including in MOs). There was no line listing of high risk mothers including severe anaemia cases.
- In Madhepura district, the OOPE for institutional delivery ranged from 1000 to 5000 per delivery. The high OOPE were for drugs, transport and diagnostics.
- Labour room protocols (such as partograph) and registers were not maintained. Oxytocin was not stored in refrigerators.
- Bhojpur has not disseminated recently launched guidelines i.e. Hypothyroidism, GDM, Home based Misoprostol, Guidelines for Deworming in Pregnancy, Maternal Near Miss at Tertiary Level Hospitals and training of Surgeons on C-section.
- More than 60% of the staff were not trained in SBA, NSSK, RKSK, and PPIUCD in both districts.
- No MDR was conducted in Bhojpur while 5 reviews were conduced in Madhepura. On review of maternal death reports, it was noticed that high risk pregnancies were not identified during the ANC visits as the line listing for HRPs and severe anaemia was not carried out in the districts. Most common cause of maternal deaths reported was PPH.
- In Madhepura SNCU, it was observed that no MO was available for night duty. SNCU admissions has a gender bias as the SNCU admissions reported only a third of sick girl children in previous 6 months.
- DH and PHCs in Madhepura has KMC rooms with poor display of IEC materials, though some had hand painted wall IECs.
- Madhepura NRC reported around 90% bed occupancy during July-Sep 2017 with a cure rate more than 90%.

- ASHAs interviewed in Madhepura district were not found to be aware of IDCF incentives for ORS prepositioning as they did not receive any such incentive in past.
- NDD coverage was 92% for Madhepura. Private school participation in NDD August round in Madhepura was also found to be satisfactory.
- ASHAs utilized VHND platform to conducted meetings with the mothers for breastfeeding promotion in village and were not aware of breastfeeding promotion except VHNDs. Counselling on appropriate breast-feeding practices is minimal.
- 125 child deaths were reported in Madhepura in 2017, however, more than 60% (73) deaths were not reviewed.
- There is overall shortage in RBSK staff at the state. The Mobile Health team in Madhepura has one AYUSH doctor and one pharmacist to conducted screening of children in the schools. The school principal reported that RBSK team referrals were not received at the Madhepura District Hospital due to shortage of staff.
- e-VIN software was operational even at peripheral facilities and immunization was carried out at VHND and PHCs. Hepatitis zero dose is not provided to many newborns as the mother leaves the health facility in less than 48 hours post-delivery. Alternate vaccine delivery mechanism was present in both the districts.

CHHATTISGARH

- Dhamtari district has a 1st trimester registration of a good 80% with four ante natal visits of 76% pregnant women. In Bijapur district, total ANC registration (April-September) has increased by 20% (57.4% to 78.02%) in comparison to last year, the 4 ANC check up percentage is stagnant at 71% against total ANC registration.
- Chhattisgarh has innovatively improved access for the hard-to-reach populations through health umbrellas at Hatt bazaars (local markets). Women come to these local markets for shopping where the they are encouraged for ANC, immunization and offered rapid diagnostic testing.
- Iron folic acid tablets, calcium and deworming tablets were available and distributed according to GOI guidelines for the past one month.
- All pregnant women were screened for HIV, syphilis and sickle cell anemia in the government facilities. At sub-centres, the ANM were provided with test kits in Thermos flask to maintain temperature. Rapid test kit are provided to service providers in sufficient quantities by the State.
- Though Dhamtari has a fairly good ANC registration, however full ANC coverage drops down to 35.5% due to low IFA consumption.
- At Dhamtari, there were no proper records/ registers, USG services, Line listing of high risk cases, nor completed MCP cards. The State on its part, has conducted a special “Quality ANC training” for all the ANMs to improve the quality of ANCs.
- There are total 213 public health facilities in the Dhamtari, of which only 20 are delivery points. In Bijapur, only 10% home deliveries are attended by SBA (which is an increase of 6 percentage points from last year) and in Dhamtari, 17% home deliveries are non-SBA assisted. The percentage of C-Sections in Bijapur DH is 5%, among the total deliveries conducted, which can be attributed to the poor primary care from PHCs and increased prevalence of quacks. There is no private delivery point in the district. DH Bijapur is the only CEmOC center in Bijapur with facilities available for C-section and a blood bank. There are three gynecologists posted in the DH with a surgeon and an anesthetist. This makes 24X7 elective and emergency C-sections possible in the DH Bijapur. Out of designated 72 FRUs 54 FRUs are currently functional.
- The percentage of C-sections in Dhamtari district is 27.7% out of the total deliveries conducted at public and private facilities. The percentage of C-sections in public facilities is 6.8% and that in private facilities is 52.6% in Dhamtari District.
- Labour room practices are well managed. One birth companion is allowed inside labour room which has a positive impact on beneficiaries, and

most women reported the practice is comforting for them. A form to nominate birth companion has also been introduced in the State, which is commendable.

- Local dialects were used in wall painting related to JSY services. MCH schemes were being played on the TV in UPHC and CHC on TVs in waiting area. RMNCH+A commodity matrix was seen displayed at only one facility (CHC Bhopal Patna).
- 77% of total deliveries in Dhamtari district received Post Natal care. There is early initiation of breast feeding (in the labour room itself) with kangaroo mother care practice in both districts
- In Dhamtari, the staff of SNCU is well trained and the data recording and reporting is done online. Of the 485 total admissions in SNCU Dhamtari in 2016-17, 70% of newborns were out born. Mortality rate is 13.8% in Damatri and 9% in Bijapur district.
- 63% children are fully immunized in the district. Due list and micro plans were available for immunization in almost all facilities. eVIN is used to maintain the stocks of vaccines in the facilities. Open vial policy is maintained in most of the facilities.
- AVD arrangements found to be well established in the District. Birth dose or zero doses are not provided before discharge at many facilities.
- Cold chain is very well maintained in all the places. In UPHC Gudiyari, Dhamtari frozen vaccines were found in IRL and the preventive maintenance records and temperature records were found incomplete. PHC Awapalli was defaulting on the cold chain maintenance protocol.
- Bed occupancy rate of NRC is 57% in Bijapur district (April-sept 2017). Incentives were not paid to the Mitanins in Dhamtari.
- As per District records, 67% of the pregnant women delivered in Institutions till October 2017 received JSY incentives through DBT. Private health facilities are “empanelled” to provide delivery services and beneficiaries of BPL category at the rate of ₹ 1000, with the mitanin being paid ₹ 200 as incentive for promoting delivery in these private health facilities. Private sector facilities are paid an additional ₹ 100 per delivery as administrative charges.
- None of the beneficiaries reported to have incurred any out-of-pocket-expenditure. The beneficiaries also reported to have received free drugs and diagnostics except ultrasound. Assured referral transport is provided and toll-free number 102 is available and communicated to the facility.
- Women delivering in Sub-centres are not provided food during their stay in health facility. No grievance redressal mechanism for JSSK was found functioning in either districts. JSSK is not being implemented in CHC Usoor. No diet was provided to mothers delivering in CHC Usoor.
- There is no distribution of misoprostol for home deliveries and the explanation given was that mothers may misuse it before deliveries. Administration of corticosteroids for preterm was unavailable (except DH). Line listing of High Risk pregnancies severe anaemia cases, gestational diabetes and thyroid screening was not being done. There was no mechanism for LBW tracking. For PMSMA, a separate register is being maintained at facilities; however, no line listing of high risk mothers is being done at PHCs and CHCs.
- There were 18 maternal deaths reported in last six month in Dhamtari district. 12 deaths were registered out of which 11 deaths were reviewed.
- District early intervention center (DEIC) was not established in either districts, though DEIC has been approved in District hospital, Dhamtari.
- Adolescent Health in most of the facilities had no separate clinics nor dedicated counsellors for AFHCs. ICT counselors were providing selective counselling services with no outreach services.
- Blue IFA tablets were available in schools and Anganwadi centre visited in Dhamtari. Supply chain is variable across blocks and the tablet

reachsthe school and Anganwadi through Block Education Officer or Sub-centres. WIFS coverage is only 30% in the Dhamtari district. School health programme is largely dependent on ANMs who regularly visit schools and deliver talks on various health issues.

- State has an EU funded MHS and the state is procuring sanitary napkins using NHM funds.
- In the school visited, teachers and students had good knowledge about anaemia. CHC Bhopalpatna has issued Blue IFA tablets to BEO and CDPO after a gap of one year. The last stock was distributed in September 2016. In Kanya residential school, Murkinaar, Blue IFA has been out of stock for many months. The students in residential schools are receiving sanitary napkins from the Rajiv Gandhi Swasth Yojna scheme. Under PE program, state is yet to start selection of Peer Educators.

JHARKHAND

- Mission Parivar Vikas (MPV) had to be rolled out in 9 districts of Jharkhand whose TFR was above National average or more than 3, with access to all FP commodities and services till the lowest level of health centre. However, Pakur has not yet rolled out MPV in their district, with limited services restricted only till the District Hospital.
- Irrational distribution of FP commodities was seen in both the districts. Newer contraceptives were not available in the visited facilities. Stock registers and indents were missing, with no demarcation between free supply and HDC supply.
- State level training of FP-LMIS, an online logistic monitoring and information system is complete; however, the same is still pending for the district level.
- Blood bank and Blood storage units are not available in either districts, although in East Singhbhum have a tie up with Red Cross society for blood.
- One FRU is in place in both the districts, however in East Singhbhum MGM medical college is also providing EmOC services.
- The State uses the Mamta Vahan for referral Transport of Pregnant women and the MoU is at the block level. Utilization was low and there was no-dropback facility which resulted in high OOPE. The state provides ₹ 250 if the patient arrived by private vehicle to the facility.
- ANC services up to CHC level are available but no routine ANC tests have been performed by the ANMs in VHNDs and SCs in Pakur. PMSMA is well implemented. Tab. Calcium and Tab. Albendazole, high risk pregnancy list and USG services were not available.
- There were no labour room protocols, Cold chain management and nor KMC. Dakshata training has been conducted for staff of pakhuras with support from UNICEF.
- Poor biomedical waste management and utilization of partograph.
- Even after the provision of Diet, drugs and transport facilities under JSSK high OOPE incurred on ultrasound, CeMOC services and transport facility. There was a 36% back log in JSSK payments.
- Implementation of CMDR is observed in Jamshedpur district but not in Pakur. First trimester abortion services are available at DH and CHC in both districts but second trimester abortion services are not available in Pakur.
- The budget has been approved in the PIP for home-based distribution of misoprostol in Pakur district, however procurement of 600 microgram is yet to be done.
- KMC, Child death review mechanism, birth dose of immunization, due list/microplan, cold chain mechanism and DEIC were not available. RBSK is in initial stages.

KARNATAKA

- ANC registration is more than 96% in both the districts and early registration is also more than 70% (72% in Raichur and 79% in Chitradurga) but the 4 (or more) ANC checkups is less than the state average in both districts.

- State average of TT2/booster is 79% and is less (58% in Raichur and 71% in Chitradurga) than the state average.
- 47% pregnant women received 180 tablets of IFA in Raichur and 51% in Chitradurga, both being below the state average of 98%.
- 99% deliveries are institutional deliveries in the State. 63% of these were delivered in public health institutions (69% in Raichur and 74% in Chitradurga) and 37% delivered in private health facilities (31% in Raichur and 26% in Chitradurga).
- The average stay for 48 hours was for 36% in the State while the visited districts were better off at 44% in Raichur and 60% in Chitrdurga.
- Overall C-section rate is 29% in the state with 15% in Raichur and 42% in Chitradurga, against the total of institutional deliveries. The C-section rate in public health facilities is 49.7% (36.2% in Raichur and 56.2% in Chtradurga) and in private health facilities it is 50.3%. (63.85 in Raichur and 43.8% in Chitradurga).
- Labour rooms were as per labour room protocols but with an acute shortage of MBBS doctors and specialists (Obstetricians, paediatricians and anaesthetist). Most post-natal cases at all levels of facilities (PHC/ CHC/Taluka hospital/RIMS) were found to be anaemic.
- PMSMA is implemented in all the blocks of both the districts but full complement of services as recommended in PMSMA is not being done in most of the places. Five to six private agencies have been contracted for providing ultrasound scan for ANC cases under the PMSMA for the past 1 year.
- JSY and JSSK are well implemented in the states but delay in payments and out of pocket expenses incurred on transport, blood and C-sections have been reported by beneficiaries. Grievance Redressal through 104 Toll free is available.
- There was no separate line listing of women-at-risk of gestational diabetes, APH or PIH cases.
- FRUs where emergency obstetric care and C-Sections could be done, were only at Taluka Hospitals and DH/Medical college hospital.
- Maternal death audit and review meetings was being conducted regularly for the 400 maternal deaths reported in the state from April 2017 to August 2017.
- PPTCT facilities are available in the district where 100% HIV screening and 80% Syphilis screening of pregnant women is done. However, ART drugs were not available at CHC level. For the whole district, ART facility was available at District hospitals/RIMS (medical college) only.
- Comprehensive Abortion Care (CAC) was available only at the Taluka hospital where an Obstetrician or Gynaecologist was available or at the District Hospitals/RIMS medical college were providing CAC services in the visited districts.
- De-worming was being done, Calcium supplementation is being given, no hypothyroidism screening, Blood Sugar is done and if suspected sent to RIMS for screening for gestational diabetes. Calcium supplementation was given during ANC visits. District officials were not aware about Dakashta guidelines.
- At the district Raichur, “Karnatka Mathru Purna Scheme for pregnant and lactating women” was being implemented by state through Aanganwadi centres where, pregnant and lactating women were provided one wholesome meal every day at the Aanganwadi.
- All the essential equipment and drugs were available in NBCC, NBSUs and SNCU visited. All the vaccines under UIP, Initiation of breast feeding within one hour, Birth doses, AEFI and cold chain management are well maintained. There was no feedback or follow up mechanism for discharged neonates.
- Infant Death Audit was being done at Raichur District, In FY 2016-17, 701 infant deaths were reported out of 39226 live births while in 2017-18 (April-September), 378 infant deaths were reported out of 19083 live births. However, no records were provided for the deaths in age group of 1-5 years.

- MAA Programme is yet to be rolled out in the state or the districts visited. No KMC practice was observed at any of the health facility visited at Raichur. KMC is functional in District Hospital Chitradurga. The state has not rolled out the policy of Inj. Gentamycin to be given by ANMs.
- IDCF, National Iron plus initiative, Deworming, Vit A supplementation, HBNC and RBSK programs are well implemented.
- Functional NRCs with not more than 60% admission rate, no follow up and feedback on discharged cases is being conducted.
- All vaccines were available and AEFI registers maintained with full immunization coverage 88% in Raichur district.
- PCPNDT Act implementation needs strengthening. 58 machines have been seized and ultrasound units sealed, 38 cases are pending in the Court and 79 cases have been filed from 2002 till date but Form F, registers and records were not maintained.
- Medico legal protocols for management of sexual/gender-based violence issued by MOHFW is not being followed by the state. Old formats for examination of rape cases were still being used.
- There is only one ART centre situated at RIMS/ DH at Raichur providing ART to 604 general clients and 22 ANC clients. District may consider ART centres at Taluka Hospitals to reduce the time taken to avail care. Family Planning:
- Family planning counselling is completely missing at RIMS, neither the FP counsellors nor the nurses of the labour room/post-natal ward had spoken about spacing of births to post-natal women who have been at the health facility for even as long as 4 days.
- As per interactions with ASHAs home delivery of contraceptives being done but it was noted that spacing methods especially Oral pills are not very popular and has few takers. ECP were not available in Raichur district at any of the health facility including ASHAs kit.
- Ensuring spacing at birth scheme (ESB scheme) was available in both the districts and ASHAs were aware about the scheme and incentives for the same.
- Though there are trained staff, PPIUCD rate was a dismal 2% of the institutional deliveries in 2016-17.

MANIPUR

- Facilities visited were found clean and well maintained with 24x7 water supply in the labour room.
- Home Based newborn care was doing well and ASHAs had good knowledge on HBNC and PMSMA.
- ILR with eVIN (Electronic Vaccine Intelligence Network) Temperature Data Logger, recording and transmitting real time temperature data is maintained.
- Cold Chain Handlers were trained and using eVIN application (on the provided mobile phones) to upload and maintain real time stock status of vaccines in their cold chain point with temperature loggers. Alternate vaccine delivery was found to be operational and cold chain points were receiving the vaccines as per the plan.
- Functional Oxygen cylinders and Colour coded bins for biomedical waste management were found in all the visited facilities.
- Active Management of third stage of labour (AMTSL) being followed in all the visited facilities. The staff was trained and providing oxytocin to all the delivered women.
- Maternal Death Review is operational in the state and there was a recent meeting on MDR and discussion on maternal death.
- Lack of human resources, especially specialists and medical officers and shortage of essential equipment such as CPAP, fetoscope in all the facilities. There is no SNCU, NBSU and NRC in both the districts except RIMS (NICU).
- District Hospital Tamenglong was in the process of shifting to a new building. Few services were

not available (such as X-ray) since the equipment were either in old building or not yet installed In addition, there are few services such as family planning, being provided in the old building causing inconvenience to the patients.

- NICU at RIMS, Imphal is 10 bedded with 6 functional beds and is unable to cater to the newborn load. There is no central oxygen supply and oxygen concentrator. There is a stepdown unit of 4-bedded which is also used for sick newborns.
- The referral facility for complicated delivery cases of Tamenglong is RIMS/JNIMS, which is a 6-7 hours drive due to hilly terrain and poor road conditions.
- Classification for storage of drugs, Essential drug list, Bin card system, Anti-snake venom, anti-rabies vaccine, atropine & PAM, tracking of high risk pregnancies, Central oxygen supply, Schedule H drugs and policy on date expiry drugs were not found.
- PCPNDT Act was not implemented. No license nor the display of "Sex Determination not done" with the prescribed forms was found (even at RIMS).
- There are no C-section services due to lack of Anaesthetist in the CHC Wangoi (West Imphal) and district hospital, Tamenglong.
- RKSK services including AFHC/ARSH clinics were not found in most facilities visited, except CHCs.
- No Child Death Review was being implemented in district Tamenglong and Emergency contraceptives not found in all the visited facilities.
- No immunization outreach sessions planned/ conducted in all 7 wards of (UPHC Langol Tarung) and No Zinc tablet, Calcium and vitamin K found in all the facilities in district Tamenglong. False reporting of Zero Dropouts in immunization in ANM's HMIS report (at UPHC Langol Tarung).
- Spacing methods for family planning are being done but limiting methods are poorly followed.
- AYUSH practitioners were not found in facilities at district Tamenglong (except PHC Longmai).
- WIFS not being provided to out-of-school children at AWC and Urban ASHAs not trained in Modules 6 & 7 in district Imphal West.

ODISHA

- Promoting family planning methods is being done by ASHAs through diligent community based advocacy for young women during opportunities like – VHSND, home based new natal care visits and small group meeting with women. However, the expanded basket of choice of contraceptives at the facilities needs to be ensured and offered during family planning counselling.
- The cases of evacuations reported from over the counter use of abortifacient pills hint at the high unmet need for family planning in the district.
- PPIUCD insertion and IUCD insertion were found to quite prevalent, desired by the community and suitably trained HR, which is in sync with national program.
- Availability of free contraceptives was less than the paid contraceptives that are available with ASHA.
- RMNCH+A Counsellors and ANMs were found to be providing counselling for FP with adequate display of IEC material at the facility. Audio-visual material was displayed in the waiting area and kangaroo care rooms.
- ECP was unavailable in the field as it was not supplied through central procurement.
- 51.8% Pregnancy Test Kit Utilization has been reported in 2016-17.
- The state has initiated a state specific initiative called SAMPurNA (Sishu Ebang Matru Mrutyu Hara ra Purna Nirakarana Abhijaan) to accelerate the reduction of maternal and infant mortality.
- A new initiative of Maternity waiting rooms for accommodating women from inaccessible and hard to reach areas before their expected date of delivery was being practiced. A "Maa Gruha"

attached to the facility at Keonjhar was also visited that was being run by a NGO.

- The state has initiated alternative referral transport like boat ambulance, bike ambulance for difficult areas.
- PMSMA has an average 50-60 registration done as per the records in facilities of Salipur and Mahanga in past 4 months
- All pregnant women were identified as high risk pregnancies based on the clinical high risk as well as geographical inaccessibility criterion had 'red cards' of HRP issued to them in addition to the MCP card.
- Due to space constraint, labour room and SNCU were not strategically placed currently but was within the MCH wing in the new DHH building at Malkangiri.
- High use of oxytocin was evident from the records (7 out of 10 pregnant women) at DHH. Throughout the District, under JSSK free diet provision, women were being provided biscuits for breakfast. The diet protocol is available but not being followed.
- *Anitary* napkins were not provided to the mothers in the PNC ward.
- PHC Govindapalli is a BeMOC facility with average 20 deliveries per month. Labour room well maintained with protocols and records, registers.
- District of Malkangiri has reported 29 maternal deaths in the period of 5 months (April-September 2017). The DM and the CDMO are involved conducting the review meetings of maternal deaths and maternal near miss at the district level.
- CAC services are being provided at PHC level and above. MVA was being done more commonly.
- Calcium Supplementation, Deworming, GDM, maternal near-miss review, home based distribution for Misoprostol for preventing PPH were recently implemented. Screening for syphilis &HIV done regularly and Screening for Hypothyroidism not yet started
- Full immunization coverage of district improved significantly from 29.6% (AHS 2012-13) to 76.9% (NFHS-4) for Malkangiri and 77.6% for Keonjhar.
- Regular analysis of immunization data, and gaps identified are shared during monthly district review meetings/district task force for immunization (DTFI) in Malkangiri district. Need based innovations undertaken to reach the unreached children through Special Immunization week, Mission Indradhanush, V-4 sub-center plan and integrated VHN session in difficult to reach areas.
- e-VIN is functional, AEFI recording and reporting, RI micro plans and Adherence to alternate vaccine delivery and open vial policy at all levels, Birth dose vaccination (BCG, Hep-B and OPV) is available.
- Records and registers at SNCU at DHH were well maintained but not in NBSU. Adequate staff as per norms was available except for paediatricians in Malkangiri.
- There was no referral to the SNCU during last one year, Infant with birth weight less than 1.5 kg discharged without documented weight gain.
- Inborn admission rate was higher at all the facilities visited. The doctors mentioned unavailability of investigations like CRP, Blood culture and electrolytes in the hospital which lead the patients to get it done from private sector.
- At Keonjhar, the bed occupancy rate of NRC is quite less. Bed occupancy rate was close to 90 percent at Malkangiri and the recovery rate was only 35 percent.
- ASHAs have helped in implementing HBNC Programme in the District as ASHAs have a strong knowledge base. However, skills for referrals and identifying illness in infants were highly compromised.
- Designated KMC ward and AV aids for BCC IEC were available.
- The availability of IFA Pink and implementation of WIFS Junior was variable. WIFS Junior

implementation at Pujarimuda Primary School was efficient as IFA Pink was available as per the requirements, stock registers were also complete and growth charts are duly filled.

- Out of 14 Mobile Health Teams sanctioned, 07 numbers are currently functional.
- RBSK individual cards were available at all the schools visited but were either incomplete or had improper prescriptions.

PUNJAB

- The State has integrated system of ANCs through the system of VHNDs, SC, 24/7 PHC, Block Hospitals and DH; thus, ensuring preparedness for providing full ANC services.
- JSY and JSSK are well implemented however there were rare instances where the beneficiaries incurred OOPE while availing JSSK services.
- Line listing of HRP was done at both facility and the community level. Although a register was maintained for recording HRP, but the register did not mention the criteria for inclusion under high risk category.
- The drugs were available but not stored as per the recommendations, for example Oxytocin not stored in the refrigerator.
- All the LR visited had HIV kits for testing but ART drugs for Pregnant Women at Labour room were not available. So they are procured from the nearest Medical college.
- At Kapurthala, only 2% were home deliveries and 52% were public hospital deliveries. Majority of clients although registered for ANC at public hospitals preferred to deliver in private hospitals.
- The district has not launched the MAA Programme and tracking of utilisation of DEIC services by Sick neonates was not present.
- Micro planning was available for the screening visits during Mid-March.
- The school nodal officer-maintained records of WIFS. The turnout at AWC was reported to be about 50-75%.
- NBSU was underutilized and Monthly bed occupancy is 5-6 babies per month, however, the ASHAs were making additional home visits for LBW and SNCU discharged babies.
- All the vaccines and logistics like MCP cards and counterfoils were found to be adequately available at the immunization points and ILR points. The vaccines were stored as per the recommended standards.
- Birth doses of BCG, Hep B and OPV are given at facilities where delivery took place.
- AVDS were managed by ASHAs and ANMs and volunteers were not identified was disposing the same. Power back up was found to be adequate in the facilities and temperature chart was maintained. Cold chain technician was available in the district.
- ASHAs were aware about the incentives linked to mobilization in routine immunization. However, the new incentive pattern for Institutional deliveries was not completely implemented.
- Newer contraceptives were not available at any facilities and Vasectomy rate was negligible
- The LHVs posted in the PPC was not trained for insertion of interval IUCD. The ANM was providing counselling for basket of choices in FP. Staff posted in the LR were not trained in PPIUCD. The patients' written consent was not being documented.
- However laparoscopic tubal ligations were not done for women infected with HIV. There was fear of infection and sterilization of laparoscope post-surgery. They were offered Minilab Tubal ligations.
- Home based delivery of contraceptives by ASHA was restricted only to condoms

TELANGANA

- In Telangana, all the maternal health indicators were better placed than the national average and the performance over the last three years has improved. MMR of the state is 92, TFR is 1.8, IMR is 28, CMR is 32, institutional delivery rate

is 91.5% and rate of children who have received full immunisation is 68% as per SRS and NFHS IV respectively. Telangana has achieved NHM target for Maternal mortality ratio and replacement level of Total fertility rate.

- Quality of services was found to be better at CHC level but blood storage units, USG services and NBSU were inadequate.
- At Madhu CHC of Khammam district, from January 2017 to October 2017, a total 122 cases had been referred to Khammam District hospital and more than 80% cases were either Post LSCS or for anaemia/PPH.
- The CHC does not have blood storage unit and at the facility a surgeon was performing Caesarean sections.
- PMSMA is being implemented from June 2016 in Telangana but due to lack of adequate number of service providers in the public or private health facilities, all the PHCs and CHCs are referring pregnant women to District hospitals incurring out of pocket expenditure to the families (₹ 6000/- to ₹ 7000/- per case).
- Telangana is a high Performing State and as per guidelines of the programme mothers from BPL and SC/ST communities are receiving entitlements from JSY.
- The state has recently introduced a scheme for mothers called KCR scheme which has a similar objective as JSY (to increase institutional deliveries). Under this scheme Government of Telangana is providing a kit of ₹ 2000/-for all eligible women and a cash benefit for Girl child of ₹ 13000/- and for the boy child ₹ 12000/- from state budget.
- The training provided to the technicians and paramedics was found to be insufficient (specifically regarding Biomedical Waste Management). There is no defined checklist provided by GVK EMRI regarding maintenance of critical equipment nor cleaning protocols for the ambulances.
- State has three types of referral transport to the community one under JSSK second one is from 108 and third is from 102 MCH services.
- The state has converted the older 108 referral transport vehicles into Hearse vehicles. 50 vehicles with body freezers are providing services. Bodies are transported, free of cost to the place of choice of families. About 6000 bodies have been transported in the past six months.
- Line listing of GDM patients is not available in both the district as there are no any clear protocols regarding diagnosis and management as per state guidelines. The high risk antenatal registers which are present in facilities do not document the expected number of GDM and PIH cases.
- Blood transfusion service are available only at two FRU out of three in Khammam district which caters 16 lakhs population. In the Adilabad district there is only one tertiary health facility available for 7 lakh population.
- In all the facilities visited in Adilabad district, privacy and cleanliness of the labour room was satisfactory. Drugs were found to be stored according to the protocol (Temperature to be stored at, Monitoring of expiration dates etc.) except for stock out of certain drugs at certain facilities.
- Partograph were attached to the case/discharge sheets and the SN posted in the labour room were more knowledge, than the PHC SNs.
- SNs and ANMs in facilities were DAKSHATA trained. State has provided training for staffs on BEmOC, Medical officers orientation training, FBNC, KMC, F-IMNCI.
- The state has MDR mechanism but Community level CDR (verbal autopsy) is not held regularly in the visited districts. Institutional review is being carried out in the District hospital/Medical college.
- The State has established skill labs with adequate HR and mannequins.
- Manual Vacuum Aspiration (MVA) and Medical Termination of Pregnancy (MTP) facilities are available at the DH. At CHC Madhira, MTP and MVA services were unavailable, though an OT and with equipment is available as the LMO is

not trained. In Adilabad district, safe abortion services are not available at any level of health care services.

- Implementation of the newer guidelines of maternal health such as syphilis screening, deworming and calcium supplementation are being done at both the districts. The guidelines for gestational diabetes mellitus and hypothyroidism have been circulated in the district but are yet to be implemented.
- Overall cleanliness was maintained at the HSCs with electricity and water supply. VHND days were carried out once weekly and essential drugs are available at the HSC level. No home deliveries were reported in the visited HSC areas.
- All the delivered babies were found to have been fed within first hour of birth at public health facilities. Separate breast-feeding rooms are available at Khammam district hospital and RIMS, Adilabad.
- In case of DH of Khammam district, it was observed that the proportion of inborn admissions is significantly more than the Outborn admissions. The observed mortality rate is 10%- 11% in SNCU.
- KMC ward with adequate infrastructure were observed at District hospital Khammam in the KMC ward and RIMS, Adilabad. Well-maintained post-natal wards were available across the delivery point facilities in both the districts.
- All babies are breast fed within 1 hour of birth and receive zero dose immunization received. All mothers complied with the 48 hrs stay at the health facility, though only at District hospital level.
- RBSK was effectively implemented in the state with adequate RBSK mobile health teams recruited and trained. Each team consisted of Medical Officer (MBBS and AYUSH), ANM and pharmacist and were trained for five days. The micro plan was found to be available for RBSK teams.
- DEICs are functional in 10 districts in the state with adequate human resource and the procurement for equipment is under process for dentistry, speech therapy and optometry.
- All vaccines were found to be available at all the visited facilities and birth doses of OPV and BCG and zero dose of Hep B were found being given at all the facilities.
- For family planning, interval IUCD insertion was being done and sterilization services provided at visited health facilities. However, records were poorly maintained and informed consent was not being taken in Adilabad district. Sterilisation certificate were not being issued according to the Supreme Court mandate in neither districts.
- The Adolescent RKSK Programme was implemented in eight high priority districts which have been identified by GOI, which includes Adilabad. Here, the RKSK Programme has trained 1679 peer educators. Essential commodities under RKSK such as, blue IFA, Albendazole etc. are available in adequate quantity. Procurement of sanitary napkins is under process. Posters with information on adolescent health issues were found to be displayed at AFHCs. Dedicated space has been provided for AFHCs and the clinics were functional with well-maintained registers.
- WIFS is well implemented in Adilabad districts though the menstrual hygiene scheme was not operational. The utilization of these AFHCs was poor and most of the beneficiaries are routed through general OPDs.
- An intensive ANC schedule is followed (1st to 5th months of pregnancy – Monthly, 6th to 8th – every fortnight, 8th – till delivery – every week) and the Kangaroo Mother Care initiated. Drugs is available at the all health facilities as per EDL of the state.
- A State-of-the-art DEIC centre with medical officer, dentist, audio therapist, physiotherapist functional at RIMS, Adilabad.

UTTAR PRADESH

- Lower ANC coverage in women was reported due to relocation of pregnant women to their

maternal house for delivery. These women were not being tracked through the MCP cards in the visited districts.

- Line listing of High Risk Pregnancies was not being maintained at all health facilities. However, the ANMs were aware of signs and symptoms of high risk pregnancies and were the anaemic mothers.
- Mini Skill lab established in 200 Block CHCs and in 25 DWHs. Dakshata lab and Nurse Mentors were available and were a big resource for mentoring of paramedical staff.
- Provision of Ultrasonography of pregnant women on PPP mode at 50 high delivery load facilities of 40 districts initiated.
- A new incentive for Maternal Death reporting by community of ₹ 1000 has been initiated. IEC in newspaper and FM channels has started.
- GDM management of all PWs in almost all 18 divisional headquarter districts has started after completion of training at the block level.
- To decrease the MMR, the state has taken an initiative to train all the Gynaecologists & LMOs for PPH management with help of the TSU & KGMU faculty. In the first phase around 600 doctors posted at FRUs were to be trained. Training of 12 out of 15 batches has been completed.
- Initiatives on hiring of specialist on regular as well as contractual basis, from open market through open bid with performance-based payment mechanism are innovative.
- There was a minimal out of pocket expenditure reported on MCH services.
- A very good coverage of eVIN system and a competent supply chain management complementing performance of Immunisation activities in the state.
- All JSY, JSSK & other Payments to beneficiaries and ASHAs were through PFMS in ADHAR linked bank A/c and the JSY, JSSK, MDR reporting was through HMIS & UPHMIS.
- The new Initiatives like "Hausla sajhedari" under Family planning where private providers (surgeons) have been empanelled with the state to improve access to family planning services in the population and to decrease the unmet need.
- Adequate supply of IFA for pregnant women was observed in the community and tablets were being distributed to pregnant women during ANC visits. However, low consumption of IFA tablets was due to lack of counselling on when and how to consume the tablets.
- EMOC and C-section services were functional at DH and Medical College in Kanpur Dehat. On the other hand, in Kaushambi, every month there were only 18 C-section being done at the DH.
- None of the FRUs visited in both the districts visited had a functional blood storage unit. The reason of non-functionality of these varied in both the districts. In Kaushambi, trained HR was not available and in Kanpur dehat, procurement of storage refrigerators was delayed due strict financial guidelines and lack of flexibility of pool funds.
- Comprehensive abortion care services were available at the DH only. Comprehensive abortion care at L2 and L3 with respectful care was missing in either districts.
- Technical skills on practicing ENBC, resuscitation, delayed cord-cutting, correctly filled partograph were mostly inadequate in Kanpur Dehat, whereas in Kaushambi it was better.
- MDSR was not yet implemented in either districts, however MDR being conducted with only 30% deaths there was no systematic analysis beyond clinical causes, including the Medical College. No major corrective actions were undertaken based on the review.
- All the mothers delivering in a facility are entitled for JSY/JSSK incentives in the state. In the state all, the payments under JSY to beneficiaries is done through PFMS. However, the physical achievement under the scheme is still at 41%.

- Provision of USG services under JSSK has helped in reducing the out of pocket expenditure on diagnostics but the utilisation within the beneficiaries is minimal due to lack of awareness amongst the frontline workers and limited IEC.
- Referral services under JSSK have shown improvement with an average reporting time of 25-30 minutes. Until Oct'17, 11099 clients availed services of the 102 ambulance service out of 20089 institutional deliveries (55%). Grievance mechanism is not yet operationalized.
- Coverage of PMSMY is still low with only 498 empanelled private doctors providing services under the initiative in the state. Free USG services for PWs have been an initiative under PMSMY which has been implemented throughout the state. 6,14,059 PWs availed facilities till date. 53,855 HRPs identified and provided services. Follow-up of these identified HRPs for referral and continuity of care however is still very low.
- New born corners are established with in labour room in all DPs visited by the team with all essential functional commodities. While majority of the equipments required for a NBCC were functional, Mucus extractor was not available in many of the health facilities.
- None of the facilities/FRUs visited had established a functional NBSU. Even at the state level, out of 240 NBSU only 36 (15%) have been established in the state.
- The functionality of SNCU varied in both the districts with adequate infrastructure, equipment and human resources. While SNCU was fully functional at Kaushambi, but only partially at Kanpur.
- SNCU at Kanpur dehat, reported only 23% bed occupancy and 80% in-born admissions. More than 50% of the morbidity was reported due to respiratory illnesses indicating poor labour room protocols. In Kaushambi, inborn and out-born admission ratio was almost 50% each – 387 and 442 respectively. The mortality was 9.4%, while the RDS, Sepsis and LAMA were 19%, 3% and 24% respectively of the total admissions.
- HBNC visits by ASHAs was adequate but the coverage through HBNC and referral of sick newborn children was very low (3.8%) as compared to 55% across the state.
- Exclusive breast feeding and skin to skin contact and practices was followed and confirmed by staff interaction and beneficiary interview, while KMC for LBW babies was not observed.
- The 10 bedded NRCs were functional in both the districts visited. Both the NRCs were maintained by adequately trained staff. Bed occupancy in both the districts was observed to be low with an average of around 45% in both the districts. 30% SAM children were discharged with partial weight gain.
- Child death reviews were not implemented anywhere in the state and the reporting was rather low.
- The immunisation coverage in both the districts has progressively improved in the last few years with an average of more than 70% in both the districts. e VIN system for supply chain management has been implemented.
- AEFI have not been reported in the state. Alternate vaccine delivery mechanism, Open Vial Policy is available. Work plans and due list are being generated by the system however there use by ANMs is minimal.
- Birth doses (BCG, OPV & Hep. B immunization): Birth doses are being given to neonates in the DH and at all health facilities before discharge. However, gaps found in birth dose within first 24 hrs after the birth in case of holidays.
- Coverage of Mission Indradhanush in the state is satisfactory. Against the 12-bedded sanctioned SNCU, 35-bedded operational SNCU has been created by the personal initiatives of the Head of the Paediatrics department. The department has 120 operational paediatric beds, 4 PICU beds, 12 emergencies paediatric beds. The SNCU has 216% and PICU 100% bed occupancy with only 7 faculties and 16 staff nurses. Mortality varied from 19% to 35%, follow up is only 50%. A proposal for paediatric surgery ward has been approved with support from CSR funds but the

approvals awaited. 61% in-born, 44.5% LWBs, 14.6% ARI are being reported. Coordination with NHM for assured follow up needs improvement

- Overall coverage of the schools under the RBSK scheme is 33% for the state and cure rate is 58%.

UTTARAKHAND

- The knowledge on ANC services was found to be satisfactory among the staff. The coverage of MCP Card was observed to be fair in the districts visited.
- Currently, PMSMA runs as a routine ANC programme every week. Record keeping of the services provided on PMSMA was observed to be poor. Many implementation issues are being faced while launching the programme in the State.
- Despite frequent stock outs of IFA and Calcium tablets being reported, the HMIS data states 839.71% women receive IFA in Udham Singh Nagar. This demonstrates that the data entered is not validated.
- The FRUs are ill-equipped to handle complications, C-sections and ultrasound testing, which are then referred to private facilities.
- There have been reports of stock-outs of several essential commodities like injection oxytocin, Misoprostol, IFA and Calcium tablets.
- 23.80% and 19.54% of the total deliveries are home deliveries in Champawat and Udham Singh Nagar respectively. 61.03% of the home deliveries in Champawat and almost all the home deliveries in Udham Singh Nagar are conducted by untrained professionals.
- The post-natal care for 48-hours is not adequately provided in any of the facilities visited. DH Rudrapur has 36 beds dedicated for PNC with two full-time staff. However, due to high case-load and over-crowding, PNC is being provided for 24 hours only.
- Abortion facilities were found only at DH Rudrapur. DH Rudrapur provides MMA and DNC facilities. MVA and MEA methods are not being used. The provision of CAC at lower facilities was largely absent.
- The beneficiaries were aware of the entitlements of JSY. The payments under JSY were pending since the last 5-7 months in Udham Singh Nagar.
- According to the data provided, no free C-sections have been conducted in Udham Singh Nagar since April 2017. However, money has been released for drugs and consumables for C-sections. This shows that JSSK is not being implemented in its spirit.
- There were three NBSUs in Udham Singh Nagar, located at JLN DH Rudrapur (upgraded to 12 bedded SNCU), LDB SDH Kashipur and CHC Kichha with well-equipped Human resources and equipment. HBNC has been implemented.
- It was observed that the facilities in both the districts visited had inadequate supply of essential drugs and vaccines like Inj. Gentamicin, Inj. Betamethasone, Syp. Albendazole, Pentavalent vaccine, Syp. Vitamin A.
- 28.77% and 36.41% of the newborns delivered at the institutions received 6 HBNC visits in Champawat and Udham Singh Nagar respectively. On the other hand, 51.66% and 62.11% of the home born new-borns received 7 HBNC visits in Champawat and Udham Singh Nagar respectively.
- The NRC is located at JLN DH Rudrapur, but underutilized as the admission rate is 3 - 4 children per month.
- The RBSK programme is in association with Hans Foundation, Mumbai (NGO) which facilitates referral and follow-up of the children. The micro plans are also well prepared.
- Child death review has not been initiated. A particular facility reported 15 still births from April to October 2017.
- The coverage of BCG, Penta-3 and OPV-3 vaccinations was observed to be fair. The

immunization services are largely provided at the DH and the SDH. No shortage of vaccine, except pentavalent vaccine, was observed.

- Micro plans, due lists and cold chain management are observed but children receive the zero dose only after 15 -20 days from birth.
- Family planning services offered to the community were condoms, oral contraceptive pills (OCPs), emergency contraceptive pills (ECPs), IUCD insertions (both in the facilities as well as in camps), post-partum IUCD (PPIUCD) and sterilization for both male and female (through NSV camps during NSV weeks and through routine services at the facilities).
- Due to the lack of specialists, the family planning services, especially female sterilizations, have declined.
- All the commodities were not available in the facilities and at the community level with ASHAs. Frequent stock-outs of condoms, Nischay Kits and Nirodh were reported. The new commodities i.e. injectable contraceptives (Antara) and Centchroman have not reached the facilities.
- There records for the family planning services were accounted for but there are no standardized registers for family planning.
- Adolescent Health in Udham Singh Nagar is an identified RKSK district. DH Rudrapur operates an Adolescent Friendly Health Clinic (AFHC). The clinic has an OPD of 30-40 adolescents per month. The major issues for which the counsellors provide counselling are - skin problems, issues about sexual health and hygiene, addiction, depression and stress.
- ANMs/ASHAs in Champawat were not aware of Menstrual Hygiene Scheme. The WIFS is facing supply issues for the last 3 years in Champawat. Udham Singh Nagar has sufficient stock for WIFS. IEC/BCC materials were mostly absent.

WEST BENGAL

- Institutional Delivery increased from 72% in 2011-12 to 93% in 2016-17 and 95% in 2017-18 (Up to September 2017). Comprehensive ANC services are in place. In 2017-18 (till Sept) 883649 ANC registration has been made, out of which 79% are registered before 12 weeks, 105% had received 180 IFA tablets and 70% had received 4 or more ANCs.
- PMSMA has not been officially launched by the State. There is no involvement/enrolment of the private practitioners in PMSMA till date. JSY and JSSK are performing well. Minimal Out of Pocket expenses have been incurred by the beneficiaries. JSSK beneficiaries ranged from 26,000 in P. Medinipur to 10,000 in D. Dinajpur for 2017-18 (up to Sept).
- Under JSSK, the state has a MoU with private service providers having ambulances; these vehicles are termed as “Nishchay Yaan”. The usual response time is about 20 minutes. 154 vehicles were registered in P. Medinipur
- Services for Comprehensive Abortion care are available at the DH. P. Medinipur showed CAC with 214 MTPs up to Sept 2017 while D. Dinajpur showed 839 for the same duration. At several facilities, option of medical abortion is not available, thereby not giving the women a choice between medical and surgical method of abortion.
- Home Based Newborn Care was good and well managed by ASHA. There was inadequate information in “ANC register”/RCH registers; and the high risk section usually remains incomplete. Line listing of HRP is done at the level of HSC and PHCs.
- MDR is very well established in the State. All maternal deaths are duly informed to all by the SMS system and facility based as well as community based MDR is carried out. 29 and 11 maternal deaths were reported in the district P. Medinipur and D. Dinajpur respectively in 2017-18 (till Sept).
- Screening for Hypothyroidism, Gestational Diabetes and Syphilis at point of care and calcium supplementation is not yet available, except at the DH. Deworming of PW is being done routinely

- There is no USG available in some blocks. Where they are available for free on block level; it is on a fixed day basis and only in a PPP mode. This leads to OOPE, besides being time consuming for the pregnant women.
- The use of Antenatal corticosteroids in preterm labour as well as Inj Genta is not very well implemented at HSC level. The ANMs are unsure of the dose and duration of treatment.
- NBCCs seen at all delivery points visited facilities. SNSU are established and well maintained with Radiant Warmer and seen at the RH visited. (P. Medinipur). While in D. Dinajpur it is underutilized and over-staffed.
- 68 out of 70 SNCUs are functional and out of which 48 SNCUs are reporting through SNCU-online software. Over 2700 admission during 2017-18 (up to Sept 2017) in P. Medinipur.
- 3 and 2 NRCs set up in P. Medinipur and D. Dinajpur respectively. There were 113 admissions in 2017-18 (up to Sept) in the former while 134 admissions in the latter and no deaths in the NRC anywhere.
- State has implemented RBSK since 2015 and has dedicated 677 Mobile Health Teams in Rural and Urban areas. Of these 47 are in P. Medinipur and 8 in D.Dinajpur. There is no functional District Early Intervention Centre (DIEC) in either of the district visited.
- Immunisation coverage of the State was 92% in 2017-18 (increased 1% from 2016-17). Birth dose vaccination is being provided at all facilities. Measles 2nd dose and pentavalent vaccine are introduced.
- ILRs and DFs were found functional. No record on defrosting nor fire extinguisher were available. There is poor management and monitoring of vaccine storage. Stock out of IPV & DPT seen at places e.g.at Kushmandi Rural Hospital (D. Dianjpur). Irregular immunization outreach sessions was observed at the HSC level along with poor monitoring of these sessions.
- The Family Planning indicators of the State are quite good with TFR 1.7 (achieved Replacement Level), unmet need 7.5 and CPR 70.9%.
- Minilap was being done once a week through a fixed day approach by trained MOs. 68,684 Female sterilizations have been held this year 2017-18 (up to Sept) as compared to 1.9 lakh last year. Interval IUCD has improved from 2.07 lakh (2016-17) to >2.5 lakh (17-18). The uptake of PPIUCD was also proceeding well with 1.61 lakh have already been inserted in 2017-18 (up to Sept) throughout the State.
- Supplies of Emergency contraceptive pills was poor in several facilities. Staff were not fully aware about the use of ECPs. The scheme of Home delivery of contraceptives by ASHA is well implemented in both the districts. Newer contraceptives as ANTARA (Injectables) & CHHAYA though launched in the State, services were made available at Medical Colleges only, and trainings are in process for the Districts. The awareness among the Hospital Staff & Community was very poor about the Family Planning Indemnity scheme.
- Pregnancy Testing Kits (PTKs) are available at Sub-centres. However, PTKs are also used in higher facilities prior to sterilisations and in case of suspected pregnancies, indicating the need for supply of PTKs at DH and CHCs.
- A total of 488 Adolescent Friendly Health Clinics called “Anvesha Clinic” were functioning in the State and 454 Adolescent Health Counsellors are working in these. Functioning AFHCs were seen at all the facilities visited. Average monthly client load is about 200 for DH facility and 50-100 for RH/PHC/SDH. Essential commodities under RKSK programme such as Blue IFA (WIFS), Albendazole and Dicyclomine were available at both the DHs and HSC visited. Packets of State sponsored packets of Sanitary Napkins are available at all level of facility.
- In D. Dinajpur, counselling is also conducted with the inmates of ‘Juvenile Justice Home’ on second and last Saturday of the month. The Juvenile Justice Home has total 250 inmates. One part of the home is dedicated as a “shelter home” for poor and vulnerable boys.
- WIFS is running in all 29 Districts for In-school adolescents and out of School adolescent girls

numbering at 12.32 lakh.15,717 schools covered and WIFS coverage is 11% in 2016-17 and 20.7% in 2017-18.

- Some peer educators have been selected in both these districts however no training has begun, as the future of these PE is deemed uncertain.

HARYANA

- Proportion of ANC mothers registered were 90% against estimated in year 2016-17 as per HMIS. It was reflected during field observations at Jui sub centre of Jui PHC where only 164 ANCs were registered against estimated 184.
- Fixed day ANC clinics were not functional at any of the facilities observed in Bhiwani and Gurugram. Pregnant mothers were being checked along with routine OPD. After the OPD, pregnant mothers were sent to the lab for routine investigation, which included haemoglobin and urine sugar. HIV, VDRL, and OGTT were not being done at some PHCs.
- All these observations related to ANC services were reflected in NFHS-4 e.g, Early ANC registration is 63%, 4 ANC is 45%, and Full ANC is only 19%.
- Infrastructure for Intrapartum care (ANC ward, PNC ward, Labor room) was adequate at most places but shortage of staff were observed at all facilities mainly specialists and Medical Officers. SNs working in labour room were not trained in NSSK. On the contrary, staff working in SNCU were trained in NSSK. Gowns were not provided to mothers in labour room in Bhiwani and Gurugram and birth companions were not allowed inside labour room in almost all the facilities.
- Bio Medical Waste segregation was very poor and few drugs like antihypertensive, vitamin K and Drug tray, Emergency trays, Mucous extractor was not available inside labour room in GH Bhiwani.
- Out of 37661 home deliveries registered in year 2016-17, only 5045 conducted by SBA and though line listing of high-risk pregnancies was not available, the ANMs could share name-wise information on high risk pregnancies. Anaemia Tracking software(ATM) has been developed by state government but real time tracking is not being done in the software.
- Maternal Death Review has been implemented at all level in both the districts, but Maternal near miss is not started. As per Haryana state MDR report, 215 maternal deaths reviewed by CMO out of reported 275 deaths.
- Newer Initiatives including Calcium supplementation was universally seen at all facilities visited but Oral Glucose Tolerance Test to diagnose GDM and Community based screening of HIV and syphilis has not started yet. Total number of pregnant women Received Antenatal care under PMSMA is 216604. Comprehensive Abortion services are provided at all facilities. JSSK entitlement was not found at many facilities in Bhiwani and Gurugram districts.
- KMC rooms were observed to be available near SNCUs or within SNCUs in both district hospitals. However, during the visits no beneficiaries were observed utilizing the KMC rooms.
- The State has formulated its 'Haryana New-born Action Plan' and the annual delivery load of DH Gurugram is about 4,500 and it has a 23 bedded SNCU which is adequate as per the required norms. Both the SNCU units at GH Bhiwani and GH Gurugram have centralized oxygen supply and manual as well as electrically operated pressure controlled slow suction. Online reporting through the SNCU software was also being done. Though Gurugram reported availability of 2 NBSUs, this was not observed in the field. While the reported NBSU at CHC Pataudi was non-functional because of the equipment being in process of being shifted to a new building; the other NBSU at SDH Sohna was observed to be equipped with one RW and phototherapy unit where non-critical infants were being admitted.
- State has established total 11 NRCs. Out of 11, 4 NRCs (Ambala, Hisar, Jind, and Karnal) are

operational with less than 10 beds (GoI norm).4 NRCs out of 11 NRCs are not reporting data.

- The campaign of IDCF was implemented in entire state as per guidelines. However, only 35% of under five children received ORS packet from ASHA. The state held NDD on 31st August 2017 with 91% coverage in Bhiwani and 95% in Gurugram. IMNCI was not seen to be implemented anywhere in both the districts visited.
- HBNC and Child death review was found satisfactory in districts visited. They have developed MIDRS software to capture child deaths. MIDRS software suggests 10253 deaths reported against 14057 estimated from April 2017 to Octo 2017.
- Dedicated vehicles for RBSK teams were not available in Gurugram district. Team reported travelling in rented vehicles/cabs with allowance of ₹ 500/- per day. RBSK team in Bhiwani screened 295617 children in year 2016-17 of which 182 children were identified with birth defect.
- GOI has shared standardized formats for Stock Register and Session Register for Immunization, but it is not being used by the state. There is different type of manual reporting formats present at cold chain points.
- Open Vial Policy is being followed and Temperature Log book was not maintained.
- DQAC was observed to be operational in Gurugram and Bhiwani district. However, almost 160 cases are report indemnity schemes in Gurugram.
- The state has reported a three-day strategy under which home distribution of contraceptives by ASHAs is undertaken on Saturday(s), IUCD services are made available Tuesday(s) and sterilization operations are undertaken on Thursday(s) at designated operating centres in various districts.
- Sufficient availability of PTKs were also observed with ASHAs. However, a cause of concern is limited counselling on family planning services (either limiting or spacing methods, including PPIUCD) by the staff in post-natal wards of health facilities across all levels.
- District hospital Gurugram has recently started Medroxyprogesterone acetate (MPA) injectable facility. The supplies were received in the current month and 5 clients were reported to have been provided with this service.
- PPIUCD insertion rates found to be very good in some of the facilities of Bhiwani districts. However, incentives were not being paid in timely manner to service providers.
- For the year 2016-17 the WIFS programme coverage for Adolescent Health was 49% in Bhiwani and 46% in Gurugram district. 13 AFHCs were functional at 1 DH, 3 SDHs & 9 CHCs while 1240 Peer educators were identified and 540 were trained.

MAHARASHTRA

- Labour rooms were well maintained, equipped with essential drugs and supplies, protocols displayed, and staff trained and practicing protocols. Staff aware of AMTSL and essential newborn care and early initiation of breastfeeding.
- Birth dose vaccination and Vitamin-K administration is provided in facilities. Early initiation of breastfeeding and exclusive breast feeding (IYCF) is practiced and KMC is also initiated in delivery points.
- PMSMA has been given prime attention in the district, full range of ANC services ensured including USG in partnership with the private sector.
- JSY payments are made exclusively through DBT mode utilising PFMS. Free and cashless delivery services under JSSK provided at government facilities. 48 hrs. stay after delivery is a norm across the facilities.
- Antenatal screening for GDM, Hypothyroidism, RTI/STI, syphilis and HIV-AIDS are in place. Newer initiatives such as antenatal corticosteroids, Ca.

supplementation and deworming have been rolled out.

- Maternal and Child Death Review mechanisms institutionalized at both community and facility levels.
- National Deworming Day is being observed bin-annually in February and August.
- RBSK teams are formed for Anganwadi and school health check-ups and referrals in coordination with other departments.
- Nutritional Rehabilitation Centres are functional, standard treatment protocols are followed and have good successful discharge rate.
- Home based newborn care is operational and well implemented. Also, State has intensified HBNC for special newborns on alternate day upto 6 months.
- Modern family planning options have a basket of choices including PPIUCD, Antara Injection and Chayya pills are available in the districts.
- Cold Chain Handlers are oriented on open vial policy and practicing with support of ANMs.
- Infant and Young Child Feeding Practices including Mothers' Absolute Affection (MAA) is being promoted at health facilities.
- Women Hospital building (Parbhani) is in bad condition and unsafe for use.
- There is overcrowding (bed occupancy rate of >200%) in district hospital Parbhani, with patients lying on floor in PNC ward and ANC ward.
- Assisted Vaginal delivery services are not available which leads to more referrals and high caesarean rates.
- Emergency caesarean is available only in district hospital. SDH and other hospitals have only elective CS largely due to absence of anaesthetists (who are available on call). Augmentation of labour and administration of antibiotics is practiced routinely in some of the facilities.
- Maternal Near Miss review is not initiated yet.
- RMNCH+A counsellors are not in place.
- DEIC in Parbhani district is yet to be established.
- SNCU in Parbhani is overcrowded and space for KMC ward is inadequate. There is no toilet facility in SNCU for staff and attendants.
- Paediatric ICU not in place.
- District Task Force – Immunization meetings in Parbhani are not regularly held. District Vaccine Store in Parbhani requires proper space for CCE repair and dry storage of vaccine carrier and cold boxes. Data entry in stock registers of Cold Chain Point is not proper which is due to training issue. CCT tour plan for preventive maintenance is not being prepared and not visited. Four key messages of immunization are not adequately emphasized by the ASHA and ANMs.
- BRIDGE training is not rolled-out yet in non-IMI districts.
- The counterfoil of MCP card though available is not implemented properly.
- RCH and other registers of ANM are not updated regularly.
- ASHAs felt demotivated and faced lack of acceptance by APL family as there is no provision for incentives for serving them.
- Toilet facilities for staff and attendants are poorly maintained.
- Specialist services (obstetric and paediatric services) in the PHCs on designated days are provided through State initiative- Human Development Program.
- The College of Physicians and Surgeons (CPS) course (2 Years) is in place to develop a pool of specialists (Obstetricians, paediatricians, anaesthetists and medicine) in the state and the first batch of about 130 specialists will be passing out in December 2017.
- Jeevan AmrutYojana – blood on call available in the range of 40 km around Parbhani, even for private hospitals. Blood is provided to the hospitals with the help of NGO.

- Interval IUCD are largely the family planning services provided upto PHC and even at HSC. Most of the providers are able to demonstrate the no-touch technique of IUCD insertion and providing interval IUCD services. Fixed day sterilization services are provided fortnightly at PHCs while IUCD services are provided routinely upto HSC level. Scheme of Home delivery of contraceptives by ASHAs is well implemented in the district. ASHAs supplied with OCP, ECP and condoms. FP commodities-condoms, OCPs, ECPs in new packing and Cent chroman (Chaya) and Injectable MPA are available. Good demand of Inj. MPA in community, currently available only at District Hospital. However, IEC material and new FP media campaign with new FP logo is not visible in facilities. ASHAs displayed good knowledge on usage of PTKs. However, its uninterrupted supply needs to be ensured.
- CAC services are available upto SDH, however, few PHCs are also providing CAC services Supply of combo pack Misoprostol and Mifepristone is not available in the facilities.
- AFHS clinic for Adolescent health was available at DH with ARSH counsellor. AFHC utilization is sub-optimal. IEC is in the local language with adequate privacy. RKSK programme is not implemented in Wardha district. AHD sessions not planned, no counselling sessions conduced outside the hospital.
- The WIFS Programme is implemented in the district in close coordination with Department of education. Blue Iron (WIFS) regular are available only for children. Reporting format is available in schools. Wednesday on each week is fixed for WIFS in schools.

MEGHALAYA

- Overall uptake of contraceptives for family planning is low, however of those being used, OCPs and condoms are the most popular Family Planning commodities. Sterilization services like minilap, Laproligation, NSV are limited to District Hospital East Khasi Hills.
- Implementation of “Ensuring Spacing at Birth Scheme” and Home delivery of contraceptives by ASHAs rolled out at state level, but field implementation is weak. Further fixed day services for interval IUCD/Tubectomy/NSV are not available in the field. The newer family planning methods MPA (Antara programme) and Centchroman are not yet implemented.
- Meghalaya Maternity Benefit Scheme and ASHA Benefit Scheme are good practices of the state. The Labour rooms are well maintained, equipped, clean and privacy for mothers is ensured. IEC material and Standard operating procedures are well displayed.
- DH East Khasi Hills is a high delivery load facility with nearly 1000 deliveries per month with 15% C-Sections, while as DH South Garo Hills has a load of only 20 per month with no C- sections.
- The line listing of high risk pregnancies is variable across facilities and no action is being taken after identification. Partograph is being used in most of the delivery points visited.
- Home distribution of Misoprostol is not taking place, despite high home deliveries. PMSMA is implemented in DH East Khasi and CHC Sohra fully, and partially in other facilities of East Khasi and South Garo Hills due lack of specialists and Ultrasonography. No private doctor or health facility has been empanelled for providing services under PMSMA.
- Early initiation of breastfeeding is being practiced and all mothers interviewed had fed colostrum to the newborn. In East Khasi Hills, there is a 12-bedded functional SNCU at the DH, however the space is inadequate. The infection control practices in the unit are inadequate and sub-optimal.
- KMC unit is yet to be established in DH, East Khasi Hills. There are no NBSUs in the visited CHCs in East Khasi. In South Garo Hills, there is no SNCUat DH, at CHCs and PHCs equipment needed for NBCC and NBSU is available but non-functional as the staff is not trained in NSSK and F-IMNCI.
- Zero dose vaccination is being provided in the Labour room and recorded, however birth dose

vaccination is not provided uniformly across all facilities in East Khasi Hill district.

- RBSK teams in place in all the blocks, screening of children (0-18 years) being conducted in schools and AWCs. In both districts, Immunization coverage was poor due to cultural beliefs and difficult terrain. Vaccines were available in sufficient quantities at cold chain points. Outreach immunization sessions are being conducted in the VHNCs by the ANMs supported by ASHA and records are well maintained.
- Nutritional Rehabilitation Centre is functional in both districts, but the bed occupancy is very low. In DH, South Garo Hills only 4 children have been admitted since April 2017. There is no system of convergence with ICDS for identification of SAM and referral to NRC and follow up linkages in community and peripheral health facilities. IMNCI and IYCF trainings have not been conducted.
- There is only one MMU in the district and is expected to cover 250 villages. Because of the road conditions and frequent breakdown of vehicle, only 15-20 visits in a month are made. The second visit to a village can only happen after an interval of at least 10 months or so.
- Under the JSSK, Ganesh Das MCH Hospital has introduced a good practice of drop back facility by hiring 17 taxis called Pink taxis driven by women drivers. Diet is being provided at all delivery points.
- In East Khasi Hills it is being partially implemented in all facilities, only medicines available in pharmacy are being provided and there is cap of ₹ 200 on diagnostic component and no pooling of the funds available under JSSK is done to cover the additional expenses. In South Garo Hills all the additional requirements are met from RKS funds and family does not purchase drugs or consumables. However, transportation is not being provided in South Garo because of lack of telecom network, poor road condition and non-existent 108. In East Khasi mostly, state owned ambulances and 108 is being used for JSSK. 102 services have not been introduced in the state.
- AFHCs for Adolescent Health are functional with counsellors at DH and CHCs in South Garo Hills being RKSK district, however in EKH counsellors are available only in DH and trained staff available running the AFHCs at CHCs and PHCs. The utilization of AFHCs is generally suboptimal. The counsellors are coordinating with OPD to identify adolescents and are also going on outreach visits with the DEIC teams which is a good practice.
- In SGH, 180 peer educators have been selected who need to be trained. 30 ANMs have been trained for peer educator training so far. WIFS is being implemented in schools, however reporting is weak. Availability of IFA supplies at District/block store & AFHCs is variable. Menstrual Hygiene Programme has not been rolled out in the state.

NAGALAND

- The trend of 50% achievement in early registration of Pregnancy & 3 ANC of Nagaland State level is continuing this year also.
- Similarly, no evidence of improving institutional delivery in the facilities. Some ANMs are attending home deliveries on call which is increasing SBA. SBA training itself is has not reached satisfactory completion in the districts.
- If community preference is strongly for home delivery and the interpersonal communication by ASHAs and ANMs have not succeeded in countering this cultural trend, then an alternative plan for covering all home delivery by SBA is to be undertaken. Also, HBNC by ASHAs need to be promoted vigorously.
- There is no well-organized pre-service entry level training in the state for both doctors and nurses. This can make them knowledgeable about National programmes and their role in implementing it. Completion of SBA-JSSK training is so crucial for nurses and ANMs and Facility based IMNCI and NSSK for doctors.
- Only 42% of Pregnant Women and 5% of Under 5 children are entered in RCH portal in the state, which is mainly a pending data entry due

to poor connectivity and a data capturing issue rather than the reality in the field.

- Only trainings were completed with regard to newer Maternal health initiatives like Calcium supplementation during pregnancy and lactation, De-worming during pregnancy, home based distribution of Misoprostol and Screening of hypothyroidism during pregnancy and the field level implementation of all of these yet to start. For Gestational Diabetes Mellitus (GDM) in pregnancy management even training not started.
- On the whole routine Immunization is working well, with good cold chain maintenance and vaccine storage. But the drop outs (17% from Pentavalent and 13% OPV first dose to third dose itself) are not adequately followed up to raise the fully immunized coverage from current 75%.
- Mission Indradhanush could accelerate completion of Immunization by 25% in Kohima and 18% in Phek and Peren districts of the targeted children, but in other districts the achievement was poor.
- State has a poor achievement in Family Planning in terms of actual numbers last year (2016-17) with 20 in male sterilization, 1613 female sterilization and 4434 IUD insertions.
- Under RBSK last year only 30% of under- 6 years and only 59% of 6-18 years were screened and 7% in each category of children with any of the congenital defects, deficiencies, diseases and developmental delays were detected and 6% were referred. There were 13 children provided free surgical management last year, which this year has gone up already to 37 heralding some improvement. In the field, Screening is mainly done by AYUSH doctors who are clinically not competent or trained to do relevant clinical examinations to identify birth defects, congenital heart diseases and internal organomegaly. This reliance only on AYUSH doctors for RBSK beats the very purpose of school and Anganwadi screening.
- Under RKSK only just 2% of the Adolescents seek counselling or treatment in the 35 Adolescent Friendly Clinics of 7 RKSK districts last year. Out of this 49% were provided counselling services and 23% were referred for further treatment. There is tremendous scope for improvement of coverage.
- Out of 11 MMUs 4 are without a doctor. Only 511 MMU camps were held last year compared to more than 700 camps in the previous two years.
- On the whole routine Immunization is working well, with good cold chain maintenance and vaccine storage. But the drop outs are not adequately followed up. Cards are issued but cross referencing with MCTS code number needs improvement. Post vaccination, the four key messages shared with the parents well during observed session sites.
- There are 5 Cold Chain points in the district, but there is no vaccine delivery using departmental vehicles. There is no funding for Alternative Vaccine delivery system. When ANMs are carrying the vaccine from these 5 Vaccine Storage Centres at their cost for transportation, they are not given the duly eligible ₹ 150/-.
- ASHAs are also not getting incentive of ₹ 100/- for each of the fully immunized infant and additional ₹ 50/- for the Measles and 18 months booster immunization child.
- No CAC is being followed. No PPTCT nor NSV Facilities available in the District. Neither MDR nor CDR are being done.
- Labour room well maintained and well used. Staffs had adequate knowledge about the Active management of third stage of labour and immediate newborn care. Partographs were used, as seen in the case sheet. No display of protocols in Labour room.
- Open Care system, phototherapy unit, Neonatal Resuscitation sets are available in the NBSU. No SNCU in the district and no Paediatrician is posted.
- Emergency room appropriately accessible from the two ambulance arrival points. Emergency drugs are not kept separately for easy access to Staff.

TOR 3

COMPREHENSIVE PRIMARY HEALTHCARE

Objectives

- To review progress of delivering Comprehensive Primary Healthcare Services
- Preparedness to provide assured free package of 12 services.
- To review plan for setting of health and wellness centres, population enumeration, it platform and linkage with higher facilities.

National Overview

Public health systems strengthening under the NHM, has laid the groundwork for an important shift from delivering selective to comprehensive primary health care services. The initiative aims to provide assured, free, comprehensive primary health care services, for a package of 12 services that cover reproductive, maternal, child and adolescent health, communicable and non-communicable diseases, management of acute simple illnesses, enabling continuum of care for chronic illnesses, including care for the elderly.

"Health and Wellness Centres" (HWCs) developed at the HSC or PHC level are envisioned as the first port of call to deliver the wider package of comprehensive primary health care. Other measures to be implemented include- population enumeration, a health card for every family linking them to primary care facility and making them eligible to avail care, placement of trained Mid- Level Health Care Providers (Nurses/Ayurveda Practitioners), multiskilling of frontline functionaries and PHC staff, effective logistics support system, building IT platforms to support care delivery and referral backup.

This section summarizes findings from sixteen states visited by CRM with reference to roll out of Comprehensive primary healthcare. It reports on- state level planning and status of-population enumeration, infrastructure upgrade, logistics, building IT platform, linkages with higher level healthcare facilities and capacity building processes that include the newly introduced Bridge Programme in Community Health for Mid-Level Health Care Providers/Community Health Officers (an additional cadre of personnel for the HWCs).

Overall Planning, Selection of Centres and Management to Roll Out Health and Wellness Centres

As an initial step, all CRM states have begun planning and preparation to roll out HWCs this year. Fourteen states confirmed receipt of funds. Identification of Sub Centres to serve as Health and Wellness centres has been completed in all states except Punjab. Even Bihar, where sensitization on HWCs has been reported to be low has commenced action with recruitment of few Mid-Level Healthcare providers and implementation of Bridge Programme. West Bengal shared a long-term vision of converting 2500 sub-centres every year to HWCs, but a proposal through submission in PIP is yet to be formalized. Nagaland reports planning for other components of CPHC such as Team Based Incentives for frontline functionaries and training of these personnel in NCD screening.

In most states, the identified HWCs will cater to a service area in the range of 3000-5000 population. However, rationale to select centres, phasing, models of implementation and type of Mid-Level Health Care Providers chosen vary from state to state.

Assam has prioritized Health Sub-Centres manned with Rural Health Practitioners (trained in three and half year course) to serve as HWCs. Chhattisgarh plans to deploy an mix of trained Rural Medical Assistants/Assistant Medical Officers, Ayurveda Practitioners and Staff Nurses as Mid- Level Health Care Providers in the HWCs of five districts that have been selected on the availability of Multipurpose Workers (males and females). Presence of Mid-Level providers such as Rural Health Practitioners and Rural Medical Assistants favourably position these two states to operationalize and scale-up HWCs earlier than other states.

Karnataka commenced its journey towards CPHC by converting subcentres of one block each in its two UHC pilot districts as HWCs and is now scaling the Nurse Mid- Level Provider led model in 11 blocks spanning six high priority districts of Hyderabad-Karnataka region. Maharashtra intends to use Ayurveda Practitioners empowered to practice modern medicine (as per the amendment of Maharashtra Medical Practitioners Act 1961) in HWCs spread across seven districts. Presently, 30 subcentres of Palghar and Nashik (20 tribal and 10 non-tribal) district are functioning as HWC known as *Aarogyavardhani Kendra*. Health sub centres with well- developed infrastructure and at a distance of minimum five kilometres from functional PHC are being upgraded as HWCs in ten districts of Odisha. State plans to train both Nurses and Ayurveda Practitioners as Mid-Level Providers for these centres. Telangana on the other hand has prioritized sub-centres with adequate Multi-purpose workers and those implementing NCD screening to serve as its HWCs. State also has detailed plan for training both staff nurses and Ayurvedic practitioner as Mid- Level Health Care Providers. In addition to 29 pilot phase HWCs, Uttar Pradesh has undertaken facility mapping to identify 30 Sub-centres with good access and population density in each of its ten select districts for upgradation as HWCs. Haryana, Jharkhand, Manipur, Meghalaya, Telangana and Uttarakhand, have also finalized centres and are moving forward with selection of Mid-Level Providers as a first step.

A positive planning feature noted across majority states except Odisha, Haryana, Nagaland and West Bengal is synergized roll out of HWCs with Universal Screening, prevention and management of NCDs.

Inputs to strengthen programme management through nomination of state nodal officer have been undertaken in all states except Nagaland. However, firm steps to leverage additional technical capacities with reference to CPHC are visible only in-Chhattisgarh, Jharkhand, Karnataka and Uttar Pradesh; which have engaged SHSRC, Jhpiego/

Intra-Health, Indian Institute of Public Health Bangalore and India Health Action Trust-TSU respectively for technical coordination.

Planning of referral linkages for HWC with PHC and other health facilities have been explicitly reported only from Assam, Haryana, Karnataka, Telangana, Uttar Pradesh and West Bengal. In Telangana all Health Sub-Centres have been linked with the concerned PHCs for referral and these PHCs also have the required HR and Infrastructure to take care of the referral patients coming from the HWCs. Other remaining states indicate field level challenges in building referral linkages. If lack of linkages with most proximal health facility is as a challenge observed in Assam, a limited sensitization of care providers at higher level facilities to support HWCs is an area of concern in Karnataka. Uttar Pradesh has identified additional PHCs and CHCs in each block for HWCs led referral but considering human resource challenges in these centres, state is planning to integrate health facilities of another block and neighbouring district for care coordination. Overcrowding of referral centres and high opportunity cost are reported as issues in ensuring continuum of care in West Bengal.

Preparedness of Sub-centre Infrastructure, Human Resources Drugs and Logistic Support to Operationalize HWCs

Operationalizing HWCs necessitates robust assessment and availability of human resources, drugs, infrastructure and logistic support in the centres selected for upgrade. On a positive side, none of the states visited by CRM indicate significant shortage of requisite human resources (Multipurpose workers and ASHAs) at Sub-centre level.

Assam and Chhattisgarh have operationalized HWCs with no infrastructure changes but both have prioritized essential inputs of- adequate human resources, equipment and drugs. While there are no shortfalls observed in availability of service providers and other resources in HWCs of Assam; service providers' orientation to focus only on MCH care is limiting optimum functionality of these centres. Chhattisgarh HWCs are able to generate a good public response but are countering marginal gaps in availability of drugs and equipment.

As regards other remaining states, an assessment to map resource requirements has been completed only in Karnataka, Haryana, Odisha, Telangana and Uttar Pradesh and other nine states are either in process or are yet to undertake resource mapping for the identified centres. Upgrade of necessary infrastructure has been completed only in pilot phase HWCs of Karnataka but even here, supply of all equipment/drugs emerge as a weak link. Sub-Centre level drug availability particularly stocking of NCD drugs and logistics support are critical common challenges observed in all other states where centres were visited to assess system's preparedness for moving towards CPHC. Telangana is the only state which reported availability of anti- hypertensives and drugs related to Diabetes care at the level of HWCs. Uttarakhand plans to leverage Corporate social responsibility to develop 50 mobile diagnostic labs to augment diagnostic services under comprehensive primary health care could serve as an innovative approach for expanding care delivery.

Universal Population Enumeration Systems, Use of IT Systems for Care Coordination and Baseline Surveys

Most states are undertaking population enumeration with reference to tracking uptake of services limited to family planning, pregnancy/delivery and immunization. Only few states have undertaken efforts to initiate universal population enumeration. Jharkhand is using M-Sakhi a mobile based application for population enumeration in its four HWCs of Kanke block in Ranchi district. Karnataka has accomplished universal population enumeration and digital data base creation for the designated service area in the 105-pilot phase HWCs of Mysuru and Raichur. Survey forms and Community Based Action Checklists for enumerating adults in above 30 years age group have been digitized for HWCs in Shravasti district of Uttar Pradesh. State is also undertaking a daily web based monitoring of survey forms using dedicated dashboards. Barring Assam, Karnataka and Jharkhand none of the other

states have commenced steps to develop IT based systems for maintaining digitized family health folders, tracking service delivery, tracking treatment outcomes and enabling care coordination.

Baseline survey to map access to primary healthcare facilities and services, system readiness, morbidity profile and out of pocket expenditures have been undertaken as part of UHC pilots in Karnataka, is in its early stages in Uttar-Pradesh and will commence from next financial year in Telangana.

Package of Care and Team Based Incentives

Since majority of the states are in the early stages of roll out of CPHC, delivery of complete package of 12 services is yet to be started in all except Chhattisgarh. Efforts at introducing team based incentives at the level of PHC or sub centre are also limited and will probably gain impetus with actual initiation of service delivery by the HWCs.

Capacity Building and Progress on Bridge Programme on Community Health

Of all the input measures, building the cadre of Mid-Level Health Care Providers/Community Health Officers and their enrolment in Bridge Programme for certificate in Community Health has been prioritized by majority states (barring Assam, Chhattisgarh and Maharashtra, which are using alternate training strategies). Overall, Jharkhand, Karnataka, Odisha, Uttarakhand, Uttar-Pradesh, Telangana have allowed significant number of candidates to be enrolled in January and July 2017 batches of IGNOU Bridge Programme for Certificate in Community Health. Completion of first batch training in January 2018, would add about 231 Mid-Level Health Care Providers in the health workforce to offer expanded range of services at the HWCs across these states.

Barring the teething issues of delays in reimbursement of honorarium for faculty at Programme Study Centres in Mizoram, no major challenges were reported in the roll of the Bridge Programme.

North eastern states of Manipur and Nagaland have planned to expand Mid-Level Healthcare Providers this year and will be deputing its candidates for January 2018 session.

Other than this, Chhattisgarh has trained its Rural Medical Assistants in a five days refresher module to strengthen their capacities in delivery of comprehensive package of services. Ayurvedic practitioners have been trained in a state specific training module on CPHC and Ayurveda, to function as HWC MO (Mid-level service provider) in Maharashtra. Karnataka before deploying its 105 Nurse Mid- Level providers for IGNOU Bridge Programme had also completed a ten days induction training on Introduction to CPHC, National Health Programmes and Sub-Centre level screening and management of Hypertension and Diabetes.

Multiskilling of ASHAs, Multipurpose workers and staff nurses to expand preventive, promotive and community based care for common NCDs has commenced in Karnataka, Uttar Pradesh and Telangana. A total of 6348 ASHAs, 1708 Multipurpose workers and 229 staff nurses have been trained in Universal screening for NCDs in these CPHC intervention areas.

Capacity building of district level programme managers on the implementation measures of CPHC and necessary change management has been completed only in Karnataka and Uttar Pradesh.

Recommendations

- As states progress towards selection and training of Mid- Level Health Care Providers, there is a critical need across all the states to address gaps in drugs and logistic support to operationalize HWCs. This is particularly urgent for states such as Jharkhand, Karnataka, Odisha, Uttarakhand, Uttar-Pradesh, and Telangana where a significant pool of Mid- Level Health Care Providers will be ready to provide services by January 2018.
- Resolution of logistic challenges is a central tenet for ensuring credibility of HWCs and states should aim for building logistics systems as first steps. Supply chain logistics is adversely affected on account of multiple issues such as- lack of adequate financing, absence of autonomous and professionally managed centralized procurement agency, limited district level warehouses that are connected to frontline facilities, over purchase of drugs outside EDLs, lack of proficient bidding systems, inefficient enactment of Transparency in Tender Acts, delayed payments to suppliers etc. Specific evaluation could be planned for identifying these challenges and remedial measures should be ensured at the outset of rolling CPHC interventions to ensure the fulfillment of key principle, viz. continuum of care.
- Early roll out of measures such as training of providers on CPHC package, resource mapping, population enumeration, initiation of IT platforms and digital tools or baseline assessments in states such as Chhattisgarh, Jharkhand, Karnataka and Uttar Pradesh could be linked with technical support from state level public health agencies/NGOs and build a case for other states to leverage knowledge/technical partners which could support in operationalizing some or all of these activities.
- While appointment of nodal officers is a positive step forward, states should also plan to build district and block level capacities in programme management and supportive supervision to ensure necessary change management for the delivery of CPHC services.
- Orientation and sensitization could be planned in phases from centre to increase understanding of district level staff across the states on the concept, rationale and requirements of HWCs and CPHC.
- While initial planning for implementing HWCs has begun in majority states, it is also essential for states to develop clarity on the long-term state specific vision for CPHC and a road map for states. This long- term plan would focus on- number and location of sub centres that state would prioritize as HWCs, activities for revamping PHCs, capacity building for service providers at different levels and institutionalizing financing mechanisms that are responsive to case loads and needs.

State Findings

ASSAM

- The biggest strength of the State is that it is well positioned to operationalize at least 350 more SCs immediately as Health and Wellness Centres to provide expanded range of services starting with NCD screening.
- State has also selected Sub centres that already have a Rural Health Practitioners posted as Community Health Officers (CHOs) in position. Rural Health Practitioners are those who have completed Diploma in Medicine and Rural Health Care (DMRHC) a 3 years course with 6 months internship.
- 123 Sub – Centres in five districts - Dibrugarh, Jorhat, Kamrup (Rural), Barpeta and Nagaon are planned to be upgraded as Health and Wellness Centres (HWCs) in the current year. The 56/123 sub-centres include those selected for NCD screening. SCs, PHC and CHC have been linked for referrals.
- Majority CHO manned SCs have a team of two-three ANMs, one pharmacist and one to two MPWs and an ASHA. The most notable aspect is that only one ANM is contractual from NHM and the rest are regular HR.

- Preparedness in stocking Sub Centres with drugs for the common NCDs and point of care diagnostics was not apparent. Power back up in the form of inverters was not found in any of the CHO manned/delivery point sub centres visited.
- Overall proper location planning for health infrastructure has not happened. For instance – SC if taken up as HWC would need to be linked to State Dispensary and not PHC on account of proximity of location.
- There was a lack of proper understanding which led the State to assume that they could not take up strengthening SHCs to HWCs despite having requisite HR in place in many SHCs.
- State has not planned training for CHO under bridge/similar programme to provide the package of envisaged 12 services.

BIHAR

- State has commenced roll out of Bridge Programme in Community Health for six students and is in the process to select 50 candidates who will be enrolled in January 2018 session of Bridge Programme.
- However, awareness about CPHC/HWC was found to be low among the Programme Officers and no proposals have been submitted for operationalizing these centres.
- Currently, most of the Sub Health Centres (SHCs) carry out limited RCH centric activities. Trainings and capacity building of the Team of health workers at the Sub Health Centres will be required for expanded range of services. Infrastructure upgradation is a major challenge and gap analysis of the upgradation works is yet to be undertaken. Planning for these activities and increasing the range of drugs and diagnostics at the SCs is yet to be initiated.

CHHATTISGARH

- State has a cadre of Rural Medical Assistants, trained for three and a half years in BSc community health and are being deployed as mid-level providers in the 100 identified HWCs of Korba district. At present, 100 RMA, 100 female MPW and 85 male MPW are posted in these HWCs
- Each HWC is covering a population of around 3000; no infrastructure changes have been made in the sub center to operationalize HWC.
- State Health System Resource centre (SHSRC) has developed module for comprehensive primary health care and training has been provided to 70 RMAs in two batches and 37 ANMs in a batch.
- Comprehensive Package of services include Care in pregnancy and child-birth, immunization, Family planning, Contraceptive services and Other Reproductive Health Care services, Screening and management of Communicable diseases, Prevention, Screening and Management of Non-Communicable diseases, Care for Common Ophthalmic problems through monthly visit of Ophthalmic Assistant.
- Plan for 400 more sub centres to be upgraded as HWC in 5 districts namely Dhamtari, Durg, Korba, Kanker and Rajnandgoaon, Raipur (Around 15-20 SHCs per block) are already in place and state intends use its RMAs and Bridge Programme Trained Staff Nurses and Ayurveda Practitioners in care provision at these centres.
- Community uptake of services at HWCs in Korba is encouraging but residual gaps in availability of equipment and drugs remains a challenge.

HARYANA

- State has identified 55 SHCs to be converted into HWCs in four Districts of Mewat (20), Palwal (15), Panipat (10) and Yamunanagar (10).
- Preliminary resource mapping of all SHCs to be converted into HWCs has been conducted in terms of availability of HR, Building and Infrastructure and budget has been allocated to the concerned District Health Family Welfare Societies for strengthening of infrastructure.
- State has decided to provide one Pharmacist and LT on job basis at each of the HWCs.

- Registered Ayurveda practitioners will be trained in Bridge Programme in Community Health. However, selection of candidates for the programme is yet to be completed.
- Four Government. Medical Colleges have been identified as Study Centres for Bridge Programme but accreditation of these colleges as training sites and faculty through IGNOU Regional office is yet to be done.

JHARKHAND

- State has a plan in place to roll out CPHC and has commenced Comprehensive Primary Health Care activities in three districts viz. Bokaro, Dhanbaad and Ranchi with a total of 114 HWCs being planned.
- As a long-term Plan, state has proposed 7 districts for HWC: Bokaro, Dhanbad, Gumla, Lohargdaga, Simdega and Khunti.
- In four of its HSCs IT system for family Folder/ Health card are in the process of being set up under Project UDAAN, Intra Health (m-sakhi).
- First batch of 'Bridge Course' comprising of 12 Nurses is running successfully at Indian School of public Health and plans to enrol AYUSH doctors as well from next year onward are in place.
- To augment resources for CPHC, state has launched BSc. Community Medicine course with a 6-months internship in lines similar to the three years course (RMA-Rural Medical Assistant) of Chhattisgarh. Currently 50 candidates are enrolled with the institute of Public Health in Ranchi. Population enumeration is completed in 04 HSCs of Kanke Block Ranchi under M-Sakhi-a mobile application pilot of Indira Health for data based Registration and follow-up for NCDs. 366 ASHAs, 108 ANMs and 48 Staff Nurses have been trained in Universal Screening for NCDs.
- HSCs visited were lacking the basic infrastructure like Electric supply, Water Supply. State will have to take these factors into account while upgrading. Resource mapping for availability of drugs and equipment is yet to be undertaken.

KARNATAKA

- Comprehensive Primary Healthcare (CPHC) is being piloted in Mysuru and Raichur Districts with a total of 105 Sub Centres being upgraded to Health & Wellness Centres (HWCs) in the pilot phase. Infrastructure strengthening has been completed in these facilities and Glucometer, new BP Apparatus, Hemoglobinometer and other equipment have been made available.
- The State is also developing an IT System (with NIC, prototype to be ready by December 2017) to support the initiative and computers have already been supplied to the facilities. Baseline Measurements has been completed with support from PHFI for mapping Healthcare Access-Awareness. Morbidity-Mortality, Out of Pocket Expenditures and system Preparedness - drug availability etc.
- District and Taluka Health Officers have been oriented on rationale and objective of CPHC and Health and Wellness Centres and 105 Mid-Level Healthcare Providers (MLHPs) are undergoing training in the Bridge Programme for Certificate in Community Health for Nurses (BPCCHN).
- The Bridge Programme in Raichur is being conducted at the Programme Study Center (PSC) Raipur Institute of Medical Sciences (RIMS) in a systematic manner and 30 candidates (BSc Nurses) have been enrolled and they have signed a bond to serve in the HWCs for a period of 3 years.
- Future Plans include scaling up the initiative - upgrading 466 Sub Centres to HWCs is being planned in two blocks each of Hyderabad Karnataka region.
- Preparedness of care providers at higher level facilities to support the HWCs in maintaining continuum of care for the 12 essential packages mandated under the CPHC, especially the non-communicable diseases is a challenge.
- The HWCs have not been supplied the entire range of equipment (13 out of 89 are yet to be supplied).

MAHARASHTRA

- Ayurveda graduate is recognized by the State Government to practice Allopathy (modern medicine) as per amendment in Maharashtra Medical Practitioners Act, 1961. State is using these doctors as their Mid-Level Health Care providers however, need for these doctors to be trained national programmes for expansion of services has been indicated.
- The implementation of HWCs is at a nascent stage in the state, 280 Centres across 28 blocks in 7 districts (Nashik, Palghar, Bhandara, Satara, Wardha, Chandrapur and Pune) have been taken for HWCs for the FY 2017-18 in the State. Out of them only 30 Sub centres in Nashik and Palghar have been upgraded as Health and Wellness Centres. State is also converging the NCD screening and HWCs.
- The gaps which were observed in terms of availability at SHCs/PHCs needs to be strengthened to ensure that provision of drugs for non-communicable diseases to provide treatment wherever required.

MANIPUR

- State has planned HWCs upgrade at Imphal West and Thoubal District in 40 facilities. a community level baseline survey for population enumeration has been completed. The average population which will be catered by these facilities will be 5000 for the plain population & 2500 for the hilly areas.
- State has selected both regular as well contractual nurses for the training under the Bridge Course programme.
- Recruitment and training under Bridge Programme for Community Health Officers has been initiated in Chudachanpur & Thoubal districts. Both the Programme study Centres (PSC) with a capacity of 20 trainees each have been approved by IGNOU. The second batch of 40 candidates by January 2018.
- Although the state has identified districts as well as the facilities for upgradations but no gap analysis has been done till date for upgrading the existing facilities to HWCs as the state is waiting for the release of funds from treasury. Once the funds are released the state will contract out to the external agencies to infrastructural development of existing SCs.
- Concerns with limited availability of funds for strengthening educational resources in Programme Study Centres for Bridge Programme, delays in release of honorarium to the counsellors have been reported.

MEGHALAYA

- State has identified officials at the State level to implement comprehensive primary healthcare. 32 sub centres have been selected across two districts namely East Khasi Hills and West Khasi Hills to be upgraded as HWCs.
- HR and infrastructure gap analysis is underway for all these sub centres.
- BSC nursing/GNM cadre has been planned as Mid-Level Providers for the Bridge programme. However, the advertisement and Selection is halted after the Court ruling on the recent case related to the recruitment of staff nurses in the State.
- Three Programme Study Centres for bridge course are identified and internal assessment is under process. State would be tentatively ready with the 1st batch for bridge course in the July term, 2018.

NAGALAND

- The State has an increased load of Non-communicable diseases and is moving towards comprehensive primary & promotive care. NCD screening has started. State is setting up team comprising of ASHA, ANM, AWW as a core team at community level – with provision for team based incentives for this team.
- It was found that there is irrational HWC planning because they are not as per NCD districts.
- Bridge programme has not been implemented.

- Despite completion of training in population based NCD screening, NCD Screening activities have not been rolled out.

ODISHA

- 36 HWCs were planned in 2016-17 and same number of Staff Nurses have been enrolled in the Bridge Programme.
- Staff Nurse & Ayurveda doctors (including contractual staff) working at co-locational unit are eligible to pursue Bridge Course on Community health. However, due to shortage of MBBS doctors, Ayurveda doctors will be engaged as Community Health Officer in PHC (N) and Staff Nurses will be engaged at SCs.
- State has been accorded approvals for infrastructure strengthening for 22 centres in 10 districts. But as per the list of the facilities shared by the State, (CPHC – A), District Keonjhar is not listed.
- The sites for Health and Wellness Centre have been identified based on the existing physical infrastructure, basic essential amenities like water, electricity, mobile network & road connectivity and location of at least 5 km radius from any functional facility above PHC-N level.

PUNJAB

- State has planned for upgrading 200 Sub-Centres into Health and wellness Centres. But it is yet to identify the sub-centres.
- State has not initiated mapping of SCs for upgradation but it has an advantage of good infrastructure in place.
- Additional centres are available under Zilla Parishad at village level equivalent to SCs. These centres are SHC-Subsidiary Health Centres with one Medical officer. State may explore functionality of SHC and convergence while identification of Sub-centres for upgradation into HWCs.
- NCD screening for Diabetes, Hypertension and Oral Cancer has been rolled but Screening for Cervical and breast cancer is yet to initiate due to lack of completion of trainings. Convergence of NCD screening districts while identifying the Sub-centres has been ensured.
- Selection of staff nurses for training them as Mid-Level Providers is underway for enrolment in the Jan 2018 batch.
- IT Systems, Drugs and Equipment are reported as critical challenges.

UTTARAKHAND

- 46 sub-centres have been identified in first phase for up-gradation to HWC across three districts (16 in Dehradun, 15 in Nainital and 15 in Pauri Garhwal). Another 44 are planned for next year – making it a total of 90 HWCs (to be spread out across nine districts) by the end of financial year 18-19.
- Identification of an appropriate PHC as referral hub is underway. The State has recently appointed a nodal officer for this initiative.
- The average population coverage for sub-centres is 3000-5000. An assessment of the status of the infra-structure, the location of sub-centres and review of the repair/up-gradation plans is being carried out currently.
- The first batch of 46 nurses have been deputed for IGNOU supported Bridge Programme. Ayurveda practitioners are being identified to join training in 2018.
- It is envisaged that the procurement system currently operational in the State will be used to facilitate the drugs and equipment procurement and logistics required for the roll out of comprehensive primary care through HWCs. Broad guidelines for infra-structure and drugs/ equipment logistics and requirement have been provided by GoI. However, State officials were unclear about this. The three districts identified for rolling out comprehensive primary care through HWCs are also the same three districts selected for implementing Universal NCD screening and 50 mobile diagnostic labs (under CSR) will be used to augment diagnostic services, including diagnostics required for coverage under comprehensive primary care.

- IT systems to support continuum of care and referral pathways have not been planned so far nor has the process for population enumeration through family folders and individual health cards been initiated.

UTTAR PRADESH

- In the year 2016-17 State was approved 29 HWC as a Pilot for Sirsiya block in Shravasti district and in year 2017-18: received approvals have been accorded for 300 additional HWC across 10 selected districts for establishment and training in (30 Sub-centres of each district Farrukhabad, Bareilly, Jhansi, Meerut, Sitapur Varanasi, Gorakhpur, Allahabad, Basti, & Mirzapur).
- The state has selected those facilities for up-gradation as HWCs which are well located within the population.
- Operationalization of 18 HWC in Shravasti is expected to be completed by January 2018 and remaining 311 Health and wellness centre in July 2018.
- State is having the technical support of TSU with a dedicated Consultant at state level for planning and implementation of programme.
- Planning and selection of facilities is based on mapping and saturation of each block is envisaged. In case a SHC is not competent to cater to the population in terms of HR or infrastructure additional linkages with HWCs in other block of the same district or other district have been ensured.
- The Programme has been integrated with NCDs and survey forms and CBAC forms have been digitalized and daily web based monitoring of survey forms is done at the state level through a dedicated dashboard.
- Supply of required point of care diagnostics and drugs in the identified centres is in process. Gaps were observed in the supply of essential medicines for diabetes and hypertension in the visited districts even at the PHC and CHC level.

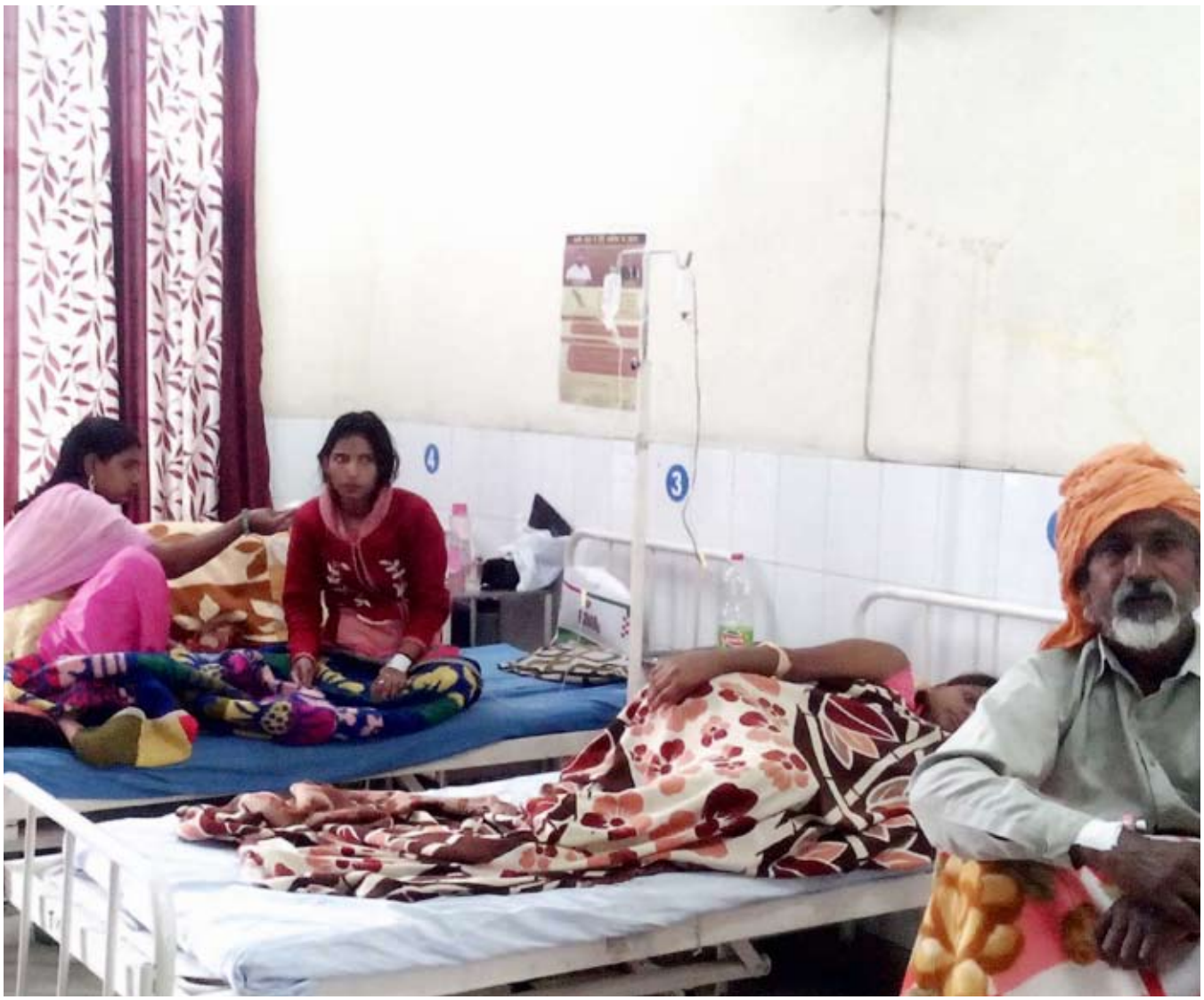
TELANGANA

- State has a specific plan with timeline and projection of resources estimated to convert all sub centres to H&WC in phase wise manner.
- These HSC have been chosen strategically and all are properly linked with the concern PHC. State has also done assessment of repair/up gradation plans for these selected HSC.
- Average population coverage of one sub-center is approx. 5000, most of the HSC which has been chosen for H & WC are those with good infrastructure and two MPW-Female as well as one MPW-Male.
- 90 Sub-centres from districts- Adilabad, Mahabubnagar and Medak are being prioritized in first phase and other sub centres where NCD screening was given to ANM & ASHAs will also be prioritized for HWCs in Karimangar, Jagitial, Sircilla, Pedapalli, Warangal Urban, Warangal Rural, Mahabubabad, Jayashankar Bhupalpalli, Jangoan, Siddipet and including 2 high priority districts. All the Sub-centres in one mandal of each district has been taken as Health Wellness Centre, so as to saturate the one mandal.
- 67 Staff Nurses are attending the Bridge Programme and process is underway to train additional 89 Ayurveda Practitioners in January 2018 batch.
- Most drugs and equipment related to NCD (Hypertension, diabetes etc) were present at visited Health Sub Centre.

WEST BENGAL

- The State has a five –year plan to convert 2500 sub centres each year to health and wellness centres so that all the 10,357 sub centres are transformed to Health and Wellness centres.
- It proposes to train nurses as Community Health Officers, and has accordingly also developed a plan to expand the number of GNM schools to ensure adequate numbers of the required workforce.

- Although State is yet to submit a request for sanction of funds in the PIP to convert sub centres to Health and Wellness Centres, it proposes to convert 250 sub- centres before March 2018.
- Currently the sub centre in either district offer little more than antenatal and immunization services. The State has two ANMs in most sub centres. The second ANM, who is a contractual worker funded through NHM, is in place in 215 districts. The condition of infrastructure in the sub centres was fairly good with water and electricity.
- Population enumeration extends only to pregnant women, children due for immunization and eligible couples.
- The sub centres are not mapped to a PHC, rather linked to a Block PHC, which is also referred to as a Rural Hospital or Community Health Centre; e.g. Khushmandi Block PHC serving 2.1 lakh population is a 30 bedded institution.



TOR 4

COMMUNICABLE DISEASE CONTROL PROGRAMMES

Objectives

- To review the extent of implementation of specific public health strategies under each Communicable Disease Control programmes, illness management and data usage.
- To assess the integration of disease control programmes with RMNCH+A initiatives, adherence to existing referral mechanisms and treatment protocol etc.

National Overview

The recently released India state-level Disease Burden Initiative Report, confirms that India is transiting epidemiologically and infectious and associated diseases are reducing overall in India. However, the states at a lower Epidemiological Transition Level (ETL) are the states of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Assam. The range of disease burden or DALY rate among the certain states of India was 9-fold for diarrhoeal disease, 7-fold for lower respiratory infections, and 9-fold for tuberculosis in 2016, highlighting the need for targeted efforts based on the specific trends in each state.[6] India's National Health Policy (NHP) 2017 also recognizes the interrelationship between communicable disease control programmes and public health system strengthening and endorses the same.

Revised National Tuberculosis Control Programme (RNTCP)[7]

Trend reversal has been achieved in incidence and prevalence of TB in India and the declining trend is continuing. The incidence of TB has reduced from 289 per lakh per year in 2000 to 217 per lakh per year in 2015. Further, the mortality due to TB has reduced from 56 per lac per year in 2000 to 36 per lac per year in 2015.

6 India: Health of the Nation's States, The India State-Level Disease Burden Initiative

7 https://tbcindia.gov.in/WriteReadData/NSP%20Draft%2020.02.2017%201.pdf

For India the WHO's Global TB Report 2017 estimated the TB incidence to be 211 cases per 1 lakh population, amounting to 27.9 lakh TB cases, in 2016. TB treatment coverage (notified/estimated incidence), 2016 was reported to be 63%. However, the challenges of MDR and XDR TB have emerged as serious threats for the country. The estimated incidence of MDR/RR-TB was 11 per lakh population, amounting to 1,47,000 cases.

In 2016, RNTCP expanded its TB care services and made landmark changes in the strategy of diagnosis and treatment of TB. CBNAAT machines were installed to expand the rapid molecular diagnostic facilities. A new drug Bedaquiline was introduced for treatment of MDR-TB at identified sites. Single window delivery of HIV-TB services was expanded at all Anti-Retroviral Treatment (ART) centres in the country. Along with it, ICT enabled treatment adherence support system (99 DOTS) was also extended for HIV-TB patients.

National Vector Borne Disease Control Program

In India, the burden of malaria has plateaued at around 1.1 million cases per year for the last 3 years (2014, 2015 and 2016). The proportion of Plasmodium Falciparum cases have also remained almost the same at around 66% for the last 3 years. Deaths due to malaria has shown a declining trend, from 562 deaths in 2014 to 331 in 2016.

Kala azar which is aimed for elimination by 2017, has shown a declining trend. A total of 6249 cases were reported from 7 states (Bihar, Jharkhand, Kerala, Sikkim, Uttar Pradesh, Uttarakhand and West Bengal) with zero deaths reported in 2016.

Indigenous cases of Lymphatic Filariasis have been reported from about 250 districts in 20 states/ Union Territories in India. A declining trend of average Microfilaria rates (%) in the country has been observed since 2004. An average Mf % of 0.26 was reported for the year 2015. Elimination of Lymphatic Filariasis in endemic pockets has been aimed by 2017 under NHP 2017.

Incidence as well as mortality due to Dengue have shown an increasing trend in the recent years in India. For instance, number of reported dengue cases increased from 28,292 (in 2010) to 1,29,166 in 2016. Over the same period, the number of deaths due to dengue has doubled from 110 in 2010 to 245 in 2016.

Chikungunya burden in the country has also been increasing. The number of Chikungunya cases reported in 2016 (64,057) showed an increase of 33% from 2010 (48,176).

Japanese Encephalitis/Acute Encephalitic Syndrome

JE is an emerging public health problem afflicting mostly children between 1-15 years of age. Because of its eco-epidemiological complexity it poses a serious challenge in terms of prevention and control. JE viral activity has been widespread in India. During recent past (1998-2004), 15 states and Union Territories have reported JE incidence.[8]

National Leprosy Elimination Program

The country achieved the goal of elimination of leprosy as a public health problem-defined as less than 1 case per 10,000 population, in December 2005. Current NLEP strategy focuses on reducing visible (Grade II) deformity due to leprosy. Several initiatives like Leprosy Case Detection Campaign

8 http://nvbdcp.gov.in/je8.html

(LCDC), Sparsh Leprosy Awareness campaign (SLAC) have been undertaken by Central Leprosy Division (CLD) for the same[9].

Integrated Disease Surveillance Program

Integrated Disease Surveillance Programme (IDSP) was launched with World Bank assistance in November 2004 to detect and respond to disease outbreaks quickly. Over the years, the vision of the programme has broadened. Currently the mission of the programme is to strengthen the disease surveillance in the country by establishing a decentralized State based surveillance system for epidemic prone diseases, and detect the early warning signals so that timely and effective public health actions can be initiated at the District, State and National level.[10]

Key Findings

Revised National Tuberculosis Control Programme (RNTCP)

Rate of case detection is showing an improving trend in Chhattisgarh, Nagaland and Jharkhand with private sector involvement. Increasing Private sector participation was also reported from Manipur, however it is a cause of concern in Assam, Uttarakhand and Uttar Pradesh.

Karnataka, West Bengal, Jharkhand have significant progression of TB notification under NIKSHAY. Case notification is low in Bihar (30%) and case entry in NIKSHAY was observed to be sub optimal in Uttar Pradesh, Meghalaya and Uttarakhand. Schedule HI registers were not being maintained in Assam, Bihar, UP and Uttarakhand.

Adequate TB - HIV coordination was observed in Chhattisgarh, West Bengal Jharkhand and Karnataka.

CBNAAT was functional in Karnataka, Odisha, Manipur and Jharkhand. However, in Bihar, Uttar Pradesh, Uttarakhand, Maharashtra, West Bengal, Meghalaya, Punjab, Nagaland and Telangana CBNAAT machines were reported to being under Utilized. TB diagnostic facilities were not available in the urban health facilities visited in Assam and Uttarakhand.

In most of the states visited (Bihar, Uttar Pradesh, Uttarakhand, Jharkhand, Punjab, Maharashtra Haryana, Nagaland and Telangana) shortage of human resource was reported. However, HR was reported to be adequate in Chhattisgarh, Manipur and Assam.

Delay in payment of salary to treatment providers was reported from Assam, Bihar and Jharkhand. ASHA payment was also reported to be delayed in Assam, Bihar, Telangana and Meghalaya and sub optimal in Nagaland. Issues with release of funds were reported from Manipur, Telangana and Uttarakhand.

Anti TB drugs Stock was readily available in West Bengal, Odisha and Jharkhand. But shortage of drugs was reported in Telangana and UP. Daily regimen has been reported to have started in West Bengal, Jharkhand, Punjab Maharashtra and Uttar Pradesh.

National Vector Borne Disease Control Programme (NVBDCP)

Malaria

Burden of Malaria has declined in many of the states and no mortality due to malaria has been reported from Assam, Chhattisgarh, Uttarakhand, Nagaland and West Bengal. However, in the districts visited in Bihar (Madhepura and Bhojpur), Uttar Pradesh (Kaushambi and Kanpur Dehat) malaria incidence showed increasing trend. Increase in malaria incidence was also reported from the states of Karnataka and Odisha.

Human Resource shortage impending effective implementation of the programme was reported for Bihar, Chhattisgarh, Odisha, Uttar Pradesh, Manipur, Punjab, Haryana and Telangana. Active

9. http://www.nlep.nic.in/pdf/NEWS%20Letter%20NLEP%20Final%20Vol%20II%20Issue%202.pdf

10. http://idsp.nic.in/index1.php?lang=1&level=1&sublinkid=5778&lid=3707

involvement of ASHAs in NVBDCP activities was observed in Assam however need of training of ASHAs and equipping them with diagnostics & drugs for detection & treatment of malaria cases was felt in Bihar and Manipur.

Surveillance activities were reported to be adequate for Assam, Karnataka, Haryana and Chhattisgarh. However, some issues in surveillance were reported from the states of Odisha and Manipur.

The indoor residual spray (IRS) room and house coverage was reported to be adequate in Assam. Quality and coverage of IRS was reported inadequate in Odisha, Chhattisgarh and Bihar.

The Bivalent Rapid Diagnostic kits for Malaria and antimalarial drugs were found to be in adequate supply in Assam, Chhattisgarh, Odisha, Uttar Pradesh, West Bengal, Manipur and Jharkhand. Shortage of anti-malarial drugs was reported from Haryana.

LLINs have been distributed with acceptable coverage in Chhattisgarh. In Odisha however, distributed LLINs were not being used. In Telangana, the first batch has been distributed amongst the villagers but there was uneven distribution.

IEC material was well displayed in the facilities and elsewhere in Chhattisgarh, Haryana and Manipur, whereas it was found to be inadequate in Uttarakhand and Telangana. Lack of knowledge about the current national drug policy was observed in the medical and paramedical staff from Chhattisgarh, Odisha, Assam and Telangana. Record keeping was inadequate at most of the facilities of Odisha and Uttar Pradesh.

Dengue & Chikungunya

Adequate quantity of ELISA based NS1 kit were available in Bihar, Manipur**.** However, they were not available in Odisha. In Assam and Chhattisgarh non-specific Dengue tests were being used by Health Staff. Decline in number of Chikungunya cases was reported from Haryana.

Lymphatic Filariasis

Hydrocele and MF positive cases are on declining trend in Uttar Pradesh, Karnataka. In West Bengal, line listing for Lymphedema and Hydrocele cases is not being maintained properly, hydrocele operations are not being conducted as a regular activity and morbidity management kits were not available and the peripheral workers and doctors were not even aware of these kits.

AES/JE

AES cases are showing decreasing trend in Bihar, Manipur. Declining trend of number of JE cases and deaths due to JE was reported for Assam, Bihar and Odisha. Sufficient number of JE Mac ELISA Test Kits were available in Bihar.

Kala Azar

Bihar, West Bengal and Uttar Pradesh are progressing well towards Kala azar elimination. Development Partners like CARE India, Kala-CORE, WHO, BMGF are also providing good support for Kala-azar elimination programme in Bihar.

National Leprosy Eradication Programme (NLEP)

Declining trend of leprosy cases has been reported in the States of Uttarakhand, Assam, Chhattisgarh, Haryana, Karnataka. However, in Assam and Karnataka, disability due to Leprosy has shown an increasing trend. Insufficient HR and Sub-optimal HR capacity was observed in Chhattisgarh, Uttarakhand and Manipur. MDT drug availability was adequate and no drug stock outs were reported in most of the states- Assam, Chhattisgarh, Uttar Pradesh, West Bengal.

IEC visibility was poor in Assam, Uttarakhand and West Bengal although they were well displayed in the health facilities in Chhattisgarh. The Leprosy Case Detection Campaign (LCDC) is being conducted in Assam, Chhattisgarh, Karnataka, West Bengal, Uttarakhand, Manipur, Telangana, Uttar Pradesh, Haryana, Maharashtra and Jharkhand. Sparsh Leprosy Awareness Campaign (SLAC) has been conducted in districts of Assam, Chhattisgarh, Haryana, Meghalaya and Manipur. ASHA based surveillance for Leprosy Suspect (ABSULS) has been started in Chhattisgarh, Karnataka, Uttar Pradesh and Haryana.

Post Exposure Chemoprophylaxis is not being done in Chhattisgarh, Telangana and Meghalaya.

Integrated Disease Surveillance Programme (IDSP)

In most of the states that were visited (Assam, Chhattisgarh, Karnataka, Uttarakhand, West Bengal, Punjab, Odisha, Telangana, Maharashtra, Nagaland) the weekly reporting of syndromic, presumptive surveillance was found to be regular, except in Uttar Pradesh, Jharkhand and Meghalaya. Data quality and data usage for planning activities was reported to be inadequate in Karnataka, Assam, Uttar Pradesh, Uttarakhand, Bihar, Chhattisgarh, Maharashtra and Meghalaya.

Inadequate reporting for notifiable diseases from private health facilities was observed in Bihar, Chhattisgarh, Uttar Pradesh, Uttarakhand, Maharashtra, Meghalaya, West Bengal and Jharkhand. Outbreak reporting and investigation through IDSP was reported to be adequate from most of the states like Karnataka, West Bengal, Manipur, Punjab, Odisha, Maharashtra, Meghalaya and Jharkhand. Rapid Response Teams have also been formed in most of these states.

Bihar, Chhattisgarh, Punjab, Odisha, Manipur, Maharashtra and Haryana have insufficient human resource under IDSP. Regular review meetings by the State Surveillance Officer were reported in Chhattisgarh, Manipur, Maharashtra and Telangana. Inadequate internet connectivity was reported from West Bengal, Meghalaya and Manipur.

Recommendations

- Involvement of front line workers needs to be enhanced by ensuring timely and appropriate payment.
- Utilization of data in picking up increasing trends of diseases, proper documentation of the investigation, and identification of particular pathogens needs to be emphasized. District Surveillance Units could contribute to data analysis at their level instead of expecting the state to do it. Regular feedback is to be given to the PHCs.
- Involvement and regulation of private sector for every Programme needs to be ensured.
- Communicable disease worker for providing services at the field level for all the communicable diseases.

State Findings

HARYANA

- Active Vector Control measures like strict implementation of laws against vector breeding, constitution of rapid response teams and use of biological methods for checking mosquito breeding in water bodies were observed in the State.
- Huge decline in incidence of Chikungunya has been reported by the State. Special Dengue Ward in GH Bhiwani for Dengue patients.
- There is no External/Internal Quality Assurance Mechanisms in place for the microscopy services.
- State has started implementing revised diagnostic algorithm however, only sensitization meetings have taken place instead of training of MOs and other RNTCP staff for daily regimen and TOG.
- Elimination status for leprosy has been achieved in all the districts of Haryana. The prevalence rate of Leprosy in Haryana in last two years has dropped from 0.25 per 10,000 to 0.15 per 10000 of the population as on 30.09.2017.
- In FY 2017-18, 1st phase of LCDC is being conducted in district Gurgaon, Faridabad, and Panipat in urban areas. Second phase will be conducted in rural areas in March 2018. Regular screening of school children for leprosy takes place under RBSK.
- Focused Leprosy Campaign for Hot Spot in village/urban areas where even a single grade-II case is detected is being considered as hotspot. This campaign was conducted in district Jhajjar, Kaithal, Gurugram, Hisar, Bhiwani and Karnal.

- Sparsh Leprosy Awareness Campaign was conducted in 2017 with the objective to sensitize all sections of society that leprosy is curable and to ensure that stigma and discrimination associated with this disease can be removed from the society.
- ASHA based Surveillance for Leprosy Suspect (ABSULS) has been started in all districts of Haryana for conducting active surveillance of leprosy suspects and Improving monitoring and supervision of leprosy cases detection activities at village level.

MAHARASHTRA

- Overall reporting under Integrated Disease Surveillance Programme (IDSP) is satisfactory in the State. Block Level data entry for IDSP should be encouraged as there is internet and computer facility in most of the facilities.
- There is an established Referral Lab Network of 10 Medical Colleges linked to nearby Districts for testing of outbreak samples.
- The state has Public Health Laboratories (although not under IDSP) that conduct water and stool testing headed by a Chief Bacteriologist, also a member of the Rapid response team. In Wardha, this lab was functioning well and involved in both routine and outbreak testing, besides reporting on quality of water sources.
- Individual treatment cards for leprosy were maintained and updated.
- Involvement of NGO "ALERT" in leprosy Programme activities was observed in District Wardha.
- Daily regimen has been launched in the state. Revised recording and reporting formats of RNTCP were in place in the visited health facilities, however more training and supervision was needed for filling the revised formats.
- The TB patients in the district of Wardha were being linked to the other social welfare programs to ensure that they get the benefits (including monetary).
- Sputum examination and distribution of drugs for RNTCP were being done by the general health personnel, thereby setting examples of integration of RNTCP with general health system.
- Use of 99DOTS for ensuring adherence is functional.

MEGHALAYA

- Most of the contractual positions in State & district are filled and have received requisite training in majority of cases.
- National disease control programmes are being periodically reviewed by DM&HO and Dy. Commissioner for key issues highlighted by programme officers.
- State has not initiated Block level data entry although in many places although HR and systems are in place. Data entry has not been initiated because of lack of internet connectivity.
- State is receiving funds regularly from GoI and GFATM.
- State has developed good IEC material targeting 4 VBDs (Malaria, Dengue, Chikungunya, and JE). They are available in 3 languages (Khasi, Garo and English) and are distributed from ASHA and up.
- The state had considerable number of JE cases (55 cases and 4 deaths in Year 2016), however, there is an issue of transportation of AES/ JE patients from PHC/CHC to higher centres. Mobility support was proposed in PIP but it was not approved. There is no functional Physical Medicine & Rehabilitation Centres for JE.
- Four centres in State have been designated for managing JE patients with complications, besides the 3 sentinel sites (Civil Hospital, Tura; Civil Hospital, Shillong and NIGRIMS, Shillong). They are provided with IgM ELISA kits from NIV, Pune. Ganesh Das Hospital in Shillong also has a Pediatric ICU.
- The state does not have an operational State TB training & Demonstration Center (STDC) of

its own and is dependent on Assam for many of the trainings. Critical components like robust M&E and quality assurance of diagnostic lab network have not been addressed as a full-fledged STDC is lacking.

- District has observed stock-out of few loose drugs like Pyridoxine, INH, Second Line medicines, PPD vials etc. The district drug store was upgraded for storage of MDR Drugs but the provisions of temperature control (AC) were observed to be non-functional and inadequate for the space.

TELANGANA

- The division of the state of Telangana from 10 to 31 districts, has resulted in a shortage of trained manpower and many operational issues leading to ineffective programme implementation and a need for an effective programme planning and implementation.
- The 2014 CRM team had observed that LLINs have not been provided in 2012 in Adilabad. This issue in 2016 has been addressed and the first batch of 2.60 lakh LLINs was provided by NVBDCP to Telangana in 2016 and second batch of 4. 60 LLINs has been provided in October 2017 and as per the state demand.
- The first batch has been distributed amongst the villagers and but serious gaps were observed in the LLIN distribution in the house to house night time visits by the CRM team. As per the LLIN distribution guidelines for distribution of NVBDCP. The district has instead distributed one family size LLIN irrespective of the number required in each household, which defies the basic principle and purpose of LLIN distribution and their use for interruption of transmission. Issues were also noticed in the records maintained for LLIN distribution in Adilabad and actual population of the villages not available.
- 17872 small size bed nets have been distributed to ashram school children and 1028 to health institutions. The users were not educated about the proper use and maintenance of LLINs despite of repeated programme guidelines and reminders.
- FRIDAY-DRY-DAY: In every village, if larva found in any village, anti larval measures continued there for six weeks.
- Professional courier services have been engaged for sputum transportation throughout the state through a Memorandum of Understanding.

PUNJAB

- Malaria is a Notified disease in the State. Migrant survey for malaria has been initiated and needs to actioned towards elimination.
- Web portal is prepared for reporting of VBDs.
- Malaria case load is lesser in State and API is less than 1 in all districts. For third consecutive year, the case load of dengue is very high in the State, and coordination with the local Govt need to be strengthened for source reduction activities. State has rolled out daily regimen in all 22 districts with effect from 30th Oct 2017.
- Almost 95% of TB patients are tested for HIV. Doctors & other workers need to be oriented about S/P/L forms & reporting should be improved.
- Private Reporting needs to be ensured for all modifiable disease including Malaria & Dengue.

JHARKHAND

- Adequate supply of antimalarial drugs, insecticides, diagnostic kits for Malaria, Dengue Chikungunya and JE by Directorate of NVBDCP and JE vaccine is being supplied by State government at several levels.
- Knowledge of Sahiya and volunteers about sing & symptoms of Leprosy was good.
- Successful JE vaccination campaign for 1-15 yrs. Children RI functioning well and night vaccination through RATH Campaign launched on 8th November for underserved children.

MANIPUR

- State is covered in GFATM - providing sufficient RDK & ACT.

- ASHAs had Drugs and RDKs and were trained.
- Vector control-LLIN coverage very high in eligible areas.
- There is no Public health Laboratory setup in the state except one District Priority Laboratory set up at Churachandpur which is functional. Public Health laboratories at Thoubal and Senapati districts are not functional yet.

WEST BENGAL

- A good practice that has been noted is that there are Entomologists at all districts as a State policy.
- Public Health lab is functional with tests for Malaria, Dengue, JE, and Diarrhoea are being done.
- In both the districts visited, ASHAs are not empowered for dispensing malaria drug to confirmed case as per National drug policy for malaria diagnosis and treatment.
- IDSP entomological wing is helping both the districts on entomological investigation.
- It was observed that regular Internal Evaluation for RNTCP is not being done. Also, SOPs were not followed during laboratory visits.

UTTARAKHAND

- Integrated Disease Control Programme (IDSP) Lab networking (District Public Health Laboratories and Referral lab) is in place, private sector data is not being collected in any of the districts. IDSP data is not being used for better planning and implementation of various disease control programs at district and State level.
- Clustering of (17 out of 27) malaria cases was reported in Kalakhera (Udham Singh Nagar). However, no corrective measures/actions were taken to address the epidemic.
- The Grade II disability of leprosy is 78%, reducing from baseline of 2011-2012. The Focused Leprosy Campaign (FLC) is being implementing in State.
- The private sector TB Notification is absent in 7 districts of the State. Most of the CBNAAT machines were underutilized. Recently Universal Drug Sensitivity testing has started in all the 13 districts. This is expected to increase the utilization. One Lab Technician is providing diagnostic services in 3 DMCs whereas 1 LT per DMC is required as per Programme guidelines. Regular Lab Technicians are not effectively involved in the program.
- Details of only 60% of registered TB patients were entered in Nikshay portal. Nikshay data entry is being done only at the district level in Champawat.
- Funds for RNTCP are not yet released in FY 2017-18 in the districts from NHM resulting in acute shortage of funds in districts to perform routine activities like trainings, supervision and monitoring, reviews etc.12/19 FMR code are showing nil expenditure at the State level financial information.

UTTAR PRADESH

- Malaria Action plan was available in both the districts visited. Antimalarial drugs, pumps, insecticide (Temephos, Pyretrhumamd Malathion) and other logistics are available in both the district.
- Only six districts of the state reporting Kala-azar and only few cases are reported and made good progress as per programme.
- Overlapping of multiple programs at a time has led to coordination issues. For example, leprosy Case Detection Campaign (LCDC) (6th to 19th Nov) and Mission Indradhanush (7th to 17th Nov) are taking place at the same time in the visited districts in the state.

ASSAM

- The disease control programmes continue to operate as verticals, there is need of greater synergy between NHM and Directorates.
- Closure of the Intermediate Reference Laboratory (IRL) in Guwahati has resulted in delay in follow up for the Drug Resistant TB

patients (DRTB). This has also delayed and slowed down enrolling of patients on the newer drug Bedaquiline, and the treatment of the DRTB patients.

- Sparsh Leprosy Awareness Campaign (SLAC) has been conducted in all the districts of Assam.
- Overall Malaria surveillance is above 10% and there is appreciable decline in Malaria burden. Bivalent Rapid Diagnostic kits for Malaria and antimalarial drugs are available and there was regular field visit and reporting.
- In Nalbari, non-specific Dengue tests were being used shortage of logistics like JSB stain, slides and other reagent were found in some of the laboratories of Nalbari.
- The weekly reporting under IDSP of syndromic, presumptive surveillance was more than 90%.

BIHAR

- Kala-Azar elimination has gained highest level stewardship in the state. Trend of Kala-azar is declining and no death reported in the year 2016 and 2017 due to Kala-azar. Development Partners like CARE India, Kala-CORE, WHO, BMGF are also providing good support for Kala-azar elimination programme. CARE India has provided District and block level HR while New Concept are involved in IEC/BCC activities.
- Kala-azar has been declared as Notifiable disease by State and Kala-azar data is well documented. State and districts are regularly monitoring the availability of logistics at the districts and sub district level on the technical rational. All the logistics related to Kala-azar were available at every facility.
- All the endemic districts of the states have adequate quantity of ELISA based NS1 kit for Dengue & Chikungunya. Malathion fogging is going on in the affected area.
- There is lack of state level supervision and monitoring for communicable disease control programmes.
- The state IDSP cell is well equipped with technical capacity and motivation, however, the same is not transmitted to the district units and field.

CHHATTISGARH

- The IDSP unit of the state is well functioning with 3 State Public Health Laboratories.
- The state had managed to bring down the API for malaria to 4.18 in year 2013 but it has again gradually increased to 5.29 in 2016. Since this is also coupled with an increase in ABER, better surveillance and introduction of bivalent RDT is considered responsible for this increase. The state has managed to keep dengue cases below 500 annually over the past few years.
- LLINs have been distributed in some villages with acceptable coverage. Mitanins are carrying out surveillance for malaria, but are sending reports directly to the district instead of routing through sub centres and blocks.
- There is high politico-administrative support to RNTCP in the state and it is performing well as per the National strategy of TB elimination by 2025.
- Mukhyamantri Kshaya Poshan Yojana- In this scheme all the notified TB patients are provided with the monthly food package containing one litre of edible soyabean oil, one kg of groundnut and one kg of skimmed milk powder.
- The state and district's Leprosy eradication plan and initiatives are in place. Leprosy Case Detection Campaign has been carried out by the state in all districts in 2017-18. Mitanins are trained and are actively involved in leprosy suspect identification. Declining trend has been observed in number of MB leprosy patients declining number of grade II disabilities over the last three years.
- Focused Leprosy Campaign (FLC) plan is in place and has conducted FLC from Jan to Aug 2017 under SPARSH Campaign, Charmrog Nidan Evam Upchar Abhiyan and Rakshabandhan Diwas Abhiyan with the involvement of previously affected leprosy patients, Legislative members and PRI members.

KARNATAKA

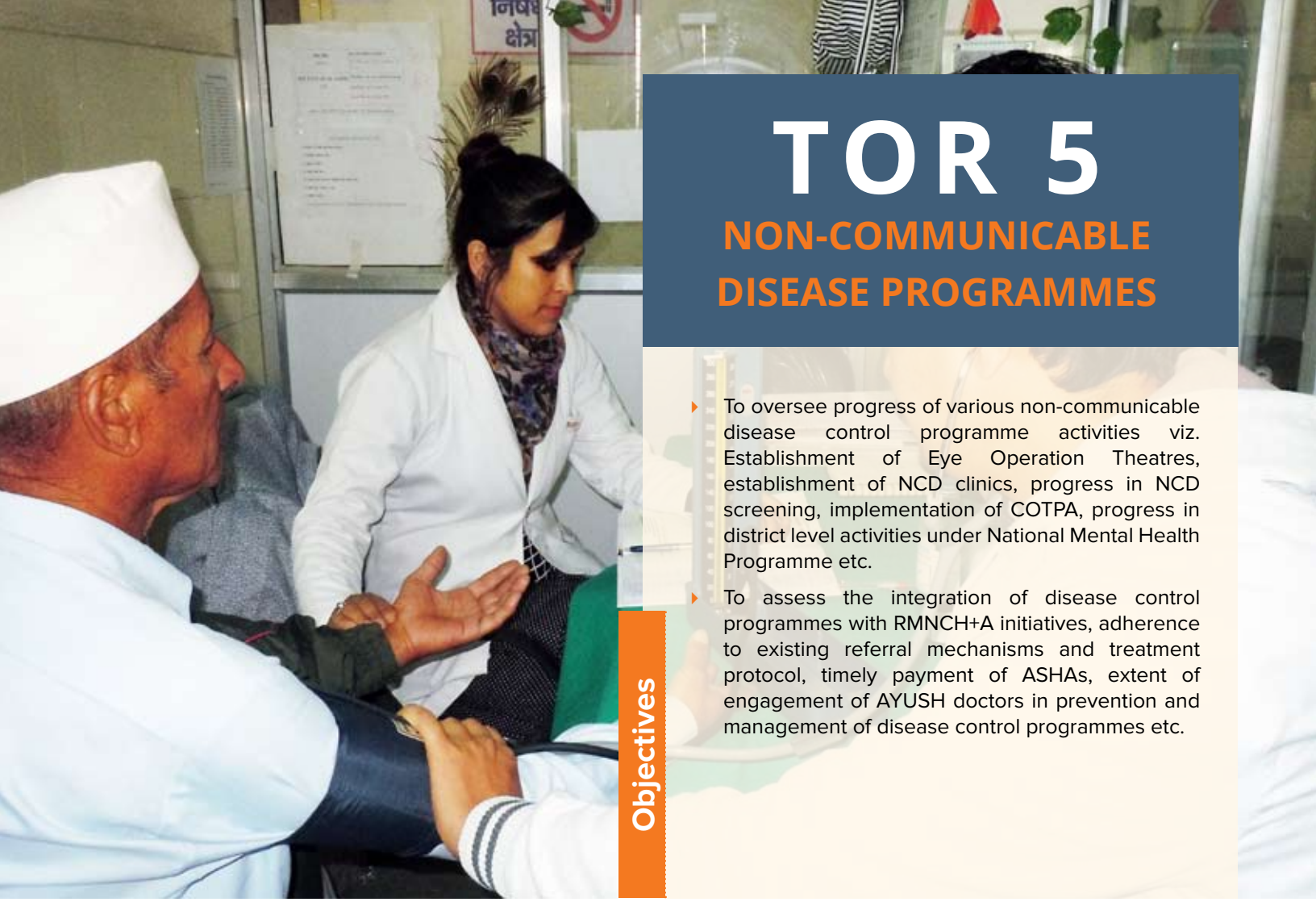
- Data reporting under IDSP of Form S, Form P and Form L was excellent in the state in terms of regular reporting from almost 100% of units. Slight improvement however is required from private establishments.
- The state Framework for Malaria Elimination is ready and has been approved by the Chief Secretary Govt of Karnataka. Intersectoral coordination and legal requirements needs to be pursued. The state has adequate and appreciable surveillance for malaria. There has been a sustained increase in malaria incidence in the state.

ODISHA

- Most of the PHCs are not microscopy center and no microscopist is available. Technicians need training on microscopy.
- DAMaN activities were carried out in 5 villages out of 11 villages targeted. In Adakata and Kuladera villages, 50% population left out for screening during DAMaN. 16 pregnant women were screened and one found positive. In Mundatangara only 1 case out of 98 screened persons detected. There is no data of the number of fever cases to know the asymptomatic cases.
- Urban VBD Scheme is in operation under NVBDCP.

NAGALAND

- The state has been covered under Global Fund Supported Intensified Malaria Control Project. In 2016-17, 9.2 Lakh Long Lasting Insecticidal Nets (LLIN) were supplied by NVBDCP.
- Shortage of funds under RNTCP is leading to pendency/compromise in all major programme activities.
- Highly suboptimal involvement of ASHAs, who are still being paid honorarium at old rate of ₹ 250 (new rates for New Case ₹ 1000, previously treated ₹ 1500).



TOR 5

NON-COMMUNICABLE DISEASE PROGRAMMES

Objectives

- To oversee progress of various non-communicable disease control programme activities viz. Establishment of Eye Operation Theatres, establishment of NCD clinics, progress in NCD screening, implementation of COTPA, progress in district level activities under National Mental Health Programme etc.
- To assess the integration of disease control programmes with RMNCH+A initiatives, adherence to existing referral mechanisms and treatment protocol, timely payment of ASHAs, extent of engagement of AYUSH doctors in prevention and management of disease control programmes etc.

National Overview

As per the Global Report on NCDs for India 2014, NCDs has the major share (60%) in mortality among all the cases in India and continues to remain a major concern for public health owing to the changing demographic profile, socioeconomic transition, increased urbanization and changes in lifestyle. While cardiovascular diseases (coronary heart disease, stroke, and hypertension) contribute to 45% of all NCD deaths; the other causes include deaths due chronic respiratory disease (22%), cancers (12%) and diabetes (3%). The latest data from Global Burden of Diseases 2015 also put Ischemic Heart Diseases, COPD and Cerebrovascular Diseases as top three mortality causes among NCDs in India. Considering the growing problem of NCDs, Ministry of Health and Family Welfare under National Health Mission launched The National Programme for prevention and control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS) in 2008 after integrating the National Cancer Control Programme (NCCP) with National Programme for Prevention and Control of Diabetes, Cardiovascular Diseases and Stroke (NPCDCS).

The NPCDCS programme started as a pilot and while most of the states visited focus on screening and treatment of Hypertension and Diabetes under NCD, states like Punjab, Chhattisgarh and Odisha have progressed further to screening of cervical cancers via Visual Inspection with Acetic Acid (VIA). Uttar Pradesh has initiated the “Sampooran Clinic” to prioritize screening of women for common cancers. Though the shortage of human resources persists across states, population-based screening of NCDs showed a substantial progress in most of the visited states.

India has a suicide mortality rate of 20.9 per 100,000 population (World Health Report, 2016). The National Mental Health Programme (NMHP) was launched in the year 1982 and thereafter the District Mental Health Programme (DMHP) was launched under NMHP in 1996. It promotes early detection and treatment by training of general physicians under the supervision of specialists, using limited drugs and includes mental health awareness and sensitization among the community. Of all the states visited under 11th CRM; Assam, Bihar, Karnataka, Uttar Pradesh and Punjab have reported progress in implementing the mental health program. State specific initiatives like “Prerna Prakalp” to curb the alarming suicide rate among farmers was launched in Maharashtra.

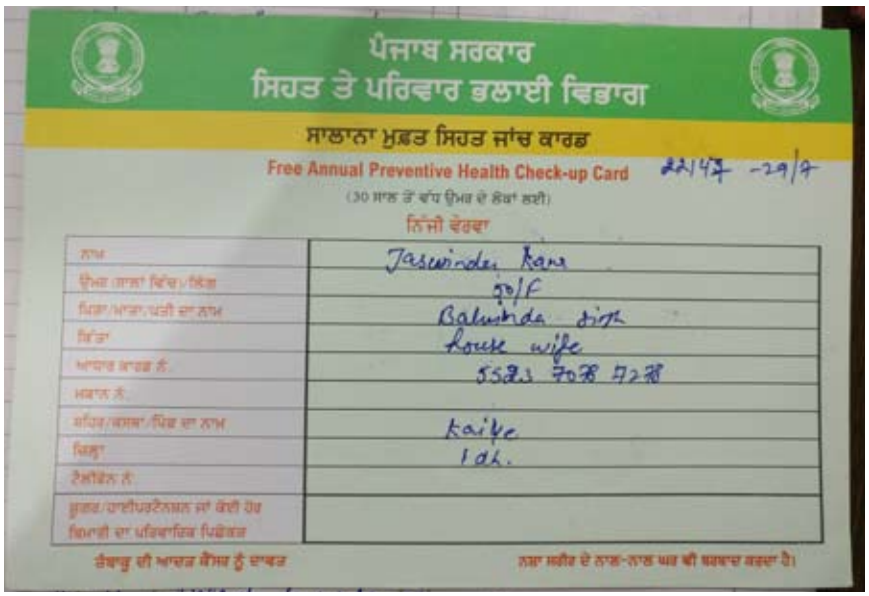
The National Tobacco Control Programme (NTCP) was launched during the 11th five-year plan has the objective to bring about greater awareness on the harmful effects of tobacco use and to facilitate effective implementation of the Tobacco Control laws (COTPA 2003). According to Global Adult Tobacco Survey-2 (2016-17), prevalence of tobacco use has decreased by six percentage points from 34.6% in 2009-10 to 28.6% in 2016-17. 19% of men, 2% of women and 10.7% of all adults currently smoke tobacco. 42.4% of men, 12.8% of women and 21.4% of all adults use smokeless tobacco. The prevalence of tobacco use among minors aged 15-17 has decreased from 10% in GATS-1 to 4% in GATS-2. The National Health Policy 2017 has set the target of “relative reduction in prevalence of current tobacco use by 15% by 2020 and 30% by 2025. Among 16 states visited during 11th CRM, Assam, West Bengal, Maharashtra, Nagaland and Haryana reported COTPA implementation. Assam has enacted Health Act 2014 to ban the sale, manufacturing, storage, distribution and consumption of smokeless tobacco in the state.

The National Programme for Control of Blindness, launched in the year 1976 as a 100% Centrally Sponsored scheme, has the goal to reduce the prevalence of blindness from 1.1% to 0.3% by 2020. Most of the states visited under 11th CRM reported increased rates of cataract surgery over the years. There was improved screening for refractive error, however, the distribution of free spectacles was lagging behind in Jharkhand and Uttarakhand. Essential ophthalmic equipment was unavailable in Meghalaya, Haryana and Uttar Pradesh while in Maharashtra the equipment were poorly maintained.

National Programme for Control of Blindness (NPCB)

Key Findings

The National programme for control of Blindness is implemented in all sixteen states visited by the CRM team. Overall, there is an improvement observed in cataract surgery in the state of Punjab, Assam, Karnataka, Chhattisgarh, Odisha, Maharashtra, Haryana and Bihar. There is considerable improvement in screening for refractive error in most of the states, however; distribution of free spectacles was falling short in Jharkhand and Uttarakhand. The role of non-governmental organization in improving the services has increased over the period of time. The role of NGOs in improving these services is commendable; there was much variation in quality and reach. Lack of human resources, irrational deployment of specialists, and poor maintenance of equipment are major challenges in the programme.



The states of Telangana and Uttar Pradesh have limited achievement in cataract surgery. The number of surgeries increased in Bihar, Jharkhand and West Bengal with low utilization of funds, as NGOs conducted the surgeries. The NGO has by far, completed more surgeries in these states than by the Government Health facilities. This Programme lags behind in the state of Nagaland due to poor infrastructure and inadequate human resource.

Underutilization of specialists reported from the state of Assam, Jharkhand and Karnataka while cadre of ophthalmic assistants are reported under-utilized in Karnataka. In Assam, eye specialist has been placed at Model hospital on promotion, where there is no eye operation theatre.

Recommendations

- Facilities should be equipped with functional and latest machines in context of eye care.
- State needs to adopt rational deployment of Human Resources under NBCP to ensure optimum utilization of specialists and follow up of surgery cases and screening of school children and refractive errors.
- Outreach and IEC activities can be enhanced with the help of Non-Governmental organizations. The activities also focus on enhancing the public awareness about prevention and timely treatment of eye ailments.

State Findings

ASSAM

Cataract surgeries have increased over a period of time. Overall physical infrastructure and instruments like operating microscope are available at the District Hospital. Screening for refractory errors and follow up of cataract surgery by a trained ophthalmic assistant has been done at Primary Health centre level. NGOs are involved in eye care services in urban as well as the rural areas.

BIHAR

There is reasonably good planning under NPCB across the state. Involvement of NGOs is commendable in monitoring of cataract surgeries.

CHHATTISGARH

Vision centres are available at District Hospital, Sub-District Hospital, Community Health Centres and Primary Health Centres. There are 75 functional vision centres across the state. Village wise surveys are regularly conducted for identifying cataract patients.

KARNATAKA

There are 146 ophthalmic surgeons working in the state against sanctioned 201 posts. Follow up of surgery cases and refractive errors not been done in Karnataka despite availability of Ophthalmic assistants.

ODISHA

There is an increase of surgeries and identification of refractive errors over period of time.

UTTAR PRADESH

70 out of 75 District hospitals have dedicated eye OT in the state. District Hospital and Community Health Centres are well positions with ophthalmic surgeons and ophthalmic assistants to perform cataract and minor eye surgery in the district.

UTTARAKHAND

District Hospital and Community Health Centres are providing basic services under blindness screening programme. Spectacles and presbyopia glasses are not being distributed on time.

WEST BENGAL

State conducts training programme for faculty members on Retinopathy of Prematurity at the MCH Centres. Orientation and sensitization of Ophthalmologist of MCHs and District Hospitals is completed. Cataract surgery is undertaken in coordination with NGOs and private clinic.

JHARKHAND

NGOs like the LNJP eye institute, Red Cross and Amritdhara are actively involved in screening and cataract surgery. Two trained technicians in the district carry out school health programme

covering three CHCs each. A total 12,733 school children examined and 100 of them have refractive errors, however free spectacles are yet to provided. Despite the placement of specialists at the District Hospitals, no surgeries were conducted and all cases are referred to MGM medical College in Jharkhand.

PUNJAB

Well-equipped units with good infrastructure were found at District Hospitals, Sub-District Hospitals and Community Health Centres. Plastic Lens Spectacles are being provided to students.

MANIPUR

Vision Centres are functional in the state. School children are screened and provided spectacles for refractive errors. Ophthalmic referral care is provided by the JNIMS and RIMS as there is no district hospital in Imphal. Eye care services are provided at facility level as well as in out-reach camp organized by NGO, but most of the cases are referred to JNIMS and RIMS.

TELANGANA

The programme is initiated in selected pilot districts. The districts visited during CRM are not covered under NBCP. The NGOs are engaged by the district blindness control society to perform cataract surgery.

MAHARASHTRA

Cataract surgeries are being conducted at district level eye hospitals. In addition, eye screening of school children, refractive error, free spectacles distribution and eye ball donation are also being undertaken. The facility at lower level (below district) provides the pre and post-operative services.

MEGHALAYA

The state has vision centres in 32 PHCs which is managed by ophthalmic assistants. There are five hospitals with dedicated ophthalmic operation theatres, and two mobile units in district hospitals with inadequate human resource. Screening of school children for refractive errors is being conducted across the state.

NAGALAND

There is poor infrastructure and human resources under National Blindness control programme in the state. The last eye surgery camp was held in 2013.

HARYANA

Human Resources (including specialists) under NBCP are available in state. Cataract surgery is being conducted across the state at District Hospital. Eye camps are being organised across the state. IEC materials are displayed at the District Hospitals.

National Mental Health Programme (NMHP)

Key Findings

Few states such as Assam, Bihar, Karnataka, Uttar Pradesh and Punjab have reported progress in implementing the mental health Programme in the identified districts in terms of well-developed infrastructure and availability of psychiatric and psychotropic drugs. It was encouraging to observe that to cope with the shortage of specialized manpower, states like Bihar and Chhattisgarh have nominated (and trained) medical officers for training on basic screening and identification of mental health conditions. However, in almost all the other reviewed states, recruitment and training of available HR still remains an impediment in Programme implementation except for Karnataka. There was a mixed picture on availability of counselling and outreach services. States like Karnataka, West Bengal and Maharashtra are providing counselling services whereas in Assam, Jharkhand, Uttar Pradesh and Haryana such services were found to be absent. Overall, as also observed in 9th CRM (2015), the status of NMHP implementation at the state level was found to be weak. The key areas identified as bottlenecks were ineffective Programme implementation at the facility and community level, availability and capacity building of manpower, clarity on fund allocation for the program, screening and outreach services.

Key Recommendations

- To cater to the shortage of specialized manpower, states need to promote and expedite training of regular general duty medical officers in mental healthcare through involvement of medical colleges, mental health institutions, Centres of Excellence in Mental Health and Central Mental Health Institutes for basic screening and identification of mental health conditions. NIMHANS, Bengaluru is providing one-year mentorship training in mental health to medical officers, which is a mix of residential training and distance learning through virtual ECHO model. Recruitment of support staff such as Clinical Psychologist, Psychiatric Nurse and Psychiatric Social Worker must also be ensured for appropriate case management and to support recovery.
- Partnering with local level NGOs as islands of mental health excellence can be explored to strengthen counselling and outreach services.
- States may consider the option of telemedicine and tele psychiatry and explore the possibility of hub and spoke model with advanced institutes on mental health like NIMHANS.
- Streamlining the process of release of funds for mental health Programme as approved in the PIP needs to be done for smooth functioning of programme activities.
- Communication and awareness generation activities must be undertaken to decrease marginalization and rampant discrimination associated with mental health problems and to facilitate improved help seeking.
- Targeted interventions for school and college students with counselling and life skills education and training of teachers are critical for promotion of mental health among adolescents. These need to be taken up on-priority by states.

State Findings

ASSAM

12 out of 27 districts in the state are providing mental health services via daily OPD conducted by the psychiatrist at the DH. Key staff positions such as clinical physiologist, psychiatric Nurse, psychiatric social worker, community Health worker and counsellor are lying vacant, adversely affecting the counselling and outreach services under the program. As on November 2017 there are 28 Psychiatrists in the state providing mental health services at the identified District Hospitals.

BIHAR

11 out of 38 districts are implementing mental health programme. There are only 3 psychiatrists available in the state to provide OPD services. Training on basic screening and identification has been provide to 22 medical officers (2 per implementing district) from NIMHANS-Bangalore to provide mental health services in the 11 identified districts. The OPD load at the clinics is very low due to non-availability of staff. The state is utilizing the psychiatrists from medical colleges (Senior Residents and Assistant Professors), to provide twice a week Psychiatric OPD services in DMHP districts.

CHHATTISGARH

The Mental health programme is yet to be implemented in the state. Due to shortage in specialist services, state is in process of training the MBBS doctors at NIMHANS- Bangalore on conducting basic psychiatric screening at the District Hospitals. The state has trained teachers in life skill education and has oriented community health worker in mental health.

KARNATAKA

All the 31 districts in the state have good provision of mental health services. It is commendable that in the FY 17-18 the state has provided mental health services to 21,60,28 patients from April 17 to Sept 17 (six months). There is online monitoring of services provided and mental health drugs are available at all level of health facilities. The state has trained the medical officers on early identification & treatment of mental illness and Para- medical staff on identification and appropriate referral. The state government has also launched Mano Chaitanya Programme (MCP) (Super Tuesday programme), a state initiative where a clinic for psychiatric care

is held at every taluka hospital on a designated Tuesday of every month and Manasadhara program, in collaboration with telemedicine unit of NIMHANS to provide specialist consultants to the patients.

JHARKHAND

Activities and interventions related to Mental Health Programme are limited at the district level, with patients being referred to the MGM Medical College to avail mental health services. No mental health screening or counselling services are provided at the facilities below the DH. Human resource positions under DMHP are largely vacant.

UTTAR PRADESH

The programme is functional in 45 districts of the state. The district visited during CRM (Kanpur nagar) was included in the programme, with little involvement of the medical college in providing specialist services. Counselling and health helpline services were found to be missing. The state has been able to recruit psychiatrists and clinical psychologists in all 45 DMHP districts and also have made IPD services functional with ear marking of 10 beds in DHs for psychiatric patients.

WEST BENGAL

State is providing mental health services in 7 districts. Training of HR to provide services is yet to be completed. All the essential psychiatric and psychotropic drugs are available at all level of health facilities. Fixed day camp services are provided at the level of SDH with the footfall of 50-60 patients per camp.

Manipur- Funds for implementing the programme in all the districts of the state has been provided, however service provision under the programme is yet to be initiated. Delay in release of funds and lack of clarity in operationalizing the Programme are major hindrances in Programme implementation. The JNIMS and RIMS city hospitals are the providers of the mental health needs of the region, as specialist staff (psychiatrist, psychologist and medical social worker) are unavailable at the district hospitals.

PUNJAB

There is very good infrastructure for de-addiction and Rehabilitation centres at the DH in the state. Psychiatrists are available for OPD and counselling services to the patients. However, during the CRM visit it was observed that resources in terms of manpower and infrastructure were underutilized. Better awareness through community-based intervention is required in order to increase awareness, demand and footfalls for the much-needed mental health services.

TELANGANA

Both the districts visited under CRM are not engaged in the NMHP.

MAHARASHTRA

State has implemented “Prakalp Prerna” initiative to curb the alarming rate of farmer’s suicide in the state. Trained medical officers and Paramedic staff at the district level were providing mental health counselling and referral services to the patients. Apart from the medical officer, the ANMs and ASHAs were also involved in community based screening of mental health conditions. Newer psychiatric medicines under the mental health Programme were not available at the health facilities visited.

MEGHALAYA

This state has launched its mental health programme in two districts namely West Garo Hills (WGH) & West Jaintia Hills (WJH), however, implementation of the Programme was found to be minimal at the field. There is a state run 150 bedded mental hospital in East Khasi Hills (EKH) manned by 7 doctors (including 3 psychiatrists) and 56 trained paramedics providing mental health services.

NAGALAND

NMHP is implemented only in Dimapur and Mokokchung district of the state. There is a psychiatrist at the District hospital who provides mental health screening services. During the community interaction, the CRM Team observed that only psychotics and people with violent/aggressive

behaviour were considered eligible for mental health treatment. Moreover, there are no facilities to manage such patients at the DH and are referred to mental health institute in Kohima. However, there is information on treatment facilities made available to the referred patients.

HARYANA

Implementation of mental health programs at the field level were largely absent. There were no programme activities undertaken at the facilities visited in Gurugram district nor nay targeted intervention at the schools, colleges, workplaces and community. This state lags behind in implementation of DMHP programme, both facility-based interventions and community based activities.

National Programme for Prevention and Control of Deafness (NPPCD)

State Key Findings

Assam is the only state which has services like prevention, early identification, treatment, referral, for hearing impairment and deafness at their district hospitals. Ear surgeries were performed in Assam and West Bengal in the identified districts but in Meghalaya none of the diagnosed deafness cases were operated for corrective surgeries. In Assam hearing aid beneficiaries were identified and listed in the districts. Although there is presence of ENT Surgeons, audiologists, other support staff, audiometric assistants and instructors in West Bengal and Meghalaya, the services were found to be underutilized. Key positions lie vacant in Assam and Nagaland. In West Bengal, the equipment as per guidelines have been procured and installed, but in Meghalaya and Nagaland equipment under the programme was found to be missing.

Key Recommendations

- Basic audiometry services should be made functional, with a special focus on early identification and referral.
- Public awareness should be through appropriate and effective IEC strategies with special emphasis on prevention of deafness.

State Findings

ASSAM

The team observed that services of prevention, early identification, treatment and referral for hearing impairment and deafness were available at the district hospitals. Ear surgeries were performed by a specialist and surgical instrument was available. Beneficiaries requiring hearing aid were identified and listed in the districts. However, key positions are laying vacant (e.g. audiometric assistant) and the programme is restricted to only DH hospital.

CHHATTISGARH

This programme is functional in 14 districts. Audiometry facility is available in DH of both the districts, and hearing aids have been distributed to 800 patients so far.

WEST BENGAL

The state has implemented in 21 districts where equipment as per guideline has been procured and installed. All units are running with ENT Surgeons, audiologists, other support staff, audiometric assistants and instructors of the total number of people screened, 2757 surgeries have been carried out and 785 hearing aids fitted.

Both districts visited had ENT surgeon and audiologist posted at DH, however, specialist services were found to be under-utilized.

MEGHALAYA

State has initiated this Programme in East Khasi Hills with support from Ministry of social justice and empowerment. Though there are trained ENT surgeons available at the district, none of the cases diagnosed with profound deafness were operated for corrective surgery, merely for want of an operating microscope. State may procure the necessary equipment from available funds.

NAGALAND

There was one ENT surgeon who was placed earlier in the district and would perform audiometry. However, after his transfer there is no HR to manage deafness cases. Currently, there are no activities undertaken under NPCB in the state.

National Iodine Deficiency Disorder Control Programme (NIDDCP)

Key Findings

Salt survey has been conducted in states like Assam, Chhattisgarh and Manipur. Awareness activities about the consumption of salt has been carried out in almost all the states. In Meghalaya, the East Khasi Hills district falls in the iodine deficient belt. State has procured the Salt Testing Kit (STK) for qualitative testing of Iodized salt at the community level at VHND/Anganwadi Centre/School Health Programs. IEC materials were displayed at the DH in states of Manipur and Jharkhand.

State Findings

ASSAM

The MBI kit is available at village and at SC for salt testing. Goitre survey and resurvey (n=19) were conducted in the state. The team found that the community was aware about the consumption of iodized salt. However, all collected household salt samples at village level and Char area contains adequate/higher amount of Iodine content as per standard norms Salt testing reports are >30 ppm in 77% of tested samples in the state. The data was not available for sample testing and reporting at village level and listing of goitre patient and thyroid disorders in the community was not available.

CHHATTISGARH

The State IDD Cell is functional. Goitre survey was carried out in 18 districts.

MANIPUR

Iodized salt is available and consumed state wide. The cost of iodized salt is ₹ 10-20 per kg. IEC is provided in print and electronic media. Global IDD prevention day is also observed. Resurvey of goitre is pending. Salt testing kits are in shortage and hence testing by ASHAs is limited. Urine iodine estimation is not done due to lack of equipment and reagents. Shortage of Human resources need to be addressed.

JHARKHAND

Under NIDDCP, IEC materials are available at DH. Iodized salt in various brands is available in the districts visited and iodized salt is consumed at household levels. Both districts visited during CRM have not been implemented the NIDDCP program.

WEST BENGAL

The state conducts IDD awareness activities and promotion of use of iodized salt at household level, along with salt testing in 12 endemic districts. Use of iodized salt was seen in community. RBSK team visiting the schools and Anganwadi centres refers suspected goitre cases to higher level facilities. ASHAs do not test salt test but play an important role in improving community awareness about good cooking practice.

MEGHALAYA

The East Khasi Hills district falls in the iodine deficit belt of the state. State has procured the Salt Testing Kit (STK) for qualitative testing of Iodized salt at the community level during VHND/Anganwadi Centre/ School Health Programmes. However, the kits are yet to be distributed in the field and there is training on its use. The State needs to conduct IEC/ BCC activities for target populations and train field workforce on use of STK.

NAGALAND

The ASHA tests salt in at least 50 households on a monthly basis. Salt of companies such as Tata, Everyday and Patanjali were seen to be consumed in the households. The cost of salt for 1 kg is `15. IEC on consuming iodine rich salt are displayed at the health facilities, ICE leaflets are distributed during VHND. As the same Programme officer is in-charge of NLEP, the IEC activities for both the programs are carried out together.

Key Recommendations

- States should conduct the salt surveys to capture the magnitude of the problem.
- States should provide health education and publicity by displaying IEC materials at all

the facilities, Government aided schools and Anganwadi centres.

- States should ensure availability of STK at the field level and ASHAs should be involved in household testing of salt samples.

National Oral Healthcare Programme (NOHP)

Key Findings

National Oral Health Care programme is partially implemented in few states. Dental chairs were available at the visited health facilities in the states of Jharkhand and Meghalaya. Specialist doctors were available in Assam, Chhattisgarh, Uttar Pradesh, Jharkhand, Maharashtra, Nagaland and Haryana.

Poor sterilization practices for dental equipment and their maintenance was seen in Uttar Pradesh. Posters were displayed at all DHs, PHCs and CHCs of Uttarakhand and Haryana. Overall, awareness of community members on availability of oral health services was wanting. There was erratic supply of dental materials at the health facilities visited. Dental X-ray was not available at any DHs of Jharkhand, Nagaland and Haryana. Curative services are available at District Hospitals of Meghalaya.

Key Recommendations

- Preventive and curative services related to oral health should be provided at PHC.
- Rational deployment of HR to operationalize dental services should be prioritized.
- The dentist and technicians need to be reoriented on screening of various oral health ailments with special focus on early detection, referral.
- Counselling to quit smoking and use of tobacco in any form need to be strengthened.
- RBSK- Mobile Health Team can be utilized for screening of oral health issues at school and Anganwadi centres.

State Findings

ASSAM

Dental surgeons at the district hospital are providing OPD services. However, no dental services were available at CHCs and PHCs visited. There is a dental OT at Model hospital in Goalpara which is lying unutilized as there is no dental surgeon at the health facility.

CHHATTISGARH

NOHP is evolving in the state with gradual expansion of the facilities providing dental services. DH Dhamtari has a full-time and a part-time dentist. However, the service remains unutilized as there is no functional dental chair. Dental clinic at DH Bijapur was found to be functional with requisite HR and equipment at the clinic.

UTTAR PRADESH

Both the districts visited were included under oral health program. All the facilities up to CHC level had dentist available but are underutilised. Most of the dentists only do extraction procedures and the Comprehensive range of services under oral health is lacking. Lack of adequate equipment, instruments, and materials is one of the reason for this poor service. Improving oral health services and Programme does not seem like a priority for neither the state nor the district. The Dental chair was however, available at all the facilities visited though many of them were non-functional. Proper sterilisation and maintenance of available equipment was found deficient in all the facilities visited.

UTTARAKHAND

The post of specialist for the majority of the specialties except for Dental health were vacant. Hence, almost all the NCD programmes, barring NOHP and NPCB were not active at the DHs of districts visited. Some posters related to NOHP were displayed at DH, CHCs and PHCs. The service is limited to dental extraction. The community is unaware of availability of oral health services at the health facilities. Supply of dental materials was poor at the clinics visited.

MANIPUR

Oral health care is provided in 7 out of 9 district hospitals in the state. Establishment of Dental care units in the remaining two districts is planned. These units will function from Wangoi CHC in Imphal West and JNIMS in Imphal East. CHC and PHC level dental care units being established and strengthened simultaneously.

JHARKHAND

Under NOHP, dental clinics are functional at DH and only one dental chair is available in both districts. Dental X-ray was not available at any of the DH. However, the dental surgeon has recently been recruited in DH Jamshedpur and conducted a 30-40 patient daily OPD, performing minor dental procedures. The indent has been submitted for procurement of 16 dental equipment items for Pakur Sadar hospital. None of the CHCs have been approved dental care units in the 2 districts visited.

MAHARASHTRA

Separate dental service providing departments exist at the district, sub-district and rural hospitals. Based on dental examination of the patients, the dental unit at the rural hospitals informs the concerned MPWs about the problems of Fluorosis in a particular area/ village, as seen in Parbhani.

MEGHALAYA

Though there is no full-fledged NOHP implemented at the districts, district hospitals and few CHCs (e.g. Chockpot CHC from SGH district) visited have a functional dental clinic. Appreciably, CHC Chokpot has recently purchased equipment like dental chairs from the revenue generated by Meghalaya Health Insurance Scheme (MHIS) claims and Rogi Kalyan Samiti (RKS). Curative services are provided at these facilities and there is further scope for improving overall service provision under the ambit of NOHP.

NAGALAND

There is no oral health programme in the Kiphire district but there is a dental OPD with two dentists. The quality of dental X-rays in Kiphire is not good and patients are referred to Dimapur (where there are dental surgeons in both public and private sector) for root canal treatment. There is no communication with RBSK team and no tobacco control activities are taking place during OPD hours.

HARYANA

There are 3 Dental Surgeons are in place in Sec 10 GH, but untrained in NOHP/PBS Oral Cancer screening. Dental X-ray facility unavailable in Sec 10 GH Gurugram. IEC material was adequately displayed. There was no linkage with RBSK dental referrals.

National Programme for Prevention and Control of Fluorosis

Key Findings

Of the states visited during the CRM, NPPCF Programme was functional in the states of Karnataka, West Bengal and Jharkhand. Sources of drinking water including tube wells were found to be contaminated in West Bengal. Fluorosis diagnostic laboratory was functional in the state and the district has clearly mapped out the affected areas and also the number of patients with skeletal/ dental involvement.

Key Recommendations

- Wider coverage of screening to be ensured through ASHAs (after appropriate training) and the RBSK Teams.
- Efforts and interventions at district level needs to trickle down to the CHC, PHC and HSCs.
- The work done by ASHA on Fluorosis mitigation, under the National Programme for Prevention and Control of Fluorosis needs to be recorded.

State Findings

KARNATAKA

Fluorosis control Programme is functional in District Raichur and rehabilitative measures are

being undertaken on cases identified from survey, checking samples.

WEST BENGAL

Fluorosis is prevalent in 6 out of the 8 blocks of Dinajpur affecting 732 villages. Sources of drinking water including tube wells are reported to be contaminated and alternative arrangements are being explored. The Fluorosis diagnostic laboratory is functional in the district and mapping of affected areas and the number of patients with skeletal/ dental involvement is being done.

MANIPUR

Fluorosis cases are not reported in the state.

JHARKHAND

As per National Rural Drinking Water Programme, MDWS, Pakur is one among the endemic district for fluorosis. The extent of the endemic is yet to be assessed in terms of dental, skeletal and non-skeletal fluorosis at population level, before effective implementation of comprehensive management of fluorosis in these affected areas. In FY 17-18, ₹ 90.58 lakhs was sanctioned for NPPCF in the state, but was not received at the district. Funds for NCDs are utilized from last year's unspent budget with the approval of district health society.

Recommendations

- Involvement of ASHA on Fluorosis mitigation, under the program, needs to be reviewed.
- Wider coverage of screening to be ensured through ASHAs after appropriate training.

National Programme for Prevention & Control of Cancer, Diabetes, Cardiovascular Disease & Stroke Implementation

Key Findings

Functional NCD clinics with prime focus on screening and treatment of hypertension and Diabetes was found in most of the states visited. Visual Inspection via Acetic acid (VIA) for screening cervical cancer was practiced in Punjab, Chhattisgarh and has been initiated on pilot basis in seven districts of Odisha. State and district level NCD cells are set up in all the states visited. However, there was no review nor monitoring of the activities undertaken by the NCD cells due the shortage in human resource (both administrative and technical) as reported in Assam, Karnataka, Jharkhand, Manipur and Meghalaya. States report a varying degree of implementation of population-based NCD screening and the activity has been initiated in most of the states visited except for Assam, Odisha, West Bengal, Punjab (Ludhiana). In Uttar Pradesh, screening of women with common cancer has been prioritized under the state initiative of Sampoorna clinic. Similarly, Maharashtra has also implemented "Cancer Warriors"- initiative where private specialist provides cancer care services on 1st sat of every month.

Implementation of the Population Based Screening, prevention and management of Non-Communicable Diseases for above 30 years age group started in the beginning of year 2017. The programme has been envisioned as an initial critical step to expand the package of services to be delivered in pursuit of Comprehensive Primary Health Care. The focus of NPCDCS programme so far has been limited to opportunistic screening for NCDs at the CHCs and District Hospitals. This new initiative has been undertaken to integrate screening, early detection, and management of common NCDs, as close to the communities as possible. The programme envisages that risk assessment, screening, referral and follow up for selected NCDs (hypertension, diabetes, cancers of the oral cavity, cervix and breast) amongst all women and men aged 30 years and above; to be included in the set of services being offered as part of CPHC. Population enumeration, community-based risk assessment through use of a standard checklist by ASHAs, sub-centre level screening by ANMs and continuity of care through referral, treatment initiation, drug dispensation and follow up are the other critical activities planned.

This section includes the CRM findings of the roll out of Universal screening of common NCDs. In all the sixteen states covered in 11th CRM, 92 districts have been selected for roll out of Universal screening of common NCDs. A total of

10,893 Sub centres have been selected across these 92 districts to operationalize the screening programme.

The programme is in early stages of implementation. All states have commenced the programme with training of health workforce on specified protocols of Universal Screening of Common NCDs. So far, 3,602 ASHAs, 2,374 MPWs (male and female), 511 Staff Nurses and 372 Medical Officers have been trained in these districts. Not much has been reported on quality of trainings, but findings from Haryana indicate a need of refresher training to reinforce all the components of the programme. While most of states have initiated capacity building measures and population enumeration progress on other components such as-screening, related health promotion, monitoring and supervision is variable on account of early stage of programme implementation.

Community Based Assessment Checklists (CBACs) are being filled by ASHAs during her household visits in Chhattisgarh, Karnataka, Maharashtra, Punjab and Telangana. The operational guidelines stipulate prioritizing individuals obtaining a four-plus score in the CBAC risk assessment. As per programme guidelines, scoring has been positioned as means to highlight risk factors and not a point of elimination. However, in certain states such as Maharashtra, it was observed that people with scores less than four are not being referred for screening.

Health Promotion is an important component of the programme and plays a critical role in primary prevention and control of common NCDs. Display of NCD related IEC for health promotion is a common finding across the states; but Chhattisgarh, has gone a step forward and is organizing Weekly Haats as innovative mechanism for community level demand generation.

The states visited conduct opportunistic screening under NPCDCS. Population-based screening to cover all individuals of age 30 years and above has been initiated only in five states i.e. Chhattisgarh, Karnataka, Maharashtra, Punjab and Telangana. Overall in these states approximately 15.8 Lakh (15,79,949) population has been screened so far for common NCD conditions.

Few states such as Punjab, Uttar Pradesh and Maharashtra are planning to integrate other existing programmes with population-based screening to strengthen continuity of care mechanisms for NCDs. Free Annual Preventive Health Check-up & Mukhya Mantri Cancer Rahat Kosh Yojna in Punjab and Sampoorna Clinics in Uttar Pradesh are such examples. Maharashtra has a scheme called “Cancer Warriors” under which diagnostics and curative care is being provided by the private specialists on first Saturday of every month.

Lack of follow up mechanisms for positively diagnosed cases has emerged a critical challenge in all the states. Due to the initial stages of the programme, another common finding from all the states was lack of clarity on details of programme implementation amongst the service providers at different levels of healthcare facilities. Progress is also variable in the states on procurement of drugs and consumables. While procurement has been completed in Assam, it is underway in Haryana; states of Maharashtra and Manipur indicate delays and highlight a need to expedite the procurement for drugs and consumables.

Key Recommendations

- The range of services provided at the NCD clinic should expand to include screening common cancers, and other cardiovascular complications. Further, active involvement of frontline workers for comprehensive management of NCD is critical.
- Robust referral linkage has to be established to attend and address cases received from the community and strengthen further referral to higher (secondary) level facilities.
- Review, supportive supervision and feedback from the state-district-health facility need to be strengthen to ensure effective service delivery in the state.
- States should continue the efforts on training and ensure completion of capacity building for all cadres on a priority basis. As per the training strategy, states should ensure the joint training of ASHAs and ANM/MPWs of respective HSCs on the fifth day of ASHA training.

- This would also support in addressing the issue of lack of referrals for screening reported in states like Maharashtra.
- There is also a need to plan a simultaneous roll out of the programme in urban areas.
- Follow up care is critical for ensuring treatment compliance and secondary prevention. There is a need to address this gap early on and needs to be emphasized and reinforced during programme reviews and trainings of frontline staff.
- States should also strengthen reporting and recording mechanism to ensure the follow up of positively diagnosed individuals.
- Improved use of CBAC in states by local translation and early printing.
- Involvement of VHSNC/MAS/PRI needs to be ensured for health promotion and screening activities.

State Findings

ASSAM

There is state and district NCD Cell in 14 of 27 districts, District CCU facility and District Day Care facility in 5 of 7 districts and NCD Clinics in 79 out of 123 CHCs in the state. However, almost 50% of approved posts are lying vacant across the health facilities. 56 sub centres in five districts have been selected for operationalizing Population-based screening. Training of ASHAs, ANMs, GNMs and MOs for screening of common NCDs has been initiated. A target of 101,978 persons above 30 years will be covered under Universal Health Screening and necessary procurement has been done at districts. However, PBS monitoring/supervision plan in the state not yet initiated. Pradhan Mantri National Dialysis Programme (in PPP mode) is yet to be rolled out in 25 district hospitals in the state.

State has selected five districts for rolling out of Universal Screening of common NCDs – Dibrugarh, Jorhat, Kamrup (rural), Barpeta, Nagaon. State has targeted to cover 25% (25,493) of total population aged 30 years and above (1,01,978) to be screened in the first year of the programme.

Procurements have been done for the roll out of the programme; however, state has not yet initiated a plan to monitor/supervise the programme. The state plans to include Medical colleges and B. Barooah Cancer institute in monitoring the programme across the districts. An MIS has been prepared for monitoring the data of screening and details of every individual captured. The state should plan NCD screening in all CHC staffed sub centres.

BIHAR

The NCD cell in the state has been established in six districts and is in process in remaining 32 districts. ANMs in these six states have been trained on screening for diabetes and hypertension. Virtual Classroom Training platform has been utilized for training medical officers on various components under NPCDCS. The state has selected five districts for rolling out of Universal Screening of common NCDs – Muzzafarpur, Rohtas, East Champaran, West Champaran & Vaishali.

No relevant information is available on implementation of Universal screening programme for common NCDs.

CHHATTISGARH

State has operationalised 14 District NCD cells and clinics, one functional Cardiac Care Unit and 58 CHC-NCD clinics. Screening of diabetes, hypertension, and common cancers are conducted through district and sub district NCD clinics. Anti-hypertensive and anti-diabetic medicines are available up to sub-centre level. Sickle cell anaemia screening is carried out in NCD districts at DH and CHC level and through RBSK teams. Mitanins are also involved in screening and management of NCDs.

State has selected three districts for rolling out of Universal Screening of common NCDs – Raipur, Durg and Dhamtari. In addition to these three districts, the state has initiated screening for the conditions of Hypertension and Diabetes which has been done up to the level of sub centres across all the districts of the state.

Mitanins have been trained for health promotion activities and awareness on NCD screening and

management. In weekly Haats, health promotion activities are being done, and information on screening of diabetes and hypertension is given. The Tobacco de-addiction clinic is functional at District Hospital, Dhamtari, but PAP smear test facilities are not available even at the District hospital level.

JHARKHAND

There is a dedicated medical officer for NPCDCS at the district hospitals. NCD related diagnostics at the DH are outsourced under PPP mode. There is shortage of HR at the district NCD cell. Other than a general surgeon, no specialist staff for diagnosis of NCD related complications were available at the health facilities. Infrastructure related to NCD is yet to establish in the visited facilities. No facility for universal screening of common NCDs at HSC or via Mobile Medical Units for is available. No IEC activity has been carried out so far and no review meeting for NPCDCS has been conducted at the state as yet.

State has selected three districts for rolling out of Universal Screening of common NCDs – Ranchi, Bokaro and Dhanbad. In the districts visited, most of the NCD related diagnostics are performed either outside the district hospital or at outsourced; at Jamshedpur it was outsourced to Medall diagnostics, while at Pakur it was outsourced at SRL diagnostics.

Screening at DH level was only limited to two NCD conditions, i.e. Hypertension and diabetes. The daily OPD load at the NCD clinic of Jamshedpur DH is 70. At the DH, the available drugs related to NCDs are anti-hypertensives, anti- diabetic and COPD drugs.

Currently Pakur district is not included in Universal Screening Programme for common NCDs; however, a micro plan has already been proposed for establishment of five NCD cells in one DH and four CHCs i.e. Liitipara, Maheshpur, Amrapara and Hiranpur.

A regular reporting on patients diagnosed with Diabetes, hypertension, CVDs, stroke and common cancers was only observed from Jamshedpur district on HMIS portal on NPCDCS.

Owing to rising burden of NCDs in the state, Universal screening programme should be scaled up to all the districts.

KARNATAKA

All the 30 districts of the state are covered under NPCDCS. Despite constraints in manpower recruitment, majority of NCD clinics at the DH and CHC level are providing screening services for hypertension, diabetes, CVDs and stroke. It is appreciable that 51,917 diabetes cases, 1,03,898 hypertension cases, 2332 cardiovascular diseases, 662 stroke and 1619 malignancies were detected newly under the programme by the end to Q-III of 2017-18.

State has selected six districts for rolling out of Universal Screening of common NCDs – Mysore, Udupi, Gadag, Haveri, Raichur and Chikamagalur. State has arranged a large screening camp for NCD screening and detected 51,917 cases of diabetes, 1,03,898 cases of Hypertension, 2332 cases of CVD, 662 cases of strokes, and 1619 cases of malignancies.

ODISHA

The selected districts for NPCDCS are KBK (Kalahandi, Bolangir and Koraput) districts and are challenging districts. During 2014-15 the Programme was extended to another 10 districts and by 2016-17, the programme was extended to extend to all the districts of the state. Since inception of Programme 58 lakhs population have been screened for Diabetes, Hypertension, Cancer and Cardiovascular diseases in Odisha. 3.41 lakh Diabetes patients and 3.86 lakhs Hypertension cases have been detected and treated at Health facilities. Physiotherapy units have been established at all DH & 39 CHC Level. Training of all Doctors and ANM and other paramedical were completed. IEC materials on NCD developed and displayed up to Sub Centre/Village Level. The District Cancer Care Programme with administration of Cancer Chemotherapy has been started in all 25 DHHs. Population-based screening for early detection of cancer oral cavity; cervix and breast have been taken up in 7 districts and 2 urban areas as pilot project.

UTTAR PRADESH

NPCDCS has not been initiated either of the districts visited. The state currently has 43 District NCD clinics and 116 CHC-NCD clinics where opportunistic screening is being done. Population-based screening has only been initiated in 5 districts of the state. State has introduced an initiative of screening of women on NCDs through "Sampoorna clinic". However, services under such clinics are yet to take off. No fixed day services or camps are being organised for screening of NCDs in the state. State had selected four districts for rolling out of Universal Screening of common NCDs – Cuttack, Khurda, Sambalpur, and Rayagada and added three more, namely, Ganjam, Kalahandi and Puri.

Under NPCDCS, state has screened a population of 58 lakhs for NCD conditions like hypertension, diabetes, cancer and cardiovascular diseases. 3.41 lakh diabetes patients and 3.86 hypertension patients have been detected and treated at the health facilities. Similarly, the number of cases treated for CVD and stroke is 4,566 and 1,677 respectively. 5,431 cases of suspected cancer were referred to higher facilities. IEC material for NCDs has been developed and displayed at the village and SC level. Under Universal Screening programme, 48,122 people have been screened so far up to the level of SC.

State has selected five districts for rolling out of Universal Screening of common NCDs – Rae Bareli, Jalaun, Jhansi, Lalitpur and Farrukhabad. The SamPoorna clinic initiative screens women for NCDs. The Clinics were not functional in any of the district during the visit. Also, there were no other fixed day services or camps being organized for screening of NCDs. Facilities for ICU/CCU were not available in the visited districts.

UTTARAKHAND

There is a state NCD cell and NCD clinics which are functional at 9 districts hospitals. Population Based Screening (PBS) for NCDs is being implemented in Pauri Garhwal, Dehradun and Nainital. Infrastructure to provide NCD services has been established in these district hospitals. IEC for NCD was found in district hospitals of both the districts visited. Treatment is focused towards HTN and DM and other NCDs are yet to find place due to shortage in specialized manpower. Follow-up of patients diagnosed with NCD is minimal. Majority of the supporting and paramedical positions are lying vacant. Drugs related to hypertension and diabetes was available at all the health facilities visited.

State has selected three districts for rolling out of Universal Screening of common NCDs – Dehradun, Pauri and Nainital. IEC for NCDs is available and displayed at the District Hospitals. Out of 9,051 individuals screened in NCD clinics in September 2017, 1,552 and 2,186 cases were diagnosed positive for diabetes and hypertension respectively. Around 55 were diagnosed with both hypertension and diabetes. Follow up of confirmed cases is poor in the state. Also, the duration of drug dispensed for NCDs is undefined in the state.

At CHCs and PHCs, cases of diabetes and hypertension are screened as a routine OPD. No other NCD related activities were observed at these health facilities. Random Blood Sugar was the only investigation undertaken at these facilities. Drugs for hypertension and diabetes were available at the PHC and CHCs.

WEST BENGAL

The programme is operational in 19 out of the 28 districts with 19 dedicated District level NCD clinics and 38 CHC NCDs clinics. However, clinics were functional only at a few facilities visited. Budget utilization for NCD programme has been poor due to lack or recently recruited staff. Population-based NCD screening was not seen in either of the districts visited. NCD drugs (including insulin) were available and provided to the patients at higher level facilities for 30 days drugs and at lower level for 7 to 30 days. Convergence between the NCD and Elderly Care clinics was seen at SDH Kharagpur. However, there was no mechanism for follow-up of patients diagnosed with Hypertension or Diabetes. A total of 558 deaths from stroke have been reported from 2015-17 (P. Medinipur), but thrombolysis was not used for the management of these strokes, although a neurologist and adequate quantity of relevant drugs as streptokinase/alteplase was available. It was difficult to run a 24X7 stroke care

unit with one neurologist, it was stated. The state will need to either train more Medical Officers in management of common NCDs or provide better support and 24X7 investigations as Lipid profile, CT/MRI to the existing facilities. In absence of District NCD Cell, State NCD Cell may take initiative for addressing this gap. IEC material on NCDs was displayed at hospital, however placement may be more strategic.

The state has selected three districts for rolling out of Universal Screening of common NCDs – Alipurduar, Birbhum and Asansol. TOT for Universal Screening programme is expected to be completed by December 2017. The budget utilization for NCD programme has been poor due to Human Resource shortfall and recently recruited staff. Universal screening was not observed in either of the district visited.

MANIPUR

NCD clinics have been established and made functional at the district facilities. Population based screening has been planned in Imphal West & Thoubal districts. The major challenges in Programme implementation are lack of equipment, low salary and non-recruitment of support staff. There is a media plan in place with both print and electronic modes. Budget for IEC/BCC has been assigned. There are issues of NGO involvement and other sectors. District NCD cell training has been undertaken. Problems reported above at state level were also reported at district level implementation. NCD clinics banner/sign was noted at CHC with IEC material displayed inside clinic; however display of available services was not made. There was lack of HR, diagnostics, medicines and equipment at clinics. Population based screenings are undertaken by sub-centres, mobile medical units are working, drugs are made available at PHC level, referral mechanism is in place. Funds release is irregular and hence implementation is affected. Reporting formats and referral slips are available and being utilized at clinics, CHC/PHC and district facilities.

State has selected two districts for rolling out of Universal Screening of common NCDs, Imphal West and Thoubal. IEC/BCC plan has been made for both the districts, and both print and electronic media has been involved. NCD clinics banners and signs were observed at the CHC level; and IEC material was displayed inside the CHC. There was no information displayed on NCD related services that are available at the facility.

Major challenges faced in implementing the screening programmes are lack of equipment, low salaries for the staff and shortfall of support staff. Fund flow mechanism has issues related to irregularity and affecting the implementation of the programme.

State has also reported issues with NGO involvement. Mobile Medical Units are also involved in Universal Screening programme. It was reported that drugs for NCDs are not available at the SC level; however, they are available at the PHCs. Referral mechanism was reported in place across the facilities. Reporting formats and referral slips are available and being utilized at NCD clinics, PHC/CHC and district level health facilities. State needs to expedite the process of procurement for drugs and equipment; and a CCU needs to be established at the district level.

PUNJAB

ANMs in the state have been providing training for screening of four common NCDs- Hypertension, Diabetes, Oral cancer and Breast Cancer. Screening for breast and oral cancer is being done up to Sub-Centre level. Mukhya Mantri Cancer Rahat Kosh Yojna is being implemented since 2014 and within such short time span it benefitted a large number of cancer patients. Empanelled hospitals are highly engaged in running this programme successfully. State has also initiated population-based screening of 30+ population. However, it is yet to be initiated in Ludhiana district. No specific micro-plan or follow up of the patients identified for Hypertension or Diabetes or both was available, as evidently this Programme is in its nascent stage and needs strong monitoring and clarity on processes. NPCDCS needs to be strengthened with more infrastructure support and human resource allocation. For screening cervical cancer, ANMs perform VIA once in a week by hiring it from PHC during Ante-Natal Check up. State is rolling

out the Universal Screening of Common NCDs across all 22 districts.

ANMs have been provided training for screening of four common NCDs, i.e. hypertension, diabetes, oral and breast cancer. The state has initiated Free Annual Preventive Health Check-up (FAPHC) of population of thirty years and above. Special focus is on providing support for the treatment of cancer patients and provision of subsidised drugs. The services under FAPHC are available at all secondary level facilities but the service is being provided only at CHC level. A communication gap has been reported between state and health facilities on guidelines to undertake the initiative.

Stroke management facility is available at three Medical Colleges and District Hospital of Jalandhar, Ludhiana, Bathinda. Fazilka and Sangrur. In state, Mukhya Mantri Cancer Rahat Kosh Yojna is implemented since year 2014, and an amount of ₹ 1,50,000 has been sanctioned for every individual who is detected with cancer. In district Ludhiana, Universal screening of NCDs has not yet started.

The data from CHC Hathoor and Dehlon reflected that only those individuals were screened who were visiting the facility because they were suspecting a disease. It was reported that screening for cervical cancer was being undertaken by ANMs using Visual Inspection with Acetic Acid (VIA). Currently the screening was not in place at the level of SC due to unavailability of autoclave, and ANMs were screening the women once in a weak during ANC check-up by hiring VIA consumables from PHC.

TELANGANA

State has implemented Non-Communicable Disease in year 216-17 in nine districts. Hands-on training of ANM, Medical officers. MPHA(F). ASHA and PHN on diabetes management and NPCDCS has been completed. The screening for non-communicable diseases is carried out at 43 sub-centres in Adilabad districts on the lines of NPCDCS through state funds. In the year 2016-17, a total of 6,75,920 people have undergone opportunistic screening. On line Data capturing has been started in Jangon and Peddapally districts and will be expanded to the rest seven district of the state for referral linkages with PHC to secondary care hospital. Funding from NHM for initiation of NPCDCS programme has not been initiated as yet and is being planned in FY 2018-19. State has selected nine districts for rolling out of Universal Screening of common NCDs, namely Karimnagar, Warangal (U), Pedapally, Sircilla, Jagityal, Mahabubabad, Jangaon, Jayashankar, Warangal(R). The state has implemented Non-Communicable Disease in year 216-17 in nine districts in the first phase. Adilabad is one of the district among them and Khammam urban area is also piloted in few months back. State has completed series of activities, such as, hands-on training of ANM, Medical officers, MPHA(F). ASHA and PHN on diabetes management and NPCDCS, Stroke management orientation of district level Physicians and Staff Nurses of the District hospital.

In the year 2016-17 total 6,75,920 persons have been screen`ed by opportunistic screening among them Diabetes- 92419, Hypertension-70446, Oral Cancer-1583, Breast Cancer-1874 detected. In year 2017-18, the detected NCD numbers were Diabetes- 15247, Hypertension-13381, Oral Cancer-1659, Breast Cancer-348, Cervical Cancer- 802.

State has trained 1110 ASHA, 1548-ANM,197- SN and 144-MOs on NCD programme. In the District Peddapally and Jangoan, ASHA has surveyed house to house and estimated 2,94,272 and 2,16,000 respectively for further screening. On-line Data capturing in the district has been started in Jangon and Peddapally districts and will be expanded to rest seven districts of the state for referral linkages with PHC to secondary care hospital.

MAHARASHTRA

District level NCD cell has been established in the state. Visibility and utilization of NCD clinic is satisfactory. However, the district NCD clinic (Wardha) does not have a dedicated medical officer. State has an initiative called “Cancer warrior” where private specialist provides cancer care services on 1st Saturday of the month. Population based screening has been rolled-out. The Operational Guidelines clearly states that scoring is not a point of elimination, but is meant to highlight the risk factors and to prioritize the individual for screening. However, it was observed that people with CBAC (Community based assessment checklist) score of

less than 4 were not being referred for screening for NCDs (Wardha). Lack of coordination was observed between ASHAs and ANMs in NCD camps organized in district Parbani. State can involve Multipurpose workers in screening the community for NCDs.

State has selected four districts for rolling out of Universal Screening of common NCDs, namely Bhandara, Satara, Sindhudurg and Wardha. District NCD cell and CCU are present at the district level and in Parbani district, there was no NCD services available at level below districts. However, at the district Wardha, no dedicated Medical officer was available.

Under universal screening programme for common NCDs, a Community Based Assessment Checklist (CBAC) is to be filled by ASHAs for individuals of age group thirty years and above. CBAC forms is intended to capture individual's general information and assessment of risk factors. Every question has been allocated a score which implies the risk associated with that individual. To expedite the NCD screenings, consumables like gloves and torch should be made available at the level of sub centres.

MEGHALAYA

State has rolled out programme in three districts namely East Khasi Hills (EKH), West Garo Hills (WGH) & West Jaintia Hills (WJH). However, allocations for this programme have not yet been approved for SGH district till current financial year. Vacancies against last year's sanctioned HR strength were observed both at state and district. Implementation of population-based screening was observed to be adversely affected by unavailability of printed IEC material and R&R formats at sub-district level in EKH district. Inadequate training of sub-district level staff, non-participation on non-governmental sectors, no sub-district level monitoring, inadequacy of key equipment at CHC level etc. were observed to be major reasons for poor performance under the program. State has selected two districts for rolling out of Universal Screening of common NCDs – East Khasi Hills and West Garo Hills.

NAGALAND

The Programme was functioning with 1 State NCD Cell, 11 District NCD Cells and 11 District NCD Clinics, 1 CCU. NCD cells have been recently set up at the district level. Opportunistic screening, management of common NCDs, counselling, physiotherapy, monthly reporting, observance of world health day, IPC and screening camps are held at the health facilities and communities visited. However, there was no ophthalmologist, Cardiologist, Neurologist, Nephrologists available at the DH. Screening for hypertension (adults above 30 years) happens during OPD but has poor follow up. Diabetes screening is more challenging as the diagnosis is dependent on fasting and PP and they are able to detect only about 3 to 5 cases a month largely from IPD. For COPD, the doctors do have bronchodilators available and they treat such patients but the number of cases is very less. For cancer patients, there is no screening facility. State has selected three districts for rolling out of Universal Screening of common NCDs – Mokokchung, Dimapur and Kohima.

HARYANA

NCD Cell was located at the Sec 10 GH and the District NCD Clinics located in GH Sec 10 & GH Sec 15. There was no functional CCU at DH-15. Gurugram is one of the five Population-based Screening Districts in Haryana. At the district NCD cell, there is no District Programme Coordinator or DEO in place. There is no NCD Counsellor in any District/CHC NCD Clinic visited. PBS training of ANM/ASHA is underway, however, the ANM co-located in sub-centres are not trained adequately about their role in Population-based screening and patient referral mechanism. There is no clarity on integration with NUHM for NCD screening in cities/urban areas through Urban PHCs. State has selected five districts for rolling out of Universal Screening of common NCDs – Ambala, Panchkula, Gurgaon, Sirsa and Yamunanagar.

Staff Nurse training in VIA was underway in Sector 10 GH. District Nodal Officer (NCD) was trained but the Medical Officers at District/CHC NCD Clinic or PHC were not yet trained for PBS. Diagnostics (glucometers) were supplied to the Sub-centres; but reporting formats not available. The integration with NUHM for NCD screening in cities/urban areas through Urban PHCs was unclear.

National Programme for Palliative Care (NPPC)

Key Findings

Funds for implementing the Programme has been approved for Karnataka and Manipur with minimal progress in Programme implementation, whereas in Assam training of trainers on NPPC at Karunashraya, Bangalore has been completed. Overall, the Programme is yet to be implemented in all visited CRM states except Uttarakhand where Programme is functional in the PPP mode.

Key Recommendations

- The Programme needs to start by training HR and rolling out some of the basic palliative care services.

State Findings

ASSAM

The National Palliative care programme is yet to implemented in the CRM districts. 5 districts, namely Dibrugarh, Jorhat, Kamrup, Lakhimpur and Sivasagar have been approved for NPPC in the state and the Training of Trainers has been completed at Karunashraya, Bangalore.

KARNATAKA

A budget of ₹ 106 lakhs has been released to implement National programme for Palliative care in 5 districts. Subsequently, state co-ordinators have been appointed and training of 2 specialists and 2 staff nurses and 1 pharmacist has been completed. Care centres in these 5 districts are yet to be established.

UTTARAKHAND

The National programme for Palliative care was functioning with PPP mode at the District (Coronation) hospital in Dehradun.

MANIPUR

The National programme for Palliative care has not yet started but budget of ₹ 175 Lakhs has been approved in RoP 2017.

JHARKHAND

The National Palliative Care Programme was not functional in the districts visited.

NAGALAND

Doctors provide opioids as palliative care and to avail treatment for cancer, patients have to go outside the state (Manipur, Assam, Kolkata, Mumbai). No palliative care cell is present in the District.

National Programme for Health Care of Elderly (NPHCE)

Key Findings

The states like Assam, Chhattisgarh, Karnataka, West Bengal, Odisha, Uttar Pradesh, and Haryana have reported progress in implementation of National Programme for Health Care of Elderly (NPHCE). Assam implemented the Programme in phase-wise manner whereas Chhattisgarh District hospital Dhamtari reported having beds reserved for geriatric patients. Karnataka, West Bengal, Odisha, Haryana, Uttar Pradesh reported progress in recruiting contractual staff and constructing physiotherapy and Geriatric Clinics, implementation was poor in the states of Bihar, Uttarakhand, Manipur, Jharkhand, Punjab and Meghalaya.

Key Recommendations

- Due to huge outmigration of working population, existing age pyramid has been skewed this Programme for “Health care of the Elderly”. Perhaps the Programme can be started in a campaign mode while addressing Geriatric Management at PHC level and Field staff’s training for Geriatric.
- States needs to prioritise mental health and geriatric care Programme and action plan for state and districts needs to be prepared.
- Initially the Programme should be initiated at the facilities where a full complement of staff is available else initiating the programs would have only a notional value.

- Mental health should be linked with outreach and our grass root workers like MPW (males) besides ANMs and ASHAs needs to be sensitized for identification and continuity of care of those suffering from mental problems or need geriatric care.
- Identified patients should be line listed and linked with definitive care with support from ambulance services.
- Involvement of medical college and district hospital is crucial in providing quality mental care and geriatric services.

State Findings

ASSAM

National Programme for Health Care of Elderly was implemented in a phase wise manner in the state. Ofa total 3,96,879 people who received OPD care at various health institutions, under the program, 9670 were been admitted and provided IPD services. A total of 8971 people were provided Physiotherapy services. Out of 471 posts approved under the Programme only 98 posts have been filled.

CHHATTISGARH

The activities of this Programme are visible with geriatric clinics in CHCs and district hospitals. District Hospital Dhamtari reported having beds reserved for geriatric patients.

KARNATAKA

NPHCE Programme has been rolled out in all the districts of the state in a phase wise manner.

In year 16-17, all the 10 districts had well-functioning physiotherapy units and laboratories and nine districts had constructed separate Geriatric wards. Significant progress has been made in appointment of contractual staff. Of the 2,44,140 elderly treated in the state, 7382 have been rendered rehabilitation services, 866 have been given service at the household level and 65 have been given appliances under the program.

UTTARAKHAND

No special OPD is being conducted for elderly patients. Geriatric ward was established at JLN District Hospital, Rudrapur but no geriatric patient has admitted in this ward till date.

WEST BENGAL

Convergence between the NCD and Elderly Care clinics was seen at SDH Kharagpur. Both the clinics have their own respective manpower but coordinate well, when an elderly patient requires services for NCD clinic or vice versa. The footfall in both the clinics is more than 10 patients daily, which is commendable as this is still a very new intervention.

Dedicated beds for elderly patients are marked in male and female wards in both the districts. 14,162 elderly patients (upto Sep 2017) have been seen during camps in P. Medinipur. Similar camps at Gram Panchayat level are also being conducted in D. Dinajpur. The commonest disorder attended to was hypertension, followed by osteoarthritis and diabetes. While the services are well utilised, the lack of follow up is a concern. Lack of integration with NPCDCS in the state is a missed opportunity.

MANIPUR

Elderly health care is not initiated. Two districts are identified with construction started for 10-bed wards. Another 5 districts are approved in the RoP 2017-18.

JHARKHAND

In DH Jamshedpur, NPHCE is not functional yet while at DH Pakur, the NPHCE also has implementation issues and DLO has requested for establishment of a geriatric ward in DH. No action has been taken till date.

ODISHA

The construction of the 10 bedded Geriatric wards within NCD Complex at 5 District HQ Hospitals has been taken up and completed. In remaining 25 districts construction of Geriatric wards is in different phases. In Keonjhar District, 10 bedded

Geriatric Ward construction has been completed. Integrated NCD clinics at DHH (5) and CHC (33/59) has been established. Integrated PT unit at DH level established.

UTTAR PRADESH

This state has initiated in 35 districts the setting up of geriatric clinics at 9 districts and Geriatric wards in 3 district hospitals. No geriatric clinic or ward has been established in DH Kanpur Dehat or Kaushambi.

MEGHALAYA

Allocations for the health care for elderly (HCE) have been additionally approved for East Khasi Hills.

HARYANA

Designated Geriatric Clinic has been set up in General Hospital Gurugram Physiotherapy Unit also in place.

National Tobacco Control Programme (NTCP)

Among the 16 states visited in 11th CRM, the states of Assam, West Bengal, Maharashtra, Nagaland and Haryana has started the process of fully implementing the COPTA 2003. Assam has enacted a Health Act 2014 to ban the sale, manufacture, advertising, distribution, and consumption of smokeless tobacco in the state. IEC/BCC activities are commendable in both print and electronic media. The district hospital (ENT Department) in Maharashtra provides medical and surgical services related to tobacco control programme. Awareness programme was observed strong in West Bengal and Nagaland. However, integration between NTCP and NPCDCS programme is absent across all CRM states except Odisha.

Poor release of fund and lack of human resources was found in Assam, while lack of human resources and inadequate IEC about COPTA was observed West Bengal.

Recommendations

- The states need to augment the awareness creation campaign in the community, about the ill-effects of tobacco using powerful IEC and BCC activities in local language.
- The states need to implement the COPTA holistically and ban manufacture and distribution of tobacco product on priority basis. All states need to include COPTA in their monthly crime review meeting for immediate outcomes of the programme.

State Findings

ASSAM

The state is moving towards in preventing the use of tobacco and tobacco use product by enacting Health Act 2014 and promoting IEC activities. The state has implemented in 14 district in phased manner. Nodal officer for the programme has identified. The state has 700 school programme, 120 tobacco free institutions and 11 Tobacco free villages in Jorhat district. The National Tobacco Testing Laboratory has been established in Guwahati for the Eastern region. The Tobacco violations have been in reviewed monthly in crime meeting of Home department.

HARYANA

This state has created awareness by promoting IEC activities at District Hospital, PHC and CHCs.

JHARKHAND

Anti-tobacco outreach activities are being conducted on World Tobacco Day to sensitize community specially youth and students.

MAHARASHTRA

The Programme has been implemented well and apart from providing clinical services, the district hospitals are counselling the patients on the long and short term ill-effects of tobacco consumption.

MANIPUR

The Programme is at a nascent stage of implementation. The recruitment under National Tobacco control programme is underway.

MEGHALAYA

The state has reported slow progress in implementing the program. The local population has a very high abuse of tobacco and tobacco-like products and the state needs to implement the NTCP on priority basis.

NAGALAND

Awareness programme in community is priority of state. Yikhum village has been declared Tobacco free village on World Tobacco Day. There are awareness programmes in school with focus on the sensitization of teaching staff to make school tobacco free. Tobacco cessation clinic has been established at the District Hospital. District level enforcement squad and flying meeting held regularly.

ODISHA

The National Tobacco Control Programme is gaining momentum at the state. NTCP and NPCDCS programmes at state and district levels are integrated under one Nodal officer. Counsellors are trained to provide counselling on Tobacco cessation.

TELANGANA

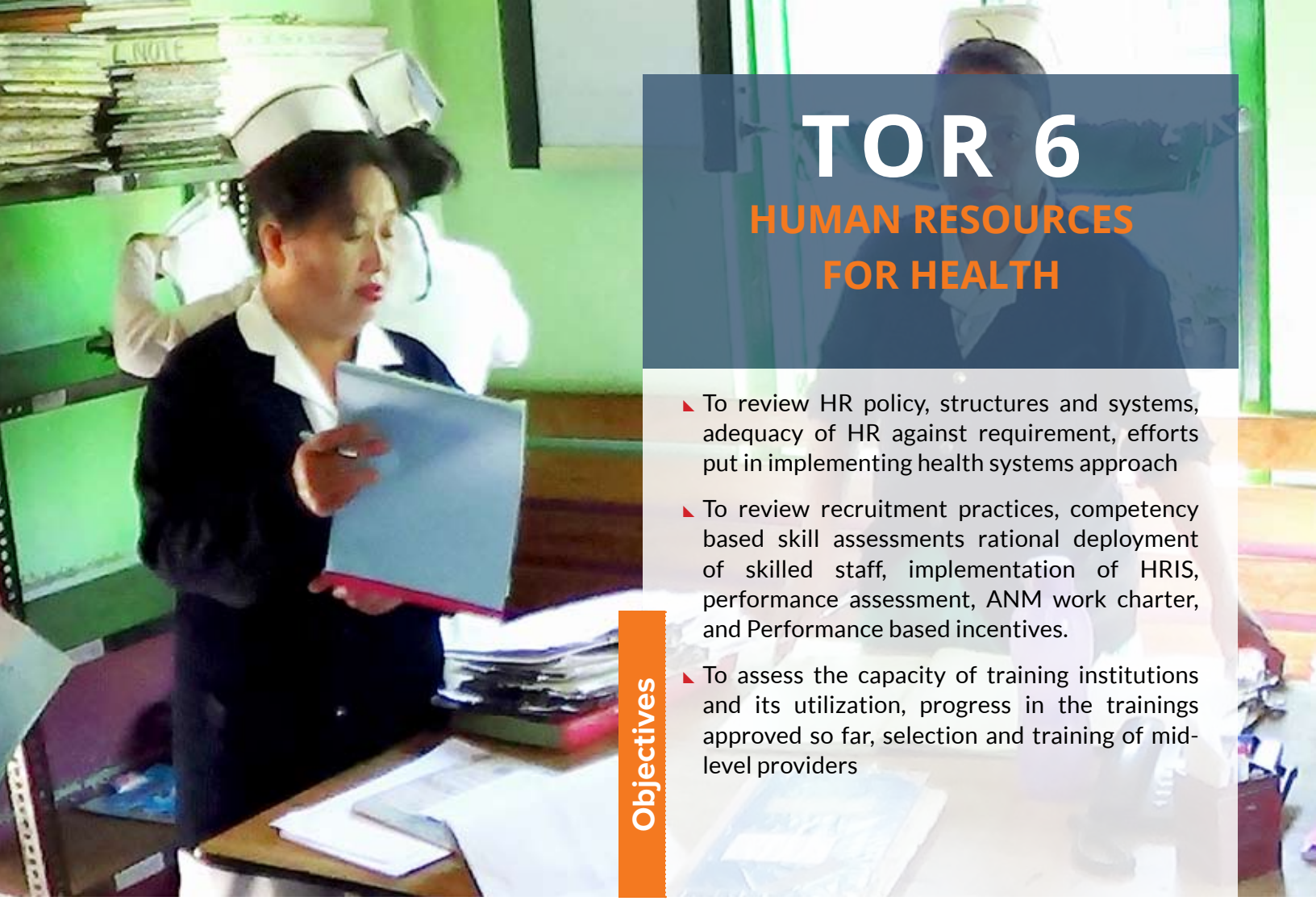
The programme has just been initiated. Police officers in the state have been sensitized under the program.

UTTARAKHAND

Very few outreach activities under NTCP were conducted in the State. Posters related to NTCP were displayed at DH, CHCs and PHCs. However, they were inadequate. A National Violation Helpline number 1800-110-456 has been made operational by NTCP in the district of Udham Singh Nagar. Few IEC and awareness sessions were being conducted for school children under NTCP.

WEST BENGAL

Enforcement squads for prevention of smoking at public place are active in state. On average ₹ 4000-5000 are collected as penalty per month in districts which reflect the use of tobacco and tobacco products in high in public.



TOR 6

HUMAN RESOURCES FOR HEALTH

Objectives

- To review HR policy, structures and systems, adequacy of HR against requirement, efforts put in implementing health systems approach
- To review recruitment practices, competency based skill assessments rational deployment of skilled staff, implementation of HRIS, performance assessment, ANM work charter, and Performance based incentives.
- To assess the capacity of training institutions and its utilization, progress in the trainings approved so far, selection and training of mid-level providers

National Overview

These are described under three headings – (1) Availability of HR (2) workforce management and (3) Training and capacity building:

Availability of HR

- Recruitment and retention of specialists and doctors still remains a challenge for many states including Assam, Bihar, Chhattisgarh, Jharkhand, Manipur, Meghalaya, Nagaland, Punjab, Telangana, Uttarakhand, Uttar Pradesh and West Bengal. Inadequate remuneration was reported as an important reason for recruitment among specialists (e.g. Manipur and Meghalaya) while lack of residential quarters for MOs was another (e.g. Haryana).
- In order to expedite filling of vacancies for MOs and specialists, states like Assam, Haryana, Uttarakhand and West Bengal have constituted separate recruitment boards while others such as Assam, Chhattisgarh, Karnataka, Manipur and Telangana are frequently conducting walk-in interviews. Karnataka has been successful in addressing specialist gaps through a bidding process under *'our post-your quote'* initiative. On contrary, highly centralized processes involving avoidable administrative delays are leading to delayed recruitment in states like Bihar.
- Measures adopted by states to fill service delivery gaps include: a) contracting-in of specialists at heavy case-load facilities on a pro-rata basis (Telangana), b) deploying MBBS interns from medical colleges (Telangana) and AYUSH MOs (Karnataka) at PHCs, c) posting Rural Health Practitioners (mid-level cadre) at Sub-centres (Assam), d) creation of additional

posts of doctors and paramedics (Meghalaya, Odisha and Punjab).

- Instances of irrational and uneven distribution of HR is observed in Assam, Haryana, Maharashtra, Nagaland, Karnataka, Punjab, Telangana, Uttarakhand and Uttar Pradesh. It is one of the major deterrents in ensuring their uniform and need-based availability at facilities across the states. This is further aggravated by the unavailability of proper residential facilities as observed in states like Haryana and Uttarakhand.
- In order to increase retention of doctors, states such as Assam, Chhattisgarh, Karnataka, Odisha and Uttarakhand have been offering educational incentives in terms of additional weightage - proportional to their service duration in rural areas.

Workforce Management

- All states except Chhattisgarh and Odisha were reportedly using a generic HR policy. In the absence of a department specific policy covering issues such as rotational transfers and career progression, concers were reported such as the frequent transfers of MOs (UP), forced prolonged postings of HR in difficult areas (Meghalaya) and delayed promotions of MOs (Haryana).
- Chhattisgarh has developed an HR policy for recruitment of NHM staff while Uttarakhand is in the process of developing one. There is no HR policy for contractual staff in Haryana, Meghalaya, Manipur, Nagaland, West Bengal and Assam. In Assam, however, a compendium of all HR orders is referred to as guidance on HR matters.
- Irrational and uneven distribution of skilled HR was observed in Assam, Haryana, Maharashtra, Nagaland, Punjab, Telangana, Uttarakhand and Uttar Pradesh.
- States like Assam, Uttarakhand and Odisha have a dedicated HR cell to look after core HR functions and assist in HR reforms, as needed. In Odisha, the HR cell has been instrumental in HR policy reforms (which includes enhancing promotional avenues for doctors through cadre restructuring).
- Incremental hard area allowances (based on degree of difficulty at workstation) are awarded to doctors/nurses in Karnataka, Punjab, Odisha and Uttarakhand. In some states, performance based incentives are also given for EmOC and LSAS trained doctors (Punjab and Odisha) or for conducting Caesarean sections and for SBA trained Nurses (Punjab).
- Performance appraisal mechanism linked with contract renewal of staff was observed in Bihar, Manipur, Odisha and Punjab. In Odisha and Punjab, it is also linked with award of annual increments. In Manipur and Meghalaya, such mechanism exists but is not linked with assessment against job specific indicators and salary increments. In Nagaland, no performance appraisal has been carried out over the last two years.
- HRMIS is functional in Assam, Chhattisgarh, Haryana, Odisha, Telangana and Uttarakhand but its linkage with Training Management Information System (TMIS) was not observed in Assam, Haryana, Uttarakhand and Telangana. Jharkhand has developed HRMIS but seeks external support to operationalize the software. Manipur and Meghalaya have initiated implementation of HRMIS but the progress has been slow.
- Assam, Chhattisgarh, Karnataka, Odisha and Uttarakhand offer additional weightage to contractual staff for gaining entry into regular services.
- Skill tests have become part of the recruitment process for skilled care providers in Chhattisgarh, Maharashtra, Odisha and West Bengal. On the other hand, Uttarakhand has developed a framework for competency based skill tests for recruitment of nurses, paramedics and management staff.
- Staff (particularly Counselors, LTs etc.) have been given multiskilling training and efforts are being made to integrate their services across programmes in Assam, Odisha, Maharashtra and West Bengal.

- In absence of a Specialist cadre in most states, General MOs and PG qualified MOs are hired at the same pay scale. In Uttarakhand, Specialist cadre has been disbanded due to issues in pays and promotions. Assam and Chhattisgarh are taking steps towards establishment of Public Health cadre, while Maharashtra and Odisha already have one.
- Odisha has successfully adopted a Health Systems Approach through integration of management posts and the introduction of rationalized salaries for staff working under different programmes. Karnataka and Uttarakhand are in the process of introducing pay rationalization for service delivery staff hired under different programmes.

Training and Capacity Building

- Systematic training plans could not be identified in most states (except Assam, Haryana, Karnataka, Meghalaya and Uttarakhand). Training progress was reported to be slow in Karnataka, Odisha and Uttarakhand. In Nagaland, no training has been conducted for the last two years.
- The lack of a proper mechanism for training needs assessment was observed in many states, including Haryana, Manipur, Punjab and West Bengal. SBA trainings have not been planned in Punjab despite the low availability of SBA trained ANMs in the state.
- Lack of clarity was observed among service delivery staff with regard to their roles and responsibilities in Assam, Maharashtra and Meghalaya.

Recommendations

- There is a critical need to fill vacancies against sanctioned posts by adopting a variety of measures such as walk-in interviews, campus recruitments and the use of separate committees to hasten approval for new posts and their recruitment (as adopted by some states).
- For issues of arbitrary postings and delayed promotions, steps towards HR policy reforms in these areas are needed. Where ever possible, a health department specific HR policy should be developed to address department specific issues.
- Competency based skill tests should be used for recruitment of skilled HR to ensure high quality recruitments.
- GOI has empaneled a list of HR agencies that may be hired by states for conducting medium and large-scale recruitments for various grades of service providers and management staff. This opportunity should be used by states, particularly those with limited capacity to conduct large scale recruitments.
- Flexible norms for remuneration of specialists should be utilized by states with specialist shortages. This is particularly important for states where they are currently underpaid (e.g. Meghalaya).
- HR cells are important for handling HR issues and undertaking HR policy reforms. States must take steps towards establishment or strengthening of HR cells at state and district level.
- In order to streamline management and utilization of HR information, a HRMIS needs establishment/strengthening. In states where these are already established, it should be linked with the Training Management Information System (TMIS) - and capacity building of nodal HR should be undertaken for its implementation and utilization.
- Performance appraisal mechanisms should be objectively linked to job-specific indicators and the appraisal process should be linked with contract renewal and the award of performance based incentives.
- States need to adopt a Health Systems approach for streamlining service delivery and management HR by merging roles for similar posts – after ensuring appropriate multi-skill training – and work towards ensuring pay rationalization for similar posts across various programmes.
- Planning for training needs strengthening across states. Any training needs assessment must

take into account facility-level needs so that training provision matches service delivery.

State Findings

ASSAM

Availability of HR

- State needs to be complimented as the regular HR strength viv-a-vis NHM contractual was unlike other states where regular HR was being substituted by NHM HR.
- Despite introduction of initiatives such as offering negotiable salaries and expediting recruitment through walk-in interviews, the state is finding it difficult to attract and retain specialists.
- A significant contribution to primary care service delivery in the state is through 560 Rural Health Practitioners (Mid Level Health Practitioners) placed at Sub-centres.
- The state has a very low MO to Staff Nurses ratio (i.e. 1:14), which calls for a hike in sanctioned posts for Nurses.
- The state has a good presence of AYUSH MOs who are mostly prescribing allopathic drugs in absence of AYUSH drugs.
- In a bid to avoid delays in recruitment, the state is taking recruitment process out of purview of the State Selection Committee. The state also intends to utilize services of NHSRC empanelled HR agencies for recruitment.

Workforce Management

- Instances of irrational deployment of specialist skill providers were observed – two gynecologists were posted at a state dispensary, which was not providing EmOC services; Dental OT at a Model Hospital was lying unused because of absence of Dentist.
- The state has recently issued orders to post ANMs at Sub-centres based on population/ caseload.
- The state is in the process of revising Job descriptions/TORs of key service delivery staff in view of the triple burden under RCH, Communicable Diseases and Non Communicable Diseases.
- The state has a dedicated HR cell with four Manager level functionaries, which looks after recruitment of contractual staff among other things.
- Rural posting is mandatory for an MO to pursue PG in a Govt. Medical College. The state also offers relaxation in PG entrance examination through additional marks for MOs serving in the notified difficult areas. This has helped in augmenting availability of MOs in the state.
- The state does not have a specialist cadre or a public health cadre and intends to propose the establishment of these before the concerned Minister shortly.
- The state does not have a specific HR policy for Health workers but a compendium of all HR orders is referred to as guideline/policy for HR matters.
- The state has undertaken the initiative of multiskilling of counselors for integrating their services across vertical programmes and is intending to undertake the same exercise for LTs to utilize their services across programmes.
- Lack of clarity was observed among certain grades of staff with regard to their expected roles - LHVs at some block PHCs were found to be doing cold chain handlers' duties rather than the supportive supervision activities designated to them.
- The state uses HRMIS software for management of information of contractual staff. It captures information on employee demographics, salary and postings and is being used for online slip generation at state level. TMIS database is also being integrated with HRMIS currently.
- The state provides preference to NHM employees for selection at regular posts. In the last recruitment round, Directorate of Medical Education gave a weightage of 5 marks for

each year of service under NHM. Recently the State has absorbed 48 of the NHM staff nurses in to the State Cancer facility and other hospitals.

Training and Capacity Building

- Training Plan and Calendar was not found at the district level.
- State Institute of Health and Family Welfare (SIHFW) is not fully operational in the state due to lack of HR. In absence of a nodal training agency, training activities are not planned and implemented properly.

BIHAR

Availability of HR

- Low remuneration for specialists was reported as one of the major reasons of significant vacancies of these posts in the state (with nearly 80-85 percent posts of Gynecologists and Pediatricians vacant).
- Instances of chronic absenteeism were observed among staff in the districts visited.
- Recruitment process is centralized and is time-taking because of delayed roster clearance in different districts. It has been leading to delayed filling up of vacancies in districts.

Workforce Management

- The state has developed a job specific performance appraisal mechanism for conducting performance assessments (based on competencies, work output, communication, teamwork and attitude of the staff). Renewal of staff contracts is also linked with their performance appraisal.
- The state has not taken any steps to provide relaxation to NHM contractual staff for absorption into regular services.

Training and Capacity Building

- Schedule/Record of trainings attended by staff members was not available to the review team.

TELANGANA

Availability of HR

- The state has significant shortages of health workforce – particularly of Doctors and ANMs. More than 90 percent of MPW (M) posts are vacant in the state.
- In absence of MOs at UPHC (like Adilabad), MBBS interns from Medical Colleges are being utilized for providing services.
- The state has made use of the flexible norms for hiring services of Specialist doctors under NHM to handle the extra case-load in major hospitals.

Workforce Management

- There is no HR policy for governing contract renewal, transfers, entitlements, appraisals, etc. for contractual staff.
- The Performance appraisal is not linked to a performance review.
- Irrational deployment of specialists was observed in the state – An Anesthetist and a Gynecologist were posted at a PHC in Khammam district.
- The state has developed a web-based HRMIS software but districts do not update information to it regularly. In the HMIS, HR data is updated only once a year.
- The training information is captured in Training Management Information System (TMIS) but its linkage with HRMIS has not been established as yet.

Training and Capacity Building

- Indian Institute of Health & Family Welfare (IIHFW) is the nodal agency in the state to plan and implement training activities under National Health Mission.

UTTARAKHAND

Availability of HR

- Service delivery across public health facilities has been severely affected by critical shortage

of human resources for health, particularly in the hilly areas. Shortages are the most acute for Specialists and MOs. In Champawat district, there was no Physician or Gynecologist at DH, SDH or CHC level.

- The state has constituted a separate recruitment board for doctors - and decentralized the recruitment process to expedite the filling up of vacancies of doctors and has had limited success.

Workforce Management

- Irrational deployment of specialists has affected the utility of their specialist skills. DH Champawat had a General and Orthopedic Surgeon but no Anesthetist to complement them in surgeries. On contrary, SDH Tanakpur had an Anesthetist but no Gynecologist or Surgeon to perform surgeries.
- The state has a system of Hard Area Allowances for service providers working in difficult ('durgam') areas. Regular MOs working in difficult areas get 20% hike in their base salary while ANMs are also provided differential salaries based on their posting at lower Himalayas, mid-Himalayas or upper Himalayas. As per state officials, this has had a positive impact on recruitment and retention of NHM nurses, but impact on doctors' retention has been limited.
- Housing facilities were provided for clinical staff (mainly doctors) at few of the facilities visited. At some of the facilities, issues such as scarce water supply, safety and security were reported.
- MOs working in rural, remote and under-served facilities are given educational incentives in terms of extra weightage for PG exams, which increases with each year of their service.
- The State has developed a framework for introducing competency based skill tests for recruitment of nurses and paramedics (e.g. nurses, laboratory technicians) and management staff (e.g. accountants, data entry operators). Adoption of this measure is expected to mitigate outside influences and make the process more objective and transparent, leading to selection of better quality candidates.
- A system of annual performance appraisal has been introduced for all contractual staff (including clinical service providers and management staff) under NHM. It is based on job responsibilities of the appraise and incremental pay increments are also linked to it. System of Appeal for performance appraisal has not been introduced by the state.
- While government health staff from the regular cadre is bound by the State's service rules, there is no formal HR policy for contractual staff. These are currently being drafted and will then be sent for government approval.
- An HR cell has been constituted at the State level. However, similar cells at district level are yet to be constituted.
- The framework for a Human Resource Management Information System (HRMIS) has been developed in collaboration with the State office of NIC. Data for contractual staff has been entered partially but it is yet to be linked with TMIS. State plans to link it with biometric attendance system and attach this PFMS so that salaries of staff are directly transferred in to individual bank accounts based on attendance. State officials complained of inadequate human resource capacity to properly support the HRMIS development.
- There is no Public Health cadre in the state. There was a functional specialist cadre initially but this has subsequently been disbanded due to issues around pay and promotions.
- The state has initiated rationalization and integration of management staff at state level under NHM. For example, services of accountants hired under different national programmes (e.g. RNTCP, NLEP, NCD and Tobacco Control) have been integrated to work across different programme areas. In similar manner, it being planned to integrate services of management staff at district level and eventually clinical staff too.
- The State is now intending to undertake

- Rationalization in the PIP, especially to ensure that functionaries get paid above the minimum wage for skilled labour.

Training and Capacity Building

- A training calendar has been developed by the state but trainings ear-marked for this year have not yet been commenced as per the plan due to delay in approvals in ROP.
- In order to ensure proper utilization of staff undergoing skill up-gradation and to reduce instances of irrational deployment, the State plans to introduce joint trainings for EMoC/LSAS staff and then post them together at facilities.

JHARKHAND

Availability

- There are significant shortages of MOs, Nurses and Paramedical staff in the state. In order to address some of these gaps, the state has hired the services of a external GOI empanelled HR agency to fill vacancies across various grades of service provider and management staff.
- Recruitment of Nurses and ANMs has been decentralized and is conducted through selection committees headed by the Civil Surgeon/Deputy Commissioner at district level. Some paramedics (Pharmacists, LTs) and support staff (Cleaning, security staff) have also been outsourced through third party agencies.

Workforce Management

- Irrational deployment of trained HR was observed – a Surgeon was found posted at a facility with no OT. Staffing of HR at facilities did not suggest that postings were done based on existing caseloads.
- There is a system of performance appraisal in place for contractual staff, this is linked with their contract renewal and salary increments.
- The state has developed HRMIS software to capture HR data but the software is not yet functional. The state has sought handholding from Development Partners for operationalizing it.

Training and Capacity Building

- The training plan or calendar was not available in the state. Any mechanism for assessing the training needs of clinical staff is also lacking.

KARNATAKA

Availability

- Although 90% of the MO posts are filled in the state, skewed distribution of doctors has resulted in their unavailability in difficult areas. In HPD Raichur, almost half of the PHCs are managed by AYUSH doctors who are practicing allopathy - without any formal training.
- In order to address the shortage of Specialists, the state has been inviting bids with remuneration quotes from specialists against vacant posts ('Our post; your quote'). The state has been able to engage 365 Specialists after the first round of bidding through this process.
- In order to scale up generation of specialists, the state has introduced DNB seats in 10 General Hospitals and District Hospitals.
- Walk-in interviews have been adopted both at the State and District levels to expedite recruitment of the NHM contractual posts. With this, the state has been able to fill some of the critical vacancies, sometimes within a short span of only 10 days.

Workforce Management

- The state is providing relaxations to contractual staff to facilitate their absorption into regular services. Recently the state has initiated recruitment of around 8000 vacancies (C grade staff); for these vacancies added weightage is being given to NHM staff.
- There is a provision for incremental salary incentives for specialists and nurses serving in HPDs.
- In order to improve availability of doctors particularly in rural areas, the state has adopted regulatory measures such as compulsory rural postings after MBBS (both for government and private medical colleges)

and also educational incentives such as extra weightage in PG entrance for those serving in rural areas.

- The state is currently in the process of ensuring pay parity for ANMs, SNs, LTs, Pharmacists, and Counselors etc. hired under NHM across different programmes.
- The state is also in the process of analyzing facility workload (OPD, IPD, Institutional Deliveries, etc.) vis-à-vis HR availability so that the required number of HR is rationally posted at facilities based on workload.
- The state does not have a Public Health cadre.
- The state has a Performance appraisal mechanism but this is not linked with the contract renewal or the award of salary increments.
- There is no information on the use of competency assessment as part of the recruitment process for clinical service providers, though this has been used in the past.

Training and Capacity Building

- The SIHFW has developed Distance Learning Programs for health staff for building their capacity in Public health management (Diplomas in H&FW Management; Health Promotion; Public Health Nutrition etc.).
- The Training Plan for staff was in place but the pace of training being provided has been slow, particularly for Medical Officers.

CHHATTISGARH

Availability

- Despite the initiation of recruitment drives through walk-in interviews (held on a monthly basis), vacancies for MOs and Specialists still remain high – more than 50% posts are still vacant for these categories of staff.
- Apart from this, there are huge vacancies of various programme specific posts in NPCDCS, RNTCP, NVBDCP (LTs) and IDSP (District Epidemiologists) in the state.
- A substantial proportion (60-80%) of seats is reserved for ST candidates in the state; these often remain unfilled due to low availability of eligible candidates.
- SNCU staff (including Nurses) have been outsourced through a Third Party agency in the state.
- The state has launched an innovative initiative for inaccessible areas under which meritorious students are selected after their 12th class and provided with professional education (for Pharmacists, Ophthalmic Assistants and Staff Nurses). After successful completion of this training, candidates are offered relevant posts with the health department.

Workforce Management

- The state has developed an HR policy for recruitment; skill based competency assessment has been included as a tool for recruitment of care providers under NHM – 30% weightage is assigned to scores of candidates in skill tests.
- The Chhattisgarh Rural Medical Corps (CRMC) policy has recently been revised and now categorizes healthcare facilities as Difficult, Very difficult and Inaccessible areas; accordingly incremental incentive packages are awarded to staff based on the degree of difficulty of their workstation. Medical and Life Insurance for staff is also covered under CRMC.
- The state provides educational incentives in terms of extra marks in PG admissions for MOs who have worked in difficult areas for more than 2 years.
- The state also offers preference to candidates for choosing their subsequent posting - after completion of their stipulated tenure in difficult areas.
- The state has an HRMIS, which is linked with annual performance appraisal, leave management and e-pay slip for regular staff.

- Performance benchmarks have been set by the state for renewal of contracts; these are only renewed for staff scoring more than 40% in the annual performance appraisal while improvement notices are issued to staff with scores between 40% and 54%.
- The state is taking steps towards the establishment of a Public Health cadre.

Training and Capacity Building

- While on the job training is being provided, yet training for many categories of staff is still not in place.
- Lack of clarity was observed among some MOs and Data managers about their expected roles.

ODISHA

Availability

- In view of shortage of HRH in the state, 2508 posts of Doctors, 400 posts of Dental Surgeons and 5719 posts for paramedics have been recently created.
- In the latest round of recruitment, 581 doctors have been selected and given appointment orders.
- In order to scale up generation of doctors, two new Govt. Medical Colleges (at Koraput and Baripada) are being established and there are plans for seven more Colleges to be set up in the next later phase. MBBS seats have also been increased from 450 to 850 and super-specialty seats from 6 to 44.

Workforce Management

- Competency based skill assessments are being used for the recruitment of ANMs and GNMs under NHM.
- The state has an HR cell known as the State Human Resource Management Unit (SHRMU) with a Joint Director from the regular cadre as HR head, and supported by two Consultants and one DEO.
- The state has carried out a restructuring of the Odisha Medical Services Cadre so as to enhance promotional avenues for doctors through the HR Cell. This has resulted in the awarding of promotions to 1850 doctors in recent years.
- The state has developed an innovative transfer policy, according to which a minimum service of 3 years at the difficult-to-access KBK+ districts is mandatory before being eligible for transfers out of these KBK+ districts. It is also mandatory for critical staff (such as MOs) to have worked in KBK+ districts before being eligible for transfer to the state directorate office.
- The state provides educational incentives in terms of additional marks for MOs who have completed a minimum 3 years of service in rural areas.
- The state has developed their HRMIS and the HR cell (SHRMU) is entrusted with the task of maintaining and updating this HR database.
- Recruitment for some NHM posts has been decentralized at district level with selection committees formed under the chairpersonship of the CDMO.
- The state has categorized facilities based on the degree of difficulty for access (V0, V1, V2, V3 and V4) and incremental incentives are provided based on degree of difficulty of the facility.
- District Collector has been vested with authority to grant top-up incentives to critical HR (such as MO) if needed. This incentive is performance-linked and is borne out of the District Collector corpus funds.
- Performance based incentives are awarded to EmOC and LSAS trained doctors. Team based incentives of ₹ 1500 per Caesarean section are offered for team members (specialist, doctors, Staff Nurse, OT technician, Attendant) for satisfactory performance over set benchmarks.
- The state has developed TORs for all staff members and devised Core Performance Indicators based on it. Performance review of staff against these indicators is done quarterly to calculate and release Performance Based Incentives.
- The state has a robust performance appraisal mechanism, which is linked with the award

of annual increments ranging from Nil to up to 25%.

- The state has successfully adopted a Health Systems approach through streamlining services of management and facility-based non-clinical posts. As part of this exercise, nomenclature of posts has been changed and roles have been merged for similar posts across different programmes.
- The state has also rationalized the salary of staff working under different programmes. All the staff has been grouped under eight categories based on their nature of work and salaries have been fixed accordingly.

Training and Capacity Building

- Progress of some training (including Minilap, NSSK, F-IMNCI, MTP, Blood Storage, SBA) have been below the targets for FY 2016-17 set by the state.
- In order to ensure quality skill training, 3 comprehensive and 22 mini skill labs have been attached to ANMTCs and GNM schools in the state.

MANIPUR

Availability of Staff

- Nearly two-third posts of MOs and Specialists are lying vacant in the state. The attrition of HR is notably higher in hard-to-reach areas.
- Salary offered to Specialists is considered less (i.e. ₹ 50,000) to attract and retain them.
- The recruitment of contractual staff is centralized at the state level; walk-in-interviews are conducted to fast track recruitments.

Workforce Management

- A number of regular and contractual staff reported delays in getting salary paid in a timely manner for the past few months.
- The state has a Performance Appraisal mechanism which involves an annual appraisal, is linked to contract extension but not with the award of incentives.
- The state has a Postings and Transfers policy for regular staff, but no HR policy for contractual staff.
- The state does not have a dedicated HR Cell to look after core HR functions.
- The state is in the process of establishment of HRMIS with the help of NIC Manipur. The software will be developed for both online and offline modes.
- Wide salary disparities exist between regular and contractual cadres.

Training and Capacity Building

- Regional Institute of Medical Sciences (RIMS) & Jawaharlal Nehru Institute of Medical Sciences (JNIMS) are the nodal training centres at the state level. There is no District Training Centre in the district reviewed (Tamenglong district).
- Training Plan was not identified at the district level. Training Needs Assessment was also lacking in Tamenglong district.

PUNJAB

Availability of Staff

- Despite the increase in sanctioned posts of key service providers, the state still faces notable vacancies of MPW (M) (53%), ANMs (40%), Specialists (28%), SNs (25%), LTs (23%) and doctors (17%).
- Acute shortage of specialists was observed at all CHCs visited.
- Uneven distribution of health workforce is one of the major deterrents in ensuring the availability of care providers at all centres in state. There are 4674 ANMs working in 2950 SCs while on the other hand 100 SCs are without any ANM at all. Similarly, there are 38 PHCs functioning without any doctor.

Workforce Management

- All Health facilities have been divided into zones and incremental incentives are offered based on the degree of difficulty for access. Hard Area allowances of ₹ 20,000 and ₹ 30,000 per month are given to Gynecologists, Pediatricians and Anesthetists serving at workstations in difficult and most difficult areas respectively.
- Performance Based Incentives amounting to ₹ 3000 per C-section are awarded to EmOC teams. SBA trained Nurses are also given incentives for night deliveries.
- Performance Appraisal Mechanism is in place and annual increments for NHM staff is linked to it.

Training and Capacity Building

- The state has a State Institute of Health & Family Welfare (SIHFW) and a Family Welfare Training Center for conducting training at the state level.
- A Training Calendar had been developed, but a systematic mechanism for Training Needs Assessment was lacking. Although there is a low availability of SBA trained SNs/ANMs in the state, yet SBA trainings have not been planned to address this shortage in the districts visited.
- In the absence of a functional skill lab, it has become difficult to conduct skill training/ assessment for skilled care providers in the state.

UTTAR PRADESH

Availability of HR

- Nearly one-fourth posts of MOs, ANMs and LTs are lying vacant in the state. Vacancies for Nurses is even higher (i.e. 31%). Acute shortage of Specialists (82%) has been observed in Kanpur district while in Kaushambi district, shortages were most acute for SNs (93%).
- Surplus HR was observed for some categories of staff at one DH (with regard to IPHS norms). On contrary, L3 and L4 facilities visited were found to be understaffed.
- There is shortage of Grade D staff, which is affecting upkeep of cleanliness at facilities.

Workforce Management

- Instances of frequent transfers of CMOs, Specialists and General MOs were reported; this has been hindering the implementation of programmes and service delivery in Kaushambi district.
- EmOC and LSAS doctors are not posted at FRUs on priority.

Training and Capacity Building

- The state has 1 SIHFW at state level and 13 RHFWTCs at regional level but there is lack of a systematic training plan.
- In both the districts visited, no training plan was found. Also there was no mechanism to monitor the quality of training or undertake post training follow-ups.
- Most of the MOs and ANMs have been provided multiple skill-based trainings. However, skill utilization post training has not been properly explored.

WEST BENGAL

Availability of HR

- There is acute shortage of Specialists (44% vacancies) in the state. Significant vacancies of SNs (24%) and LTs (20%) also exist. Staff shortages lead to overburdening of the existing staff.
- The state has constituted a Medical Recruitment Board in order to fast track recruitment of all technical staff. It has been found to be helpful in filling up of vacancies of MOs and LTs significantly.
- In absence of MPW (M), ANMs were found to be overburdened and unable to devote required attention to the disease control activities.

Workforce Management

- Recruitment for some posts is decentralized at district level. Skill based competency assessment is also conducted for selection of skilled HR.
- The state does not have a specific HR policy in place.
- There is no system of maintenance of HR database at the state level. As a result, it becomes difficult to get HR data for planning for recruitments, postings and transfers.
- The state has provided multi-skilling training to LTs working under different vertical programmes and integrated their services so as to ensure efficient utilization of their services.
- The state has also covered contractual staff for providing hospitalization benefits under a State owned Swasthya Sathi scheme.
- The state has introduced compulsory one-year rural service bond for fresh PG doctors.

Training and Capacity Building

- The state has an SIHFW, which is adequately staffed with faculty to run training batches.
- Skill labs were found operational with competent trainers in both districts visited. However, their utilization in recruitment or skill gap assessment was found to be limited.
- Training plans do not take into account facility level needs. Training Needs Assessment needs strengthening.

MAHARASHTRA

Availability of HR

- Significant number of vacancies of doctors, specialists, nurses, paramedics and support staff (Class IV) at all levels of facilities was identified. No LT was seen in many of the facilities visited.
- The sanctioned strength of Staff Nurses and ANMs under the regular cadre is lower than the required number of staff.

Workforce Management

- The state has taken initiatives in integrating service delivery staff such as LTs, Counselors and Nurses working under various vertical programmes.
- Promotion of ANMs to LHVs was reported to be delayed by five to eight years.
- Instances of irrational deployment of staff was observed- Gynecologists were found posted at PHCs and at CHCs without Anesthetists/LSAS trained doctors. 2 Dentists were posted at DH with only 1 Dental chair.
- Shortage of equipment in the state – only 255 dental chairs available against 291 filled posts of Dentists.
- The state has initiated skill based competency assessment for the recruitment of LTs and ANMs.
- Lack of clarity was observed among the newly recruited staff with regard to their roles and responsibilities. There was no system of orienting newly inducted staff.
- HRMIS is not yet implemented in the state.
- The state does not have a Specialist cadre and therefore both MBBS and PG qualified doctors are hired at the same pay scale.
- A robust performance appraisal system is lacking.

Training and Capacity Building

Training schedule was found in place.

HARYANA

Availability of HR

Considerable shortages of HR is seen in the state particularly for nurses and LTs (with around half of the posts vacant), followed by MOs (with one-fourth posts vacant).

Stay orders issued by the Court due to various litigations has been attributed as one of the reasons

for delayed recruitments of various nursing and paramedical posts.

In the SPMU, crucial posts of State Programme Manager, State Accounts Manager and State Data Manager are vacant. Various such posts (including DPM, DAM, DDM) were vacant in DPMUs of some districts too.

Workforce Management

- Special Hard Area Allowances of ₹ 10,000 and ₹ 25,000 are provided to the regular Doctors and Specialists respectively posted in Mewat and Palwal districts.
- Lack of residential facilities was observed for MOs - No quarters for MOs in 5 CHCs/SDHs in Bhiwani. Incidentally, most of these facilities had critical vacancies of MOs.
- The state doesn't have any dedicated HR policy for the Health Department. Haryana Civil Services Rules 2016 are followed for MOs in the state, which doesn't address department specific needs and issues.
- Lack of availability of Gynecologists, Pediatricians and Anesthetists is still an impediment in operationalizing many FRUs at CHC and SDH level.
- Mechanism of Performance appraisal of the clinical (ANMs, LTs etc.) and management staff (like DAM) was found objectively linked with their routine deliverables in Bhiwani district.
- There is no dedicated HR cell to look after core HR functions (including recruitment, postings/ transfers, training need assessment, HR data management, etc.) at the state as well as district level.
- Training Needs Assessment and Rational HR deployment was not properly done- 16 F-IMNCI MOs were found posted at PHCs while only 1 FIMNCI MO posted at SNCU in DH Bhiwani.
- HRIS and HRMIS separately capture information on contractual and regular staff respectively and both are not integrated to provide comprehensive HR information. Moreover, limited understanding was observed among the nodal staff in (using HRIS software) for eliciting the information required for the HR data uploaded on HRIS.
- The state offers relaxation to NHM staff for absorption into regular services. Grace marks of up to 8 percent (1 percent per year of experience) in addition to relaxation of five years is given to NHM staff for selection into regular services.
- There is no Public Health or Specialist cadre in the state. Specialists/PG qualified MOs and General MOs enter services at the same pay-scale and are given similar career progression opportunities.
- Career Progression pathways particularly for MOs is reported to be dated in the state. As reported by some MOs, it takes as long as around 20 years for an MO to avail promotion to become a MO.

Training and Capacity Building

- Training Plan and Training Calendar was found in place and uploaded on the TMIS in Bhiwani district.
- All trainings were executed as per the planned schedule last year except Minilap training due to lack of trainers in Bhiwani. Training targets for SBA, RTI/STI and IMEP have already been achieved in Bhiwani district for the current financial year.

NAGALAND

Availability of HR

- Despite recent efforts made by the state in recruiting health workers, a significant shortage of doctors, nurses and paramedics was observed - even at the DH level (i.e. DH Kiphire). There is no Specialist in the whole DH.
- Recruitment of all Health HR is centralized at the state level.

Workforce Management

- Irrational deployment of HR was observed - a Surgeon was found posted at PHC Likhimo while the nearby CHC did not have any.

- Skill based competency tests have not been used for recruitment of skilled care providers.
- There is no HR-MIS in the state to manage HR information.
- There is no HR policy in the state for NHM staff.
- The state does not have either a Public Health or a Specialist cadre.
- There is no robust mechanism for performance appraisal; this has not been done in the state for the last two years.

Training and Capacity Building

- SIHFW is the nodal agency for planning and implementation of trainings in the state.
- The state neither had a systematic training neither plan nor a training calendar in place. No training has been conducted in the state for the past two years.

MEGHALAYA

Availability of HR

- The state has significant vacancies of doctors, nurses and ANMs both under regular cadre as well as NHM.
- In view of the shortage of HR, the state has created additional posts of medical and paramedical staff. However, State Public Service Commission is yet to initiate recruitment for these posts.
- Specialists attributed inadequate remuneration as an important disincentive from joining public services.

Workforce Management

- In absence of a clear HR policy governing rotational transfers, MOs serving in difficult areas are forced to serve for long duration. There is no HR policy/ guideline for contractual staff.
- The state has a dedicated HR cell comprising a Nodal Officer, HR Officer and nominated representatives from NHM.
- Staff at most of the facilities were provided residential quarters near the facility. This facilitated round the clock service provision at these facilities.
- Performance appraisal of staff is conducted on generic templates and does not take into account job specific indicators. A flat increment of 5% is given to all staff irrespective of the result of performance appraisals.
- There are no separate additional incentives like hardship allowances, team based incentives, etc. for existing staff.
- The state has initiated implementation of HRMIS and has sought approval in the current financial year. However, the progress has been slow.
- The state does not have a Public Health or Specialist cadre.
- There was limited clarity among BPMs, MOs ANMs and Paramedics with regard to programme guidelines.
- The state has not yet introduced any relaxation norms for absorption of NHM staff into regular services.

Training and Capacity Building

- Training institute (i.e. RHFWTC) needs strengthening in terms of infrastructure and HR. Currently, the training infrastructure and resources of Guwahati Medical Colleges are being utilized for training of senior and technical HR.
- There is a limited pool of Master Trainers in the entire state, this needs to be expanded considering the requirements.
- A Training Calendar is in place and most in-service HR were found to be trained on basic aspects of major national programmes.

TOR 7

COMMUNITY PROCESS

Objectives

- To review the present status of ASHA Programme with reference to progress and the quality of training, analysis of ASHA drop-outs, promptness in selecting new ASHA, monthly incentive amounts, payment mechanisms (PFMS and Aadhar linked) and regularity of payments, non-monetary incentives, periodicity of replenishment of Drug Kits, adequacy of equipment kits, quality of home visits and community interaction, with a focus on the marginalized.
- To document the key challenges and constraints faced by the ASHA.
- To appraise the progress made under NUHM – with regards to (a) Mapping of vulnerable population; (b) Mapping of slums in target setting for ASHA and MAS and adequacy of targets of ASHA and MAS: (c) Assess the challenges faced by the state in implementation of community processes interventions in urban areas.
- To assess the extent of integration and effectiveness of support structures at various levels for VHSNC, ASHA and Community Action for Health (CAH).
- To analyze the preparedness of ASHA and VHSNC to undertake tasks related to rolling out comprehensive primary healthcare.

National Overview

- ASHAs have emerged as an important resource at the community level, who have been able to play an important role in linking community with the health services especially in the areas of RCH and Communicable Diseases. In the current backdrop of strengthening delivery of primary care services closer to the community, ASHAs are now being viewed as a key member of the primary health care team at the Sub centre level. This has also been articulated in the National Health Policy 2017 which suggest that ASHAs in coordination with the Multi-Purpose Workers (M/F) will play an important role in addressing issues of Non-Communicable Diseases and provision of palliative care and mental health etc. These recommendations have paved the path for the future roles of the ASHAs depending on the state context.
- Currently 9,38, 054 ASHAs are in position across all states and UTs of the country except Goa, against the target of 10,21,543 ASHAs, both in urban and rural areas. The selection figures reflect that 93% ASHAs in rural areas and 81% in urban areas have been selected.
- States are at varying stages for completion of training of ASHAs in module 6 & 7. Across the country about 97% ASHAs have been trained in Round 1, 88% in Round 2, 70% in Round 3 and 49% in Round 4 in rural areas. In urban areas about 70% ASHAs have completed training in Induction module and training of Module 6 & 7 has begun in few states (MP, Odisha, Rajasthan, Meghalaya, Mizoram, Nagaland, Gujarat, Haryana, Punjab) while Delhi has completed all rounds of Module 6 & 7 training. Overall

the training progress indicate a plateau in the training pace over past one year.

- Since the launch of universal screening of NCDs in the year 2017, training of ASHAs has been initiated across selected districts (160 in first phase) across all states. So far nearly 20,000 ASHAs have been trained under this initiative.
- Process of ASHA certification has been introduced across seventeen states (Arunachal Pradesh, Assam, Chhattisgarh, Delhi, Gujarat, Himachal Pradesh, J &K, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Punjab, Sikkim, Tripura, Uttarakhand and West Bengal). As part of this process, all training components of the ASHA training would be certified i.e, Training curriculum, State and district trainers, state and district training sites, ASHA facilitators and ASHAs.
- Supportive institutional network at state level and below has expanded rapidly over few years, as states have increasingly become cognizant of the necessity of a strong support structure to enhance the community processes component. However, commensurate investment in building capacities of the support structures is still lacking in most states affecting the effectiveness of the supportive supervision.
- Provision of social security to ASHAs in the form of medical and life insurance has also emerged as a state led mechanism to provide motivation for the ASHA. These have been started in the states of Chhattisgarh, Assam, Jharkhand, Kerala, Uttar Pradesh, Uttrakhand, Odisha and West Bengal. States of Delhi, Maharashtra, Sikkim, Gujarat and Madhya Pradesh have facilitated enrollment of ASHAs in existing National Schemes.
- Progress is noted in creating additional support mechanisms for ASHAs such as – additional monthly honorarium to ASHAs, implementing social security mechanism and creating career opportunities for ASHAs. However, critical components like operationalizing Grievance Redressal mechanism and creating rest rooms for AHSAs have not received due attention.

- Systemic issues like absence of a systematic logistics system to ensure timely drug and equipment kit filling of ASHAs and persistent delays in payment of incentives especially for activities related to NVBDCP, NLEP and RNTCP are yet to be fully resolved.
- Nearly 5 Lakh VHSNCs and 65,000 and MAS have been constituted across states. However, despite theefforts made by states in training the VHSNC and MAS members, the progress has been limited mainly on account of the challenge of training large number of VHSNC/ MAS members across states.
- VISHWAS (Village based initiative to synergize health, water and sanitation) campaign has been launched by MoHFW to strengthen the convergent action on social determinants of health, utilizing the platform of VHSNCs. This would facilitate capacity building and strengthening the VHSNCs.

Key Findings

- Overall, the findings from the eleventh common review mission have once again acknowledged the efforts of the ASHAs as a critical frontline worker who has enabled improved access to health care services and has facilitated behaviour change at the community level. Most reports applaud ASHA's agency and high levels of motivation, who do not hesitate to use their own resources whenever required to support the community.

- With the launch of universal screening of Non-Communicable diseases, ASHAs have also been trained in selected districts to conduct enumeration, risk assessment, mobilize community for screening and support treatment compliance. Preliminary reports from states where field level activities have been initiated, indicate towards the high potential of ASHAs and ANMs working as a team to deliver these services. However, the issues raised in the findings about slow pace and variable quality of training of ASHAs in some states would need to be addressed as a pre-requisite to achieve this potential. Though the convergence at field level has been documented across states through the individual efforts of ASHAs, ANMs and AWWs, primarily in organizing VHNDs, but none of the states (except UP) have reported a systemic mechanism of team building among the three frontline functionaries. The monthly meeting of the ASHAs, ANMs and AWWs at SHC, envisaged to plan and improve service delivery is yet to be fully operationalized across all states.

- Despite several initiatives taken in the recent years to address delay in payment of incentives, the issue is yet to be fully resolved especially for payment of incentives under NVBDCP and RNTCP. Stock out of drugs/equipment with ASHAs and limited availability of safety measures for ASHAs are also few critical components of the programme that continue to affect the performance of ASHAs.

- The review of mechanisms for ensuring gender equality within the health system show low levels of preparedness and warrant much more concerted efforts at all levels. With regards to the community based platforms of VHSNCs, CAH, MAS and convergence, slow pace of implementation is noted across states with varied status of implementation. Except for few states, which have invested in building capacities of these platforms and where ASHAs play a leadership role, the progress made is far from satisfactory and highlight the need for a comprehensive review.

ASHA

Selection and Training

- Selection of ASHAs against the set target is near completion (over 95%) in all states visited during CRM, except in states of West Bengal, Karnataka, Uttar Pradesh and Bihar where a

shortfall of 10-20% was reported. Findings from states of Bihar, Meghalaya, Haryana and West Bengal, highlight inter and intra district gaps in ASHA selection. E.g.- Shortfall of 345 and 452 ASHAs was reported from District Madhepura in Bihar and Dakshin Dinajpur in West Bengal respectively. About 132 villages in Meghalaya and certain minority dominated areas in Gurguram, Haryana are yet to be covered by ASHAs. Even in other states, which report a shortfall of 5-10%, the gaps are more likely to be in areas which have are difficult due to geographic dispersion or have high proportion of marginalized population. As a stop gap measure, ASHAs of the neighbouring villages are often given the additional charge of the villages which do not have any ASHA as reported from Meghalaya. This arrangement however was not found to be effective on account of poor rapport with the community and large distances between villages in the hilly terrain of Meghalaya. The selection process was reported to be largely community based with either PRI representatives or VHSNCs leading the process except in both districts of Meghalaya. For instance, in South Garo hills, the village headmen (Nokma) selects the ASHAs without consultation with the community and even without consulting the ASHAs. This affects the level of motivation of ASHAs, who often drop out from the programme because of lack of interest. Lack of adequate representation of marginalized population in selection of ASHAs was reported in West Bengal, raising a concern about the selection process. In Odisha, despite the process being anchored by VHSNCs, it was reported that ASHAs from neighbouring villages (within 2Kms) are selected if any suitable candidate is not available from the village. As the programme completes thirteen years of implementation, it is imperative that the left out and uncovered areas are mapped and measures are taken to cover such areas by ASHAs effectively. In urban areas, states have selected over 80% ASHAs against the set target. However, mapping of areas which need to be covered by ASHAs is yet to be completed across states which has not been reported from any state. In West Bengal, the existing 5444 Honorary Health Worker covering a population of 700-800 have been recently selected as urban ASHAs.

- Dropout rate for ASHAs has remained low in rural areas i.e, up to 4-5% except in West Bengal and UP with drop rate of around 8% and 10% respectively. However, attrition is reported to be high in urban areas of Banglore in Karnataka and Gurugram in Haryana, on account of better employment opportunities and high level of migration.

- In urban areas, induction training of ASHAs is underway in all states and is at various levels of completion. Training of ASHAs in Module 6 & 7 has also begun in some states (Assam, Chhattisgarh, Karnataka, Megahalaya, Nagaland, Odisha, Haryana, Punjab). Training of ASHAs in rural areas have progressed well in most visited states as training of round 3 and 4 is near completion in all states except states of Bihar, Haryana, Telangana and Uttar Pradesh. State of Bihar has not been able to resolve the issue of selection of district training agencies and trainer's attrition for over two years, therefore no training of ASHAs has been conducted since 2015. Even in states where ASHA training has been completed in all four rounds of Module 6&7, plateau is noted in terms of organizing training of ASHAs in newer areas or organizing refresher trainings. About ten districts across seven states (Chhattisgarh, Haryana, Karnataka, Maharashtra, Manipur, Meghalaya, Punjab and Telangana) have been selected for launch of universal screening of

NCDs. However, training of ASHAs on NCDs was reported to have begun only in states of Karnataka, Haryana, Maharashtra and Telangana.

- As states move towards certification of ASHAs, it is important that pre-requisites of having a consistent team of trainers and well-equipped training sites at state and district level be met. Among the states visited, ASHA certification has been initiated in states of Assam, Chhattisgarh, Jharkhand, Karnataka, Maharashtra, Odisha, Punjab and Uttarakhand. Certification process of state trainers and training sites has been completed in these states and the subsequent step of certification of district trainers and training sites is underway. Challenge of non-availability of residential training sites in Karnataka, Meghalaya and Nagaland and shortfall of district trainers in Meghalaya, Bihar and Uttarakhand, are key issues that affect quality and pace of training. In state of Telangana where district training centresare used for training of ASHAs, identification of district training sites is yet to be completed in the newly formed 11 districts.

Support Structures

- States have invested in creating support structures for the programme, either through dedicated support structures at all levels (Assam, Chhattisgarh, Jharkhand, Haryana, Karnataka, Maharashtra, Manipur, Meghalaya, Nagaland, Odisha, UP and UK) or through a mix of existing and dedicated staff in Punjab, Telanaga and West Bengal. Reports from Assam, Jharkhand, Maharashtra and UP document the efforts made by states to provide on the job mentoring support to ASHAs. ASHA facilitators continue to function as ASHAs in Bihar, Jharkhand and Odisha, this dual responsibility affects their performance in both the roles. Similar mechanisms of providing on the job mentoring support to ASHAs are however yet to be extended to urban ASHAs. Low amount of remuneration earned by ASHA facilitators, in comparison of ASHAs, was reported as a challenge in Assam. IT applications designed for ASHA facilitators (ASHA Sangini app in Kaushambi) and BCMs have emerged as useful tools to facilitate the mentoring support being provided to ASHAs in state of UP. Monitoring of rural ASHA's performance (based on ten indicators) is being done in states of Assam, Haryana, Maharashtra, Meghalaya, Nagaland, Telangana and West Bengal. Only in state of Assam, this was reported for both rural and urban ASHAs. Though regular monthly meeting of ASHAs at PHC or CHC level were a common finding reported across most states, only in state of Assam these meetings were reported to be used as platform for refresher training. Despite the high level of investments in creation of support structures, commensurate efforts in capacity building of support structures and building mechanisms of regular review meetings were lacking across most states. Regular review meetings of support structures at each level were reported in three states of Maharashtra, Odisha and Haryana. Limited capacities of district and block level functionaries on community processes affected the mentoring support provided to ASHAs in Assam.

Incentives

Monetary

- Average monthly incentives earned by ASHAs range from ₹ 1500 pm to 4500 pm. This is inclusive of the routine- recurring and other incentives approved under NHM and incentives provided from states funds in states of Chhattisgarh (50% top up), Haryana (1000pm) Karnataka (100% top up which has recently been changed to ₹ 3500pm), Meghalaya (100% top up) and West Bengal (2000pm)). The payment process has improved significantly to facilitate timely payments, yet delays of up to 7-9 months were reported in few areas of Chhattisgarh and Champawat district in Uttrakhand, 2-5 months in Madhepura, Bihar and both districts of Manipur, 2-3 months in Goalpara district of Assam, Jharkhand, Bhiwani in Haryana, East Khasi Hills in Meghalaya and Telangana. Large delays in payment of incentives for NVBDCP and RNTCP were common in states of Assam, Bihar, Jharkhand (extending up to 3-4 years), Meghalaya, Nagaland, Punjab (mentioned in few areas) and Telangana. Delays in Chhattisgarh were mainly on account of delay in linking of AADHAR IDs with bank accounts while in Uttrakhand this was due to systemic issues in PFMS and in South Garo hills of Meghalaya it was because of poor internet and telephone connectivity. States of Telangana and Uttrakhand have also recently announced monthly honorarium of ASHAs (Rs. 2000 pm in UK and ₹ 6000 pm in Telangana) through pooling of NHM funds and state funds. In order to streamline payments, Mitanins are paid ₹ 1500/month fixed from April to December and adjustments are made according to incentives in subsequent months of FY.

Non-Monetary

- States of Assam, Chhattisgarh, Jharkhand, Maharashtra, Odisha, UP, UK and West Bengal have also introduced social security measures for ASHAs. These are – Accidental insurance cover in Assam, Odisha and UP and a mix of Life and accident insurance cover, pension benefits and scholarships etc. in Chhattisgarh. States of Karnataka and Maharashtra have enrolled ASHAs in existing state (Suvarna Arogya suraksha Trust) and National schemes (Prime Minister's Accidental Insurance Scheme) respectively. Awareness about the insurance scheme among ASHAs was reported to be low in UP.
- In addition, career opportunities for ASHAs have been created in states of Assam, Chhattisgarh, Karnataka, Maharashtra, Odisha, Telangana and Uttrakhand. So far 119 ASHAs have enrolled in these courses (of which 76 have completed their courses) in Assam, nine ASHAs has enrolled in Karnataka, 120 in Maharashtra (90 have completed their courses) while ASHAs met in Telangana were not aware about such provisions. Enrolment of ASHAs in equivalency programme is supported in state of Jharkhand (1800 enrolled), Odisha (450 enrolled and 269 cleared matriculation).

Drugs and Equipment Kit

- Availability of drugs and equipment with ASHAs has only improved marginally since last year's reports in most states. Of the 16 states visited, only eight states (Assam, Chhattisgarh, Haryana, Karnataka, Maharashtra (drugs provided to 24,000 ASHAs including Wardha and Prabhani few months before CRM visit), Odisha, Punjab and UP reported availability of drugs and equipment kits with ASHAs during the visits. In the remaining states drugs and equipment were either partially available or not available with the ASHAs met during the visit. For instance, in Bihar, except weighing scale no medicine and other equipment was available with ASHAs and no replenishment was done in Madhepura since last 4 years. In Jharkhand, ASHAs reported purchasing thermometers using their own money. In Meghalaya, ASHAs had weighing scale, digital thermometer and digital watch but no drugs in East Khasi Hills while in South Garo Hills stock out of HBNC kit and drug was reported as only 150 digital watches and 200 torches were supplied to the district to be equally divided among all blocks. In Uttrakhand, ASHAs have digital scale and warm bag but drug kits have not been replenished since last 2 years. In Telangana, only 26846

ASHAs currently have drug kits and HBNC kits. In West Bengal, HBNC equipment like digital watch and weighing scale were found to be non -functioning in some areas. Contraceptives were not available with ASHAs in Assam and Haryana.

- Unavailability of drugs and equipment with ASHA, affect her functionality and undermine her credibility as community level care provider at the village level. As the tasks performed by ASHAs, continue to expand to include tasks related to NCDs, mental health, palliative care, it is necessary that these systemic issues are resolved to ensure undisrupted supplies.

Safety Measures for ASHAs

- In order to ensure safety of ASHAs various measures v.i.z.-creating rest rooms, help desks and establishing grievance redressal mechanisms for ASHAs are essential. Rest rooms for ASHAs were available only in five states but even in these states these were available at one or two facilities visited during CRM. Eg- Rest rooms were available in PHC in Khammam district in Telangana, CHC in Bihar, at DH/CHC in Odisha (142 restrooms at facilities with high caseloads), DH and CHCs in Uttrakhand, Civil hospital in Goalpara in Assam and DH in West Bengal. Help desks for ASHAs were operational in CHCs and DH in Uttrakhand, DH in West Bengal and at all health facilities in one district of Meghalaya (East Khasi Hills). These findings reflect the variation in planning for positioning of help desks and rest rooms based on caseloads.
- Grievance Redressal committees have been constituted at district level only in states of Assam, Haryana, Manipur, Odisha, Uttar Pradesh, West Bengal and Telangana. In addition, grievance boxes were placed at health facilities in Assam and UP and toll-free no “104” was also used in Assam, Maharashtra, Haryana and Telangana. However, findings highlight that even these states, the committees had low levels of functionality.

Functionality of ASHAs

- Findings from field report high levels of functionality of ASHAs in improving access to health care services for Maternal and Child Health Services across all states, indicating the continued focus on these areas and facilitator role of ASHAs. Thus, across all states, ASHAs

are viewed as enablers of accessing services such as immunization, ANC, institutional delivery and to some extent family planning services.

- Though ASHAs were found to be equipped with skills to perform these tasks, reports emphasize the need for refresher trainings to address the gaps in skills pertaining to identification of danger signs, nutrition counselling, family planning, safe abortion services and adolescent health. Findings from Maharashtra highlight that in many cases families shared that the newborns were weighed at the Aganwadi centre rather than by the ASHA. Access to marginalized has also improved with the continuous efforts of ASHAs. Effectiveness of ASHAs is affected by larger systemic issues such as geographical barriers and non-availability of phone and road connectivity, this was reported specifically from states of Meghalaya and Manipur. In Wardha district of Maharashtra, where training of ASHAs in NCDs has been started, findings indicate high skill levels and interest among ASHAs.

- The average daily time spent on ASHA work (as per existing work load) ranged from, 5-7 hours per day in Assam and Uttar Pradesh to 3-4 hours in Haryana, Karnataka, Maharashtra, Odisha, and Uttrakhand and 2-3 hours in Nagaland. However, ASHAs in Assam and Uttrakhandsaid that the actual time spent by them in accompanying a pregnant woman for delivery and travelling difficult hilly areas is much more.
- Interest of ASHAs in NCDs and newer roles was supported by Programme managers of states of Assam, Odisha, Karnataka, Uttar Pradesh and West Bengal. These recommendations along with the finding of average daily time spent by ASHAs being in the range as envisaged in the guidelines, suggest that it is feasible to plan for new tasks for ASHAs (depending on local context and National Priorities) linked with skill based training and appropriate incentives.

Gender

- The eleventh CRM reviewed the status of training of health service providers on gender, availability and use of Medico-legal care protocols at public health facilities for survivors of sexual violence, functionality of gender resource centers and one stop crisis centers, implementation of VISHAKHA Guidelines at district and state level and availability of safety measures for frontline service providers.
- The findings however show no efforts made by all states in each of these areas. Out of the five objectives, only in terms of training of service providers on issues related to gender some progress has been made in two states of Chhattisgarh and Meghalaya. Protocols to provide medico-legal services to survivors of sexual assault were not available in any state at any level of health facilities. Similar findings surface for implementation of VISHAKHA guidelines and functioning of gender resource centres/one stop crisis centres. Formation of district committee for sexual abuse and harassment in 2013 was reported from Bijapur, Chhattisgarh, however only one case was reported.

- With regards to safety measures for frontline workers, few states have invested in creating rest rooms, help desks and grievance redressal committees for ASHAs (as documented earlier). However, no such efforts have been made for ANMs, who are often expected to reside in the SHCs and travel to outreach sites for immunization/ANC sessions.
- Despite the fact that nearly 90% of service users of public health system are women and children, 100% of frontline workers are women (ASHAs and ANMs) and almost 50% of the total workforce comprise of women, the gender issue has not received the due attention across all the visited states.

VHSNC

- As per the reports shared by states, among the 16 states visited in the CRM, constitution of VHSNCs is near complete (over 95%) in most states. Uttar Pradesh is the only state which reports less than 90% formation of VHSNCs (at 88%), with West Bengal and Uttarakhand being close at 91%, and Assam at 92%.
- A number of state reports show that restructuring of VHSNCs has been done as per the new guidelines released in 2013. The village panchhas been made the Chairperson, replacing the other existing Chairpersons in almost all states where reconstitution has been done. In Assam, School teachers who were in position as Chairperson, have been replaced by village PRI members. Meghalaya, where the VHSNCs are headed by the village headman of the traditional village council under the provisions of Panchayat Extension in Scheduled Areas (PESA) Act, the VHSNCs have been restructured and ASHA has been made member secretary, though the village headman remains the Chairperson as earlier. States of Maharashtra and Odisha, continue to have Anganwadi Worker as the member secretary of VHSNC. States of Karnataka, Meghalaya and Uttarakhand, have reported that the restructuring of all VHSNCs of their states have been completed with ward panch as Chairperson. The process of reconstitution has not been undertaken yet in Uttar Pradesh, though a government order has been released recently for reconstitution of the VHSNCs at revenue village level (i.e. villages of 500 and above population will have a separate VHSNC).
- With regards to training of VHSNCs, Meghalaya is the only state where training of VHSNC members has been reported in current year or within last one year in South Garo Hills. While in Uttarakhand training of 374 VHSNCs was conducted about 18 months back. In other states no efforts on training of VHSNC members have been reported. Orientation of VHSNC members was conducted in Bihar and Odisha nearly two years ago. This is despite the fact that in Odisha, VHSNCs have been reconstituted after the panchayat election. In Maharashtra, the last training of VHSNCs was done in 2008.
- Only few state reports have commented on regularity or quality of the VHSNC meetings. Regular monthly meetings of VHSNCS are conducted in Assam, Chhattisgarh, Karnataka, Odisha, Manipur, Punjab and Uttarakhand. Among these states, the meetings are being used to discuss issues related to health and sanitation in most states. Quality of deliberations in Manipur and Karnataka reflects substantive gaps, as the discussions focussed only on the expenditures incurred form VHSNC funds. States of Chhattisgarh and Odisha have put in place mechanisms for ensuring quality and effectiveness of VHSNC meetings. In Odisha the meeting is attended and

supported by pachayat representatives to discuss issues like, institutional delivery, LLIN distribution, JE vaccination, support from ICD etc. while Gram Panchayat also conducts one review meeting with every VHSNC every month. State of Chhattisgarh has introduced Public Services Monitoring tool to be used by VHSNC to monitor issues like malfunctioning handpumps, ration shop functioning, quality of mid-day meals etc. This tool has subsequently been incorporated in the revised VHSNC guidelines of VHSNCs in 2013.

- Release of untied fund was reported to be regular in all states except in four states of Jharkhand, Manipur, Assam and Uttrakhand. Untied fund has not been released for nearly two years in Jharkhand and in one district of Manipur. In states of Assam and Uttarakhand, fund for FY 2017-18 are yet to be released. Assam has also reported a specific problem of funds being released in instalments of ₹ 2000, with the next instalment being released after submission of Utilization Certificate (UC) of the earlier instalment. Some irregularities were also reported in Maharashtra (funds of one VHSNC were deposited in the account of another neighbouring VHSNC). Most of states report release of funds in two instalments of ₹ 5000 each.

- Nearly 100% expenditure of untied fund is noted in Odisha and Chhattisgarh and 70% in Uttrakhand. The pattern emerging from the expenditures of united funds across the states, reflects focus on issues of hygiene, sanitation, support for vulnerable families in seeking healthcare by providing transport in emergencies, and supporting in buying medicines in some cases, and providing loans for medical expenses for very poor households. In Uttrakhand, "Doli" locally made stretcher cum Palnquinis used in hilly areas for transporting pregnant women and old patients up to road head using VHSNC funds. Purchase of equipment, furniture and other aids for the VHND, support for stationary and small expenses for refreshments for VHSNC meetings are few other areas of expenditure reported. In Maharashtra, expenditures from united funds were made without any proposals and approvals in the VHSNC meetings and all withdrawals, in large amounts, were made in cash, by the Anganawadi worker, who is the member secretary. In Bihar, influence of PRI members on the decision of using untied funds was reported to affect the utilization of funds.

- Odisha has introduced innovative mechanisms such as awards to VHSNCs - one best GKS (VHSNC) in every block, and one best GKS in every GP every year. In addition, state has provided one stretcher to every village in difficult areas of High Priority Districts (HPDs) to help in transporting pregnant mothers from remote villages to the nearest road head under Sammpurna programme. This was purchased from ₹ 1000 of GKS funds which were later reimbursed from NHM.

VISHWAS (Village Based Initiative for Synergising Health, Water and Sanitation) Campaign

- SHWAS Campaign has been recently launched for building synergisitic action on social determinants of health using the platform of VHSNCs. Training of state level trainers has been completed in Manipur while in Odisha training of both state and district trainers has been completed and training of VHSNC is planned to start in November and December. In Maharashtra, the rollout of the campaign is planned from December.

Mahila Arogya Samiti (MAS)

- All states except Haryana have MAS in place. Five states (Assam, Bihar, Jharkahnd, Punjab, and Telangana), have not given any update on MAS programme. Though 14 out of 15 states have achieved the target for formation of MAS, there are still major gaps in proportion of MAS which have bank accounts. States like Bihar report that almost all of the target MAS have formed but only about 50% of them have bank accounts. Meghalaya has reported problems in opening of zero balance bank accounts. West Bengal has formed less than 50% of its target MAS (4748 formed against the target of 11709, with only 3304 with bank

accounts). State reports have underscored the problems being faced in formation of MAS in metropolitan cities under municipal corporation areas such as Banglore, Kolkata and Mumbai. Maharashtra report highlights this issue despite the collaboration with NGO Sneha, which has substantial experience in such community level interventions.

- Regular monthly meetings and good functionality of MAS has been reported from states like, Chhattisgarh, Odisha, Manipur and Meghalaya. Odisha has developed an innovative system of grading of MASs on 10 measurable indicators, based on which they are marked Red, Yellow and Green, and corrective action is undertaken accordingly. Report from Chhattisgarh documents that MAS has been successful in addressing issues like alcoholism and facilitation of land donation for opening of Swasthya Suvidha Kendra.

- Capacity building of MAS has been reported from only few states like Odisha, Chhattisgarh and Meghalaya. All state reports have emphasized on the need for; strengthening support processes for formation and handholding of MAS, regular training of MAS members and also assessment of adequacy of MAS targets.

Rogi Kalyan Samiti (RKS)

- All state reports state formation of RKS being in place at all levels of facilities except in Manipur where RKS is yet to be formed in urban areas. However, low functionality in RKS of facilities at block level and below and low investment in training of RKS members emerge as major concerns.

- General Body (GB) and Executive Committee (EC) are reported as being in place in all states except Assam and Bihar, where separate mechanisms do not exist. Although there are variations across states in regularity of meetings and active role being played by these two institutional mechanisms. Across states, GB meetings are held on a biannual basis while the EC meetings are held either monthly or once in two months. Some states like Uttarakhand and Bihar, report RKS meetings being held, when required. In Chhattisgarh, GB meetings are held regularly but EC meetings are not regular. On the other hand, GB meetings not regular but EC meets mostly on monthly basis in Manipur. In Maharashtra, and Telangana, two meetings of GB and 3 to 5 meetings of EC are reported as being held every year.

- Diverse nature of membership is noted across states, ranging from local MLAs to PRI representatives, representatives of NGOs and community members. Manipur reports inadequate representation of civil society and community. In West Bengal members are mostly facility staff, with weak PRI and community representation. In Chhattisgarh, active role is being played by members in monitoring of facilities through regular visits, and it has led to perceptible improvements in facilities. While in Maharashtra members have no regular process of conducting review of facilities, and they reportedly do it whenever they visit the facility. Low participation of RKS Members, especially PRIs representatives was reported in Jharkhand.

- States Assam and Maharashtra have reported that untied funds received by RKS and the earnings from user charges are not being pooled, and the user charges, are being pooled into state funds. In Assam, facilities had not received untied funds for 2017-18 yet. In Chhattisgarh, RKSs funds were received in May 2017. Income sources of RKS in Bihar include,

OPD and Emergency registrations, renting out premises, charges from C-sections and ambulance services. In West Bengal in addition to untied funds, RSBY funds and *Swasthya Saathi* reimbursements are also being pooled.

- Expenses incurred from RKS funds are mainly on gap filling in HR, mainly support staff, contracting of services like cleaning, and minor repairs. Use of RKS funds for drug purchases was reported in Maharashtra and West Bengal while in Uttarakhand, expenses were found to be mainly on improving facilities in hospitals, for service providers.
- Systems for Patient feedback or Grievance Redressal are clearly not high on agenda of the RKSs, which is reflected in absence of such systems across states.
- Need for training of RKS members and enabling them to conduct assessment of facilities and its key services, especially food, laundry, cleaning etc, and also building a road map for facility improvement, has been highlighted in various states reports.

Community Action for Health (CAH)

- Only eight states have reported Community Action for Health programme being implemented (Assam, Bihar, Jharkhand, Maharashtra, Meghalaya, Orissa. Uttarakhand and UP). While in Karnataka the initiative has been discontinued after the implementation of the Community based Monitoring Programme – CBMP in its pilot phase). Among these states, an active programme at field level is evident in Jharkhand, Maharashtra and Meghalaya, where the programme has been operational since pilot phase. In Maharashtra, the CAH programme is being implemented in collaboration with NGO Saathi, since the pilot phase and has expanded from six to 14 districts. In Meghalaya, the CAH initiative is being implemented in four districts through one state level resource organization and two district level implementing NGOs. In Jharkhand, CAH is being implemented in all 24 districts. Findings from these states show positive results of the community based accountability mechanisms. States of Uttarakhand and Assam have not received approval for CAH for FY 2017-18 but shared plans to initiate the CAH and expand it to 100 VHSNCs (from 40) in 105 BPHCs while. Uttar Pradesh is implementing CAH in 12 districts, though no specific activities are reported to have been conducted since last two years. State of Chhattisgarh focusses on VHSNC as the fulcrum for CAH activities.

Convergence

- Convergence in programme implementation is reported from nine states (Assam, Chhattisgarh, Maharashtra, Meghalaya, Uttar Pradesh, Nagaland, West Bengal, Haryana).
- Evidence of convergence was seen only at the field level among the frontline workers, the panchayat representatives and VHSNC members. No mechanism of promoting convergence between different departments has been reported at state, district and block level except in states of Chhattisgarh and Maharashtra.

- Organisation of VHNDs, school health programmes, Adolscent Health programme, and water and sanitation campaigns efforts, are the main areas in which convergence was noted at community level. Active role of ASHAs and VHSNCs is reported in activities under Swachh Bharat Abhiyan and village hygiene and sanitation campaigns. Convergence between different departments at the district level, is reported to be through the regular meetings conducted by either Collector or the Minister in Charge of the district.

- State of Chhattisgarh has implemented Swasthya Panchayat Yojana (SPY), under which every Gram Panchayat is scored on a set of parameters of health and its key social determinants. A monthly process of public services monitoring on 29 key indicators in monthly VHSNC meeting, is facilitated by ASHA. The state report also mentions convergence at other levels, like, leveraging of the resources from different sources for strengthening health facilities (District Mineral Fund, Panchayat funds, Zilla Nirman Samiti and CSR funds polled-in in Bijapur district). The Central Reserve Police Force (CRPF) also provide support to health department in organizing health camps, identifying malaria cases, and in helping locals in accessing the ambulance services (in Bijapur district which has poor mobile services in remote areas). Strong convergence is also reported through meetings held by Minister in Charge and active District Level Vigilance and Monitoring Committees (DLVMCs).

- In Maharashtra, close institutional convergence exists between Panchayat System and Health System, as the rural health system is placed under District Panchayat. The District Health Officer (DHO) oversees the rural health system, (including PHCs and SCs) and reports to CEO- Zila Panchayat (ZP). The Civil Surgeon (CS), who reports directly to the state's Health Department, is in charge of the DH, SDH and CHCs. The active role of ZP ensures close coordination with all other departments, like, Education, ICDS and Water and sanitation, and also integration with district level planning process under district planning committee (DPC). The NUHM programme implementation is through municipal corporations and councils, who coordinate with CS and oversees the DH, SDHs and CHCs. But challenges of coordination still remain at these two levels of convergence.

Recommendations

- As the current policy discourse positions ASHAs as a key member of the primary health care team to jointly deliver an expanded package of services, closer to the community, it is essential that the challenges of slow and varied quality of training, delays in payments, stock out of drug and equipment kits, are resolved.

- Process of regular refresher training for ASHAs needs to be institutionalized using PHC meeting platforms and periodic modular training to achieve a minimum of 15 days per year.

- With the changing role of ASHAs, the capacities of the support structures also need to be strengthened simultaneously to enable effective on the job mentoring support for ASHAs.

- In urban areas, the issue of high attrition rate due to high level of migration and better employment opportunities, highlights the need to design urban context based tasks linked with new incentives to facilitate retention of ASHAs. Extension of all existing programme components vi.z, training, non-monetary incentives and support measures to urban ASHAs also needs to be prioritized.

- Delays in payment of ASHA incentives across most states despite several initiatives of routing all payments through PFMS, need an urgent action. Larger delays were reported for payment of incentives for activities related to NVBDCP, RNTCP, NLEP.

- Lack of efforts at the state level in implementing measures for ensuring gender equality is a major concern that needs to be addressed on urgent basis. This was noted even in the slow progress made by states in operationalizing grievance redressal mechanisms and creating rest rooms for ASHAs.

- The untapped potential of VHSNCs, RKS and MAS in most states on account of limited capacity building initiatives, have highlighted gaps in utilizing these community based platforms to address social determinants and take collective community actions. Strategies such as proactive engagement with NGOs and building capacities of support structures to effectively supervise VHSNCs, RKS and MAS could be adopted to bridge this gap.

Key Findings from States

ASSAM

- Knowledge and skills of ASHAs/ASHA Supervisors were modest in Nalbari while in Goalpara ASHAs were very active, motivated with good knowledge levels.
- Attrition of ASHAs was reported from Nalbari district particularly in the difficult outreach sites of Char areas. Issue of difficulty of removing non-performing ASHAs due to political pressure was reported.
- Limited capacity of district and block- level functionaries on community-level processes was reported but active involvement of ASHA supervisors was observed at field level.
- Despite prompt refilling mechanism, stock-out of NISCHAY kits and OCP pills was reported.
- Grievance redressal committee is formed but ASHA rest room is available only at Civil hospital, Goalpara.
- About 19 ASHAs have received benefits under ASHA Kiron scheme in 2017 in Goalpara district.
- 119 ASHAs are enrolled and 76 have completed the ANM/GNM course since 2016-17.
- District urbanhealth staff was unaware about most non - monetary incentives available to urban ASHAs
- Long delay in incentives under vertical programme (RNTCP incentives) since 2015 was noted.
- VHSNCs have been reconstituted and regular monthly meetings are conducted but poor knowledge regarding public services monitoring tool was noted.
- Untied VHSNC funds are released in installments of ₹ 2000 each and further releases are linked to submission of UCs. Fund are yet to be released for the FY 2017-18
- RKS is constituted across the health facilities but variability in their functioning is noted. Most RKS are unaware of pooling of untied grants. Untied funds for 2017 - 18 are yet to be released in most facilities.
- All MAS have bank accounts and active engagement urban local bodies with MAS with was noted.
- Good convergence was noted in Gaolpara with ICDS (VHND); education department (NIPI/WIFS and NDD programme); water and sanitation department and red cross society etc.
- Medico-legal protocols for survivors of sexual violence, one-stop crisis centres and implementation of VISHAKHA guidelines was not available at the district health facilities. No gender-related training was given to any health service providers.

BIHAR

- Selection of ASHAs and ASHA Facilitators is yet to be completed in the districts visited.
- ASHA facilitators continue to work as ASHAs which affect their performance in both roles.
- No systematic training done for ASHAs since 2015 as selection of district training agencies has been pending for past two years. Reimbursement of payment to the State Training Agencies is still pending.
- Payment of ASHA incentives is done within 15 days in Bhojpur except for incentive for Disease Control Programmes, which have not been reimbursed since a couple of years. However, payments were delayed in Madhepura by 3-5 months, including payment of ASHA Facilitator honorariums.

- Vacancies of support structures like DCM and BCMs in both districts affect mentoring and monitoring of ASHAs. No meetings of BCMs and ASHA facilitators have been organized over last 15 months.
- No systematic process is present for grievance redressal while ASHA rest room was available only at one CHC Sahar.
- As part of HBNC kit, only weighing scale was available. Nishchay kits, condoms and OCPs were available in Bhojpur but in Madhepura no replenishment was reported since last 4 years.
- Sarpanch and ANM are VHSNC account signatories while ASHAs have no role in organizing meetings and planning untied funds use.
- Orientation of VHSNCs was conducted in 2013-14 with no follow-up orientations have been organized.
- Untied fund for VHSNC has not been received this year in the visited block of Madhepura district.
- One common RKS committee is constituted with no separate GB and EC.
- Irregular pattern of RKS meetings was noted in both district but in the meetings performance of contracted out services, functioning of 102, hospital repairs, maintenance, etc. are discussed.
- Significant progress has been made in urban areas with 347 ASHAs selected against the target of 391. Of which 342 ASHAs have been trained in Induction module but they are yet to receive drug kits.
- 407 MAS out of 500 is functional in the State and 53% MAS have bank accounts.
- CAH is currently implemented in 2 districts (Darbhanga and Nawada district across 4 blocks) with plans to scale-up in these 2 districts (28 blocks, 1966 villages).

CHHATTISGARH

- Mitanins are well trained and skilled with good practical knowledge and good community connect.
- *Mitanins* are adequately compensated for the activities undertaken with 50% additional incentive amount coming from the state budget. Incentives for current financial year are yet to be received by few *Mitanins* mainly because of the AADHAR linked accounts and procedural delays.
- Non monteray incentives like career progression opportunities and insurance for *Mitanins* have been introduced. Drug kit is adequately stocked with drugs and contraceptives.
- Bi-annual meetings of the governing body of *Jeevandeep Samiti* (JDS) are regularly held while executive committee meetings are irregular
- Constitution of VHSNCs is at the revenue village level with *Mitanin* as member-secretary. Regular meetings are held with active participation of the panchayat members with discussions on various issues of social determinants and public services.
- *Swasthya Panchayat Yojana* (SPY) has been implemented in the state under which a *Swasthya Panchayat Samanvyak* (SPS) has been appointed to mentor the VHSNCs and support the process.
- Jan Samwad at all blocks are organized annually in which ministers, PRI members, government officials from different departments participate and address the problems raised by the community.
- Good leveraging of the resources from District Mineral Fund, Panchayat funds, Zila Nirman Samiti and CSR for strengthening the health facilities across Bijapur district was observed.
- District NHM officials have undergone gender-related training and there is an existing district committee for sexual abuse and harassment (Bijapur) since 2013.
- Well-functioning MAS with regular meetings and proper records maintenance is been noted. MAS has taken actions to address various local issues with active engagement with Urban Local Bodies.

JHARKHAND

- Knowledge related to Home Based Natal Care (HBNC) of Sahiyas was observed to be good and they were aware about the health status of each family in their area.
- Strong training support structures at each level is present. In rural areas, Sahiya Sathi and Block Training Teams (BTTs) supervise the Sahiyas while in urban areas BTTs and ANMs support them.
- Incentives payments are delayed for more than three months in both districts. Grievances like delay in payments (3-4 years delay for incentives under National Programme) and issues related to stay in hospitals were reported during the field interactions.
- No documented mechanism for resolving issues or addressing the grievances of Sahiyas was reported.
- Availability of thermometers, digital watch and weighing scale and drugs was found to be poor. However, their knowledge regarding drug dispensing was adequate. Sahiyas reported of purchasing thermometer on their own.
- As a special initiative all Sahiyas in Jamshedpur have been provided with the cycles.
- Around 1800 Sahiyas have attempted for 10th and class 12th last year through NIOS.
- 100% VHSNCs are functional with trainings being provided to the members by state and block training teams. Members were aware of their roles and responsibilities and meeting registers are being maintained.
- During a VHSNC meeting at village Kumardobi in Baragohra Block, it was observed that VHSNCs have not been provided with funds for the last two years.
- Convergence between WCD and health department is working well at field level.
- Mixed response to the awareness of the mandate of the RKS among the members and low participation of PRIs and community participation was noted.
- Training of Programme Officers in CAH has been conducted. About six Jan Samwad have been organized in Baragoraha Block of East Singhbhum District.

HARYANA

- Selection is about 96% complete in the state. However, report highlights high attrition and non-availability of ASHAs in some minority dominated pockets of Gurugram.
- Functionality of ASHAs in HBNC, other mother and child care and TB-DOTs related activities was good. All ASHAs met shared the issue of attending multiple meetings at district level (other than regular monthly meeting), without being provided anywage loss compensation.
- State is close to completing Module 6&7 training up to Round 4, by end of FY 2017-18. Training of ASHAs on NCDs is underway in 5 districts.
- ASHAs are actively involved in state's initiatives of *Beti Bachaoo Beti Padhaao* campaign and PCPNDT related campaigns.
- ASHA Incentives payments, being made online, are largely streamlined, and are linked with PFMS, but some delays in payments were reported by ASHAs in Bhiwani district. State provides ₹ 1000 pm to ASHAs and 50% topup payment on incentives from state funds.
- Grievance Redressal System is in place with a toll-free number, and district committee chaired by District Collector.
- Under NUHM, state has not planned for constituting MAS.
- VHSNCs are in place in state with Anganwadi Worker as member secretary. About 38504 VHSNC members have been trained on VHSNC Handbook but low levels of functioning of VHSNCs was noted in Bhiwani.
- *Rogi Kalyan Samitis* (RKS) are in place across state. Particpation of PRI members was observed as weak. Untied funds were being used mainly for purchase of medicines and consumables, under *Mukhya Mantri Muft IlaajYojana* (MMIY) of the state.

- VHSNC, RKS and Meetings conducted by District Collector at district level were reportedly being used as platforms for interdepartmental convergence and well as forums for participation of PRIs, ULBs, and school representatives.

KARNATAKA

- Despite the progress made in selection of ASHAs, there are about 5500 villages/slum pockets where selection of ASHAs is yet to be completed. Selection process was found to be slow in Bangalore city mainly on account of high attrition rates.
- State has initiated the process of ASHA certification, under which 4 state training sites, 2 state trainers and 50 district trainers have been certified by NIOS.
- Unavailability of residential training sites in the districts is a constraint in rolling out ASHA training.
- ASHAs are knowledgeable and skilled to act as a link between the health systems and community
- Regular ASHA incentives are paid through PFMS both in urban and in rural areas.
- No Help Desk, ASHA Ghar/Rest Rooms for ASHAs are observed at the health facilities.
- 10% seats are reserved in ANM & GNM courses, 9 ASHAs have been enrolled for ANM course and 9 ASHAs have been elected as PRI members.
- ASHA grievances cell exists at State/district level and also at Taluka level in Chitradurga district
- Some good practices documented include - ASHA NIDHI Portal an online payment portal, ASHA Diary as an integrated job aid; Refresher Training through Satellite mode/SATCO; coverage of ASHAs Suvarna Arogya Suraksha Scheme and SMS alerts to ASHAs about incentives and new updates through Mobile One Karnataka portal.
- VHSNC is formed at revenue village level but representation of minorities communities has not been ensured.
- Participation of ANMs in VHSNC meetings was very low and the focus of VHSNCs meetings was only to spend the untied fund. Lack of awareness among VHSNC members about their roles, public services and social determinants was noted.
- Good progress in formation of MAS, opening of bank account and disbursement of untied funds is observed in the districts but the progress has been slow in Bangalore urban due to difficulty in identifying ASHA in the city.
- MAS members have received training but lacked awareness about their roles, use of untied funds and have limited knowledge on health and WASH.
- *Arogya Raksha Samiti* (ARS) popularly known as Rogi Kalyan Samitiare formed in all the facilities with meetings being held once in two months. However, engagement of ARS members towards improvement of the facility, patient's feedback and grievance redressal was found very less.

MAHARASHTRA

- State has a fairly well managed ASHA programme, with above 96% ASHAs in position, and above 95% support structures in place.
- The knowledge and skills levels of ASHAs were found to be good in most of their tasks but gaps were observed at in areas of nutritional counselling, family planning and weighing of new borns.
- ASHAs had good quality HBNC equipment however many families met reported that the newborns were weighed at the AWC and not by the ASHAs during the home visit.
- Incentives are paid through PFMS linked electronic payment directly to bank accounts of ASHAs with no delays.
- Call centre with toll free no 104 is used as Grievance Redressal mechanism for ASHAs and other health staff. However, the process of tracking of complaints is yet to be built.

- Rest rooms and help desks for ASHAs have not been created at any level of health facility.
- State has also engaged ASHAs in the Prerna initiative to help and support farmers in distress to address the issue of farmer's suicide.
- State has a dedicated support structure at all levels and has set up regular programme review mechanisms at every level.
- Avenues of career progression have been created for ASHAs and so far 120 ASHAs have been enrolled in ANM course, of which 90 have already completed their course.
- State has also enrolled ASHAs in Prime Minister's Accidental Insurance Scheme recently.
- VHSNCs in place with all of them having functional bank accounts and AWWs as the member secretary. Training of VHNSCs have not been planned since 2008.
- Process of formation of MAS is underway in the state in collaboration with an NGO but limited progress was noted in MAS formation.
- RKS receives the untied funds provided by NHM while the user charges are deposited in the state's PLA account. State shared the recent decision of raising the user charges from ₹ 3 to ₹ 5, of which ₹ 3 would be deposited in RKS accounts.
- State has a well established CAH programme, actively supported by an NGO, which has been expanded from six to 14 districts recently.
- State has institutional integration of Health Systems with the institutions of local self-governance, in both NRHM and NUHM programmes. The Zila Panchayat oversees the health system's structure at PHC level and below (includes SCs and village level).
- In urban areas, the implementation of NUHM programme is overseen by municipal corporations and councils but challenges in coordination were reported.

MANIPUR

- Selection process is near completion in the state and low drop out rate of 2- 3% was reported.
- Grievance redressal committees have been formed at all the level but they are not functional.
- In-spite of ASHAs satisfactory understanding on their roles and responsibilities, their effectiveness was affected by factors like hilly terrain, poor last miles connectivity through ambulances and poor communication facilities.
- Despite being trained in all modules, ASHA's had limited understanding on Module 6 and 7 indicating the need for refresher training.
- Delay in ASHA incentives by 5 and 3 months in Tamenglong and Imphal West districts, respectively were reported. Travel allowance paid to ASHAs were insufficient to cover with their travel expenditure.
- No mechanism in place to replenish the ASHA drug and equipment kit.
- VHSNCs have been constituted at all revenue villages and regular monthly meetings are organized with active participation of ASHAs. However, the content of meeting was not substantive and documentation of meeting was found to be weak. This can be linked with low levels of motivation of VHSNC members in absence of availability of funds since last 2 years and no training conducted in the last 3 years.
- RKS is functional at all rural health institutions but there is no representation of civil society and eminent community members. RKS meeting happens largely on monthly basis but the governing council meeting is rare, and no patient feedback mechanism is in place. No orientation/capacity building initiative for RKS members has been undertaken.
- MAS was formed in the slums visited, 2 members per MAS had received training and orientation and the meetings were undertaken on monthly basis.

- No convergence mechanism was found in place at state/district/block level. No mechanism in place for genders sensitization in the state.

MEGHALAYA

- Community level interactions reflected that ASHAs have good rapport, and community seeks ASHAs services actively. Good team-work observed between ANMs and ASHAs.
- About 132 villages are yet to be covered by ASHAs. These villages are assigned to ASHA from neighbouring village but challenges were reported in covering such villages.
- Shortage of district trainers in few districts and non-availability of residential facilities for ASHA trainings were reported as key challenges.
- Inaccessible and remote areas with poor connectivity affect ASHA's performance and effectiveness.
- Various support and welfare processes eg- yearly 100% top up, ASHA Ghar, ASHA Help desks, and annual ASHA Divas have been implemented by states.
- Backlog was reported in payment of incentives in South Garo hills due to poor internet and telephone connectivity.
- Stock out of all drugs except ORS and Paracetamol was observed. HBNC equipment was available with ASHAs but irrational distribution of digital watches and torches was reported in South Garo Hills.
- Untied fund of ₹ 10000 is being released regularly, in two instalments of 5000 each (in East Khi Hills, single release of ₹ 10000 was done). Lack of coordination with the village headmen in South Garo Hills was reported as a major challenge affecting the utilization and release of untied funds.
- Wide variations in functionality and fund utilization were observed across districts.
- Training of VHSNC members has been conducted in five Garo Hills districts but is planned in November 2017, for six Khasi Hills districts.
- 88 MAS against the target of 105. Training of MAS has been conducted in the year 2015. About 71% of MAS have bank accounts while the remaining MAS are facing challenge in opening of zero balance bank accounts because of lack of cooperation from banks.
- RKS has been set up in all facilities but process of restructuring of RKS as per recent guidelines has not been initiated.
- Irregular meetings of RKS were reported in both districts which is also affected by availability of members for meeting in difficult to reach areas.
- CAH has been implemented in five districts in state. The programme is supported by NGOs in all districts however in 2016 state has revised the strategy where the existing staff for community processes support the initiative while NGOs facilitate training and field visits.
- VHSNCs are the key platform for all CAH activities. Various achievements of CAH include building an AWC and declaration of one village as ODF due to community mobilization efforts.
- Training of Medical officers on Gender issues was conducted in collaboration with Cehat at state level. Lack of awareness was observed for VISHAKHA guidelines across districts.

PUNJAB

- Functionality of ASHAs in RMNCH+A was found to be satisfactory. Knowledge of ASHAs regarding the 10 key functions was adequate.
- Training of ASHAs in modules 6 and 7 has been completed. Availability of equipment and drugs were found to be adequate.
- ASHA payments are being done by DBT and delays in payment were observed in few areas.
- Regular VHSNC meetings were reported with participation of PRI members.
- Mechanisms for programme review and monitoring of community processes interventions are not present.

- RKS have been constituted as per the target but no trainings undertaken
- PRI members actively participated in mobilization of beneficiaries to avail the services and also lend spaces for conducting VHND sessions.
- Training on gender related issues has not been provided at any level

NAGALAND

- Non availability of residential facility for ASHA training has been reported as a major challenge.
- ASHA Incentives payments are being done through PFMS linked system butt major delays were reported as no ASHA has received incentive since February 2017.
- Payments for incentives related to Malaria/ Leprosy/etcare being done in cash. ASHAs have also not received incentive for DOTs.
- Helpdesks and ASHA restrooms are not present in facilities.
- Average time spent by ASHA on her work is 2-3 hours per day.
- No grievance redressal committee is in place and the grievances are discussed during block ASHA meeting.
- Constitution of VHSNC has to be approved by PRIs (Village council). Village head is the chairman of VHSNCs and ASHA is member secretary. VHSNCs have not been trained on VHSNC Handbok.
- VHSNC along with religious leaders provide support to ASHA.
- RKS is constituted in all the health facilities. Eminent citizens and civil society representatives were have been included in all the Samitis.
- No training have been organized on gender issued for Health service providers in the state. Protocols for Medico legal care for survivors of sexual violence were not available at visited facilities.
- Coordination with Education department for WIFS, Adolescent Health, and RBSK programmesis ensured through District Collector.

ODISHA

- Field visit indicate high level of acceptance of the ASHAs at the community level. Panchayat members and District Officials in Malkangiri district felt that community health seeking behavior has changed, because of active role of ASHAs.
- State had 13 state trainers and 285 district trainers but high attrition was reported among district trainers, as only 160 district trainers are currently available.
- Annual refresher training of 5 days is conducted @ 1 day every month from November to March every year. Training topics are decided in consultations between state and district teams.
- ASHA Facilitators are in place, but they continue to work as ASHA, which hampers their performance.
- Monthly incentive payment system is streamlined with no backlog.
- State supports ASHAs in enrollment in equivalency programmes in National Institute for Open Schooling for passing 10 & 12 class and weightage is given to ASHAs for admissions in ANM course.
- Grievance Redressal System is in place, with District ASHA Coordinator responsible for registering and addressing complaints (their phone no. is advertised for making complaints).
- ASHA Gruha are in place in major facilities (total 142 in state), with three to six neighbouring ASHAs managing it on rotation, who are receive extra incentive for it.
- ASHA *Kalyan Yojana* provides for financial assistance of ₹ 1 Lakh on ASHA's death or disability (smaller amounts in partial disability based on category of disability).

- State has recently implemented an exit policy for ASHAs, with ₹ 10000 as one time assistance as 'golden handshake' when she reaches 60 years of age.
- VHSNCs (named as *Gaon Kalyan Samiti* – GKS in state) are in place, with 98% constituted against target. They have active engagement with panchayats, with Gram Panchayat conducting a quarterly review meeting with every GKS in its area. Funds are regularly released and spent well.
- Every GKS (VHSNC) has ASHA Kantha – a public notification and message writing wall, which is used for regularly update the information related to health services and promote health messages.
- State has started rollout of VISHWAS Campaign (Village based Initiative to Synergise Health Water and Sanitation), and has conducted state TOTs.
- State has selected urban ASHAs (1435 against target of 1482) and formed MAS (all 3132 target constituted). Ward *Kalyan Samiti* (on lines of GKS) has been formed in urban areas. A system of grading of MAS is in place based on which required support and handholding is ensured.
- RKS has been formed in all health facilities however meetings were reported to be need based. Review of the records indicated that most expenditure are service provider centric rather than being patient centric.
- Good interdepartmental convergence is seen in VHNDs, but education department's participation has been reported as weak.
- No specific action has been taken by state to address the gender issue.

TELANGANA

- Level of Knowledge, skills, commitment and functionality of ASHAs is reported as good.
- Pace of ASHA training is slow, with Round 3 coverage being only 30%, and Round 4 yet to start.
- Despite completion of training of ASHAs in round 1 of Module 6 & 7, only 26846 ASHAs currently have drug kits and HBNC kits. In Adilabad district, some ASHAs are yet to receive the kits.
- State has support structure in place at four levels using a mix of dedicated and existing staff. Performance monitoring based on ten indicators has been implemented in the state.
- DBT and Adhar linked payment systems are in place in state, but delay of 2-4 months for RCH incentives and huge delays for NVBDCP and RNTCP related incentives were reported.
- State officials reported that state supports enrolment of ASHAs in ANM/GNM course since 2013 but ASHAs were found to be unaware of this provision.
- ASHA rest rooms were found in one PHC in one district, but was not in place in district hospital.
- Grievance Redressal committees have been formed at district level, with a toll free no. (104) but ASHAs met were not aware about it.
- ASHA functionality was found to be good, in services of ANC, PNC, institutional delivery and HBNC.
- State has introduced universal screening of non communicable diseases in 9 districts and so far 1115 ASHAs have been trained on NCD module.
- VHSNCs have not been given training in recent years. VHSNCs were found involved in organization of maternal and child health programmes and control of communicable diseases. Weekly "Friday is dry day", in which VHSNC members go house to and request for emptying of stored/stagnant water are organized.
- RKSs were in place across facilities, and have the two structures of Governing Body (meet twice in year) and Executive committee (meet 3-4 times in year). Fund flows for untied funds were found regular.

- RKS were found to be pooling additional resources from user fee from APL families, earnings from Arogya Shree Health Insurance Scheme, CSR fund for improving the hospital facilities, MP/MLA Local Area Development Fund and District Hospital Strengthening Project.
- Significant involvement of PRIs in health system was seen. Standing committee of District Panchayat on Health and family welfare reviews the plan and implement of PIP in the district, and District Panchayat's Chief Executive officer is chairperson of DHS and also reviews all maternal deaths of the district.
- Strong convergence was seen between ASHA, ANM & AWW in community level activities, and in active role of DWCD dept and Education dept. in RBSK programme.

UTTARAKHAND

- ASHAs were found to be empowered, motivated, knowledgeable and committed to their work.
- Rural ASHA caters to a population of 500 in hilly areas and 1,000 in plains while urban ASHA caters to 1,000-2,500 population.
- Replenishment of paracetamol, iron, calcium and zinc have not been done since last 2 years. No mechanism in place for timely replenishment.
- No systematic mechanism for addressing grievances of ASHAs was noted in both the districts.
- ASHA rest rooms were available and ASHA help desks staffed by ASHAs were formed in some of the facilities visited in both the districts.
- As per State government order, ASHAs are to be given a fixed incentive of ₹ 5,000/- per year and ₹ 2,000/- per month . During field interaction only few ASHAs reported receiving the fixed incentive of ₹ 5,000/- while most ASHAs have neither received the annual fixed incentive nor the monthly fixed incentive till date.
- Linkage of ASHAs bank accounts with AADHAR has been completed and payments are made through electronic transfers yet delays of around 7-9 months were reported in Champawat district.
- Around 15,296 VHSNCs have been reconstituted in 2013; with ward member as the chairperson and ASHA as member secretary. About 374 VHSNCs have been trained about one and half years back.
- VHSNC plays an active role in supporting frontline workers; and during monthly meetings discussions on issues of water and sanitation are generally held.
- Around 69% of the untied VHSNC fund was utilized in the FY 2016-17 while the districts are yet to receive the budget for FY 2017-18. Untied funds are being spent on purchasing chairs or for 'Dolis' which are used to carry pregnant women/elderly patients in hilly areas.
- Around 750 MAS are constituted with ASHA as member secretary and ANM as joint signatory; but the process of formation of MAS is not community based. About 250 MAS have been trained and bank accounts have been opened. Funds for 150 bank accounts of MAS have been utilized while for 100 bank accounts the funds remain unutilized. At present, there is no linkage with ULBs.
- Functioning of *Chikitsa Prabandhan Samiti* (*or Rogi Kalyan Samiti)* was fairly good in both the district. Most of the RKS funds at one of the visited CHC was being spent on purchase of equipment and medicine.
- Around 95 Jan Samvad/Sunwais at block level and 10 at district level were conducted in FY 2016-17 while these have not been conducted so far in FY 2017-18.
- Involvement of PRIs in the VHSNC, RKS and District Health Society was noted and convergence with water and sanitation department was also reported.
- Vishakha guidelines are not yet implemented.

UTTAR PRADESH

- ASHAs were found to be articulate, confident and fulfill health-related expectations of the

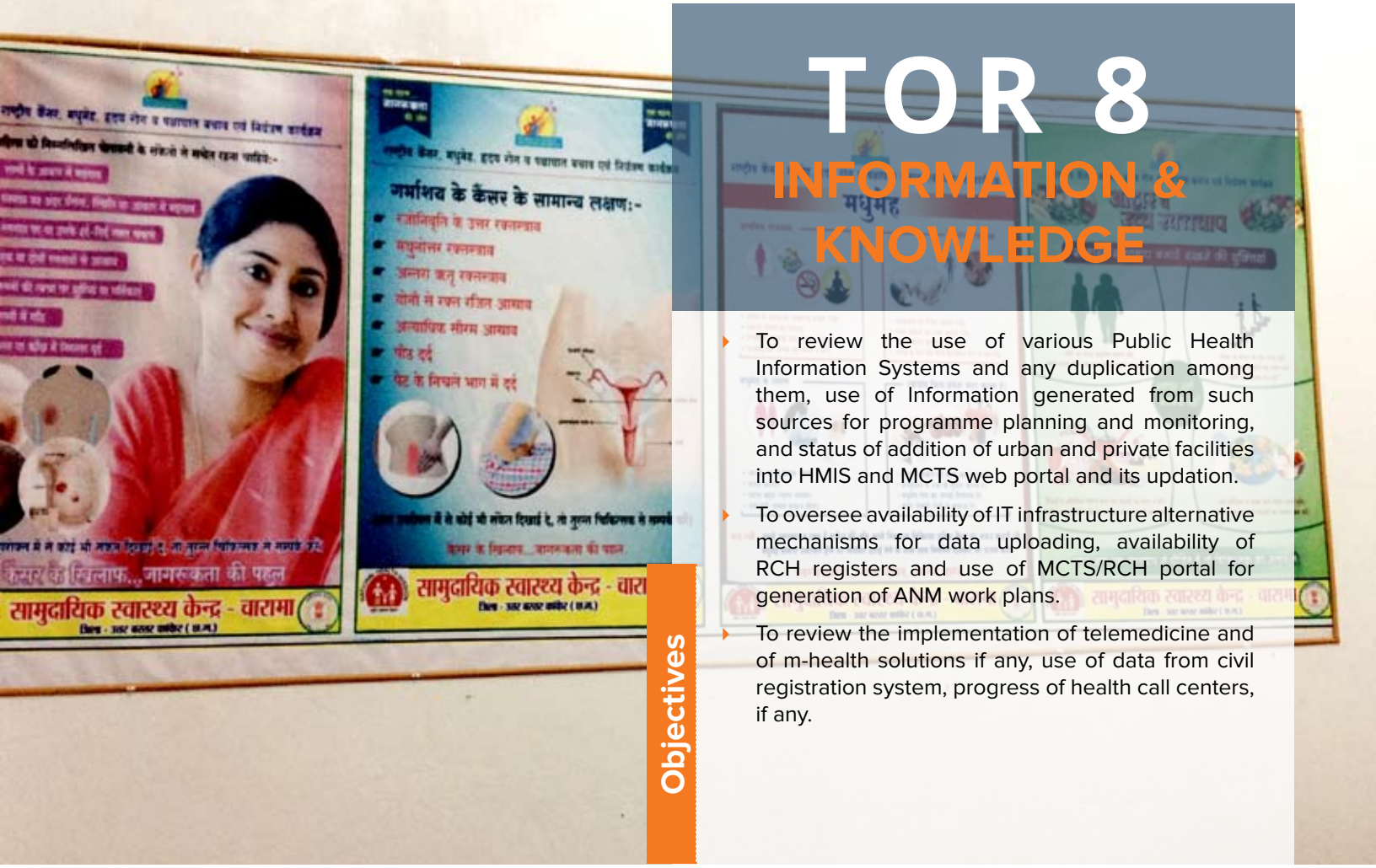
community members. However, they were unable to reach out to the entire population due to multiple responsibilities, time constraints and lack of motivation.

- On an average, the ASHAs spend about 4-7 hours per day on her work; and in addition to this, they are also engaged in performing household chores and agricultural work.
- Dropouts and attritions of approximately 10% at state level and 3-4% in districts visited was noted.
- Most ASHAs reported receiving timely payment of incentives but some ASHAs met reported delayed payments which were linked with systemic issues in PFMS.
- Grievance redressal mechanism is in place but not functional; with only 1 out of 10 grievances being addressed. Poor reporting of grievances by ASHAs due to fear of higher authorities was reported.
- Although a strong support structure exits for ASHAs through ASHA Sangini, they still require more hand-holding support, training support and supportive supervision.
- ASHAs understanding and knowledge was low on adolescent related health issues and safe abortion practices, gender and rights- based approach, side-effects of various contraceptives and counselling.
- Rest rooms, waiting area or toilet facilities for ASHAs were not available at any level. The only safety measure is the drop back by ambulance but its availability is random as no guidance has been issued.
- Good practices documented were - AAA co-ordination at field level; ASHAs awards and sammelans; ASHA Sangini application in Kaushambi and provision of bicycles to ASHA Sangini.
- Integration of various IT platforms like supportive supervision app, HBNC app, m sakhi and ASHA Sangini app has been undertaken.
- Lack of proper awareness about social welfare schemes was noted among ASHAs.
- At the district hospital levels, one committee has been formed but the health personnel did not have understanding about Vishakha guidelines.
- Re-constitution of VHSNCs has been completed in Kaushambi while formation of VHSNC at revenue village level is still pending in Kanpur Dehat. Lack of capacity within the members is reported primarily due to lack of training thus most VHSNCs are non-functional and meetings are irregular.
- RKS have been formed at the higher facility levels at district and CHC. Irregular meetings, unkept records and minutes of meetings were reported.
- Rogi Kalyan Desk at the district hospital and provides support to the patients and visitors.
- CAH process is functional in 12 districts but it has not been not initiated in Kaushambi district.

WEST BENGAL

- Shortfall of 20% ASHAs at state level against the set target with 10% shortfall in Dakshin Dinajpur and 12% in PaschimMedinipur was noted. In addition lack of adequate representation of SC/ST in ASHA selection was reported. High attrition rate lading to 7.61% shortfall of ASHAs was reported.
- HBNC equipment like digital watch and weighing scale were non-functional in some areas.
- ASHAs are provided with a mix of monetary and non-monetary incentives. State has recently enhanced the state incentive from ₹ 1500 to ₹ 2000 pm.
- Weekly live radio talk show for ASHAs is broadcasted to disseminate newer guidelines.
- Grievance redressal mechanism is yet to be fully established in the state/district; although formed 2 years ago in D Dinajpur district, it is currently non-functional. In P Medinipur district, grievance boxes were observed in health facilities, but processes of redressal were not clear.

- Incentive Performance Entry Tool has been implemented to monitor ASHA's performance by analyzing ASHA incentives and activities conducted by the ASHAs. Based on the reports, every month top 10 and bottom 10 ASHAs are listed for field verification.
- In urban areas, state has recently co-opted the existing HHWs (Honorary Health Workers) as urban ASHAs. Currently there are 5444 workers against target of 6058. The HHWs have been working since last 15-17 years and are responsible for 700-800 population each. They receive fixed honorarium of ₹ 3125/- and performance based incentives as ASHAs.
- Strong monitoring and programme review mechanism exists at the district/block/sub-centre level with support and guidance from State.
- VHSNC are functioning under Panchayat & Rural Development department. No coordination observed at the field level between VHSNCs and health department. ASHAs are not involved in the VHSNC activities.
- In D Dinajpur, there are 91 functional MAS against target of 120 while in P Medinipur 404 MAS have been formed in 3 Municipality areas but no MAS has been formed under Kolkata Municipal Corporation.
- MAS are involved in community mobilization, referral, preventive and promotive care, improving access to identified health facilities and management of grants received.
- In both districts, RKS is functional with periodic meetings. RKS members were mainly hospital staff, few PRI members and community members with no NGO/CSO representation.
- RKS received funding in D. Dinajpur from untied funds and RSBY and Swasthya Saathi reimbursements. The funds obtained from reimbursement of insurance claims are largely being spent of drugs and outsourcing of diagnostics.
- Convergent mechanisms were observed to be good between ICDS and Health Department
- Training of health service providers on issues related to gender is yet to be initiated in the state. Protocols for medico-legal care for survivors of sexual violence were not observed at the health facilities. Implementation of VISHAKHA guideline and functionality of gender centres as 'one stop crisis centres' has not been done.



TOR 8

INFORMATION & KNOWLEDGE

Objectives

- To review the use of various Public Health Information Systems and any duplication among them, use of Information generated from such sources for programme planning and monitoring, and status of addition of urban and private facilities into HMIS and MCTS web portal and its updation.
- To oversee availability of IT infrastructure alternative mechanisms for data uploading, availability of RCH registers and use of MCTS/RCH portal for generation of ANM work plans.
- To review the implementation of telemedicine and of m-health solutions if any, use of data from civil registration system, progress of health call centers, if any.

National Overview

The national HMIS is a national portal which provides timely reliable health information at each level of management at the right time, in the right form and covers qualitative and quantitative information that can help in decision making to aid provision of better health care services to the Indian people.

HMIS has been implemented in all States and UTs to provide information on the function and service at 2,15,984 health care facilities. However, 2,05,691(95%) facilities are reporting on HMIS portal across India.

Various other Information Technology initiatives have been implemented, such as MCTS/RCH portal, ANMOL, E- raktkosh, E-Aushadi and Mera Aspataal to have the information remotely for transparency and accountability.

Key Findings

- Facility wise reporting on Health Management Information Systems (HMIS) has stabilized in most health facilities (above 90%) in CRM States/UTs, except for Haryana (72%) and Nagaland (71%).
- On the MCTS/RCH portal around 99.5% districts, 96% health blocks, 88% health facilities other than Sub Health Centres (SHCs) and 94% SHCs; are reporting data in MCTS. However completeness, correctness and timely updating of records (HMIS, MCTS) in Assam, Karnataka, Uttarakhand, Maharashtra and Haryana remain concerns.

Supporting structures (Registers, infrastructure, internet connectivity)

- Jharkhand, Uttarakhand, Bihar and Nagaland reported a lack of standardized registers, training and orientation on handling technology, poor internet connectivity and inconsistent power supply.
- Adequate availability of RCH registers was reported from most states. However, data discrepancies between recording registers and HMIS/MCTS/RCH portal was an issue almost all states. Bihar, Chhattisgarh, Karnataka, Uttarakhand, Maharashtra, Nagaland, and Uttar Pradesh felt that there needs to be more clarity and refresher training for data quality and analysis for decision making. However, in Uttarakhand, MCTS data is used to upgrade health facilities in areas with high home deliveries. Further, MCTS data is being monitored at State level in Uttarakhand with special focus on the districts having worst sex ratio at birth. Uttarakhand is planning to fetch data from MCTS for pregnant women having two daughters and focus on them.
- Multiple registers are being maintained under various programmes, such as FP, RKSK, Delivery register, Stock register, Immunization, lab register, Line listing. ASHAs and ANM spend 5-6 hours completing the registers.

RCH Portal

- Delay in identification and service provision has been a major hurdle in achieving above goals. In view of this, innovative RCH portal has been designed so as to achieve early registration and timely provision of services to all potential beneficiaries. RCH portal is partially operationalised in states visited such as Nagaland, Odisha these states have started uploading the data on RCH portal but not fully operationalised in states such as Bihar, Assam, and Uttarakhand). However, Uttar Pradesh is in the process of collecting data in revised format for RCH portal.

Capacity Building

- Capacity building on HMIS, MCTS, RCH portal is needed. Most of the States were not aware the new data elements and the training needs. The knowledge and data analysis by the staff found lacking in the states of Bihar, Karnataka, Uttarakhand, Uttar Pradesh, Odisha, State like Chhattisgarh and Meghalaya have conducted HMIS training on new elements.
- National Identification Number to Health Facilities of India (NIN-to-HFI) was initiated in Bihar and Uttar Pradesh.

Multiple e-Initiatives

- 'Mera Aspataal'- (My Hospital) application is an IT based feedback system to collect information on patients' level of satisfaction using a multi-channel approach viz. Short Message Service (SMS), Outbound Dialing (OBD), Web Portal, and Mobile Application. This application has been implemented only in Karnataka and Uttar Pradesh.
- e–Raktkosh is a biometric Donor Management System for identifying, tracking and blocking donors based on donor's health, donation history. A centralized Blood Inventory Management System for keeping track of the blood stock across numerous blood banks. This application has been implemented only in Uttar Pradesh and Uttarakhand.

- KILKARI provides the awareness among pregnant women, parents and health workers on the importance of ante and post-natal care, institutional delivery and immunization, right from the second trimester of pregnancy, till the child is one-year-old. This application was functional only in Haryana of the all the CRM visited States. In Uttarakhand, awareness of Kilkari is lacking although the State is covered under Kilkari, this results is low uptake of Kilkari. Karnataka is using the 104 vatslyavani app in place of kilkari.
- ANMOL- training has started in Chhattisgarh

Multiple e-initiatives, including health information and logistics management softwares, were being used in CRM States. Some of these include – NIN-TO- HFI and EVIN (Bihar), e-kalyani and EVIN (in Chhattisgarh), e- Arogya, e-Hospital and e-laj clinics (in Karnataka), NIN (in Uttar Pradesh), Health advice call centre (in Maharashtra), e UPCHAR (in Haryana). Many of these softwares work in silos and are often not interoperable.

Key Constraints

Structural

- Lack of infrastructural facilities for storage and maintenance of records

Procedural

- Excessive information
- Incomplete, unreliable and intentionally managed information
- Inappropriate forms/cards and reports
- Absence of feedback and monitoring

Human Resource

- Absence or lack of profession trained person
- Lack of motivation and extra incentives
- Staff Nurses/medical officer are collecting and preparing data

Technological

- Manual paper-based system (Formats)
- Lack of internet connectivity

Recommendations

- As now there is data reporting, a boost for IT systems to be used as a tools for action rather as tools for data reporting is required, progressing to Public Health Informatics.
- The distribution of specific printed registers is essential at all the facilities. Latest HMIS formats need to be available to all the health facilities.
- Training in the new HMIS formats is required at the SC and PHC level.
- State, District, Block level Monitoring and supervisory visits to be conducted on regular

basis. Random check of data from registers should be performed at regular intervals.

- Ensure data quality before and after uploading of HMIS data. It is suggested that facility in-charge should countersign the hard copy of uploaded HIMS data.
- In place of Multiple IT system one integrated system should be explored.
- Use of information is lacking in states. All Programme managers should ensure that HMIS data is reviewed on monthly basis and optimal feedback is given to the peripheral staff about quality of data and performance of health facility. Culture of use of information needs to be built into the system.
- IEC for Kilkari and Mobile Academy should be carried out. MOs I/c should regularly review the progress of Kilkari and Mobile Academy and take steps to address the gaps. ASHAs may be encouraged to complete the Mobile Academy course and awarded certificates when they complete the course.

State Findings

ASSAM

- While HMIS data updation was timely, the updated data did not match the register entries.
- The new RCH register format is not being used and the formats used are variable across facilities. Registers should also be in local language.
- The OPD registers are a decade old and does not capture all the required information.
- The HMIS staff were found trained for data entry but not well conversant about the utility of use of unique id, use of data, work plan generation. The BPMs need to be actively involved in briefing and mobilizing this process.
- Assam has established Sarathi 104 – Health Information Help Line. Sarathi 104 is a one stop Health Information Helpline for resolving all health-related issues of the citizens of Assam in a time bound manner.
- State also has a MCTS Call centre since 2013-14. However, there are delays in resolving complaints and as on 30th September, 2017, action is pending on 96% of 108 complaints (75% related to ASHAs, 80% JSSK and JSY, 83% about MAMTAs, 85% of complaints on medicines).

BIHAR

- The list of various portals for NHM functioning in the state Bihar, are HMIS Health Management Information System, RCH Portal, DHIS2, HRIS, SANJIVANI, Supportive Supervision, RBSK, PMSMA, E Aushadi, NIKSHAY, National Identification Number to Health Facilities of India (NIN-to-HFI).
- All 38 districts of state Bihar are regularly reporting facility wise data on HMIS portal. The data reporting status of MIS monthly formats, which comprises of service delivery items is 98.54% while the data reporting status of Infrastructure annual formats is 64.10%. All NUHM approved cities are mapped under HMIS portal and the data reporting was apparently upto 98%.

Other IT Systems

- Online OPD registration through SANJIVANI is being used at all district hospitals, sub-district hospitals, referral hospitals and primary health centres in the state. Patients are registerd under the SANJIVANI system and their details like mobile number, Adhar number are maintained for future correspondence. Roster of MOICs, OPD performance is monitored and reviewed on regular basis. Integration of SANJIVANI with Mera Aspataal application has been done.
- An MoU has been signed between BMSICL, Patna and CDAC, Noida for e-Aushadhi (DVDMS) and the software is being customized as per state needs.

CHHATTISGARH

- Chhattisgarh has multiple state-driven and GOI-driven information systems, across all the

facilities. All the government health facilities are maintain registers, HMIS and e-mahtari (Mother and child tracking) systems.

- Register at the facilities still need to be updated according to new data elements of HMIS All the health facilities in Chhattisgarh have reported data in HMIS during 2016-17, though accuracy of data is a key issue.
- e-Mahatari Software, the state equivalent to National MCTS, is running at all the health facilities across districts in the State. Awareness about the system was found to be quite good at the facility level. State plans to shift on RCH portal in a months' time. Training of all the concerned officials is complete.
- There are four call centres working at 102, 104, 108 and 1099 number for health department in Chhattisgarh. It is centrally managed and monitored at the State level at Raipur, through multiple setups. Ambulances are placed at each of the Block level. ("102" is to get ambulance services for pregnant women, "104" is for Medical Advice to people to get all information related to health, follow up of registered women in e-Mahatari, "108" for emergency ambulance services. Some patients interviewed, reported having to wait for the ambulance due to unavailability. "1099" is a toll-free number for transportation for the dead.
- Central IT application such as RCH, Mera Aaspatal, Kilkari software were not functional at the CRM visited districts.
- Training on ANMOL has been provided to ANM of two blocks Dhamtari & Kurud. However, the RCH portal has not been launched in the State.
- Electronics Vaccine Intelligence Network (eVIN) is being rolled-out in the field. All the Cold Chain Handlers are found to be trained on updating the vaccine stock on eVIN via mobile phones, all the vaccine stock, vaccine distribution and temperature log books were updated and well maintained and remote temperature loggers are installed. However, the data updation is delayed from the health facilities due to a poor mobile network.
- State has developed 37 IT applications for its various requirements and four mobile based applications. Some of these information systems are Ministry driven while most of it is state specific as per need identified by the State Health System List of IT based Applications in Chhattisgarh.
- Monitoring Applications being used for Health facility mapping and Programme monitoring are the Hospital Reporting System, Supportive supervision monitoring system, Private hospital reporting, Monitoring of court cases, Epidemic Reporting system, Maternal death report, VHSC fixed day services and Jeevan deep.
- Services Applications are the e-Mahatari mother and child tracking system (equivalent to the MCTS), Blood Bank Management system, Blood Storage Management System, First Referral Unit, Nursing home act, PCPNDT, Mukhyamantri Baal Hriday Suraksha Yojana Mukhyamantri Baal Shravan Yojana, Sanjavini sahayta kosh and E-kalayani.

KARNATAKA

- In Karnataka, 12,298 health institutions upload onto the HMIS National web portal, on a monthly basis. Facility wise data is available from August 2010. Training at District level is nearly complete, and 60% at block level of a total of 716 batches.
- In Karnataka, the health worker identifies the pregnant women in her area and issues the Mother Card. After issuing Mother Card, the details of the pregnant woman are filled by the health worker, the information sheet then detached from the card and sent to concerned health facility for entry into MCTS portal. Health worker receives regular SMS, from MCTS portal (Server) to follow up the pregnant woman and provide the services that are due to her. Soon after delivery, child part is detached from Mother card and sent to concerned health facility for entry into MCTS portal. The health worker receives SMS from MCTS portal to follow up the child and provide the immunization services. This application was recognized in the international forum and awarded the "Top 11 in 2011 innovators challenge award"

Other IT initiatives

- e-Arogya is an Android Tablet based application for digitalizing the work process of ANMs and ASHA workers who are part of Rural Healthcare echo system.
- e-Hospital is an open source health information management system (HMIS) which is configurable and easily customizable with multi-tenancy support. It is designed to deploy within a cloud infrastructure to manage multiple hospitals seamlessly.
- e-Laj Clinics has three interconnected workstations in the e-Laj system, which includes Registration, Medical Consultation and Diagnostics.
- Registration – Demographic details and vital parameters (blood pressure, pulse, blood sugar, weight and pulse oximetry) recorded with the help of a Multiple Parameter Monitoring (MPM) device and stored.
- Doctor – Symptom-based prescription for diagnostics/medicines and diagnosis.
- Diagnostics – More than 30 tests performed for comprehensive primary healthcare.
- M-Clinic is a mobile application for Register, Consultation, Attendance, Inventory and Account.
- Aushada (iSCMS) Software computerizes the supply chain management system at KSDLWS, 26 district drug warehouses and 2742 Health institution all across Karnataka.
- Karnataka Telemedicine System is a concept of digital health care and is expanding in Karnataka. The Department of Health and Family Welfare, Government of Karnataka, has recently launched a new initiative titled “Primary Health Centre Management Information System” in 1000 selected Primary Healthcare Centre(PHCs).
- The state has implemented teleradiology through Karnataka State Electronics Development Corporation Ltd (KEONIDS) in nine hospitals and will be extended to remaining hospitals by the end of this year. This improves patient care by allowing radiologists to provide services without actually having to be at the location of the patient.

ODISHA

- HMIS is being updated regularly but missing data is still a major issue. The transition from old to new format contributes to this issue.
- MCTS/RCH training of district & block level officials and use of data in monitoring and evaluation of RCH programme require attention. Peer education by well-performing BDO/.
- Electronic Tablets have been procured and will be distributed to ANMs. SIM Cards are provided.
- ASHAs have been registered for the Mobile academy but none of them have yet started with their training.

UTTAR PRADESH

- The State extensively uses applications developed by MoHFW such as HMIS, MCTS, NIKSHAY and PFMS. Use of PFMS for all financial transactions has resulted in transparency and reduced grievances.
- IT based activities like m-Sehat by State Innovations in Family Planning Services Project Agency (SIFPSA) to convert ASHA VHIR into a mobile app is a good initiative taken by State, but needs regular review, monitoring, training and follow-up to ensure effective implementation.
- At district level major IT applications are only used for reporting data rather than for monitoring and analysis of data for healthcare decision making in respective programmes.
- MCTS records do not reach to data entry operators on time leading to delay in feeding of the data. Mismatch between physical and electronic data was also observed. Completeness of reporting in MCTS is another major issue and ANMs and ASHAs need more handholding support to effectively report quality data in MCTS Portal.
- Induction training to new DEOs is yet to be initiated.
- Manual drug stock registers are used in drug stores and they do not present true picture about availability of drugs in the stores.

- Internet connectivity was not found satisfactory in some of the facilities visited in both districts.
- Remuneration of DEO (outsourced) is very minimum, resulting in lack of motivation and affects data entry and reporting.
- Participation of private facilities for data reporting under TB and Leprosy is very minimal.
- The training and capacity building of IA/DEOs on the reports available on the portal and their usage, is needed.
- For the use of SAS WRS, the State has been provided with 3 WRS user ID's but only 1 is being used at the State level. It is suggested that training should be given to the district officials on WRS for regular monitoring of data through customized reports and graphical representations. It was suggested by state that if possible, district specific project monitoring data may also be saved in WRS for analysis.

MCTS/RCH Portal

- The RCH register is available at all rural facilities and work plans are generated on regular basis with the help of MCTS portal. However, the work plans are generated in English, which are not helpful for the ANMs. The MCTS beneficiary ID number is not being entered in labour room register/MCP card at many facilities. MCTS is functional in all districts and data is entered by MCTS operator at CHC/BPHC and above level from registers of ANMs, though MCTS reporting is low in several blocks.

UTTARAKHAND

- In Uttarakhand, MCTS data is used to upgrade health facilities in areas with high home-based deliveries. MCTS data is used to track the districts which have the worst sex ratio at birth. Uttarakhand plans to fetch data from MCTS for pregnant women having two daughters and focus on them.
- Though covered under Kilkari, it has low uptake and awareness in Uttarakhand.
- 99% of the active sub centres, PHC, CHCs and DHs reported on HMIS portal during April 2017-September 2017.
- Most of the CHCs are not eligible for CHC rating, as they do not fulfil the mandatory criteria of infrastructure and HR.
- MCTS data is being used for monitoring due services. ANMs are called in batches of up to 6 in PHC/CHC. However, approximately 20% Sub centres are not reporting data related to pregnant women whereas approximately 3% blocks and 36% sub centres are not reporting child data. Further only 59.47% pregnant women and 39.83% children were registered in FY 2017-18 till October.
- As per information provided by State officials, 8,320 of 10,929 ASHAs have completed the Mobile Academy course and 7,465 of them have been awarded certificates. The urban ASHAs are however, not aware about the Mobile Academy.
- 104 Integrated Call Centre is operational in the State. This call centre has contributed significantly in validating mobile numbers of ANMs and ASHAs. This call centre is being used in pro-actively to inform ANMs and ASHAs about due services. Report is being shared with concerned divisions. Further, this call centre is being used for checking whether RBSK teams visited schools, as per submitted work plan. This call centre has facility for RKSK counselling.
- PFMS has been implemented for ASHAs and contractual employees. However, payments are delayed due to data migration issues from MCTS and problems with cooperative banks.
- State has launched tele- radiology which covers 32 out of the 65 DHs, CHC. X-ray, CT scan an MRI and mammography will be made available which would help in cutting down the cost of diagnosis and treatment.

WEST BENGAL

- Health Management Information System (HMIS) Data flow mechanisms with timelines for reporting across rural & urban areas have been established. 98% of facilities reporting monthly basis MCH & DH/RH data (for reporting facilities – facility wise) is uploaded on HMIS portal.

- The RCH Portal has been rolled out in late 2016 and all 10,357 SCs reporting are entered on the portal regularly. RCH Registers have been printed and distributed to all Sub centres. In 2016-17, 95% of mother and 88% children were registered. As on Sept' 2017, 83% of mother and 67% of child has been registered in the new portal on pro rata basis.
- The State has its own Store Management Information System (SMIS) to procure, indent, track & monitor, receipts & bill payment, distribution and demand generation for drugs, equipment, OHCs and consumables. The CMOHs, MCH, DH, SDH & SGH are the procuring agency under SMIS. Stock maintenance and online indenting is maintained up to PHC level. Facility wise EDL has been developed & disseminated.
- Hospital Management Information System exists at MCH & DH & SSH level for patient enrolment, admission and IPD discharge, although full alignment with HMIS portal is still to be done (in P. Medinipur only).
- The e-prescription module is yet to be initiated in either District.
- The 'Nikshay' theMIS for DCP portal needs strengthening and there is a backlog of data entry in the new TB formats at the RH/BPHC level.
- Mobile based daily reporting was noted for MMU (P. Medinipur) but no m-health/e-health apps were in use. Kilkari, ANMOL have not been initiated in the State. Kayakalp programme has just been initiated but is not a part of the HMIS portal. Dedicated phone numbers exist for 'Nischay Yan', ambulance services, however, there is no dedicated call centre for this initiative nor for counselling information provision, grievance redress, managing emergencies. At State level, discussions regarding such initiatives are being held. Telemedicine was restricted to Tele-ophthalmology in three districts.

Institutions for knowledge creation, translation and dissemination:

- There is no SHSRC in the state. However, on discussion State officials revealed that SHSRC was established in 2004 with the support of DFID. Later, when funding was withdrawn the SHSRC could not be sustained. Research on various aspects of health systems and NHM has not been undertaken.

MEGHALAYA

- It was remarkable that the state of Meghalaya was reporting through the Health Management Information System despite many challenges like no internet connectivity at facility level and manual transportation of all the filled formats to the data entry point and back to the facility.
- The state has made an attempt to connect all the facilities with internet via VSAT but this was not active at the block level in peripheral areas at most times.
- Facility wise formats are filled and submitted to the Block Data Manager who validates and enters these data into HMIS while data entry in RCH portal is outsourced.
- Uploading into HMIS database is done at District Level after validation and verification by DDM. These data are received, consolidated and further validated at state-level by HMIS consultant.
- New formats of HMIS are being practiced for each facility. HMIS formats are found to be signed by facility in-charge. Facility staff including ANMs is aware about HMIS and RCH formats however the usage of data/information from this portal in monitoring and planning at facility level is almost nil.
- In many cases the data from primary registers did not match with the data given in the HMIS report at South Garo Hills.

MAHARASHTRA

- In State currently 100% facilities are reporting data on HMIS portal.
- All the facilities are reporting on time in the monthly New HMIS formats. Reporting in corporation need to be strengthened.

- As per HMIS data, most of the Urban Health facilities are mapped and all are reporting on HMIS portal.
- Work plans have not been generated at the facilities and not found at the RI and ANCs sessions in the field. However the manual due-list of beneficiaries were available with ASHAs.
- Despite the training conducted for district and block level staff, Civil hospital (Parbhani) lacked knowledge about the new data elements added in the monthly HMIS formats.
- District Health Information System (DHIS-2) is an internal software in Maharashtra State. In 2016-17, all the facilities were uploading their service delivery performance in DHIS-2 based on HMIS formats and after downloading it from DHIS-2; the data was uploaded for all the facilities on Government of India HMIS portal. Now from 2017-18, state has started the direct entry in Government of India HMIS portal.
- The RCH portal and RCH registers were available in most of the visited facilities but there was huge backlog in RCH portal data entry. The ANMs and data entry operators have not been trained properly in data entry for the RCH portal. As a result, work plans, line list have not been used for provisions of quality services to beneficiaries and report for monitoring work.
- Role of m-health/e-Health in generating knowledge for action.
- A telemedicine facility is utilized from last 4 year for the continuing medical education (CME) and video Conferencing of the department at Civil hospitals, Parbhani and in the past two months, this facility was utilized for the prisoners for taking health opinion from the central jail and Wardha.
- E-Aushadhi application is being used for management of drugs and vaccines stocks. PFMS is being used for making payments including JSY payments. CRS software of Registrar General of India is being used to generate birth and death certificates in most of the facilities. Evidence based planning has been reported by using HMIS/RCH data for situation analysis, preparing PIPs, planning, monitoring and decision making.
- There are total 20 e-Health systems is utilizing in the state for easy data generation including HMIS, RCH Portal, IDSP, SNCU, MEMS, CRS, PFMS, HRMS, RNTCP and Biometric Attendance etc.
- New Initiatives include the Health Advice Call Center which is a Unique innovative project of NHM, Govt of Maharashtra. It is a 22-seated project (24/7) (10 seats health advice+ 6 Grievance +2 Adolescent health +2 blood cell + 2 Mental Health). Under this scheme advice is given to caller who dials toll free number “104” from any landline or any mobile network phone. Advice is given 24/7 for quick action in epidemic outbreak, disaster, natural calamities and major accidents. It also provides live specialists advice by a pediatrician, gynecologist, surgeon, physician and Public Health Specialist (PSM).
- HMIS E-sushrut (e hospital) project has an MoU signed with CDAC on March, 2013 for two hospitals namely District hospital, Raigad and RRH, Nashik. This includes the complete system integration to computerize all the activities in hospitals. It is expected that CDAC will complete system integration and 2 hospitals will start using software by March 2018. CDAC will continue to support for training and running of software for next 18 months after go live of the software as FMS will be given by CDAC at both the hospitals. Then expansion to remaining 25 hospitals will be started.
- Pilot project of RCH Portal data entry in Bharanati Block, Pune is an initiative to complete the RCH portal entry on pilot basis in Pune. They hired an agency to do the data entry in RCH portal on per entry payment basis.
- It will also save the ANM time for data entry and will get more time to do her technical work. Learning from the experience of data will be utilized before outsourcing data entry in all districts in state.

NAGALAND

- Integrated RCH Portal training is complete and Districts are ready with data as per new formats.
- Data is not being analysed/used for performance monitoring, service delivery, and supportive supervision that was observed during the visit.
- There are no telemedicine, e-initiatives or m-Health initiatives in the state.
- Difficult terrain, lack of physical connectivity, inadequate network of phone and internet in the both districts. Available IT infrastructure is also not being utilized because of poor connectivity.
- For MCTS data entry mobiles are provided to ANMs but they are not able to enter data due to network problem.
- The facility of uploading the information in HMIS and MCTS is not available below the District level.

HARYANA

- The state has operationalised multiple e-initiatives to improve service delivery as well to have a robust e-monitoring mechanism. Key initiative among these includes Integrated HMIS system on DHIS-2 platform, E- UPCHAR, Anemia Tracking Module (ATM), Maternal Death and Infant Death Reporting System (MIDRS), supportive supervision software and Human Resources Information System (HRIS).
- Incomplete data records related to symptoms and diagnosis, primarily due to lack of dedicated staff assigned for data/information entry.
- At the facility visited, the data entry was being done by MBBS interns, who are sporadic and engaged for short assignment periods, reducing accountability.
- Another major challenge is the server capacity to upload heavy diagnostic files which often results in reduced functionality of the system.

TOR9
HEALTHCARE FINANCING

Objectives

- To review the status of fund release and utilization against the approved activities and financial allocation to High Priority Districts (HPDs).
- To oversee fund flow mechanisms and implementation of Public Financial Management System.
- To review adequacy and effectiveness of finance management, utilization of untied funds and adoption of differential financing.
- To examine compliance of statutory matters.
- To document measures taken by the Public facilities to reduce the Out of Pocket Expenditures (OOPE).

National Overview

From its inception in 2005-06 to March 2017 about ₹ 1.5511 Lakh Crore has been released under National Health Mission by the Union Ministry of Health. Sound financial management is a critical input for decision-making and programme success. Accurate and timely financial information provides a basis for informed decisions about the programme, fund release and assists in reducing delays for smooth programme implementation. States have been encouraged to build effective financial management capabilities, which are critical for ensuring that programme implementation does not suffer. To provide additional flexibility to the RKS to prioritize need-based expenditure and to obviate the cumbersome process of transfer and accounting of three separate small amounts of untied funds, the untied grants provided to facilities as Untied Grant, RKS corpus Grant and Annual Maintenance Grant were pooled into a single untied grant to the facility. A provision was also made for differential financing to allow for responsive allocation to facilities based on caseloads, fund utilization, and range of services. To address high OOPE, NHM has been supporting many interventions including the provision of free essential drugs and diagnostics, free ambulance services, and JSSK entitlements, which include free blood services besides, free diet, drugs, transportation and blood services.

Key Findings

Key findings emerging out of various CRM States reports are as follows:

- The issue of shortage in finance and accounts staff seems to be resolved in most of the states visited. This could be seen as a major

11. National Health Mission, State wise progress as on 30.06.2016, Ministry of Health and Family Welfare, Government of India

achievement as the issue was highlighted in all the previous CRM reports. However, it is still a challenge for Chhattisgarh, Uttarakhand and Uttar Pradesh.

- Certain good practices observed during the CRM visits which could be implemented in other states are: simultaneous release of central and state share under NHM to the SHS in Chhattisgarh; a mandatory test on financial guidelines and Government Financial Rules (GFR) for all the Finance staff to ensure thorough knowledge of all rules and regulations in Assam; use of a new software called ASHA-Soft payments of ASHA incentives, which helps in accurate identification of activity wise incentives and implementation of a group health insurance scheme for all the contractual staff working for various state departments in West Bengal.

- Most of the CRM States visited have put systems in place for electronic fund transfers barring States like West Bengal, Manipur, Meghalaya and Nagaland. This system has helped the states in ensuring faster fund transfer to the beneficiaries and has eliminated certain malpractices.

- All the states visited have successfully implemented Public Financial Management System (PFMS) leading to a better financial management system that facilitates real time monitoring and reporting of expenditures under the various flexible pools under National Health Mission.

- However, the progress of implementation of PFMS in different states is at varied stages. States such as Odisha and Punjab have completed 100% agency registration followed by Jharkhand with 95%, Maharashtra with 94%, Bihar with 90%, UP with 87%, Meghalaya with 81%. Overall implementation of PFMS in West Bengal is reported to be unsatisfactory throughout all the facilities, as only 68% agencies have been registered under the PFMS portal with pendency at District and below level.

- As far as transfer of fund through PFMS portal is concerned, in states such as Bihar, Chhattisgarh, Haryana, and Karnataka all the funds are being transferred from the State to the Districts and District to Sub District Level through PFMS.

- Household Out of Pocket Expenditures (OOPE) still remains a major concern. Despite implementation of various schemes such as free drugs and diagnostics in government hospitals, instances of high OOPE were reported in most of the states visited. Patient/beneficiary interactions during state visits show high OOPE on drugs for chronic diseases such as diabetes and hypertension in Assam and Uttar Pradesh; on diagnostics and lab tests in Telangana and Uttar Pradesh; OOPE by JSSK beneficiaries in Nagaland and informal payments to hospital staff for patient care and transportation in Uttar Pradesh.

- Delay in transfer of funds from State treasury to State Health Societies (SHS) continues to be a major problem for most states visited. Delays of 20-21 days in Odisha, 30-33 days in Jharkhand and Chhattisgarh, 30-45 days in Telangana, 60 days in Bihar, 65-164 days in Karnataka, 31-238 days in Punjab, 50-100 days in West Bengal, 90-100 days in Uttar Pradesh, and 256 days in Maharashtra were noted.

- The dissemination of 'district RoPs' was reported only in few States such as Assam, Chhattisgarh, Jharkhand, Maharashtra, Uttarakhand and Punjab. In the absence of district RoPs fund allocation to the lower facilities becomes difficult and leads to delay in fund transfers, which ultimately leads to lower utilization of funds by CHCs and PHCs. Utilization of funds was reported low in the first two quarters of FY 2017-18 in most of the states visited.

- Fund utilization was particularly low under NUHM and NCD programs. Uttarakhand has reported the lowest utilization of funds amongst the CRM States under CD and NCD programs.

- States such as Bihar, Chhattisgarh, Meghalaya and Telangana were found to have allocated additional funds (at least 30% per capita) for HPDs; the remaining States, except Uttarakhand have either allocated additional funds/additional (but not following the norms) or have allocated based on utilization in the previous years.

- As regards untied grants, despite the issue of guidelines for differential allocation of untied grants, none of the CRM states have reported adoption of differential Financing of untied grants. Poor utilization of untied grants is still an area of concern.
- Non-compliance with statutory obligations also seems to be a prominent issue in many states. Bihar, Maharashtra and West Bengal were the only states that have complied with all the statutory obligations. The statutory Audits for 2016-17 were observed to complete in most CRM States but the final report were still awaited. However, compliance with concurrent audit was found to be poor across all the states.
- Amongst the 16 States visited during CRM, none of the state reports have commented or collected information on measures undertaken by the States to reduce OOPE and on state health insurance programs. The state reports of Assam, Punjab, and West Bengal have mentioned the names of health insurance schemes functional in the states.

Recommendations

- States should ensure timely release of funds from Treasury to the State Health Society Accounts along with the State share for effective utilization of funds. Similarly, the SHS should also release funds to District Health Societies (DHS) in a timely manner.
- States should ensure timely dissemination of RoPs and District Health Action Plans for better planning, rational allocation and timely release of funds.
- States need to ensure that the flexibility in the diversion of funds between pools is used only when it is necessary and not make it a regular practice by ensuring better planning and use of resources. Further, diverted funds should be settled within the same financial year and permanent diversion of funds should be strictly avoided.
- States should adhere to the banking guidelines prescribed by the MoHFW and implement it at the state and district level and not carry out transactions through a single account.
- States have to address the issue of bank integration and ensure synchronization to avoid transaction delays.
- The Northeastern States and Hilly States should liaise with Nationalized banks to increase the number of branches in areas with no banking facilities.
- The States facing problems in Internet connectivity should also liaise with the concerned Government departments to address the issue.
- Settlement of long-standing advances and unspent balances needs to be addressed by States to avoid differences between the balances shown in books of district and sub-district level accounts.
- The states should ensure higher allocations to High Priority Districts as per the GoI norms.
- In order to address high OOPE, States should strengthen the implementation of programs such as free Drugs and Diagnostic Schemes and the JSSK scheme.
- Other recommendations including those that were made in the 9th and 10th CRM and have not been addressed by most States and require immediate attention are:
  - The recruitments of finance personnel and accountants positions need to be completed at the district level on a priority basis to ensure bookkeeping and better management of funds.
  - States need to examine regularly the areas and reasons for under utilization of funds and provide supportive supervision for making corrective actions for better utilization of funds.
  - States need to address delays in transfer of funds under JSY, JSSK such that the benefits reach target groups on time and also make timely payments to staff and ASHA incentives.
  - Capacity building on PFMS training is essential for accounts staff at the district and block levels for expenditure ling and MIS reporting through PFMS.

State Findings

ASSAM

- The mandatory test of all finance Staff in financial guidelines and GFR is an excellent idea which needs to be promoted across States as this is a weak area for most State Finance HR.
- However, there are multiple bank accounts at the facility level which needs to be rationalized.
- Maintenance of records was found to be meticulous at every level.
- There is no system in place for making payments to the migratory population who do not have bank accounts.
- In Assam, registration of societies is required to be renewed every three years. Some of the RKS registrations are due for renewal.
- There are multiple bank accounts at the facility level and consequently; there are multiple audits of each account. A government order has been issued for a merger of RKS and User Charges accounts but is yet to be implemented across State.
- An analysis of staffing and workload revealed that most of the transactions at Block and PHC are routine in nature.
- Approximately 24% of funds are locked up as Bank/Cash Balance and Advances to vendors.
- District RoP/approval details were not shared below the district therefore blocks and PHCs do not have any clarity about annual funds allocation.
- A high proportion of cash/bank reserves at PHC level (55% of available funds). The cash/bank reserves at DHS level are low (around 2% of available funds).
- Drugs for diabetes and hypertension are insufficient in government supplies and people have to purchase it from the market.
- Rashtriya Swasthya Bima Yojana (RSBY) was not being implemented for the current year. However, Atal Amrit Abhayan (Tertiary care scheme) was operational.
- The State has undertaken a novel initiative of putting all Finance staff through a mandatory test in financial guidelines and GFR.

BIHAR

- The state health society is allocating untied funds to the districts on the basis of their fund absorption capacity in the previous year.
- There are 10 'HPD' districts in Bihar and State has allocated more than 30% funds to the HPDs.
- About 90% of the agencies are registered and remaining registrations are pending due to the duplicity of agencies in PFMS. Incentives to beneficiaries and ASHAs are paid through PFMS irrespective of the status of linkage to Aadhaar card. However, payments are pending due to the insufficiency of funds with the DHS.
- Payments at all levels are made through PFMS after generating PPA. However few border areas have not implemented PFMS due to poor Internet connectivity. EAT (Expenditure, Advance, and Transfer) Module also has been adopted in the state.
- The cashbook maintenance at District level is not satisfactory.
- At block level 7-8 bank accounts are operated, which is not allowed as per the GoI guidelines. Duplication of work observed due to lack of reporting data in PFMS. Integration of accounts could solve this problem.
- Training of trainers of PFMS not conducted due to unavailability of resource persons.
- The State takes about 60 days to transfer funds from the treasury to SHS bank account and the District takes 10-15 days to transfer funds to the block.
- The pace of expenditure is very low due to lack of programme awareness.
- User charges are deposited to the RKS accounts for which a separate cashbook is maintained. These funds are used for the benefit of patients after approval from the RKS.

- All Statutory compliances are made.
- All accounts are operated by dual signatory one of them is a regular employee.
- There is no inoperative account at district and State.
- There is no practice of giving advances after implementation of PFMS.

CHHATTISGARH

- The state is currently facing a shortage of Accounts personnel. At SPMU level, out of 25 sanctioned finance and accounts posts, 11 are vacant. DHS Dhamtari and CHC, Berhampur Block also has some vacant positions.
- It takes around 33 days for the State to release NHM funds from treasury to SHS account. The Treasury has transferred all the funds (except ₹ 17.95 crore) to the State Health Society (SHS).
- During the current financial year, funds up to 75% (Rs.379.87 crore) of the Central allocation (Rs.565.46 crore) are already released to the State under all the Flexi-pools of NHM.
- It was reported that the SHS disseminates District ROPs to all the Districts and the same was confirmed in Dhamtari and Bijapur districts.
- Inoperative bank accounts are still being maintained at the State level where approximately ₹ 5.43 lakh is lying.
- The prescribed accounting practices are not being followed in the maintenance of cash register.
- Accounts of NHM and non-NHM funds were found to be maintained together and also reflected in the SFP of 2016-17 (DHS Dhamtari).
- Permanent diversion of funds from one pool to the other was also observed. No efforts for recouping the funds to the original pool were reported.
- The issue of payments through cheques due to facility accounts in Gramin (Rural - Cooperative) banks still persists in the State. JDS, Kurud, is one such case reported during the visit.
- All payments (DBT, non-DBT payments) and expenditure filing up to Sub-Centre level are being done through PFMS.
- Good utilization of funds in the first two quarters of the current financial year was observed (Dhamtari - 39% and Bijapur - 42% respectively).
- Higher allocation to High Priority Districts (HPDs) was observed and reported.
- Discrepancies in auditory obligations were observed and reported.
- Action Taken Report on the Statutory Audit for FY 2015-16 was furnished.
- Statutory Audit Report for the Financial Year 2016-17 was submitted in the month of November 2017 after a delay of more than three months.
- Concurrent Audit Reports of the districts have not yet been reviewed by the State.
- There has been no audit of JDS DH Dhamtari for the last two years.
- Concurrent Audit of facilities in Bijapur has been conducted up to September 2017.
- Non-preparation of Bank Reconciliation Statement (BRS) is the most common observation made in all the audit reports.
- The State Health Society receives both Central and State share simultaneously from the Treasury.

HARYANA

- Financial management system including maintenance of Books of Accounts and control records is functioning well. However, certain discrepancies were observed:
  - Holding/not disseminating RoPS to the Districts to provide scheme-wise & Head-wise budget allocation,
  - Renewal of SKS registration,
  - Age-wise advance registers not being maintained at DHS, CHC and PHC level,

- Inappropriate utilization of untied funds/ Annual Maintenance Grants/RKS/SKS grants,
- Blocked or unutilized funds lying for long duration, and
- Inconsistency in reporting formats used at District Health Society, CHC, and PHC in both districts was observed.

- Books of account maintained both manually and electronically and were authenticated by the signing authorities at DHS Bhiwani and Gurugram.
- Implementation of Public Finance Monitoring Systems (PFMS) up to PHC level.
- Timely payment of ASHA incentives and staff salaries by both the DHS.
- Both districts (Gurugram & Bhiwani) facing problem of Internet connectivity for implementing PFMS system at CHC and PHC level.
- Bank Reconciliation Statements are prepared at all level.
- Program and activity wise funds monitoring at District and State Level was observed.
- In some cases, money was not credited to the beneficiary accounts even though it was debited from the facility account. It appears that this amount was parked with the banks for a long time.

JHARKHAND

- Transfer of funds from Treasury to SHS takes at least a month.
- GIA for all Pools in FY 2017-18 (Rs. 335.00 Crore) not withdrawn from PI account/Treasury along with the proportionate State share.
- Higher Financial allocation to High Priority Districts was not observed.
- No directions/training given at District/Block level for Optimum utilization of Funds.
- Low utilization of funds in the first two quarters (i.e. till September 2017).
- A major portion of Untied Fund is parked at CHC, PHC and SC level and released in full without deducting old balance.
- Around 6.86 times increase in outstanding advances. No appropriate action for settlement of these Advances.
- Delay in the payment to ASHAs and the JSY beneficiaries was observed at East Singhbum and Pakur blocks and at the Sadar Hospital.
- Some IRS Payments for NVBDCP are pending for last one year.
- The National disease control programmes are currently running on loans from the major pool. This is due to paucity of Programme funds at all levels as the corresponding State share not being released since 2012-13.
- Distribution of LLIN Kits was pending as the Treasury did not release funds for transportation.
- DREs were disseminated through email (only) to Districts at DAM level.
- The state does not apply differential financing method for fund allocation, instead releases lump-sum grants for the whole year.
- PFMS is implemented at all levels. Approximately 95% of Agencies are registered. However, Only 50% of the transactions are PFMS based. Some of the beneficiary accounts are currently in 'Co-operative Banks' where PFMS support is likely to be hampered.
- Large numbers of the operative/Non- operative bank Accounts related to HMS/RKS/old banks were not mapped to agencies in PFMS at District level.
- No action was taken on observations of Concurrent Audit Report for March 2017 in East Singhbum. At the State level, adherence to Statutory Rules of Income Tax Act was observed.
- Noncompliance with TDS for third-party payments and delay in depositing TDS amounts deducted from staff remuneration was also observed.

KARNATAKA

- All sanctioned posts are duly filled up to the sub-district level except the vacant post of State Accounts Manager (SAM). Block Accounts Managers (appointed for financial monitoring below the block level) posted at all 176 blocks. But it was observed that the BAMs did not possess required skills resulting in poor financial monitoring.
- The Districts booked low expenditures during 'April to August 2017', because of lack of clarity regarding spending on ongoing activities as the DHAP was disseminated only in August 2017.
- Books of Accounts have not been maintained as per the guidelines. Multi-column cashbook is in practice even after the necessary instruction issued from the State and District level for maintenance of account books as per guidelines. The Books were also not updated and signed.
- Below the taluk level, books of accounts maintained by paramedical and other staff on an incentive basis. However, at some centres other staffs posted in nearby facilities were maintaining the books of accounts resulting in a delay in updating of records.
- The staff at District and State level was not observed to be working in integration despite the integration of Societies.
- SHS, DHSs and Arogya Raksha Samitis (state equivalent of RKS) have been registered. Meetings have been conducted on regular basis at almost all the facilities visited.
- State Health Budget enhanced by only 7%, State Share pendency is nearly 6% and the 1st tranche of funds is yet to be received from State Treasury. Therefore, MoHFW is unable to release the 2nd tranche of funds.
- All payments (DBT and Non-DBT) from State Health Society to DHS and from DHS to the periphery are made through PFMS software without any reported delays. EAT (Expenditure, Advance, and Transfer) module is followed in the state.
- A delay of Avg. 65-164 days has been observed in the F.Y. 2016-17 and 2017-18 from State Treasury to State Health Society Bank Account.
- The state is providing 30% higher salary to Doctors and Specialists serving in the High Priority Districts but not in terms of overall higher allocation to the HPDs in comparison to Non-HPDs.
- There is no utilization reported under NCD pool (Except Mental Health Programme) as on 30.09.2017 in Chitradurga District.
- Some discrepancies in audit obligations were observed. There was a delay in appointment of Auditors for concurrent audits. Even after the appointment in October 2017, the Concurrent Audit hasn't been initiated.
- State Nodal officer for National Health Account (NHA) is yet to be appointed. The State has planned to implement it through Karnataka State Health System Resource Centre.
- The state is using ASHA soft for paying ASHA incentives. The software helps in accurate identification of activity wise incentives.

MAHARASHTRA

- The State has circulated District PIP and releases for the F.Y. 2017-18 to both the districts of Parbhani and Wardha.
- At DHS level books of accounts are updated regularly and Tally is used for the account. However, some discrepancies with respect to bookkeeping were observed; separate ledger books or Tally not being maintained for each programme, books of records for all Programmes are being maintained in one manual cashbook.
- Public Financial Management System (PFMS) has been implemented at DHS and up to Block level. 100% registration of agencies completed in both the Districts.
- All JSY, ASHA incentives, and vendor payments are processed through PFMS in both Districts. No delay in payments of JSY and ASHA incentive was observed in both the districts.

- The overall utilization of fund under NHM for FY 2016-17 has decreased compared to 2015-16. Poor fund utilization under NDCPs, NCD and NUHM were observed. Very low utilization of fund under HSS, NDCPs, NCDs and NUHM up to the 2nd quarter of 2017-18.
- Grant-in-aid for 2016-17 (Rs. 93.62 crores) under RCH & HSS have not been released by State Treasury (delay by 256 days). Delay in fund transfer from PHCs to Sub-Centres was also observed.
- Tally ERP 9 Accounting software is implemented at the Block level. However, it is not functioning at all CHCs. Also, there is no procedure in place for knowing the current position of bank balances of the programmes where Tally software is not used.
- Large number of cash transactions happening at PHC level as highlighted in the Statutory Audit report 2016-17 and concurrent audit of 1st and 2nd quarter of 2017-18,
- Physical progress against the financial achievement was not reported in FMR at District level. At PHC level the FMR & SFP were not maintained in the prescribed GoI format.
- Banking Guidelines prescribed by Ministry not followed at District level. Non-NHM funds are also kept with NHM funds.
- TDS is deducted from most of the payments at SDH and CHC level but it is not deposited in-time to the Government Treasury. The returns file is also not maintained timely.
- Differential financing not used at District level for disbursing RKS/Untied/AMG funds.
- Public Financial Management System (PFMS) is implemented in the State only up to CHC level (92% agencies registered) because the accountants posted at PHCs are not trained.
- Timely compliance with all the auditory obligations reported.
- The Government does not charge user fees at District, CHC & PHC level.

MANIPUR

- The state health society has not received any funds under RCH Flexible Pool and Health System Strengthening in FY 2017-18 for not fulfilling the conditionalities linked to funding release.
- As per the ROP (Aug 2017) an unspent balance of 107 crores is blocked at different levels which includes ₹ 24 Cr in the treasury, ₹ 12 Cr at the level of District Health Societies, ₹ 8 Cr at the level of Block Health Societies, 59 Cr with the implementing agencies and ₹ 4 Cr pending state share for FY 2016-17.
- Out of total release of ₹ 46.64 crore under RCH & HSS in FY 2016-17, ₹ 7.85 crore is still pending with the state treasury.
- The contractual staff under NHM has not received salaries for past 2 months and is reported to be a regular practice in the State. Usually, the delay is of about 3-4 months.
- ASHAs have not received their incentives for a long time (ranging from 2 months to 2 years). This was reported in all the interactions with ASHAs during the field visit.
- Despite the fact that linking of Aadhar to bank accounts is not mandatory, several employees and beneficiaries (holding non-Adhaar ceded bank A/C) have not received salaries/ incentives.
- It was observed that cash payments are still in practice as opposed to DBT in the hilly areas due to non-availability of banks.
- Though the SHS is in a financial crunch, it is not able to optimally utilize the available funds. The SHS could spend only half of the total funds received. This raises serious questions about the state's ability to spend money, points towards poor financial management and also speculates the existence of a financial crisis.
- A typical case of permanent diversion of JSSK funds under the transportation head was observed. The infants treated under JSSK scheme in RIMS hospital, are not provided with free pickup and drop facility, the funds for

transportation are used for buying drugs and diagnostic for the infants. This has been done without seeking approval from MoHFW.

- The SHS is reimbursing the cost of treatment to the JSSK beneficiaries at fixed rates for those services promised to be delivered free of cost at government health facilities under the JSSK scheme. This is done without any approval from MoHFW.
- At present, the payment of approximately 4500 beneficiaries is pending due to non-availability of bank accounts, non-Aadhar linked bank accounts and a paucity of funds.
- The state has reported certain PFMS related issues to the FMG, MoHFW that haven't been addressed for a long time. Some of the issues are critical for the smooth functioning and need to be resolved at the earliest.
- The SHS has not completed its auditory obligations as per the GOI guidelines. The Action Taken Report (ATR) of Statutory Audit review for F.Y. 2015-16 and the Statutory Audit report for FY 2016-17 are still pending. Executive Summaries of concurrent audit reports for FY 2016-17 and for the 1st quarter of FY 2017-18 are yet to be submitted.
- Most of the major issues raised in the statutory audit report of 2015-16 still remain unaddressed.

MEGHALAYA

- Almost all sanctioned posts are duly filled up to the level of District and sub-district level with respect to Finance and Accounts.
- The HPD districts have been receiving more budget than other District.
- State's utilization against the approved PIP for the FY 2017-18 under two major pools of NHM is poor. Utilization under RCH Flexible Pool (Including RI, IPPI, and NIDDCP) is only 10.97% and under Health System Strengthening (HSS) it is 14.33%.
- E-Transfer method is followed for all Expenditures, Advances and Fund Transfers at the State Level and District Level and block level.
- Statutory Audit for the Financial Year 2016-17 is yet to commence. The Audit report along with the Executive Summary and Utilization Certificate will be submitted by end of the year.
- Appointment of Concurrent Auditors for all districts has been decentralized. Till date, only one district has appointed their Concurrent Auditor and the remaining districts are yet to appoint.
- NHM Meghalaya follows a system of Pre VAT payment. For all Supply Work, the office obtains a VAT Challan issued by the Superintendent of Taxes, Shillong after which a full payment is issued to the concerned Vendor.
- Tally Solutions is used only in the SPMU, East Khasi Hills and some place in South Garo Hills. Manual Books at facilities are being maintained but not updated and signed on regular basis.
- The state has not reported physical data along with the financial data in the Financial Monitoring Report (FMR).
- Fixed Asset and stock registers have been maintained but not signed by the custodian and In charge of the facility.
- Bank Reconciliation Statement has been prepared on monthly basis but authorized signatures were not found at some places. BRS not prepared at some places in South Garo Hills.
- The State has registered 81% of the agencies in PFMS. Expenditure filing (DBT and non-DBT payments) on PFMS portal has been implemented at the State and District Level.
- There is a backlog of ASHA Incentives in spite of State having sufficient fund available. Only 85% ASHAs are having their bank account. Majority of ASHAs are receiving their incentives only once in a quarter.
- JSY payments significantly delayed (more than 6 months in some cases) and erratic in South Garo Hills. In some cases, the payment made through cheque. At some places, there is no facility to open zero balance account.

- The problem of integration of accounts exists at State, districts, and facility level.

NAGALAND

- The state has an adequate number of accounts staff at all levels, except 13 vacant positions of BAMs out of total 56 positions.
- District ROPs are not disseminated leading to disconnect between the approvals and final release of funds to districts.
- Differential financing is not practiced for disbursing RKS/Untied/AMG funds based on performance and utilization pattern.
- The untied funds were mostly used for procuring the stock of medicines/supplies and ambulance maintenance. Thus, the funds are not used for activities to be undertaken through untied funds.
- The delay in fulfillment of conditionalities linked to funding release has in-turn led to a delay in the release of GOI funds. The State received its 1st tranche of GoI funds in September 2017 (about 45 days ago), but the Treasury has not yet released any funds for FY 2017-18 to the SHS.
- The State has failed to fulfill the conditionalities for release of 2nd trance (releasing state share of ₹ 2.72 crores/3% by 31.08.17), therefore the timely release of GoI funds is also affected.
- The State Health Budget has been increased by 4% only compared to the last financial year.
- Poor fund utilization against approvals for FY 2017-18 under RCH Flexi Pool (20%) and HSS (14%).
- Salaries of NHM staff were delayed at all levels and employees under NHM had not received any compensation since August'16.
- E-transfer is available at all levels. However, timely submission of UCs is still a challenge. DBT has not been implemented in both the CRM districts due to lack of banks in the blocks etc.
- The Books are maintained in double entry system up to DHS level along with computerized books in Tally Erp9 software. However, Bank Reconciliation Statements are not prepared at any level except SHS.
- The payments to ASHAs and JSY/JSSK beneficiaries were made through cheque at DH Wokha. However, cheque details were not recorded and the payments could not be tracked. Moreover, the detail of backlog under ASHA and JSY beneficiary not found at DH Wokha.
- The State has not completed its auditory obligations. CAG, Statutory and Concurrent Audit reports have not yet been received.
- The user charges collected by the district hospital are not deposited in any account; instead, the cash is spent directly.
- Out of pocket expenditure on drugs, diagnostics and transport were observed in the districts. JSSK beneficiaries were also observed to be spending on transportation/ambulance due to lack of assured pickup and drop back services.

ODISHA

- There is no system of orientation and training to the accounts staffs at PHC and lower level.
- JSY payments not made due to non-availability of banking facilities in 90 out of 111 Gram Panchayat in District Malkangiri. Payments to ASHAs and beneficiaries of JSY and Family Planning have delayed in District Keonjhar also.
- The Interest earned by the Sub-District level is not accounted in the books of accounts which may cause inappropriate utilization of Funds.
- All funds released under NHM have been transferred from State Treasury to SHS with a maximum delay of 21 Days and 20 days in FY 2016-17 and 2017-18 respectively. However, State share of ₹ 3.80 (i.e. 13.32%) crore is pending against releases till date.
- Poor Financial Management at District Level. There is no monitoring and supervision by the District Accounts Manager (DAM) for Sub District level Financial Management.

Funds are released without considering the unspent balances of the last Financial Year in Malkangiri.

- PHCs are not submitting the FMR/SOE for the utilization of Funds under Untied Fund and unspent balances of Block CHC, PHC, Sub Centres and VHSNCs are not reconciled in Malkangiri.
- The State has registered 100% of the agencies in PFMS and has implemented expenditure filing (DBT and non-DBT payments) on PFMS portal at State and District Level.
- In Malkangiri district the Expenditure reported in FMR did not tally with books of accounts.
- The State has submitted an executive summary of the concurrent audit reports for F.Y. 2016-17. However, the same for the first quarter of 2017-18 is pending.
- Statutory Audit Report for the FY 2016-17 from the State is pending. Therefore Action Taken Report (ATR) of Statutory Audit review for F.Y. 2016-17 not prepared yet.

PUNJAB

- Books of Accounts are well maintained and updated.
- PFMS has been implemented in full up to Block Level. The JSY incentives, salaries of contractual employees and ASHA payments are all being made through PFMS.
- DHAPs have been disseminated to the entire district in accordance with the approved ROP.
- There is a time lag in the transfer of funds from Treasury to the State Health Society in Punjab ranging from 31 days to 238 days during 2016-2017.
- The State has reported negligible expenditure against the approved PIP amount under the heads of Training and Capacity Building (0.11%).
- BRS is not properly maintained by the District levels. A proper BRS is prepared and updated regularly.
- The untied funds released to VHSNCs, SCs, and PHCs were found to be lower than the prescribed norms.
- All facilities have a separate account for user charges and this money is not deposited in the RKS accounts. The funds are mainly used for purchasing drugs.
- PFMS Training is required to all the finance people. 15% of bank accounts of ASHAs/ANMs are not linked to their Aadhar.
- CAG performance Audit review is still pending. The Statutory Audit Report has already been placed before GB up to 2015-2016. The Statutory Auditor has been appointed through an open tender as per the mandate of Government of India.
- The state has completed all tax-related obligations as per the GoI guidelines.
- The State Government of Punjab started cashless health insurance scheme called Bhagat Puran Singh Sehat Bima Yojana for Blue Card Holders (BCH) families in Punjab. Under this scheme, the government provides cashless health insurance up to ₹ 50,000/- per family per year. Accidental death, permanent disabilities, and maternity are also cover under Bhagat Puran Singh Sehat Bima Yojana.

TELANGANA

- Human Resources at state and district level are adequate. However, many accountant positions are vacant at the facility level.
- The transfer of funds from State Treasury to SHS takes 30-45 days via PFMS print payment advice. Further, transfer to DHS and peripheries (through e-transfer) is done within 7-10 days of receiving funds.
- High Priority Districts have received at least 30% more budget per capita as compared to the other districts.
- State Health Society provides untied funds to the districts on the basis of last year expenditure.
- State Health Society, District Health Society, and RKS are registered. However, some RKS

societies did not convene any meeting of the governing body during the year 2017-18.

- The practice of inter programme loans is being followed at State and district level and these loans are adjusted during the year. However, in some cases, settlement of loans is still pending.
- State books expenditure on the basis of monthly FMR received from Districts. Usually, Utilization Certificates are submitted in time, but the SOEs submission is mostly delayed. Daily Cashbook is maintained on the basis of Double Entry system at State and District level.
- State holds monthly financial review meeting and after considering the unspent balances next tranche of the fund is released. However, there are instances where new advances have been given without settling old advances.
- Certain discrepancies in audits were observed. The CAG performance audit was completed but exit conference is yet to be held and no action has been taken on the audit observation. Statutory Audit for FY 2016-17 has been completed in all the Districts but the Audit Report is yet to be compiled at State level. Concurrent Auditor for the FY 2017-18 has not been appointed. RKS audit not being done separately as per NHM guidelines.
- The state has utilized 31.72% of the approved budget under RMNCH Pool During the Financial Year 2017-18. However, the total utilization of 10% was reported under NUHM against the total available funds.
- TDS has not been deducted from salary payments to contractual employees in the Districts as DHSs are not having separate TAN for filing TDS returns.
- Payment to JSY beneficiaries is done through DBT except for few facilities where cheques are still being given. However, all payments under Family Planning Scheme are done through account payee cheques. NHM norms are not being followed for payment to JSY beneficiaries.
- All the operative bank accounts are registered with PFMS at State and District level. The state has started expenditure filing on PFMS. However, there are systemic issues in using PFMS for payment to beneficiaries.
- No user charges are being collected since 2015-16. However, out of pocket expenditure is observed due to unavailability of equipment and diagnostic and laboratory services at facilities across all levels.

UTTARAKHAND

- No block of the districts visited is maintaining books of accounts in a computerized accounting system. Single Entry accounting System is still followed. Delay in the finalization of Books of Accounts was also observed.
- Finalization of Books of Accounts and filing of financial statements for FY 2016-17 are still pending at State level.
- State books expenditure on the basis of monthly FMR received from districts. Usually, UCs and SOEs are not submitted by the facilities in time.
- Executive Committee Meeting is not being conducted on regular basis by the State. The same situation prevails in respect of districts.
- Internal controls and monitoring of the NUHM programme are not being done as per guidelines of NHM.
- Registration of District Health Society of Udham Singh Nagar has not been renewed since 2012. As per norms, it should not be in existence legally.
- Payments to JSY/JSSK beneficiaries and ASHA's incentive were found to be irregular in both the districts visited.
- It was observed that the payment is not credited to the beneficiaries' accounts even though the payment is debited. This amount lies in the parking accounts of the bank for a long time.
- While initiating the payment, the validated beneficiaries are not displayed immediately.

- Aadhaar based payments do not reach the beneficiaries in time. In some of the Aadhaar based payments, the status of Payment in PFMS does not show a successful transaction even though the amount gets credited to the beneficiaries' bank account.
- There is no accounting integration of the Communicable and Non-Communicable Disease Control Programme under NHM.
- Utilization of funds for infrastructure maintenance during FY 2015-16 was high, exceeding 200%. However, utilization of funds for other heads was low, with no utilization under communicable diseases and non-communicable diseases.
- The first tranche for FY 2017-18 has been already released in September and is parked with Treasury since then. The State has reported nil expenditure under Annual increment for all the existing positions, EPF (Employer's contribution) and IEC/BCC NUHM.
- The State has reported negligible expenditure (less than 5%) of the approved PIP under the heads of Training and Capacity Building (0.11%) and very low expenditure under Programme Management (7.01%).
- Tender of recruitment of concurrent auditor has been initialized. However, none of the districts visited has appointed a concurrent auditor since 2014-15.
- Action Taken Report (ATR) for the Statutory Audit Report for FY 2016-17 has not been received from any of the districts visited. Hence, discrepancies, if any, mentioned by the auditor could not be analyzed.
- The audit by AG was conducted in July 2017. However, Udham Singh Nagar has not received Action Taken Report.

UTTAR PRADESH

- Books of account are maintained at DHS Kaushambi and Kanpur Dehat manually as well as electronically and the same are authenticated by the DDOs. Bank Reconciliation Statements are prepared at all level.
- The position of Senior Manager Finance and three audit officers are vacant at the State level. Positions of four DAMs and four DDAAs are vacant at the District level. All the positions of Accountants are vacant at District Hospital and 14 positions of Block Account Managers are vacant at the Block level.
- Major delays have been identified in the transfer of funds from Treasury to the state health society. 207 days in FY 2014-15 and 90 days in FY 2015-16 and 100 days in FY 2016-17. The funds for FY 2017-18 (i.e. ₹ 1982 crore) are still parked in the Treasury.
- The state releases funds activities wise, this delays in funds transfer from DHS to sub-district level. There was fund transferred 34 times under Health System Strengthen and 24 times under RCH flexible Pool.
- No financial management system followed for proper maintenance of Books of Accounts and control records at District Health Society Kaushambi.
- A substantial amount of advances (including District Release) of ₹ 2116 crore is pending for settlement at the State level as on 30-09-2017. Bank balance of ₹ 458.28 crore was also reported as on 08-11-2017. Age wise advance registers were not prepared at DHS and CHC and PHC level.
- Delay in payment to JSY beneficiaries was observed at all levels. There was pendency of 515 cases at District Hospital Kaushambi and 1034 cases at District Hospital Kanpur Dehat.
- Integration of accounts personnel under NUMH and disease control programmes at the DHS, CHC, and PHC level pending in both the districts.
- No proper utilization of untied funds by the HMS/RKS at District/sub-district level facilities. Unspent balances were observed at all VHNSCs and Sub Centres.
- District Health Society, CHC, and PHC at Kaushambi need to maintain same reporting format for FMR and Statement of funds position.

- Implementation of Public Finance Monitoring Systems (PFMS) up to PHC level and has achieved 87% registration under PFMS. District of Kaushambi facing the problem of Internet connectivity for implement the PFMS system at CHC and PHC level.
- Lack of monitoring from State Health Society and District Health Society level for sub-district level units: It was observed by the teams that there is the lack in planning implementation and monitoring due to which there is no proper utilization of funds and no proper documentation of these activities in the field. No tour reports were made available to teams.
- Certain discrepancies w.r.t. auditory obligations were reported. Statutory Audit Report for the FY 2014-15 and 2015-16 are not yet put in the meeting of GB meeting for approval. The concurrent auditors were not provided the detailed Financial observations in the report.
- The state is in process of implementing State health accounts. Finance Controller, Medical Health has been nominated a nodal officer for NHA/State Health Account. No further activity has been initiated under NHA.
- High OOPE on diagnostics (especially on USG, CT & other lab services) at DH and medical college. Informal payments on patient care and transport were widely reported by the beneficiaries. OOPE on drugs was reported to be minimal (only in one or two instances) under MCH. The expenditure was higher for other acute and chronic conditions.
- Community interactions revealed that people were purchasing medicines for chronic diseases (for e.g. Hypertension and diabetes) from private pharmacies due to their unavailability in Government facilities.

WEST BENGAL

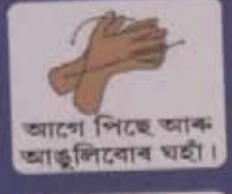
- The State has adequate staff at all levels except at the Block level where 23 out of 80 sanctioned posts are vacant.
- RoPs have not been disseminated to the Districts, though the state has received it in June 2017. However, dissemination of RoP approvals based on expenditure patterns of previous years is practiced.
- The SHS has experienced a delay of 50-100 days in receiving funds from the State Treasury. There is a State share pendency of ₹ 147.19 crore i.e. 5% as on 31.10.2017.
- No pattern followed across the State to allocate 30% additional funds to High priority Districts, however, HPDs get some privileges on activities.
- All DHS in the state (except DHS D. Dinajpur) were found to be registered. RKS and VHSNC's in all the facilities/villages visited were registered. Meetings are being conducted in most of the facilities and minutes have been recorded but the frequency of meetings is not regular.
- At the DH Balurghat of D. Dinajpur District, an RKS bank account and NHM funds are both maintained in the same bank account.
- A Very slow pace of expenditure across the State of West Bengal. The expenditure under CD and NCD programme was reported at 9% and 3% respectively, while nil expenditure was reported under the heads Drug Ware Housing, Other Expenditures, NPPCD and NOHP. The SoE for the programme Infrastructure Maintenance is also pending.
- Under the activity 'Mainstreaming of AYUSH', the incurred expenditure is 341%. The expenditure limit is exceeded from the approved budget.
- The Districts have wrongly reported HR expenditure under RCH as the activity has been shifted to HSS from the FY 2017-18.
- No proper mechanism is adapted to settle the long-standing advances across the State. High-unspent balance lying across the State. Approximately 66% of funds have been parked with the State against the total approved budget of c.f.y. 2017-18; out of which only 33% of utilization reported by the State.
- Further, under the programme NLEP ₹ (-)228.13 crore unspent balance reported in the audited Utilization Certificate of the State.

- In all the facilities visited, cash books have been maintained both in Tally software and manually and were found up to date.
- Bank Reconciliation Statement (BRS) for all the bank accounts have been prepared as on 31.10.2016 at the State and in both the Districts visited.
- RKS for UPHCs not formed, funds kept under the Municipality/Municipal Corporation account maintained by a clerk from the Municipality and not by a NUHM staff.
- PFMS Registration completed for 68% agencies since the accounts of the VHSNC agencies are with co-operative banks. All payments, DBT/ Non-DBT and expenditure filing are currently not happening through PFMS.
- The State has completed all the auditory obligations except a few discrepancies. Compliance with the Programme division observations w.r.t. CAG audit report is still awaited from the State. Statutory Audit Report is yet to be placed before the Governing Body. The gaps highlighted in the concurrent audit report of F.Y. 2016-17 (March'17) are still persisting. A separate RKS Audit not conducted at any facility across the State.
- The State Government has launched a Group Health Insurance Scheme called "Swasthya Sathi" in December 2016. The scheme is intended to benefit the contractual/casual employees of different departments of the Government.
- The Accounts Manager (of Kushmandi Block) has designed a linkage system on excel for quick, error-free data entry and calculation of a large number of vouchers for Free Drugs, Diagnostics, and JSSK Free Referral Transport.

HAND WASHING

TECHNIQUE	MAIN PURPOSE	AGENTS	RESIDUAL EFFECT
Routine hand washing	Cleansing	Non medicated soap	Short
Careful hand washing	Cleansing after patient contact	Non medicated soap	Short
Hygienic hand rub	Disinfection after contamination	Alcohol	Short
Surgical hand disinfection	Pre-operative disinfection	Antibacterial soap Alcoholic solutions	Long

STEPS OF HAND WASHING



Ensure handwashing for 5 minutes before surgical procedures

Please Close the Tap
After Use

TOR 10

QUALITY ASSURANCE

Objectives

- To review the status of implementation of National Quality Assurance Programme in the States/UTs for assessing the improvement in public health system.
- To oversee the status and activeness of the States/ UTs in rolling out of Quality Assurance under NUHM.
- To assess the facility level improvements gained by achievement of the Kayakalp and oversee the sustainability of hygiene promotion in public health sector.
- To review the convergent action undertaken for Swachh Swasth Sarvatra and assess the integration of the MDWS & MoHFW.
- To evaluate the progress made after roll out of Free Drug Service Initiative.

National Overview

In pursuit to ensure provision of safe, accessible and affordable services to every citizen of the nation, MoHFW (GoI) came up with "National Quality Assurance Program" (NQAP) in 2013. The program's foundation lies on framework of "Quality Assurance" which envisages upon the idea of provision of "Quality" services to everyone seeking treatment and care in public health facilities. Provision of quality care will not only improve the outcome indicators but will ultimately enhance the patient satisfaction and their belief on public health system.

Delivery of quality healthcare services is an articulated commitment and priority for the government which is well reflected in latest 'National Health Policy' that has special focus on providing quality health care to every section of the society in the country.

The "Quality Assurance" framework is based on an easy to understand and implement methodology of continual improvement, which consists of assessing the facility on pre-determined standards and checkpoints, followed by gap identification, gap closure, re-assessment, fulfillment of criteria, certification and incentivisation. The whole process is skill and knowledge intensive and hence requires regular capacity building. These national standards are currently available for DHs, CHCs, PHCs and Urban PHCs. Quality Assurance Programme has provision for the national and state level quality certification of health facilities on meeting the predetermined certification criteria.

Since the inception of quality journey of the nation the number of National quality certified facilities has tripled from 13 to 59 in one year (16-17) which

includes 27 District Hospitals, 4 Community Health Center/Sub District Hospital and 28 Primary Health Centres, while there are 286 State certified facilities (67 district hospitals, 64 Community Health Center/ Sub District Hospital and 155 Primary Health Centres) as per NQAP standards. Fifteen states now have certified facilities which can be replicated as successful models at other health facilities.

Dedicated HR as per the operational guidelines and states' requirement has been approved for every state/UTs. Many of the states/UTs have completed the recruitment process while majority of states are still undertaking it. As stated the process of quality assurance is skill based and hence requires continuous capacity building by training to generate a pool of internal and external assessors. In FY 16- 17, total 73 trainings (with cumulative total-268, since 2014) under Programme have been conducted nationwide, resulting into pool creation of 2479 Internal Assessors and 199 External Assessors. Also, various health personnel from public health facilities have enrolled themselves for quality courses which are being offered by premier institutes like TISS, PHFI and ASCI in collaboration with NHSRC.

As per the program's mandate, states have to constitute state level (completed) and district level (majority have been formulated) Quality Assurance Committees. Both the committees should conduct periodic meetings (SQAC – biannual and DQAC- quarterly) to roll out and formulate road map of QA for the state. In comparison to last year baseline assessment as per NQAP standards has been initiated in all states/UTs. Baseline assessment of UPHCs has also been initiated in majority of states (yet to be initiated at Manipur, Meghalaya, etc.).

"Kayakalp" A sub component of NQAP which has rejuvenated the whole public health system, has witnessed tremendous acceptance and appreciation since its inception. Kayakalp award scheme aims; to promote cleanliness, hygiene and infection control practices in public health care facilities; to incentivize and recognize such public healthcare facilities that show exemplary performance in adhering to standard protocols of cleanliness and infection control; to inculcate a culture of ongoing assessment and peer review of performance; to create and share sustainable practices related to improved cleanliness in public health facilities linked to positive health outcomes.

For capacity building of human resource to undertake the assessment and gap closures under Kayakalp 51 trainings have been conducted nationwide. In current FY Twenty five thousands and nine hundred fifty three (25953) facilities were enrolled under Kayakalp out of which 694 facilities are being evaluated as per the criteria for assessment. States and UTs shall be declaring the results by December' 17.

The **'Swachh Swasth Sarvatra'** initiative was launched in 2016 and aims to meet the requirements of two complementary programs namely, 'Swachh Bharat Mission' of the Ministry of Drinking Water and Sanitation and 'Kayakalp' of the Ministry of Health and Family Welfare with an objective to strengthen Community Health Centres in 700 open defecation free blocks across the country. Many of the States/ UTs have initiated the process and have identified the ODF blocks to strengthen CHCs there.

Quality Assurance under National Urban Health Mission (NUHM) The aim of mission is to provide quality primary healthcare services to the urban population, especially the urban poor and other vulnerable sections of society. QA for NUHM was launched in 2015.

Free Drug Service Initiative was initiated in 2014 with an aim to reduce OOPE on drugs and consumables by providing free of cost drugs to the patients who seek treatment in public healthcare facilities. Apart from provision of free drugs, the initiative envisages upon developing a transparent, demand driven, cyclic system from drug procurement till disbursement. It emphasizes upon creating a

Centralized Procurement Body in state, which will ensure procurement, quality testing, storage, disbursement of drugs, grievance redressal and ensuring prescription audits etc. Many states have adopted the FDSI to ensure drugs under EDL to be available free of cost to the patients.

Key Points

Organizational Structure for Quality Assurance

One of the essential necessities to ensure implementation of NQAP is formulation of State (SQAC) and District (DQAC) level Quality Committees and Units. In the consecutive fourth year of program's implementation SQAC have been formulated in every state. However few of the states like Bihar, Karnataka and Manipur are still undergoing the process of formulation of district level committees.

Also, as per the mandate regular meetings should be conducted at both level (state and district), which currently is not taking place specially at the district level. However, States like Maharashtra, Haryana and Uttar Pradesh are holding meetings regularly. It seems the leadership of Programme is being stagnant at state level, for the successful implementation of the Programme it becomes important to create leaders at every level vis a vis district and facility level.

Implementation of Programme is HR intensive and for ensuring desirable implementation of program, states are provisioned to recruit dedicated staff as per the guidelines. States like Bihar, Punjab, Jharkhand and Meghalaya are still lagging in process to fill the vacant positions while; states like Haryana, Uttar Pradesh, Odisha and West Bengal have ample amount of trained staff. Vacant positions and high turnover of dedicated HR inversely affect the program's implementation.

Trainings and Skill Building

Various trainings have been provisioned under NQAP and Kayakalp. In current FY 73 trainings have been undertaken nationwide. Along with this, courses like Post graduate diploma in quality management (in collaboration with TISS and PHFI) and MDP (in collaboration with ASCI) are also conducted. Through these rigorous trainings a trained pool of assessors (Internal and External) has been generated (2479 internal assessors and 199 external assessors). Almost every state has conducted trainings in their respective state.

Assessment and Certification

In comparison to last year, all states (Telangana and Nagaland did assessment in current FY) have initiated the baseline assessment of the facilities and numbers indicate overall improvement in quality scores of states. One of the major concerns is after assessment gap analysis and gap closure. Action planning at state level was found in few states like Punjab and Haryana but no action planning for gap closure was found at almost every other state being visited.

National and State certifications have increased in current FY (286 State and 59 National certified). Significant progress has been made by Haryana, Punjab, Meghalaya and Maharashtra in current FY while West Bengal, Uttar Pradesh, Bihar, Uttarakhand, Manipur, Assam, Jharkhand and Chhattisgarh haven't performed as committed.

Common observation is that progress after assessment/gap analysis is slow in terms of prioritization of gaps, development of action plan and gap closures.

Measures Ensuring Quality Services at Facility

Standard Operating Procedures (SOPs): Facility and department specific SOPs are necessary to ensure quality services. Almost at every visited facility well defined SOP were not found (Manipur and Uttarakhand had no SOP at all). However, many states do have SOPs for labour room, SNCU and infection control (Vis. Assam, Jharkhand) but staff was found not oriented to it. Hence, it becomes imperative to involve the process owners while formulation of SOPs.

Patient grievance redressal (conducting Patient Satisfaction Surveys and integration with "Mera Aspataal")

One of the important parameter that assures provision of quality services is measuring patient satisfaction and addressing their grievances. Through patient satisfaction surveys and "Mera Aspataal" (A simple, and multi-lingual application that captures patient feedback in a very short time on the services received from public hospitals) scores are generated. Also, in-detail analysis provides information about "dissatisfying factors" on which action should be taken by state.

Patient Satisfaction Surveys (PSS) are being done in few of the facilities of Jharkhand, Haryana, Punjab and Karnataka. While no PSS are conducted in Manipur, Maharashtra, Nagaland, Chhattisgarh, Bihar and Odisha. Another common finding was that no analysis and further action planning is done to raise patient satisfaction.

Through **"Mera Aspataal"** at present 1052 health facilities in 25 states and UTs have been enrolled, according to which 76.8% of the patients visiting these hospitals are satisfied with the services provided. The initiative has been initiated in few facilities of Bihar, Chhattisgarh, Haryana etc.

Measurement of Key Performance Indicators (KPI)

Key performance indicators are other criteria which are used to measure efficiency, effectivity, productivity and quality of health services. In comparison to last FY, numbers of facilities capturing these indicators have increased. KPIs are being captured in facilities of Uttar Pradesh, Haryana, Orissa, Uttarakhand, Punjab etc. West Bengal has taken an appreciable initiation by creating an online portal through which KPI are captured. However, one of the important pitfalls is that no action planning is being done using these indicators.

Statutory and Legal Compliance

As per NQAS it is mandatory for a facility to obtain few important approvals or certification. Majorly it was found that compliance to fire safety (NoC from fire department), AERB regulation and in few cases authorisation for BMW (eg. Nagaland) and to PCPNDT (eg. Manipur) was not found.

Bio Medical Waste Management and Infection Control

Bio medical waste management is one of another area which seeks attention nationwide. Undoubtedly few of the facilities of Punjab, Haryana and Maharashtra etc. are abiding to protocols. However, as a general finding the common issues like non-compliance to segregation protocol, no transportation trolley, lack of storage area in facility, non-availability of required supplies (PPE, liners and needle destroyer), no regular transportation of waste from facility to CWTF (especially at the level of PHC and SC), over filled disposal pits and burning of BMW are few of the general findings. Bio medical waste authorization was missing in Nagaland. State of Jharkhand is planning to have their in house incinerators in facilities however it is advised to have more CWTF.

One of another concern is lack of awareness, knowledge and motivation among the staff. Infection control committees have been formulated to oversee and maintain infection control standards however, regular meetings for gap finding and analysis is one of the another concern.

Kayakalp

States have shown tremendous interest in up roll of the program. Due to the initiative complete "Kayakalp" of facilities have taken place. In this FY for capacity building 51 trainings have been conducted nationwide and **Twenty five thousands and nine hundred fifty three (25953) facilities** have been enrolled under Kayakalp out of which **694 facilities** were evaluated as per the criteria in external assessment.

In all states; state and district level Kayakalp committees have been formulated. States are undertaking assessments and shall be declaring the results by December' 17. Till now Assam and Chhattisgarh have declared results in CRM visited states. However, slow progress was observed in Manipur and Bihar.

Swachh Swasth Sarwatra

States have initiated the process of identification of ODF blocks and are getting funds approved for the initiation of program. However, no awareness about Programme was seen at Bihar and Nagaland, also disbursement of funds is taking longer time.

Quality Assurance under NUHM (National Urban Health Mission)

In the financial year 2016-17, baseline assessments as per DLI target were achieved well in time and by the end of financial year it surpassed the set target i.e. 50% of selected UPHCs in defined 15 States. In financial year 2017-18 baseline assessment process is in continuation to achieve target as per DLI-ADB norm for continuation of assessment reports and apply for NQAS certification.

Total of 839 Urban Heath facilities have been assessed till date. 798 selected Urban Heath facilities from 20 states, 33 assessments from Uttar Pradesh & 8 in Gujarat (Total 839); out of which 256 have been carried out by NHSRC, 276 by Technical partners (TISS, IHMR, KHSRC) and rest by the State NUHM Team in State of Bihar, Haryana, Odisha, Karnataka, Delhi, Chhattisgarh, Nagaland, Arunachal Pradesh, Sikkim, Rajasthan, Gujarat & Uttar Pradesh. UPHC Krishnanagar, Gamri, Kurukshetra in the State of Haryana has applied for NQAS External Assessment in the month of August 2017 and shall be undergoing external assessment.

Free Drug Service Initiative

It was observed that states like Assam, Jharkhand, Karnataka, Maharashtra, Odisha, Punjab and Telangana have formally initiated the scheme as reported in visit. Central procurement board is present at Chhattisgarh, Haryana, Jharkhand, Karnataka, Odisha and Telangana. However, Uttar Pradesh, West Bengal, Uttarakhand, Nagaland, Manipur and Meghalaya have yet to centralize the system.

EDL are available at Chhattisgarh, Jharkhand, Haryana, Karnataka, Punjab and Maharashtra. While Bihar, Nagaland and Assam yet have to formulate their facility wise EDL. As a common observation it was found that at very few facilities EDL have been displayed.

IT enabled inventory management and procurement system was available at Chhattisgarh, Jharkhand, Karnataka, Odisha, Punjab and Telangana upto various levels of the health system. It was a common finding that Standard Treatment Guidelines (STGs) were not available at many of the facilities, and if present the clinicians and paramedics were unaware about it. Absence of Prescription audits and grievance redressal were missing in almost all CRM visited states.

Recommendations

Organizational Structure for Quality Assurance

- States should expedite the formulation of DQAC where ever they have not been formed yet. Apart from this they need to operationalize the already constituted state and district quality assurance committees and units.
- As per the mandate biannual meetings at state level and quarterly meetings at district level are necessary to be conducted. The meetings should come up with concrete action plans to

do the gap closures. The state should take an initiative to find and create local leaders (facility wise) who can take up the initiative.

- Recruitment of HR wherever pending should be accelerated to speed up the program's implementation. Also it is recommended that states with ample number of dedicated and trained human resource but showing slow implementation may think of reallocation of duties and facilities. State may also take initiative (eg incetivisation) to reduce the rapid turnover of HR as seen in few states.
- State should regular monitor and mentor available QA HR for Quality Improvement and Certification of Health Facilities. Periodical Field visits by the State QA Unit and trained personal (eg. people with Quality certification from TISS) to district Health Facilities for support & mentoring are required.

Training and Skill Building

- Trainings have been conducted in all the 16 States visited during CRM and the states have huge trained resource which is underutilized at many of the states. States should utilize their trained human resource to train and conduct refreshers trainings at their level. Trained resource should participate in conducting internal assessments and should prepare their facility for certification by striving hard for certification.

Assessment and Certification

- Since the implementation of the NQAP growth has been seen as number of state and national certified facilities have increased tremendously. However, it's been observed that after assessments no action planning for gap closure is undertaken in majority of the facilities. Hence it is recommended that leadership at state should monitor and ensure gap closure with in the set timeline.

Facility wise Standard Operating Procedures (SOPs)

- States should initiate the process of formulation of SOP at state level which may then be modified as per the facility needs. However, it is also recommended to involve the process owners for creation of SOP. Apart from the formulation of SOP trainings and orientation of SOP should be ensured at the facility level.

Patient Grievance Redressal (Conducting Patient Satisfaction Surveys (PSS) and Integration of "Mera Aspataal")

- States should ensure formulation of patient grievance committee at each facility and should ensure periodical conductance of PSS. Apart from this state should expedite the enrollment of facilities with "Mera Aspataal". Also, it becomes equally important to analyze and undertake action to close gaps as per the analysis report.

Measurement of KPI

- State should ensure periodical collection and analysis of facility wise KPI. A facility wise state level monitoring dashboard may also be considered for same (online reporting). After analysis it becomes highly important to take necessary actions for the closure of such gaps.

Statutory and Legal Compliance

- State may expedite the matter of obtaining approval from AERB, NoC from fire department, BMW authorization etc. at state level only.

Bio Medical Waste Management and Infection Control

- State should
- Ensure that each facility should tie up with nearest CWTF or should have proper disposal pits (after proper authorization).
- Ensure proper supply of consumables as required for waste disposal.
- Ensure regular training of staff as per BMW management rules 2016 and for infection control protocols.

- Constitute infection control committees which should monitor the waste management and infection control practices of the facility. Roles and responsibility should be specified to each member of the committee.

Swachh Swasth Sarvatra

- The states are advised to expedite the whole process of selection of Health facilities in ODF declared facilities and disbursement of funds to initiate the process of Kayakalp implementation.

Free Drug Service Initiative (FDSI)

- States where FDSI has not been implemented should adopt the plan to ensure provision of quality free drugs to the patients.
- A centralized procurement body may be constituted to ensure transperancy and uniform system of drug procurement.
- States where facility wise EDL are not present should make and display them in each facility.
- IT enabled inventory and procurement system should be developed in states, preferably till the level of SC.
- If required drug ware houses as per the state's requirement may be constituted at regional, district and facility level.
- State must empanel with lab for quality testing of drugs.
- Patient's grievance redressal forums and prescription audits should also be implemented at states.

State Findings

ASSAM

Quality Assurance

The state has constituted its state quality assurance committee (SQAC) for which it is recommended to hold regular and periodic meetings as only one meeting has been held since its formulation.

Since the initiation of Programme the State has organized, 3-Internal Assessors' Trainings, 2- Service Provider Trainings, 2- NUHM Trainings and 5 Kayakalp Trainings. Through these trainings state has been able to generate a pool of 70 internal assessors and 1 external assessor.

Kayakalp implementation appeared to be adhoc in nature as seen from the condition of a kayakalp winning district hospital defeating the very objective of inculcation of sustained culture of swachhta.

The state has 4 district quality consultants and 17 hospital administrators and is under process of recruitment of state and regional quality consultants.

State reported that three facilities (CH-Nalbari, CH-Goalpara and CH-Diphu) are under process for National certification.

Under NUHM, for current FY 2/38 health facilities have done internal assessment as per NQAS and for Kayakalp as well. U-CHC Pandu in Guwahati has obtained a Kayakalp score of 70.2% with a commendation certificate.

"Mera Aspataal", a platform for patient grievance redressal has not been initiated yet. The State has informed that they are taking it up with NIC and the service shall be functional soon.

The SOPs have been formulated for the limited number of departments like labour room and SNCUs.

For legal and statutory compliance, the facilities are yet to obtain NoC from fire department. Similarly, AERB approval was not present in any of the facilities. It is recommended to expedite the process for closure of such gaps.

Kayakalp

The state has constituted State level Award Committee and District level Award Committee under Kayakalp.

The Kayakalp awards for FY (2016-17) were awarded to 10 DH (1 winner facility, 1 runner-up facility and 8 Commendation awards), 3 SDH/CHC (1 winner facility, 1 runner-up facility and 1 Commendation awards) and 18 PHCs.

In this FY 2017-18, 12 DHs (2 winner and 10 commendation award), 9 CHC (2 winner, 7 commendation award), 22 PHCs and 3 UPHCs will receive the Kayakalp award.

The facilities visited were clean, well-maintained and some of them had herbal gardens and rain water harvesting.

Facilities have taken important steps like constitution of infection control committee, measures for pest control etc.

For BMWM; sharp pit, deep burial pit and solid waste management were available at few of the visited facilities. However, overall status of BMW management was found miserable as segregation and disposal was not being done as per the guidelines.

Under *"Swacchta Hi Seva"* campaign, all the health facilities of Nalbari and in few of dist. Goalpara; initiatives like VHSNC meetings, cleanliness drive, awareness drives regarding usage of toilets, hygiene, vector control, trainings on biomedical waste management, cleaning of water tanks etc. have been undertaken. BPHC Agia- Golaghat received 3rd prize for their work in *"Swacchta Hi Seva"*.

Swachh Swasth Sarvatra

State has proposed health facility, Lakwa CHC at Sivsagar district for Swachh Swasth Sarvatra but no activities has been initiated yet.

Free drug Service initiative

State has ensured availability of most of the drugs free of cost and has constituted a central procurement body (AMSCL).

However, State needs to prepare facility wise EDL. Currently three categories of drugs namely; primary (149), secondary (262) and tertiary care drugs (441) are available. The number of free drugs has been increased from 238 to 407 (Total 731 as per dosage form/strength/packing).

Drug dispensing is a critical weak link in the chain with no mechanism that ensures supply till the end user. It is recommended to make the process IT-enabled till end user.

Currently, there is no grievance redresssal mechanism. State needs to put proper and effective grievance redressal mechanism to address this.

BIHAR

Quality Assurance

State Quality Assurance Committee (SQAC) and Regional Quality Assurance Committee (RQAC), a subordinate of SQAC and supportive unit for District Quality Assurance Committee (DQAC) are in place since 2015. The state is strongly recommended to hold regular and periodic meetings at both state and district level.

The State has one dedicated nodal officer who is supported by one consultant to undertake the QA work. For district level; 1-consultant and 01-program assistant were approved per district. The state has initiated the recruitment process for the same. State has a trained pool of internal assessors (70) and external assessors (03), however this trained pool of assessors is grossly underutilized.

In comparison to last year, state has done internal assessment of 25 health facilities (15 DH, 05 SDH, CHC & 05 PHC) as per NQAS standards. It was reported that state shall be nominating 2 health facilities (DH Motihari–East Champaran & PHC Simri–Buxar) for national certification this year.

It was found that no NQAS initiative has been taken up at district Bhojpur and no internal assessor was also there at district level. However, it was also found health facilities of Bhojpur hold monthly facility level quality improvement committee meeting to identify the gaps (An activity initiated by CARE India from 2016) about which the state officials were unaware.

State should conduct regular refresher trainings, as on interaction knowledge of few of the service providers was found weak pertaining to Quality Assurance protocols, Kayakalp and Swachh Swasth Sarwatra.

Cleanliness & Hygiene of critical areas (Labour Room, OT, PNC Ward etc.) of district hospital in both the district was found unsatisfactory. Also, limited knowledge of infection control protocols was found among health staff (Nursing & Paramedical).

There is no infection control committee at any level particularly in DHs.

36 DHs are integrated with *"Mera Aspataal",* while at other facilities no system for grievance redressal was found.

Awareness about BMW rules among facility staff is very limited which was evident from the prevailing practices which were highly unsatisfactory.

Bihar has outsourced five important services (housekeeping, laundry, security, diet and electricity backup (Generator Set)) which have got some positive impact on quality of services. However, there was lack of supervision and monitoring of these services, also huge disparity for utilization of funds was also observed.

Under NUHM, no monitoring/supportive visits have been conducted by SQAU to urban health facilities. Baseline assessment of 71 UPHCs (38 by NHSRC fellows & 33 by State NUHM model) and two trainings for UPHCs staff has been conducted.

Kayakalp

In 2016-17 all health facilities were covered under this initiative; 04 DH, 01 CHC and 01 PHC (from each district, except Bhojpur & East Champaran) were awarded. Award money of both years has been sanctioned to the concerned district.

It was found that no consultation or workshop on Kayakalp has been held at districts level, as a result knowledge about the Programme with district health functionaries was found very poor.

In current FY all the facilities of both the visited districts have done their internal assessment while peer assessment has been done for District Hospital- Madhepura, which scored 63%, but there was no planning for gap closure was available at the facility.

Free Drug Service Initiative

Bihar Medical Services & Infrastructure Corporation (BMSICL) has been established by the Govt of Bihar with an objective to expedite procurement and distribution of drugs and equipment for all establishments.

Facility wise Essential Drug List has not been developed yet.

There is huge shortage of drugs and patients reported spending money on drugs even for entitlements under JSSK (as seen in Bhojpur).

The condition of drug warehouses was unsatisfactory; improper ventilation, no racking system, no quarantine area and no rodent/pest control were few of the startling findings.

State need to make whole drug indenting and dispensing sytem IT- enabled.

CHHATTISGARH

Quality Assurance

The state has constituted their SQAC and DQAC, though regular meetings are not taking place.

At the state level QA positions (2/3) are in place, Divisional level QA consultant (1/4) and (0/4) office assistant are in place and at the district level, out of 27 sanctioned post of district hospital/quality manager, 23 posts are in position.

One Service Provider (1/4) and 2 Internal Assessor training has been completed under NQAS in the State.

In comparison to last year in this FY, external assessment for quality certification at State level has been done for 4 DHs, 1 CH and 3 CHCs (while baseline assessment has been done for 5 DH and 17 Civil Hospital and CHC). Nomination of these health facilities for national level quality certification would be done in current year as committed by the state.

Hospital cleanliness management and infection control committees are formed for which regular meetings are held. Both these committees have also been formulated at SDH, CHC and PHC level in District Dhamtari.

Standard Operating Procedures were unavailable in most of the facilities; also the awareness and adherence to it at the facility level was inadequate.

State need to take important steps to ensure important things like calibration of equipments, AMC, internal and external calibration of labs etc.

State has circulated guidelines for patient grievance redressal system, however it is yet to be implemented.

Compliance to infection control practices (sterilization and disinfection) are lacking. Segregation and disposal of biomedical waste is not done according to GOI guidelines. Training of staff and ensuring regular supply of consumables is recommended to state.

Under QA for NUHM, all the UPHC (36) have been assessed and out of them 8 Urban PHCs in the State have been recommended for external quality assessment.

Kayakalp

The Kayakalp awards for FY (2016-17) were awarded to 5 DH (1 winner facility, 1 runner-up facility and 3 Commendation awards), 11 CHC (1 winner facility, 1 runner-up facility and 9 Commendation awards) and 15 PHCs.

In the FY 2017-18- a total 812 Facilities (DHs - 22, SDHs - 7, CHCs-132, PHCs 630, & UPHCs – 21) were undertaken and awards were given to 4 DH (1 Winner, 1 Runner-Up, 1 Consistency and 1 Commendation Award), 22 CHC's (1 Winner, 1 Runner Up and 20 Commendation Awards), 62 PHC's (1 Winner, 1 Runner Up and 60 Commendation Award) and 6 UPHC's (1 Winner, 1 Runner Up, 1 Consistency and 3 Commendation Award).

PHC Keregoan, and PHC Chhatoth in Dhamtari District, were found to be very ideal in terms of cleanliness and hygiene maintenance and can be developed as model PHC in the country.

Swachh Swasth Sarvatra

14 CHC located in ODF blocks were granted ₹ 10 lakh per CHC to strengthen the initiative. However, Out of 14 CHC which received the fund, 5 CHCs have not utilized the fund yet.

Free Drug Service Initiative

Drug Procurement is done through a central procurement agency, Chhattisgarh Medical Services Corporation (CGMSC).

IT enabled procurement & inventory management system has been developed by the state through an agency - Broad Line System. However, there is scope to upgrade online indenting system and percolate it down till SC.

Essential Drug List (EDL) is present, but has not been displayed at the facilities. EDL is periodically reviewed as per the requirements. Out of the 673 drugs existing in EDL only about 150 to 200 drugs were available.

Local purchase is done in case of non-availability of essential drugs and laboratory consumables. Jeevan Deep Samiti (RKS) funds are used for local purchase with approval of committee.

Standard treatment guidelines (STGs) have been developed by state health department however service providers are not aware of them.

Irrational use of Antibiotics is found in all the facilities when prescription audits were done.

Drug warehouses are well maintained. Proper racking system (alphabetical order) was in place.

CGMSC ensures Quality Assurance of Drugs through 4 NABL accredited labs – samples from Drug Warehouses are sent for checking.

HARYANA

Quality Assurance

State has constituted its State Quality Assurance Committee, State Quality Assurance Unit and District Quality Assurance teams. Regular meetings are undertaken to plan the road map of quality assurance in state.

There are 2 trained State QA/PH Consultants and 31 trained Quality Consultants/Managers working at district level.

A total of 328 facilities were taken up for assessment as per NQAS out of which 56 have been 'state assessed' and assessment for National certification has been done for 10 facilities (4 District hospitals & 6 PHCs) so far. Out of these, 3 DHs and 5 PHCs have been certified as per NQAP by the Government of India in FY 2017-18.

Under NUHM out of 94 functional UPHC, baseline assessment of 47 facilities has been done as per NQAP standards. Out of these 1 facility (UPHC Krishna Nagar Gamri, district Kurukshetra) has been nominated for national certification.

As a general observation it was found that customary usage of quality improvement tools like process mapping is present but no further action planning and implementation is carried down after gap identification. Similarly the facilities are undertaking patient satisfaction surveys but no action planning has ever been done to raise the satisfaction standards. Key performance indicators are being reported and monitored only at DH level and in UPHCs.

Preparedness for fire safety was found unsatisfactory throughout the state; NoC from fire department was unavailable. Furthermore, number of fire extinguishers was insufficient and hydrants were non-functional. Bare electrical wires were observed at DH Gurugram and other facilities of District Gurugram.

State need to enforce bio medical equipment maintenance Programme as most of the equipments were non-functional due to lack of AMC.

Compliance to Biomedical waste rules was unsatisfactory, regular training at facility level and proper supply of consumables should be ensured for the same.

Kayakalp

The Kayakalp awards for FY (2016-17) have been awarded to 5DH (2 winner facilities and 3 Commendation awards), 5 SDH/CHC (1 winner facilities and 4 Commendation awards) and 38 PHC (13 winner facilities and 25 Commendation awards).

Though Kayakalp for UPHC is yet to be initiated.

Swachh Swasth Sarvatra

1. No nomination has been done by state under it yet. The disbursement of funds (Rs. 10 lakh each) to CHCs mapped with ODF blocks which have scored less than 70% is under process.
2. One Master Training on SBM and Awareness cum Internal Assessor Training has been done at State level. Facility level Training on ''Swachh Bharat Abhiyan'' for 22 District has been completed.

Free Drug Service Initiative

The Haryana Medical Services Corporation Ltd. (HMSCL) leads the procurement of medicines, equipment and instruments in the State.

To meet the demand of 21 districts, the State has established 7 Regional/Divisional Drug Warehouses. Rate contracts for 322 medicines and 31 equipment have been finalized for bulk procurement.

While the warehouse at Bhiwani was optimally functional and was observed to be well managed; the Gurugram warehouse was lacking in infrastructure with sub-optimal storage practices (particularly for medicines). Injectable and vaccines however, were stored appropriately.

Quality testing for each batch was observed at both warehouses and medicines were released to health facilities only after being quality certified. In case of receipt of adverse report on quality the onus is on supplier to collect the supply from warehouse.

EDL were available at all health facilities up-to PHC level.

The State is yet to initiate prescription audits.

JHARKHAND

Quality Assurance

The state has constituted SQAC and DQACs though regular meetings are not taking place. The state is recommended to hold regular and periodic meetings at both state and district level.

The state has conducted 03 Awareness Trainings, 04 Internal Assessors' Training, and 02 Service Provider Trainings (under NQAS) and has developed a pool of 66 trained internal assessors. Also, MoHFW has sponsored two candidates for quality assurance course being run by TISS, although this trained work force is grossly underutilized.

State is yet to recruit 18 consultants at district level. Currently there are 45 personnel recruited under QA (21 state/districts and 24 administrative assistants).

DH facilities have maintained cleanliness to a satisfactory level. Citizen charter has been displayed, good signage system is present and many KPIs are being captured. Facilities have made SOPs and also conduct patient satisfaction surveys.

Limited knowledge regarding Kayakalp and NQAS was found among hospital staff in visited facilities. No health facility has got the NQAS certification so far.

Biomedical waste management was virtually nonexistent in the state. Practices such as mixing of infectious and general waste, disposal in single pit, throwing and burning of biomedical waste in the open and no liquid waste management was observed.

There is only one CWTF (for state), which is functional at Ramgarh. On intervention by the High court, 'State Environment Impact Assessment Authority' has instructed the state to come up with 3 more Common Waste Treatment facilities. State is planning to procure incinerators for its DHs in accordance to 2016 Rules wherein it is recommended to build CWTF instead of installing incinerators.

Health facilities visited were not prepared to handle any major fire. Expired fire extinguishers and No NOC from fire department were the major concerns.

One of the startling finding was provision of ANC services, labour room on first floor (both at DH and CHC). State needs to take necessary actions for the same.

Under NUHM, out of 47 UPHC, 25 have been assessed as per the NQAS checklist. However, no initiative has been taken yet under Kayakalp.

Kayakalp

Overall progress on Kayakalp is very slow, in current FY internal assessment has been done for 20 DH (Out of 24), 0 SDH (out of 13), 7 CHC (out of 188) and 14 PHC (out of 330). Also, peer assessment has been completed for 6 DH.

There is no housekeeping staff, no regular water supply and erratic electric supply at the PHCs visited.

Swachh Swasth Sarvatra

None of the blocks visited has been declared ODF (Open Defecation Free). Only ODF block-Churchu is in District Hazaribagh. The Kayakalp score of CHC Churchu is 55% in internal assessment. Efforts need to be taken to upgrade CHC Churchu to a Kayakalp score of 75%.

Free Drug Service Initiative

Jharkhand has declared free drug policy in the state. However, patients are still incurring out of pocket expenditure for drugs due to non-availability of certain drugs prescribed by the doctors in the facility.

Though the Jharkhand Medical & Health Infrastructure Development & Procurement Corporation Limited (JMHIDPCL) is operational for the last three years, its procurement capacity is still not to the full extent, resulting in continued district level procurement in an adhoc manner.

EDL although formulated at state, but were not available at facilities visited. Standard Treatment Guidelines were not available.

It was stated that state has well defined procedure for quality control of drugs but no documents were found supporting the same.

There are seven existing warehouses in Ranchi out of which two are assigned for JMHIDPCL, the rest are being used for national supplies such as vaccines, contraceptives, TB drugs, and IEC materials. The state has got approval for 24 drug warehouses, one for each district. Construction was started for 14 warehouses, out which four are completed but yet to be handed over. The existing warehouses in Ranchi were not up to the mark.

There is no proper system for transportation of supplies. Hospital staff carries drugs as per their vehicle capacity from time to time.

The state has completed the development of C-DAC's e-Aushadi for inventory management, but it has not been rolled out yet in the state.

Prescription audit is not done at any level in the state.

KARNATAKA

Quality Assurance

The State Quality Assurance Committee (SQAC) and District Quality Assurance Committee (DQAC) have been constituted as per guidelines in 20/30 districts. The remaining 10 districts are being strengthened in the year 2017-18 for establishment of DQAC and related activities. One DH, One SDH (Taluka) and One UPHC in each district has been targeted for 2017-18. However, it's also been observed that SQAC meetings are not taking place periodically.

The quarter wise self-assessment of the QA Programme by the facility has been completed in 20/30 districts. Twelve out of these 20 facilities scored more than 70% as per the assessment by SQAC. The State has proposed 7 DH for national certification out of which DH Tumkur has achieved full NQAS certification.

The gaps identified include physical infrastructure gaps, process and outcome gaps are being tracked by an excel based tool developed by the State team (Gap Identification & Closure Tracking Format) to ensure time-bound actions for filling gaps in districts/facilities.

Patient Satisfaction Survey is being conducted in 20/30 district hospitals. At the CHC, PHC, Sub Centres visited, patient grievance redressal systems were found to be lacking.

Under NUHM, out of 348 UPHC 165 have been assessed as per the NQAS checklist.

Kayakalp

The State of Karnataka had distributed 103 awards under Kayakalp Scheme in 2016-17 and for the year 2017-18, 120 facilities (including 36 urban health facilities) have been selected and are undergoing peer assessment. The total facilities selected for Kayakalp Peer assessment (>70% score) have increased from 744 in 2016-17 to 1251 facilities in 2017-18 out of which 547 facilities are eligible for External Assessment .

State and District level Award Nomination Committee, State External Assessment team are established and are meeting regularly. Similarly Hospital Infection Control & Cleanliness Committee/Infection Control Committee exist in all facilities and meetings are conducted.

Bio-medical waste management is being done as per 2016 rules. However, lacunae observed include non-availability of color coded bins, non-secured deep burial pits, unrestricted access to the site etc.

Swachh Swasth Sarvatra

There are 26 ODF Block in Karnataka and one CHC in each of these blocks have been nominated (excluding Kayakalp awardee). Intersectoral collaborative activities are yet to be initiated and the Swachh Swasth Sarvatra Programme is in an infant stage in Karnataka.

Free Drug Service Initiative

The State is in the process of adopting the GOIs free drugs services initiative. Under the initiative (in 2017-18), the state is procuring medicine worth ₹ 400 Cr (Rs. 150 from NHM and ₹ 250 Cr from State fund).

The Karnataka State Drugs Logistics & Warehousing Society is the centralized procurement Agency for the State and is a registered society.

Essential Drug List (EDL) for Public Health Facilities is available (PHC - 452, CHC – 572 and DH-737). However EDL (Essential Drug List) is not provided to the facilities and there is no mechanism for prescription audits and monitoring of OOPE (Out of pocket expenditure).

There are no empanelled laboratories for drug testing.

There are 26 functional district ware houses and six are under construction. Facility level drug store needs proper maintenance of drugs and consumables. The drug warehouse in DH Chitradurga had water seepage and there were inadequate racks.

E-aushadi is functional in the state, and the reported time for delivery is within 15 days following receipt of request from health facilities. IT enabled inventory management system was functional up to the PHC level.

MAHARASHTRA

Quality Assurance

State has reconstituted their SQAC and DQAC. All districts have operationalized District Quality Assurance Units/Teams. However, quality team was found non-functional at the visited facilities.

The State has one Quality Assurance Officer as a nodal person and two Programme Officers. There are vacant posts for 2 Consultant (public health and quality monitoring), 14 post of District Coordinators and 10 posts of Corporation Quality Coordinators in NUHM.

The state has conducted awareness training for NUHM (2), Internal Assessor training for DHs and PHCs (2) and Service Provider Trainings (1) and has created a trained pool of 97 internal assessors and 4 external assessors. Four candidates from state have been trained from TISS for roll out quality assurance program, however this trained human resource has not been utilized to the full potential.

State has committed for 604 facilities to be certified under NQAP which includes 21 DHs, 4 GHs, 12 WHs, 27 SDHs, 86 RHs and 454 PHCs. In comparison to last year state has made effective efforts and has got 15 national and 39 state certified NQAS facilities. Also, 12 more facilities have been identified for national certification.

In the districts visited this time 13 facilities at Parbhani and 12 facilities from Wardha has been identified for certification under NQAS. However, none of the facilities from Parbhani district has conducted baseline assessment.

The state need to ensure uniform signage (directional, departmental and 'Fire-Exit' signage) across all its facilities. Staff preparedness for fire safety was not upto the mark as most of the facilities had installed fire extinguishers, but staff was not trained to use these extinguishers.

External Quality Assurance Programme for Laboratories has not been initiated in any of the facilities. Similarly, AERB approval for X-ray equipment & layout was not available at any of the facilities.

State need to strengthen the infrastructure of facilities as per IPHS standards (as it was observed that ANC care in civil hospital Parbhani and PHC Rani Sawargaon were being provided at first floor of OPD Complex where there was no provision of ramp for pregnant women).

Proper Segregation was observed in almost all facilities as per new BMW Rule 2016. However, at few facilities due to non-availability of storage area, sharps/plastic fluid bottles were found in pits and in open area. There was no liquid waste management as well in any of the visited facility. Also, no bio medical waste management system was observed for UPHCs under NUHM.

State should ensure measurement of patient satisfaction level through structured manual feedback form or through ''Mera Aspatal'' initiative and measurement of KPIs for all level of facilities.

Kayakalp

State and district Award nomination committee has been constituted.

In FY 2017-18 Kayakalp has been rolled out in 23 DHs, 4 GHs, 12 WHs, 1814 PHCs, 360 RHs and 86 SDH level facilities. State has completed internal assessment and peer Assessment of all DHs and SDH/CHCs and external assessment of selected facilities are in progress.

State has disbursed ₹ 160.5 Lakhs to the districts for distribution of award money to winner and runner-up PHCs for FY 2016-17.

Infection control Committee has been constituted in all of the visited facilities. Although, staff was not well trained in infection control practices like correct method of disinfection and sterilization of equipment, preparation of chlorine solution etc.

Kayakalp under NUHM is yet to be initiated.

Swachh Swasth Sarvatra

Under this program, provision of ₹ 10 lakhs was provided to every identified CHC (48) under open defecation free block. However, during field visit to RH Pulgaon, underutilization of money was reported.

Free Drug Service Initiative

The State has implemented NHM Free Drug Service Initiative across the State.

State has recently out sourced the procurement of drugs to PSU named Haffkines, which will function as independent centralized procurement corporation.

Drugs are released to health facilities only after being quality certified.

EDL are available at all health facilities up-to SC level.

Visited drug ware house had certain structural deficiencies viz. office on ground floor and storage facility on first floor & some parts of ground floor, no ramp, no sunlight reflecting glass on window etc. Ducts for provision of lift has been created, however provision of lift is not there in type plan.

The State has initiated process for implementation of prescription audits.

Lack of awareness about the disposal of expired drugs and proper maintenance of drug stock registers indicate lack of proper staff training.

MANIPUR

Quality Assurance

The state has constituted State Quality Assurance Committee (SQAC) at state level, while District Quality Assurance Committee (DQAC) has been formulated for 9 districts (DQAC is yet to be constituted in 7 newly formed districts). However, Regular and periodical meetings were found missing at district level and hence it is strongly recommended to hold the same.

State has 2 State Quality Consultants and 9 personnel at district under Quality Assurance Program.

During 2017-18, state has conducted 1- Internal Assessors' Training, 1-Service Provider Training and 1-Kayakalp training. In FY 2016-17, 1 NQAS-NUHM training has been conducted.

The state has 9 functional Urban PHCs but no Urban PHC has been assessed under Quality Assurance Programme or as per Kayakalp checklist.

State has planned State & National level assessment for 8 facilities (2 DH, 2 CHC & 4 PHCs) for FY 2017-18 but no progress has taken place yet for any of the facility.

Among the facilities visited, Quality Teams were present in Tamenglong District Hospital, Nungba CHC, Wangoi CHC and Noney PHC. Quality Teams were not found at Mekola PHC, Sekmai CHC, Kurkhul CHC and Langol Tarung UPHC. It is recommended to formulate quality teams and facilities with QI team should undertake regular QI team meetings for internal assessment, gaps identification & action planning to traverse the gaps.

Under statutory and legal compliance none of the facilities were found following protocols as per PCPNDT act. Similarly, NoC from Fire Department were not available at any of the facilities visited.

SOPs for Labour Room were present in the facilities visited. However, many of the hospital staff was unaware of them.

Citizen charter was found in most of the facilities visited. Display of Essential Drug List and monitoring of key performance indicators was absent.

The state has no mechanism for conducting patient satisfaction survey.

Kayakalp

Slow progress is evident under Kayakalp as internal assessment was still pending for health facilities of district Tamenglong for current FY.

Infection Control Committee was present in few of the facilities. It is recommended to constitute the committee at each facility and to train staff for infection control practices.

Biomedical Waste Management system was in place in Tamenglong District Hospital, Noney PHC (Tamenglong district) and Wangoi CHC, Mekola PHC (Imphal West) while it was lacking in Nungba CHC (Tamenglong district), Sekmai CHC, Kurkhul CHC, Langol Tarung UPHC (Imphal West). Training and provision of required bins and consumables are recommended to ensure complete adherence.

Free Drug Service Initiative

The state level procurement committee has been constituted however there is no centralized procurement body. Essential Drug List has been prepared, but none of the facilities have displayed EDL.

No standard treatment guidelines are available in the state. The state is in the process of developing these guidelines which will be implemented thereafter.

The state is in the process of implementing DVDMS with the help of CDAC.

State has Drug Regulatory Department for quality control control of drugs. All drugs are issued after obtaining certification from national level drug testing centres, mainly from Kolkata. However, there is no process for checking the quality of drugs received.

The facilities had adequate drug storage space, except for those drugs which require refrigeration due to non-availability of refrigerators.

There is no prescription audit taking place at CHC Wangoi.

MEGHALAYA

Quality Assurance

The state has constituted SQAC and DQAC.

The approved post of consultant and hospital manager under QA is vacant. State may take necessary steps to fill these posts to strengthen the QA activities.

The state has certified 02 DHs & 02PHCs and applications for the same has been sent for National Certification (documentation awaited).

There are 19 UPHC but none has been assessed so far as per NQAP standards.

Kayakalp

In the FY 2016-17, Tura Civil Hospital in West Garo Hills District and Community Health Centre Chokpot (South Garo Hills) were chosen best health facilities in their respective categories, along with selection of one Kayakalp PHC in each of the Districts.

Peer assessment score of Health facilities in the State shows an upward trend, as number of health facilities scoring more than 70% score has gone up vis a vis 25 (FY 2016-17) and 32 (FY 2017-18).

Health facilities were maintaining cleanliness to the satisfactory level and were also having Rain Water Harvesting System.

Health staff was well informed about the revised BMW protocols and were found adherent to the protocols. However, visited Health Facilities do not have linkage with the Common Biomedical Waste Treatment Facility (CBMWTF) and facilities are disposing the waste by deep burial. For waste under yellow category facilities have made their make shift incinerators. The startling fact was that for both of the processes no prior approval from the prescribed authority has been obtained.

Swachh Swasth Sarvatra

There are a total of four ODF blocks in the State. However, two ODF Blocks do not have CHCs located within the block. Hence the state may utilize the funds for strengthening of the Kayakalp activities for strengthening those neighboring CHCs, which cater to maximum population from these blocks.

Free Drug Service Initiative

State is yet to notify Free Drug Initiative. The State Government has formed a Joint Procurement Committee. Also, a Central Purchase Board has been constituted for price discovery, quality control and to promote rational use of drug.

Facility wise EDL is under approval of the State government.

There is one state drug warehouse from where the drugs are dispatched to the districts warehouses.

The state sends the drugs to NABL accredited labs for quality testing.

State government is planning to launch DVDMS in the month of November, 2017 with the help of CDAC. Existing system of indenting, calculating the requirement and maintaining buffer stock etc. is erratic across all the level from PHC to State level.

Standard Treatment Guidelines (STGs) and Prescription Audit mechanism are not in existence.

NAGALAND

Quality Assurance

State has constituted its state and district level committees (SQAC and DQAC). Also, quality teams have been constituted at district hospital level but same are yet to be constituted at CHC & PHC level.

In comparison to last financial year this year the state has completed its internal assessment of district hospitals and has committed one DH for national assessment. However, internal assessment of CHCs & PHCs is yet to be initiated.

State has not formulated SOPs for DH, CHCs & PHCs yet.

Mera Aspataal Initiative or Patient Satisfaction Survey for Grievance Redressal Mechanism has not been initiated yet. Although same has been notified by Government of Nagaland.

Legal & Statutory requirements such as PCPNDT act, NOC for Fire department were unavailable. Although, Blood Storage Unit (BSU) license was available at DH.

State needs to initiate; collection and monitoring of Key Performance Indicators, periodic and regular prescription and medical audits. Analysis of the same will be helpful for planning & improvement of health facilities.

Internal & External Quality Assurance Programme for validation of lab tests, calibration of equipment, monitoring of radiation exposure by TLD badges etc. needs to be done on regular basis.

For quality assurance under NUHM, one state level Internal Assessor Training under Quality Assurance has been conducted in FY 2017-18. The induction training of the QA team is in process. Out of 5 UPHC facilities, UPHC- Kohima is the first facility to have identified for national certification. In FY 2016-17, RRC-NE has conducted baseline assessment of this UPHC with a score of 69%.

Kayakalp

The Kayakalp awards for FY (2016-17) have been awarded to 3 DH (1 winner facility and 2 Commendation awards), 3 SDH/CHC (1 winner facility and 2 Commendation awards) and 13 PHCs.

Under NUHM, 5 of UPHC have been assessed (internal followed by peer assessment) in current financial year.

Infection Control Committee was available at District Hospital Wokha & PHC Chukitong but it's yet to be constituted at other CHCs & PHCs. However very limited usage of PPE was observed in the facilities.

Indoor and Outdoor were clean and well maintained at District Hospital Wokha, CHC Bhandari & PHC Chukitong.

State needs to take measures for Pest Control at DH, CHCs & PHCs level.

Biomedical Waste Management Segregation, Storage & disposal was being done as per rules at DH, CHCs & PHCs. However, no authorization certificate and SOP was found for BMW management.

Swachh Swasth Sarvatra

Hospital Staff were unaware of Swachh Swasth Sarvatra (SSS) at District, CHCs & PHCs level. None of the blocks are ODF in the State.

Free Drug Service Initiative

The state has notified free drugs initiative although its percolation down to the district level was found very weak.

The facility wise essential drug list was not available in all the visited facilities.

The drug supply in the district is highly irregular from the state level, (Drug House, Kohima) and is not demand driven.

Drug ware house is located at CMO office and as reported each district has one drug ware house from where; the supplies are distributed to the peripheral health facilities without Quality testing.

There is no facility for maintaining Cold chain while transportation of medicine/vaccine.

IT management Inventory system i.e. Drugs Vaccines distribution & Management system (DVDMS) has not been implemented, despite of the fact that funds have been released in the ROP for the implementation of the same.

There are no approved STG and no prescription audits are done.

Due to non-availability of the medicines in the health care institutions, a lot of OOPE was reported; even the JSSK patients were reportedly spending ₹ 5000/- per case on an average.

ODISHA

Quality Assurance

The state has 1 Consultant QI & QA (Tech.), 1 Data Entry Operator in position. However the post of Senior Quality Consultant is vacant. There are 37/42 Hospital Managers.

The state has conducted extensive number of trainings which has resulted into creating a pool of 76 assessors (5 internal assessors training, 5 service providers training and 5 NUHM training). The state also has 5 qualified external assessors.

Infection control committee has been formulated but they were found inactive in both visited districts.

Thirty two DHs, 25 SDHs, 38 CHCs, 85 UPHCs were assessed for NQAS in the state. Two district hospitals (Kalahandi and Koraput) got state level NQAS certification out of which DHH Koraput got NQAS national certification (for 10 departments only) in year 2016-17. For 17-18, state is planning to certify 5 DH and 10 SDH for state/national level certification. Only FRUs are selected for NQAS certification. The state is recommended to expedite the process of national certification.

State need to ensure proper signage system, infection control practices, display of IEC material for Kayakalp and Swachta Abhiyaan, cleaning of clogged drains, cleaning of toilets, no stray animals and provision of clean drinking water at all level of facilities. There is an eminent need of training hospital staff for Infection control protocols.

Infection control committees were formed but no regular meetings/rounds in hospital were conducted.

For Bio Medical Waste management, MoU has been signed between ADMO (Med) Keonjhar and Mediaid Marketing services. BMW management is being done as per BMW rule 2016 in most of the facilities. IEC has been displayed for segregation of waste in colour coded bins with availability of color coded bins in facilities. However, state should provide covered trolleys for BMW transportation.

State is in process of implementation of Mera Aspatal.

Under NUHM 62 out of 85 functional UPHC have been assessed.

Kayakalp

State level Kayakalp award nomination committee and District level Kayakalp award Nomination has been constituted at all districts.

One master training on Swachh Bharat Abhiyan (state level), Awareness Cum Internal Assessors Training (District level), internal assessment training for MOs from PHC (2017) and Facility level training on Swachh Bharat Abhiyan (DHH and SDH) has been conducted.

The Kayakalp awards for FY (2016-17) have been awarded to 8 DH (1 winner facility, 1 runner up facility and 6 commendation awards), 12 CHC (1 winner facility, 1 runner up facility and 10 Commendation awards).

Under NUHM, 59/81 UPHC have been assessed (internal followed by peer assessment) in current financial year.

Despite of rigorous trainings, providers were unaware of internal assessment scoring. Facilities have been incorrectly scored when checked physically against scoring criteria.

Kayakalp award winning CHC Ghatgaon has developed continuous audio messages, posters in local language on Swachh Bharat for patient's sensitization which is one of the innovative approaches.

Swachh Swasth Sarvatra

Only one block namely Kasinagar under Gajapati district was declared as ODF (open Defecation Free) in 2016-17; and budget of ₹ 10 Lakh has been released to the CHC for supporting the gap closure activities so that the facility can meet the Kayakalp standards.

Free Drug Service Initiative

"Niramaya" is the free medicine and medical consumable distribution scheme at the state of Odisha. The State has established Odisha State Medical Corporation Limited (OSMCL) as an independent agency for procurement and supply of Quality Medicines, Surgical and other medical consumables.

State EDL has 572 drugs. Also, State has developed IT platform for supply chain and drug inventory management called e-Niramaya that is extended till CHC. The state is in the process of developing first of its kind the "e-Niramaya" mobile App which will enable the monitoring officers at state level, as well as, at facilities level to know the stock status of the drugs under free supply scheme.

Patient prescription audit are being scanned at every facility and being maintained for record keeping. However, no further analysis like irrational use of antibiotics etc. is done.

The cold storage supply chain was robust in the districts especially after the implementation of eVIN. Digital temperature loggers were functional with most of the units and were being regularly monitored and manual monitoring was also in place.

There was no temperature control mechanism, rodent and pest control facility, prevention from sunlight, proper racks and no power backup for District drug ware house. For drug distribution dedicated drug transport vans are available.

PUNJAB

Quality Assurance

State Quality Assurance Committee (SQAC) and District Quality Assurance Committee (DQAC) have been formulated. However, regular meetings are not taking.

State has not yet put in the dedicated manpower for the program. However, Assistant Hospital Administrators have been placed in few district hospitals.

State has organized 4 Internal Assessors' training, 1-Service Provider Training, 2-NUHM Training and 1 training under Kayakalp by which a pool of 201 internal assessors and 5 external assessors have been created.

Proper action plan was available at state level to fill the identified gaps, whereas no action plans were available at district level.

State has got four facilities (3 DH and 1 SDH) national level and 26 state level (7 DH, 12 SDH and 7 CHC) facilities NQAS certified.

State need to give more attention to patient safety. No compliance to visitors' policy for prohibited areas like NICU, trauma care, dengue unit; no usage of PPE and no separate male and female wards were few of important findings.

State need to expedite the process to obtain AERB approval for the facilities.

Some facilities are conducting the patients' satisfaction survey on regular basis but district officials were unaware about the "Mera Aspataal" application.

Quality is maintained in terms of floor cleaning and laundry services in almost all facilities. Toilets are also cleaned periodically in almost all facilities

Biomedical waste management is done properly and in accordance with the regulations. Infection

control practices need more careful implementation, especially regarding instrument processing, disinfection and hand washing.

There is unavailability of SOPs and departmental policies. However, SOPs were available for labour room.

Under NUHM 65/93 facilities have been assessed as per NQAP standards.

Kayakalp

The Kayakalp awards for FY (2016-17) have been awarded to 5 DH (1 winner facility and 4 commendation awards), 4 CHC (1 winner facility, 1 runner up facility and 2 Commendation awards) and to 27 PHCs.

For FY 2017-18, State has completed assessments of 14 DHs, 12 SDHs and 21 CHCs for Kayakalp award. PHCs and UPHCs assessments are also in the process of assessment.

State has included outside boundary and provided 100 scores over and above the Kayakalp scores. Urban health facilities are also included for Kayakalp award and they are categorized into two clusters for Kayakalp awards.

Swachh Swasth Sarvatra

Under ''SSS' scheme state has received ₹ 10 Lakhs per CHC for 18 blocks through NHM PIP 2017-18. No training under this scheme has been conducted in WASH (Water, Sanitation and Hygiene).

Free Drug Service Initiative

The State has adopted GoIs free drugs services initiative.

The state has Punjab Health System Corporation (PHSC) through which drugs are purchased and supplied through DVDMS (E-Aushadhi).

Three regional drug ware houses are available in the state. Civil surgeons at district level monitor online demand raised through DVDMS (E-Aushadhi), consumption pattern and performance of the Hospitals. The drug distribution to facilities is directly from regional warehouse.

Essential Drug List (EDL) for public health facilities is available where 214 drugs, 125 consumables and 28 suture material have been included but there is no facility wise EDL. Shortage of supply of drugs under EDL was also observed (Oxytocin, Inj. Suprasef 750, Inj. Gentamysin and Inj Diclofenace etc.).

For Quality Assurance of the drugs, one testing Center is available at state.

State reported availability of Standard Treatment Guidelines, but they were unavailable at the facilities, nor were service providers aware of it.

TELANGANA

Quality Assurance

The state has constituted a unified organizational structure at State, District and Facility level which are operationalized and active. State Quality Assurance Committee has been constituted during month of Sept. 2017 with inclusion of NUHM Programme Officer.

State team consist of 01 State Programme Officer and 02 Consultants. At District Level, District Quality Assurance Managers (DQAMs) – 31/31 has been positioned. At each facility, a quality team has been formed which include Medical Officer In-charge, Staff Nurse, Pharmacist and Lab Technician.

Internal assessment has been completed and 3 DHs, 6 AHs, 2 CHCs and 150 PHCs are presently undergoing peer assessment to seek state level certification. State team is planning to assess and seek national certification to 37 PHCs in coming year.

PHC- Bheempur of Adilabad district has become first facility in the state to become National certified against NQAS with an aggregate score of 94%.

In DH- Khammam, quality improvement team at the hospital conducts regular audits on compliance with hand hygiene, hand rub availability, and compliance with aseptic peripheral intravenous line insertion techniques. These improvements have contributed to a significant reduction in newborn deaths and admissions to the special newborn care unit over the past three months in the district.

Few gaps were observed in terms of crowd management, unclean toilets and non-compliance to infection control protocols in the District Hospital.

Under NUHM, Baseline Assessment of 69 UPHC as per NQAS and 114 facilities as per Kayakalp have been completed.

Kayakalp

In the FY 2016-17, 836 facilities were internally assessed out of which 143 facilities (DHs – 7, AHs – 30, CHCs – 32 & PHCs – 74) were eligible for external assessment and there were 27 winner facilities (1-DH, 1-AH, 1-CHC and 24- PHCs).

In FY 2017-18, Kayakalp will be extended to all UPHCs. Internal assessment has been done for 683 PHCs, 98 CHCs, 30 AHs and 6 DHs.

Improper segregation of Bio Medical Waste was observed. Color coded bins were lined by black liners which does not ensures proper disposal of hospital waste. Staffs at some facilities were not aware of proper segregation and disposal of waste.

Swachh Swasth Sarvatra

Fund has been distributed to 32 identified CHCs for which internal assessment, gap analysis and action plan has been completed.

Free Drug Service Initiative

State has adopted GOI guidelines on free drugs initiative and use e-aushadhi for strengthening Drugs and logistics procurement system.

Procurement and supply of drugs is done centrally through TSMSIDC.

Presently, there are no state level or regional level drug stores. There are 10 district level drug stores.

Transportation of drugs to health facilities is by hospital staffs' vehicle or ambulance.

During stock out in the district drug store, health facilities buy medicines from the nearest drug store by using the money available in Hospital Development Society fund.

Quality assurance of the drugs is done through Drug Regulatory Department & TSMSIDC. There are 6 NABL accredited labs in the State.

IT enabled inventory management is operational in the districts till PHC level.

No prescription audit mechanism is conducted in any of the facility.

UTTAR PRADESH

Quality Assurance

State Quality Assurance Committee and District Quality Assurance Committee have been formulated. Regular meetings are taking place at both levels.

Facility level Quality teams at DH and CHCs have been formed but functionality was limited to district hospitals where hospital managers were available.

Nineteen (out of 36) divisional and 49 (out of 75) district consultants have been recruited.

So far, the state has organized 7 - Internal Assessors' Training, 5-Service Provider Training, 2- NUHM Training and 5 Kayakalp Training. Apart from this 189 CHC in-charges have been trained in BMW and infection control.

Total 6 facilities have been certified till date and out of these 3 have been certified at the national level. For the year 2017-18, forty (40) facilities were taken up for certification, due to non-availability of District Quality Managers/Hospital managers, these facilities are now being taken for partial certification.

Key performance indicators are being reported only by District hospital.

Authorization for BMW and blood bank license has been obtained. Processes for registration for Fire safety and AERB have not been initiated in the facilities. Gaps were also identified in availability of TLD batches and radiation safety equipments availability with the staff.

Biomedical waste management has been outsourced up to PHC level facilities. Training and orientation on new rules have been provided to all the staff. Supplies with respect to BMW management were available in all the facilities visited. However

gaps were identified in practices related to proper segregation of waste in the facility.

Infection control committees were functional at the district hospital level. Housekeeping facility in DH was outsourced. Most of the bigger peripheral facilities like FRUs and CHCs were understaffed with respect to availability of safai karamcharis. Sterilization practices in critical areas like OT, labor room, laboratory, blood bank etc. were found satisfactory.

Prescription audits have not been initiated in the district. However rational prescription was observed to be practiced in all the facilities.

A comprehensive policy for disposal of expired drugs was not available at the state/district level. Expired drugs were disposed through the outsourced agency which might lead to mis-utilization in the market if not properly monitored.

Mera Aspatal initiative is yet to be implemented in the district.

Kayakalp

A total of 42 facilities including, 13/157 District Hospitals, 11/189 CHCs and 18/369 PHCs won the award for Kayakalp in the year 2016-17. In 2017-18, External assessment of 74 district level hospital (completed) and 57 CHCs (under process) has been taken up. Internal Assessment of PHCs has been completed & 130 facilities scoring more than 70% will be subjected to peer assessment. The initiative is yet to be implemented in the urban facilities.

Information on services and service providers were displayed in most of the facilities, however directional signages within the facility and outside needs to be improved.

SOPs and protocols have been developed by the state for all critical departments and have been disseminated. However, implementation of these protocols has not been initiated in the districts. Also, most of the staff at district and facility level were not aware of these protocols.

Swachh Swasth Sarvatra

Under the SSS platform, 8 CHCs have been identified in ODF block for which the funds have been released. Of the districts visited none of the facilities have been taken under SSS initiative.

Free Drug Service Initiative

Currently, the drugs are procured through three different methods which is rate contract finalized by directorate, rate contract of ESI and local purchase.

Facility wise EDL are present which have been displayed as well.

Batch wise certification of drug testing were not available neither randomized sampling is being done.

Prescription audit is not done.

State has online Drug Procurement and Inventory Contract System (DPICS) functional up to district level.

The warehouse and stores are not well designed for storage, no ventilation, no mechanism to maintaining room temperature was found. The improved racks and storage facilities can make the efficient use of space.

UTTARAKHAND

Quality Assurance

State Quality Assurance Committee and District Quality Assurance Committee have been formulated. The last meeting of SQAC was held in February 2017.

Human resource dedicated to QA Programme has been approved at the State level has been completed while the recruitment at the district level should be expedited soon to accelerate Programme implementation.

Apart from this 4 health personnel (2 completed and 2 ongoing) have got PG Diploma in Healthcare Quality Management (PGDHQM) from Tata Institute of Social Sciences, Mumbai. As reported by state, re-assessment of 29 health facilities has been completed in current FY 2017-2018 and 9 out of 29 facilities have scored more than 70%. PHCs, UCHCs and UPHCs were not covered under National Quality Assurance Programme in the State. None of the facilities have received NQAS certification so far.

For statutory and legal compliance, the facilities have got required permission for PCPNDT and blood bank (Re-licensing of blood storage unit, District Hospital Champawat is to be initiated). However, NoC from fire department and AERB certification have not been obtained.

Standard Operating Protocols (SOPs) and Departmental Policies were not displayed in any facility of the districts visited. No Disaster Management protocols were displayed.

System for Grievance Redressal Mechanism/Patient satisfaction surveys was not found in place at any facility visited.

Kayakalp

In the year 2017-18 under the Kayakalp Award Scheme, 345 health facilities (DH/SDH-20, CHC-64 and PHC-247) were covered under this scheme. The internal assessment is completed for 316 (DH/SDH-32, CHC-62 and PHC-222) health facilities while the peer assessment is currently in progress for both the districts. UPHCs were not nominated for the Kayakalp Award. District Hospital Rudrapur (Udham Singh Nagar) won the Kayakalp 3rd prize three years back. PHC Barakote and Pati in Champawat and Jawahar Lal Nehru District Hospital & SDH – L.D. Bhatt, Kashipur in Udham Singh Nagar have internal assessment score of more than 70%.

The Infection Control Committee is not in place at all levels in the state. The overall impression of the facility was satisfactory for both the districts visited.

Bio Medical Waste Management has been outsourced to external agency for all the facilities (DH, CHCs, PHCs and UPHCs). On interaction with staff, knowledge gap on segregation and disposal of waste was observed.

Swachh Swasth Sarvatra

Under the SSS, ₹ 1.5 Lakh per CHC was proposed and approved in ROP 2017-18 for ODF declared blocks (38 CHCs in 50 ODF declared blocks). However, the funds for the same have not been released. Staff has not been trained under this scheme. Nodal officers have not been appointed for the implementation of this scheme at the facility level.

Free Drug Service Initiative

State has implemented FDSI and ₹ 15.17 cr was approved for the same (FY 16-17); 99% of the budget has been utilized so far.

The store department of DG Health is functioning as central procurement agency and performs activities like demand generation, procurement, quality assurance, supply chain management, stock management, and processing RTIs. Furthermore, there are two separate committees both at state and district level.

The EDL was revised and approved (2016) with 575 drugs, 66 Surgical Items and 77 Sutures. The EDL was not displayed at any of the facilities. Vital drugs such as IFA, Vitamin A, Vitamin K, ARV, ASV, Oxytocin, Misoprostol, etc were reported stock out at the time of visit.

Quality testing: 4 NABL accredited labs are empanelled by the state. The state also has its own lab in Rudrapur (Udham Singh Nagar). However, drugs are tested randomly (not for each batch) and there is no mechanism of quality testing of locally purchased drugs at district level.

State distributes drugs through the State Warehouse at Dehradun to its 3 Regional Warehouses (RWHs) which further distribute them to 13 District Drug Warehouses (DDWs). There is shortage of space for storage of drugs in most facilities. There is no mechanism for temperature monitoring during the transit of temperature-sensitive drugs.

No prescription audit is carried out at the facilities.

E-Aushadhi software is planned for implementation in both DH visited but is not yet functional.

WEST BENGAL

Quality Assurance

The State and District Quality Assurance Committees have been constituted and notified as per the guidelines in all the Districts. However the review meetings are not conducted periodically at both levels.

Adequate HR has been approved in the State PIP but a number of sanctioned posts lie vacant.

The skill building of all consultants had been carried out by the State authority with the support of NHSRC but the capacity building of facility level staff was lacking in both the Districts.

The State has shortlisted 43 facilities DH & SDH for NQAS certification. Although the baseline assessments and gaps analyses have been conducted as per the records; DH Siliguri and Coochbehar have applied and got the National Certification. National team has completed external assessment & reporting of the said facility.

The Standard Operative Procedures (SOP) has been formulated and notified at the state level but these SOPs were not available in the visited facilities except for those displayed in the Labour room and SNCU of DH & SDH in both the Districts.

The State has taken a good initiative in developing a web portal for measurement of Key performance Indicators (KPI) which helps measure the KPIs regularly. However the follow-up mechanism and roadmap for guiding the facilities for improvement in the indicators was missing.

Irrational prescription of antibiotic was observed at some level of facilities. There is no mechanism for any medical & prescription audit in the facilities.

The Mera Aspataal Initiative has not been implemented by the State. At some facilities Patient Satisfaction Surveys are being conducted manually but in an arbitrary way, analysis of feedback survey reports mechanism was lacking.

The State has taken an initiative of strengthening/ maintenance of the infrastructure of health facilities especially high load facilities. It has been observed that there are some issues with the structural Planning of hospital e.g. Labour room was located at the sixth floor with no provision of ramp in the hospital, only elevators were used.

None of the UPHC visited have implemented Kayakalp or NQAS for quality improvement of their facilities.

Kayakalp

Under this Programme 22 DH, 37 SDH, 24 State hospitals, 348 RH/BPHC and 908 PHC have initiated Kayakalp activities in the State. 9 DH, 8 SDH, 7 State Hospitals 76 RH/BPHC & 37PHC have been shortlisted for external assessment.

Biomedical Waste Management: Poor waste segregation at the point of generation, unavailability of PPE, no designated storage place were few of the startling findings. The infection control practices are not followed strictly by service providers.

The Kayakalp Programme is not rolled out & implemented in Urban Health facilities.

Swachh Swasth Sarvartra

Under Swachh Swasth Sarvartra the State has received an amount 8.5 crores in PIP 2017-18 for 85 CHCs (10 lakh for each) in the ODF blocks. The funds have not been allocated to the qualifying CHCs.

Free Drug Service Initiative

The state has recently revised its EDL which consists of 450 drugs which shall be provided free of cost at public health facilities.

State has decentralized drug procurement system, wherein District Health Samitis and big hospitals like Medical Colleges are empowered to procure drugs as per their needs based on rate contracts at state level. The District Reserve Stores are responsible for procuring drugs for facilities in districts. The rate contracts are prepared by West Bengal Medical Services Corporation (WBMSC) followed by a competitive online bidding process (on NIC portal) half yearly or annually as per requirement and are made available online.

State has developed its own online portal vis a vis Store Management Information System (SMIS), which is functional till district stores.

Prescription audit was not seen anywhere nor were the health officials aware of it. Instances of ANMs prescribing anti-biotic were seen in the field, even though they were not given prescription rights or given comprehensive training.

OOPE on drugs was reported only in case of high end antibiotics which were prescribed by doctor at Mobile Medical Unit after prolonged disease condition. However, in D. Dinajpur, stock-outs as well as OOPE on drugs was noted during beneficiary interactions.

Fair price shops under PPP mode were seen at MMCH and SDHs, ensuring access to drugs at subsidized upto 60% of market price.

TOR 11
NATIONAL URBAN HEALTH MISSION

Objectives

- Review of NUHM implementation, GIS and vulnerability mapping, convergence of NUHM with other programs and missions like NRHM, RMNCHA, National Health Programs and Urban local bodies.
- Examine the adequacy and service delivery of UPHCs and UCHCs, reporting of urban health facilities in HMIS/MCTS, constitution of RKS and untied fund utilization.
- Review the community outreach services, UHND and special outreach functions, MAS formation and status of their accounts, status of ASHA selection and trainings.
- Review the status of QA activities in urban health facilities.

National Overview

The National Urban Health Mission aims to provide comprehensive primary health care services to the urban poor with special focus on all types of vulnerabilities including but not limited to homeless, rag-pickers, rickshaw pullers, slum dwellers etc. The Programme has shown a significant progress since its inception in 2013, where now most states have well established urban health facilities, in line with the NUHM framework. States have shown a good progress in infrastructure development both in terms of new constructions as well as the renovation works. Further with the increase in convergence meetings at the State level, involvement of ULBs in NUHM has increased.

As the States gained more understanding on NUHM and its components, the activities under NUHM have gained pace. Almost all the States have initiated work on GIS mapping and vulnerability assessment and are expecting to finish it in this year. The ANMs, ASHA and MAS are largely in place and with completion of mapping and vulnerability assessment; they will further have clear understanding of their designated areas. The community outreach activities through UHNDs and special outreach sessions have also increased this year but were largely immunization centric.

Capacity development of all stakeholders and service providers has been identified as a major strategy in improving the performance of NUHM further. Several other areas of improvement as identified in CRM-11 are completion of mapping both GIS and vulnerability, rational deployment of HR, improving the convergence activities both at State and district level, quality assessment and certification of UPHCs and accelerating the process of formation of RKS and release of untied grants to the urban facilities.

Further the range of services provided by UPHCs needs to be expanded from mere maternal and child care to incorporate all the National health programs with special focus on NCDs and mental care. The upward and downward linkages of the UPHCs need to be formed and sustained. Low fund expenditure was also common to all the States due to various different reasons. States like Jharkhand, West Bengal, Uttarakhand and Maharashtra are still struggling on RKS formation. Further the States where RKS are formed, either have not opened their accounts or have not transferred untied funds in their accounts.

Key Findings

Planning and Mapping

Current status of mapping gives a varying degree of progress in all the sixteen states visited by different teams of CRM. States that have completed spatial GIS mapping are Punjab, Haryana and Meghalaya while Chhattisgarh is not far behind and have finished mapping 75% of the districts. States where mapping is still under progress are Karnataka, Odisha, Telangana, Maharashtra, UP, Nagaland and West Bengal. On the other hand states like Assam, Bihar, Jharkhand, Uttarakhand and Manipur have not yet initiated the mapping process and needs to prioritize it. Further, most states have not yet started vulnerability assessment exercise, but states performing well in this are Chhattisgarh, Telangana and Odisha having finished 75%, 61% and 57% of VA respectively. Others like Haryana, Meghalaya, Nagaland and Uttarakhand are in the beginning stage. Similarly states performing exceptionally good in terms of facility mapping are Odisha, Manipur, Karnataka and Telangana covering 100%, 100%, 95% and 71% facilities respectively; while slum mapping has almost been finished in Punjab, West Bengal, Nagaland, Odisha and Telangana. Rest states are on different levels of facility and slum mapping.

Institutional Arrangement and Programme Management

Most states have strengthened their institutional arrangements and have established Programme management units at State, district and city level. Key positions under the Programme management units are largely filled except for Assam, Jharkhand, Uttarakhand, Telangana, district Programme management units in Haryana & Chhattisgarh and city Programme management units at Uttarakhand & Maharashtra. NUHM was driven by corporations in West Bengal, Karnataka and Maharashtra, but coordination between corporation and state health departments was found best in West Bengal followed by Karnataka and needs a serious attention in Maharashtra. Convergence with WCD was satisfactory in almost all the states while involvement of ULBs in NUHM was very limited to nil. Haryana, Odisha and Chhattisgarh demonstrate good convergence with the ULBs, while it needs to be strengthened in Assam, Bihar, Jharkhand, Manipur, Punjab, UP, Uttarakhand and Nagaland.

Infrastructure

Most States have got more than 77% of the sanctioned facilities as functional. While new constructions and renovation of the facilities is completed in Assam and Telangana; it is still underway or pending in Manipur, Chhattisgarh, Uttarakhand, UP and Karnataka. Acquiring land in congested urban areas still remains challenging for the States and is quoted as the main reason of delay in identifying the sites for construction of the new UCHCs/UPHCs/Kiosks. RKS formation is almost finished in Punjab, Haryana, Assam, Telangana and Nagaland though account opening for few is still pending. In all the other states, RKS formation is under varying degrees of progress. Regarding the status of releasing untied grant to the

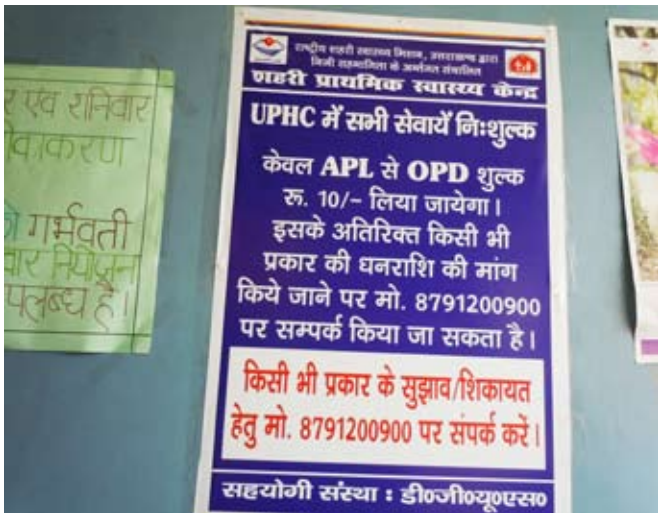
facilities, it was largely found poor among the states with Bihar, Jharkhand, UP and Manipur showing the least progress.

Human Resource

Most states like Karnataka, Odisha, Punjab, UP, Telangana, Uttarakhand and Meghalaya are performing good in terms of HR recruitment and positioning; however high attrition rates among the clinical staff was prevalent across all states which was majorly observed in Jharkhand, Chhattisgarh, Maharashtra and Manipur. Main reasons quoted by the states were less remuneration and more competitive clinical opportunities in urban localities. Further the availability of competent and qualified personnel remains a challenge for many states like Jharkhand, Bihar, Odisha and UP, due to which the positions were either lying vacant or filled with HR having compromised skills and qualification. Similarly, availability of paramedical staff was also a challenge for most states like Bihar, Chhattisgarh, Telangana and West Bengal where more than 50% positions under staff nurse, lab technicians, pharmacist, and PHM categories etc. are lying vacant. The clinical positions in Bihar were only 39% filled, and the state had no ANMs, LTs, PHMs or pharmacist which is seriously affecting the NUHM implementation. Further, though 50% of the states have given induction training to their staff; need for a detailed all-staff NUHM training workshop was observed while interacting with the service providers.

Service Delivery

Besides the routine OPD, major services currently provided in UPHCs across all states were RCH and immunization. In addition to these, some states like Maharashtra, Haryana and Assam are also providing family planning services and adolescent health counselling. Few states like Chhattisgarh, Odisha, Assam and UP have opted to function some of their UPHC's as delivery points. Integration with National Health programs was found weak in all the states, while all UPHCs in Chhattisgarh have integrated with RNTCP and functioning as DOTS centres. Population based NCD screening has not been initiated in most of the states, while all of them are handling opportunistic NCD cases. Telangana has initiated a pilot project on community based



NCD screening in Karimnagar city, for which they have given special trainings to ASHAs and ANMs on NCD management and screening. Karnataka and Odisha are conducting fixed day specialist clinics at the UPHCs including specialties like skin, medicine, OBGYN, pediatric, dental etc.

Outreach Services

While Assam and Bihar are not conducting any outreach sessions, percentage of UHNDs conducted across all other States show a stark variation. Kanpur Nagar in UP has conducted 97% of the sanctioned UHNDs, on the contrary Kharagpur in West Bengal has been able to conduct only 2.5% of the total sanctioned number. Further observations reveal that the reporting of UHNDs and booking of expenditures is also not properly done at the district or facility level, as noted in Karnataka, Manipur and Uttarakhand, which needs immediate attention. Though most states are conducting special outreach sessions, their percentage against the sanctioned are very less due to unavailability or disinterest of specialists in conducting the camps. Hence, many states like UP and Nagaland have started conducting special outreach using medical officers of their UPHCs, which has basically diluted the whole purpose of conducting a specialist camp for the remote vulnerable population.

Community Processes

Recruitment and training of ASHA was satisfactory across all states except Manipur, where their number

is below population norms. States like Odisha, Punjab, Haryana and Meghalaya have almost achieved their targets with approximately 95% of ASHAs in place. Induction trainings of ASHA have also largely been finished by all the states; however the training in module 6&7 is under progress. Further the ASHA payments are being done through PFMS largely across the States. Similarly, most states have achieved the target of MAS formation and orientation in their districts except Haryana which has not initiated the MAS selection process. Accounts for MAS have also been open for most of them except for Bihar.

Quality

States that have constituted committee for Quality Assurance and started the baseline assessment of UPHCs are Assam, Karnataka, Telangana, Odisha, Punjab and Haryana. While states that have yet not incorporated any quality measures are Bihar, Jharkhand, West Bengal, UP, Uttarakhand and Maharashtra. Compliance to BMW was not found satisfactory in most of the States, also the waste segregation practices were found compromised. In Assam, the outsourcing for BMW was not centralized leading incurring big costs to the facilities on individual outsourcing. Patient feedback forms or grievance redressal mechanism was found missing at most places. States like Assam and Uttarakhand where feedback forms were filled, had no proper mechanism to register complaints or analyze the feedback forms. In Manipur. Patient feedback system is pending the launch of 104 helpline service.

PPP and Innovation

PPP was found largely restricted to outsourcing the complete UPHC for service delivery, HR and management like in Uttarakhand, some UPHCs Odisha and Telangana. 39 out of 40 UPHCs in Uttarakhand are running under PPP mode, while in Odisha 33 UPHCs and 8 MHUs are operational under PPP mode. Similarly in Telangana, 2 UPHCs are running under PPP mode on pilot basis in Rasoolpura of Secundarabad Cantonment Board and Shadnagar of Rangareddy district.

Finance

Fund utilization under NUHM has been found very low due to various different reasons like non recruitment of HR, pending infrastructure works, non-performance, wrong bookings etc. States like Jharkhand, West Bengal, Uttarakhand and Maharashtra are still struggling for RKS formation. Further the States where RKS are formed, either have not opened their accounts or have not transferred untied funds in their accounts.

Recommendations

- All types of mapping including spatial GIS, facility and slum mapping and vulnerability assessment of the identified slums areas should be completed on priority.
- States should make sure that all the key positions under the State, district and city Programme management units are filled and functional.
- State level meetings for strengthening convergence with ULBs and other concerned departments should be organized regularly and roles and responsibilities of various departments under NUHM should be clearly identified and communicated among all stake holders.
- All vacant positions under management and service providers should be filled and

state should focus on rational deployment of HR under all category. NUHM trainings under the training module developed by GoI should be completed for officials at all levels of implementation including Secretary, MDs, DHS, SPMUs DPMUs, CPMUs and service providers.

- UPHCs across the states should be made as hubs for providing comprehensive primary health care which incorporates range of services including NCDs and National health programs and not just limited to RCH services.
- Improving ambience and client friendly environment at the facilities need to be prioritized at UPHCs and UCHCs.
- States should make sure that all the UPHCs have registered RKS and release of untied funds to their individual accounts must be expedited. There should be clear understanding over the utilization and dissemination of untied funds by the CPMs and MOs.
- Process of drug procurement should be streamlined to ensure assured drug availability at all the UPHCs.
- There is a need to reinforce coordination among ANM, ASHA and MAS through regular meetings of ANMs with all ASHAs & MAS of their catchment area. There should be special emphasis on their catchment areas, work profiles and level-wise monitoring.
- All the urban health nodal officers in states and districts should be oriented and engaged in quality assurance committee. States should further expedite the process of baseline assessment of UPHCs in developing a practical "action-plan" for prioritization of gaps and closure action for meeting the standard of UPHCs.
- Under the PPP arrangements, the MoU must clearly define the responsibility of private partner and develop a framework to monitor performance of PPPs in terms of defined time bound deliverables and measurable outcomes.

State Findings

ASSAM

Planning and Mapping

Spatial GIS mapping has not yet been initiated but facility maps indicating ward boundaries was present at the facility. State is collaborating with medical colleges to initiate vulnerability mapping in bigger cities and on a pilot basis in Bongaigaon with support from NULM-ALF members.

Institutional Arrangements and Programme Management

Position of only urban health consultant is filled in SPMU while the positions of the Urban Health Nodal Officer and Urban health Planning Consultant is vacant. Out of the total 14 DPMUs, 10 are functional with 2 positions (Consultant & Data manager). State level NUHM-SBM-NULM convergence initiated and trainings have been planned for concerned stakeholders. Involvement of ULB is limited to source reduction, fogging etc. MAS members were involved in SBM activities at ward and UPHC level but documentary evidence was not provided.

Infrastructure

There are 21 UPHCs and 2 UCHCs, mostly running in rented buildings. Upgradation for 5 health facilities to UPHC (approved in 2015-16) is completed and for 3 UPHCs (approved in 2016-17), is under progress. RKS have been formed at all urban health facilities; however, formal registration is awaited in some. Untied grants released and utilized.

Human Resources

Most of the HR both Programme and clinical is in place. Only induction trainings have been provided to all Clinical and non-clinical staff but not on NUHM components.

Service Delivery

OPD, ANC/PNC, Delivery, Basic New Born Care, Immunization, Leprosy, FP, diarrhoea control program, Nutritional support to malnutrition case

in Dhirenpara FRU. Cancer screening Programme is being done in the UHTC under medical college. Pharmacy is well maintained but drugs stock out has seen in some health facilities. Sample collection for 14 diagnostic tests done at facility and sent to Lab maintained by HLL at 44 SMK Civil Hospital, Nalbari for testing.

Urban Health Training Centres (UHTC) - UHTC, Ulubari is being used for providing training to the interns for the Medical colleges. The state has planned to upgrade UHTCs to UPHCs so that in addition to providing health services, they act as training centres for health functionaries under NUHM.

Outreach Services

Outreach services are being provided only for ANC/PNC, Immunization and Family Planning. Specialist camps and UHNDs have not yet been initiated. It was observed that the ANM, ASHAs require refresher training on conducting UHNDs and Specialist outreach camps.

Community Processes

Presently, 88% of the 1336 ASHAs are in position, the selection of remaining under progress. Induction training for ASHAs has been completed and training in 6th-7th Module is ongoing. Regular ASHA performance monitoring is being undertaken. HBNC kits have been provided to ASHAs. 99% of the total 634 MAS are formed and given induction and re-orientation training in 2016-17. MAS grants have been released and have also been utilized.

Quality

SQAC, DQAC are in place and Urban Health Nodal Officer inducted into the State and District Level Quality Assurance Committees. Internal assessment has been completed for majority of the facilities. Goalpara UPHC received a score of 75% in internal assessment while Pandu-UCHC obtained a score of 70.2% in Kayakalp. Patient feedback mechanism was found in Guwahati but there was no structured complaint registration or grievance redressal mechanism. Facilities have contracted a private agency for BMW on individual basis as against centralized contracting, this incurs high cost.

Innovations

NVBDCP and ULB ward level convergence has been observed as best practice in Kamrup metro. Number of Dengue cases is reduced from 9000 cases in Dec 2016 to 3300 by 2017 due to NVBDCP and ULB convergence.

Finance

In Guwahati, RKS has been formed and untied funds released and utilized in all the health facilities. In Goalpara, RKS constitution has been done, however formal registration is awaited.

BIHAR

Planning and Mapping

Vulnerability assessment (VA) has not been started in the state however slum mapping is complete. The tender for GIS mapping and VA is in final stage and will be rolled out soon.

Institutional Arrangement & Programme Management

Executive Director, SHS leads NUHM Programme implementation with support from SPMU. Out of the 4 approved positions in SPMU, 3 are in-position i.e. State Programme Manager, State Finance Manager and Data Entry Operator. Establishment of DPMU is in progress; however nodal officers in only 2 districts have been recruited so far, while other districts have officer in-charge as temporary nodal under NUHM. Convergence of CPMU with the ULBs is weak hence involvement of ULBs in NUHM implementation was not found.

Infrastructure

There are 99 UPHCs out of which 76 are functional. 18 of these are new but HR is not available in them. RKS have been constituted in 57 but bank accounts for all these facilities are not open yet, hence untied funds not released. All four UPHCs including Maulabagh and Gausganj under district Bhojpur are functioning in rented building. Further state does not have any UCHC, Maternity homes, Health kiosks or MMUs.

Human Resources/Programme Management

Though 80% SN are in place, but positions of only 39% MO were filled. State has not recruited any ANMs and pharmacist till date. State has not proposed any LT or PHM positions. Though SNs are trained in routine immunization, drugs and inventory management but there was no orientation/training on NUHM for any staff category.

Service Delivery

UPHCs are operational from 12 to 8 pm providing OPD, ANC, immunization, and other counseling related services. On an average 30-40 patients are availing the health services in the OPD. Drug procurement and distribution in facilities is a part of State Drug procurement and distribution system is under NHM through DHS. Though printed registers were present both the facilities, OPD registration of patient's is done through SHS's software "SANJIVINI".

Outreach Services

UHNDs are not conducted in the state as there are no ANMs, however state is conducting Special Outreach Health Camps. The patients are referred to Sadar Hospital if required.

Community Processes

Out of the total 562 approved, 62% ASHAs are on board, and 61% have completed induction training. ASHAs are neither trained in 6th & 7th module nor provided with drug or HBNC kits. 81% of the total 500 MAS are in place but accounts for only 53% are open till date. All the 23 MAS in district Bhojpur were formed and had their account in place.

Quality

There is 1 SQAC and 14 functional DQAC in the state. No meeting was held at State while 29 meetings have been held at district level.

Finance

Out of total 99 UPHCs, RKS have been constituted in 57 but bank accounts for all these facilities are not open yet. The overall fund utilization under NUHM is 28% (up to September, 2017). Further the State has a high unspent balance of INR 37.11 Cr, up to September 2017.

CHHATTISGARH

Planning and Mapping

Facility and slum mapping has been completed in all the 19 approved cities. SHSRC is helping the state in spatial and vulnerability mapping which also is 75% complete by now.

Institutional Arrangements and Programme Management

SPMU is functional with one Programme Manager, one community process consultant, one finance manager and one DEO cum Accountant. 14 DPMUs and 4 CPMUs are currently functional with 70% of approved HR in place. Regular coordination meetings with ULBs are being held. Nagar Nigam provides free water and electricity to UPHCs. SHGs under NULM have been co-opted as MAS members.

Infrastructure

State has 36 UPHCs, all except one functioning in government building and 2 new under construction. State has additional 12 MMUs, 345 SSKs working in urban slums. Institutional branding of NUHM has not been done as per GOI recommendations. RKS has been formed in 23 UPHCs and all the UPHCs have been provided with untied funds.

Human Resources

The State faces an acute shortage of MOs with 68% positions vacant. The existing part-time doctors have been given additional incentives under State budget to work as fulltime MOs. NSSK, IYCF, RTI/STI, IMNCI, RI, Quality ANC, BEmOC and BLS trainings were conducted last year but all the service providers need to be saturated with the respective trainings related to their field of work.

Service Delivery

RMNCH+A services are being provided at the UPHCs along with routine OPD. All the UPHCs are

providing 24x7 delivery services. PMSMA has been implemented at all the UPHCs but NCD screening not yet started. Effective integration of RNTCP with NUHM was seen, eventually making all UPHCs as DOTS center and DMCs. Integration with other NHPs was found lacking. Patients are referred to DH and Medical College for secondary and tertiary level care. Drugs are centrally procured through CGMSC and supplied to the PHCs.

Community Processes

Approved number of ASHA and MAS has been selected. All ASHAs have been trained and MAS training is going on. ASHAs earn their incentives mostly under MCH services. 50% of the matching grant is provided from the State budget. ASHA incentives are directly transferred to their accounts through PFMS.

Outreach Services

Urban health nutrition days are being held regularly at AWC and SSKs in coordination with WCD.ASHAs are actively involved in mobilizing the community to avail health services through sessions.

Quality

SQAC and DQAC have been formed where the nodal officers for NUHM have been oriented. Patient feedback form and prescription audits are not been undertaken. BMW management is outsourced to E-tech in Raipur; however there is lack of segregation at the facility level.

Innovations

Swasthya Suvidha Kendra-These are physical structures provided to the ANMs to conduct outreach sessions in the community. For five days in a week field ANM works from SSK and provide MCH services. Patients with other minor illnesses are seen on designated day once a week. (Average 8-10 patients).

Finance

Fund utilization against the sanctioned ROP was low ie. 32.68% was used till September 2017. All the facilities have been registered on PFMS and concurrent audit has been done up to September 2017.

JHARKHAND

Planning and Mapping

Mapping of facilities and slums is not initiated. State is planning to collaborate with JSAC for GIS mapping and will start vulnerability mapping once the GIS mapping is complete.

Institutional Arrangement and Programme Management

SPMU has Planning Manager, Monitoring & MIS manager and a CP Manager; while the positions of State Finance Officer and Assistant MIS officer are vacant. 18 persons have been recruited in 18 DPMUs in the State. CPMUs are also formed in Ranchi, Jamshedpur, Bokaro and Dhanbad. Jamshedpur CPMU has a Planning Consultant, CP consultant, MIS consultant, accounts officer and 2 PHMs for the facilities. The team at state and city level has been oriented on NUHM framework. Convergence meeting with NULM and SBM has not been conducted due to which inter departmental coordination at State level was found weak.

Infrastructure

UCHCs in Jamshedpur are operating in government structures while 5 out of 8 UPHCs are functioning in buildings provided by TESCO under PPP. None of the facilities were close to slums. RKS has also not been formed for the district and untied funds not released.

Human Resource

There is a strong crunch of HR especially medical officers and specialists under NUHM. At all the UPHCs in Jamshedpur, only part-time MOs were conducting OPD in the evening hours. Most regular doctors (22 regular doctors) posted are on deputation.

Service Delivery

Morning OPDs at UPHCs (9am-3pm) are managed by ANMs and evening OPD (5-8 pm) is taken by a

part-time doctor. RMNCH+A along with other OPD services were being delivered at all facilities. ANCs were not being conducted at the UPHC/UCHC in Jamshedpur because of absence of female doctors. Hence no ANC register maintained. Immunization provided at the UPHCs on Thursdays and Saturdays, however register for the same was not maintained. It was also observed that NCD services are not being provided at any facility. Integration of other national health programs except NVBDCP was also missing. Process of drug procurement was challenging.

Outreach Services

Urban Health and Nutrition days and special outreach camps are being conducted in the State. Sites and days of camps were not planned because of lack of mapping and household survey. The UHNDs are being organized at AWCs.

Community Processes

76% of the total 981 MAS are functional and have been oriented on the NUHM framework. Jamshedpur has 89 MAS and bank accounts for 70 are in place. State has 216 ASHAs which are trained on the orientation module. ASHAs are not provided with drug kits and their training on module 6&7 is pending.

Quality

The State is yet to incorporate a nodal person into SQAC for Quality Assurance under NUHM and undertake Kayakalp on an early process. The bio-medical waste management at UCHC Mango in Jamshedpur was very poor, with all wastes being mixed up and collected and dumped in a nearby common disposal site of TATA.

PPP/Innovation

5 out of 8 UPHCs in Jamshedpur are functioning in buildings provided by TESCO under PPP.

Finance

The facilities do not have a separate bank account as of now. There are two bank accounts at the District Jamshedpur for NUHM. In Jamshedpur, instead of municipal corporations, 3 notified areas viz Janasi, Mango, Juksala are in place, each having a functioning body of its own, as a reason of which collaboration in the district remains a challenge. Owing to this, RKS has also not been formed for the district.

KARNATAKA

Planning and Mapping

Karnataka is divided into two segments i.e. BBMP and Rest of Karnataka (RoK). Planning and Mapping of all urban health facilities in the BBMP area is completed and is being monitored by software named Public Health Information and Epidemiological Cell (PHIEC). It is not initiated for RoK. Vulnerability Assessment of slums and wards has not yet been done. The State has completed the facility mapping of 348 districts out of total 364 UPHCs. The tenders were made from the District level and the payments have been done last year. State needs to include the additional information as per GoI guidelines to complete their mapping which is pending.

Institutional Arrangement and Programme Management

The Programme implementation and fund transfer is done through DHS in the RoK and through CHS in BBMP. BBMP is sub-divided into 3 inner and 5 outer zones. CHS is managing the implementation of the Programme in inner zones whereas Bangalore Urban District Health Society in outer zones. Funds have been transferred from BBMP to the Bangalore Urban DHS for NUHM whereas the other funds under NHM being managed by Bangalore Urban DHS, are being transferred directly from SHS.

SPMU, DPMU and CPMU is established as per the mandate of NRHM and NUHM. The position of 19 District Data Manager (DDM) has been sanctioned for providing support to 16 existing DAMs.

Infrastructure

The State is having good health infrastructure with 99% functional UPHCs. Delay in execution of civil

works was found as only 1 UPHC against the 8 approved, is constructed and the balance is under process of approval.

Human Resource: At UPHCs

State is having 70% Medical Officers (Full Time), 61% Medical Officers (Part Time), 77% Staff Nurse, 82% Pharmacist, 86% Lab Technician, 69% ANM, 84% Support staff, 76% LDC in place. LDC posted at the UPHC level for maintaining the books of accounts and computer data entry work.

At UCHCs

The State is having 79% specialists, 71% Medical Officers, 81% Staff Nurse, 89% Pharmacist, 67% Lab Technician, 75% other Support staff. State has done number of trainings for Programme management staff, MO, ASHAs and MAS; however the trainings were largely induction trainings with clinical content and components of core NUHM was found missing in course content.

Service Delivery

UPHCs are providing the OPD services from 9 am to 4 pm. No evening OPDs being organized in Bangalore. Specialist services like Gynaecologist, Paediatrician, Anaesthetist, Radiologist Dentist etc. are given on fixed days weekly between 5pm to 8 pm. The procurement of drugs & medicines is centralized at the State level except for NUHM which is decentralized at the District level. The procurement is done from Karnataka State Drugs Logistics & Warehousing Society (KSDLWS). No shortages of medicines have been found in any of the urban health facilities visited.

Outreach Services

Microplan for UHND & outreach camps was not found at any facility. Against the sanctioned, only 21% UHNDs and 28% special outreach have been conducted till date.

Community Processes

70% ASHAs are in position in urban areas. Attrition rate is higher in BBMP area and therefore state government has decided to pay fixed salary of ₹ 3500 per month. ASHA payment is through PFMS and expenditure has been booked under NUHM on a monthly basis. 70% MAS are formed and accounts for 82% are in place, but trainings of MAS is not started yet. MAS were not aware of their roles and responsibilities.

Quality

The State has formed the State Quality Assurance Committee both at the State and at 30 districts. The nodal officer of NUHM has been inducted into the SQAC.

Finance

Against the ROP approvals of 2017-18, the overall fund utilization under NUHM was only 19% by the end of 2nd quarter. Though State has conducted 21% UHNDs and 28% special outreach camps, the same has not been reflected in the booking of expenditure up to 2nd Quarter, 2017 which shows 3% and 16% respectively. In Raichur, fund release from district to the UPHCs was found delayed. Further issues like low unspent & unsettled balances, pending payments, wrong bookings delayed cashbook updations were also present.

MANIPUR

Planning and Mapping

Facility level mapping of UPHCs has been completed, gaps identified and proposed in PIP of 2016-17 and 2017-18. GIS mapping will be undertaken if approved in RoP. Capacity building for vulnerability mapping is being undertaken in partnership with NHSRC, after which the state will initiate vulnerability mapping.

Institutional Arrangement & Programme management

SPMU is functional with 1 Consultant and 1 Accountant but there is no MIS assistant. 3 DPMUs are functional in Imphal East, Imphal West and Thoubal. Thoubal has a District Consultant and an accountant, while Imphal East and West have no accountants or MIS assistant. State level Convergence meeting held with SBM and NULM. ULBs in State lack the capacity and technical expertise to implement NUHM.

Infrastructure

UPHCs are functional but with very poor infrastructure. Construction of 2 new approved UPHCs initiated. There was no electricity in the facility from the past 2 years. RKS has been formed in 4 UPHCs and untied fund released for 2.

Human Resource

Positions of 5 MO, 6 SN, 3 Pharmacists, 3 LT, 7 ANM and 7 Support Staff are vacant. Further, there is no PHM or DEO in the State. A total of 9 MOs, 51 Staff Nurse/ANM/Paramedical staff were oriented and trained. All staff training on NUHM needed.

Service Delivery

RMNCH+A and Immunization are major services provided at UPHCs while NCD screening yet to be initiated. Lack of drugs is a key concern due to lack of funds from the state. Instead facility has fixed 1st 10th & 20th day of every month for immunization. Data reporting under HMIS did not match the records in the facility. Availability of standard register was also missing.

Outreach Services

UHNDs and Outreach Services are being provided through the ANM, ASHA and MAS, but immunization and ANC not done in outreach. Record maintenance for outreach was found poor.

Community Processes

In spite of strong presence of ASHA and MAS at ground level, it was difficult to mobilize patients to UPHC as the placing of UPHC was close to Territory centre facility (RIMS). Gaps exist in the total number of ASHAs and MAS to cover all urban population of Imphal West, Imphal East and Thoubal. 409 MAS and 81 ASHAs are trained and oriented. Training of ASHAs in 6th & 7th module yet not started in Imphal West. Drug Kits and HBNC kits are not provided from past two years. Delay in payment of incentive observed due to fund constraints from state side.

Quality

Quality Assurance training on NQAS Standards for UPHCs conducted and 17 officers have been certified. Baseline Assessment conducted in UPHCs show very poor scores for most of the UPHCs except UPHC Mantripukhri. State Level Quality Assurance training conducted and 17 officers certified as Internal Assessors. BMW Management and disposal was not appropriate. The waste material is either burnt or sent to PHC-Khurkhul.

PPP

A private diagnostic lab was roped in for screening of cervical cancer during outreach camps in Imphal West as an experiment but was abandoned due to prohibitive costs out of the available funds for outreach camps.

Finance

State is showing 71% fund utilization with an unspent balance of INR 37.8 Lakhs at State level and INR 21.98 Lakhs at district level. RKS has been formed in 4 UPHCs and untied fund released for 2. Positions of NUHM Finance consultant at State/District/City level are vacant. The State Finance Department has not released ₹ 1.94 Crores for 2016-17 till date and has impacted the activities of NUHM.

ODISHA

Planning and Mapping

State has completed facility mapping whereas slum mapping is under progress. Vulnerable mapping of 57% household has been done so far. Out of 36, GIS mapping for Bhubaneshwar and Cuttak is complete and is under progress for the rest of the districts. The reason for the non-completion of the Spatial GIS mapping is the recent shifting of the facilities to newly constructed buildings and the other being the non-availability of the bidders for the tender.

Institutional Arrangement and Programme Management

State level coordination committee (SLCC) formed, consisting of 20 representatives from

government, corporate Civil society organizations with major stakeholders namely HFW department, HUD department and WCD department has been constituted under chairmanship of Principle secretary, H &UD for effective delivery of basic services like health, water, sanitation, nutrition etc. to urban poor in the state. State has developed a road map for convergence with NULM and SBM where Urban ASHAs and MAS members will be involved and will be declared as Swachhgrahi. Ward Kalyan Samiti (WKS) is an innovative ward level convergent platform in the interest of the urban communities.

Infrastructure

85 UPHCs are functional against the 93 approved (29 for renovation and 64 new construction). 36 UPHCs are in rented premises of which 33 are functional under PPP mode. Approximately 30% of the 64 newly approved UPHCs have been constructed. There are six Virtual Sub Centres under each UPHC managed by designated ANMs at available spaces such as community centre, AWC etc. Five UCHCs against 7 approved are functional (3 under renovation and 4 New under construction). Construction work of 2 UCHCs has completed and two is in progress. The infrastructure work is under progress and is pending due to the non-availability of land in the urban areas and also due to limitation on vertical expansion of building (BMC-UCHC-Bhubaneswar) near the historical Lingaraj temple by archaeological department. There are 79 UPHCs with registered RKS and untied funds have been transferred to these.

Human Resources

Positions of 72% MO, 71% PHMs, 67% SN and 58% LT are filled and functional. State needs to do performance assessment of current positions and gap analysis as per the patient load, to fill the remaining vacant positions at UPHC and UCHC. HR integration also not seen and there are separate counselors for STD and ICTC in same facility (UCHC-Bhubaneshwar). Work assigned to LHV posted at UCHC Nayapalli needs to review as it seems only immunization activity is given to her.

Service Delivery

Facility timings are 8 am to 11 AM and 5PM to 8PM with an average 130 to 140 patients per day. Services provided at UPHCs are OPD, Specialist (Skin, medicine, O & G), ANC & PNC, pathology services, immunization services, PMSMA and disease control Programme related services (i.e. NVBDCP, NCD, RNTCP etc). In addition to these services, UCHC provides services such as IPD, Normal and LSCS deliveries, surgeries, emergency care, X-ray etc. UPHC at Keonjhar also focuses on geriatric care and organizes camps for geriatric patients as well as eye care camps. However quality of all services was compromised. Grievance Redressal Mechanism in form of complaint boxes was in place in all the visited health facilities. The referral slip was available in UPHC with referral register but ultimately referred patient has to go through all process which other patients go at referred hospital. There is no mechanism to prioritize patients referred for emergency care as well as specialist care at the higher/tertiary level facility.

Outreach Services

UPHCs are not able to meet target set for UHNDs. UPHC Keonjhar could met 50% of target similarly UPHC Barbil could met 72% of target till Sept 2017. PHMs play active role in managing UHNDs on Tuesdays and Fridays. However specialist camps are not conducted. Branding of all UPHCs, UHND sites & MHU sites have been completed.

Community Processes

100% MAS are formed, trained and functional (3132). Similarly 96% ASHAs have been selected (919). MAS conducts monthly meeting on last Thursday of the month. The Quarterly MAS checklist was made available to the City Programme Manager, but it was not being adhered to and monitoring mechanism for the MAS was not in place. One concern shown by MAS at Keonjhar was non availability of community toilet for themselves which is unfortunately forcing them to prefer Open defecation. It's very difficult for them to spread ODF messages when they themselves could not follow.

Quality

State quality assurance committee (SQAC) has been formed. 25 DQAC formed in 25 districts covered under NUHM. Facilities have infection control committees but they are not functional. There are no regular meetings, gap finding analysis and follow up action. IEC related Bio Medical waste seen in UPHCs along with available colour coded containers but BMW protocols were not followed in UCHC. Kayakalp assessment is going on covered 79 UPHCs this year of which 59 scored more than 70% score in internal assessment; out of which 36 scored more than 70% in peer assessment and now eligible for external assessment. Kayakalp outside boundary wall is not yet implemented. Kayakalp is not yet extended to UCHC.

Innovation and Public Private Partnership

In Odisha, 33 UPHCs and 8 Mobile Health Units are operational under PPP mode. Some projects under innovation category are grading of MAS, Community monitoring system to monitor UPHC activities, Composite register of MAS, Active role of Ward Kalyan Samities at ward level as convergent platform and compendium of Guidelines (program and finance).

Finance

Utilization of NUHM funds is 24.46% out of the approved budge at the end of Sept. Quarter 2017-18. Unspent Balance available with State is ₹ 4621.00 lakhs, with Municipal Corporation is ₹ 3528.53 lakh and with District level is ₹ 1116.29 lakhs. Separate bank accounts at the Municipal Corporations, district and facilities level were found. PFMS registration of urban health facilities (including municipal corporations) have almost completed, but training is yet to start. 79 UPHCs have RKS registration and have been provided with untied fund.

PUNJAB

Planning and Mapping

Slum mapping has been completed in urban areas of Punjab. However Vulnerability mapping as per the GoI guidelines has not been initiated. Area maps are seen in some of the UPHCs but GIS mapping is not visible, although GIS mapping is done in the state. City Health Planning is primarily PIP oriented. No short term and long term planning could be ascertained about the Urban Health. However, in Ludhiana, a concept of coverage of peri-urban areas with a view to improving immunization coverage by dividing the urban areas into 9 zones under the control of one UCHC has been generated and that was found to be encouraging.

Institutional Arrangements and Program Management

One post at district and two posts in city level are lying vacant whereas both the posts at state level are filled. In Ludhiana, posts are filled up. The urban unit is under direct control of District health society; however there is lack of prioritization about urban health in both the districts. There is lack of convergence so far as the involvement of various stakeholders in this regard are concerned. Only AWCs under ICDS/WCD departments are participating in outreach sessions.

Infrastructure

40 designated urban areas are covered under NUHM in the state of Punjab. There are 93 UPHCs and 2 UCHCs operational in the state along with 23 Health Kiosks running in various urban areas. Review of NUHM has been undertaken in the cities of Ludhiana, Khanna and Kapurthala. Ludhiana has 16 UPHCs, 6 UCHCs and 6 HK while Kapurthala only has 2 UPHCs. RKS has been formed in all the UPHC and UCHCs. However a few is required to be registered (4 out of 16 in Ludhiana). No untied grant has been released since February 2017.

Human Resources

Number of HR under different category was found satisfactory. Positions of 100% MO, 82% para-medical and 82% PMU are filled and functioning. However the training at various level are lacking and there is no monitoring about the level of training and capacity building of the HR engaged.

Service Delivery

General OPD, immunization, ANC, free drugs and diagnostics along with services of RNTCP, NVBDCP and NLEP etc. are provided at the UPHCs. None of the UPHCs in these two districts have indoor facilities or delivery points. UCHC at Ludhiana are 40-100 bedded hospitals having ambulance facilities. The UPHCs are generally operating in 2 shifts, but the ones having no part-time doctors are operating from 9 am to 5 pm. Medicine supply at the UPHCs is done from the concerned Civil Hospitals (SD or DH).

Outreach Services

QPR report till June 2017 shows that 1097 such camps have taken place in the current financial year. UHNDs are taking place every week on Saturday at the facility.

There is no linkage with Anganwadi, NRCs, and UHNDs; although in many of the cases the UHNDs take place in the AWC only. In Punjab, the special outreach services are taking place in a big way especially through the Health Kiosk with support from religious organizations and private specialists. In Ludhiana, it has been seen that specialists in different disciplines like Medicine, Skin, Dental, Gynae, Eye are being engaged. These sessions are providing a platform to informally identify the common NCD and the risk factors for these NCDs like Diabetes, Hypertension, sometimes common cancers. Till date, 2050 special outreach have been organized monthly where average attendance is around 100-200.

Community Processes

98% ASHAs are in place and all have received induction training but training in module 6&7 is completed for 65% ASHAs only. Their awareness regarding activities against which they are supposed to get incentives, was found compromised. Similarly 83% MAS are formed out of which 90% have been trained so far.

Quality Assurance

SQAC and DQAC are formed and having State and District nodal officers as members. During this year 15 supervisory visits made to the urban facilities by the SQAC and 15 meetings of state committee have been organized. 85 supportive/ monitoring visits to the Urban Facilities have taken place. Baseline assessment of Quality of the UPHCs has been initiated in the state. Quality Assessment has been done by NHSRC in 3 UPHCs in Ludhiana and 1 in Kapurthala. In Model Town UPHC Ludhiana the quality assurance marking was very satisfactory (75%). No action plan has been mooted for Kayakalp. No financial support had been asked in PIP. BMW disposal is exemplary in Ludhiana which is outsourced to the common agency for the whole state. Daily disposal after having segregated at the point of generation is being done. Necessary training of all concerned has been done.

Innovations

Intersectoral convergence is happening in urban areas under *Swachhta hi Seva* Campaign, with Medical colleges for conducting outreach sessions, strengthening of UHTCs (Amritsar, Patiala) and support from Private Medical Colleges for Haemoglobinopathy.

Finance

RKS has been formed in all the UPHC and UCHCs. However a few are required to be registered (4 out of 16 in Ludhiana). No untied grant has been released since February2017. RKS formation has been formed; however few registrations are pending. DBT payment to ASHA account is taking place. Delay in transfer of Fund from treasury to the NHM account and then to NUHM account from district is resulting in overall delay of fund flow. Issues of wrong and incomplete booking are pending. No fund transfer occurred since March 2017.

TELANGANA

Planning and Mapping

61% of slum and vulnerability mapping is finished. In Hyderabad, Vulnerability mapping is being conducted with support from Indian Institute of Health and Family Welfare (IIHFW) for mapping

Greater Hyderabad Municipal Corporation (GHMC) slums, and in rest of Telangana state with support from Mission for Elimination of Poverty in Municipal Areas (MEPMA). Ward assessment has been completed in 50 of the 150 wards. MEPMA is assigned to map the vulnerable population/slums in 47 cities/urban towns in rest of Telangana. Further GIS mapping is under progress across the State. Also, facility mapping is 71% complete.

Institutional Arrangements and Programme Management

State has initiated the NUHM activities on faster pace though some procedural delays are due to State division (Telangana, Andhra Pradesh) and staff allocation to State, and relocation of staff and subsequently creation of new districts by newly formed State of Telangana from 10 districts to 31 districts. Deputy District Medical and Health Officer (Dy. DM&HO) is the District Nodal Officer (DNO) for NUHM in both the districts viz. Khammam and Adilabad. DNO holds the management functions for the urban health programs with support from District Programme Officer (DPO), MIS manager, Accountant. District level convergence committee is formed and held one meeting in the month of October along with Department of Women and Child Development (DWCD), representatives from Water and Sanitation department. Functions of the convergence committee did not start in the district. The Urban Health Cells under the existing district Programme management units are not fully functional, as recruitment of Programme management staff has not been done while the existing DPMU's under NRHM has extended its services to NUHM by additional resources. The city Programme management unit has been established, but not functioning due to lack of understanding and orientation on NUHM at GHMC level.

Infrastructure

As per the 2016-17 RoP, 83% 0f the sanctioned 249 UPHCs are functional in Telangana. Out of these, 112 are in the Greater Hyderabad Area and 94 are in Rest of Telangana. 80% of these are operating in government premises and have completed branding of facilities. All facilities have been provided with equipment, surgical items and furniture. Out of the total 14 functional UCHCs in the State, 13 are in Hyderabad and 1 is in Warangal. Four Kiosks were approved out of which 2 are started on pilot basis. Four MMUs are also approved, while none of the MMU is functional. Though RKS formed, but untied funds not transferred. Further, the staff was unaware of RKS fund utilization.

Human Resources

60% FT and 74% PT positions of MOs are functional in the State; however approximately 40-45% of the other positions like SN, pharmacist, LT, DEO and ANM are filled. Performance review systems of staff are not commenced. Dy. DM&HO, District Nodal Officer of NUHM shared that the performance monitoring system will be kept in place. In Adilabad, Pharmacists, ANM, ASHA are recruited for all five UPHCs while post of 3 MOs out of 5 and post of LTs in all the facilities are vacant. The recruitment process is under progress. While in Khammam, the UPHCs are managed by 1 FT MO and 1 PT MO, 1 PHM, 2 SN, 1 Pharmacist, 1 LT, 5 ANMs, 1 DEO and 3 supporting staff.

Service Delivery

All facilitates are providing the services of RCH viz. ANC, PNC, family planning and immunization while NCDs and Communicable diseases are inadequately addressed. Only part of NCD activities (diabetics, hypertension) screening has been started in UPHC where medical officers are available. In Khammam, the OPD timings were 8:00 am to 8:00 pm, (12 hrs functioning), while the average number of OPD attendance is 60-70 per day, which is very less. UPHC staff is maintaining registers for OPD, Referral, ANC, Immunization, Special Outreach etc. Referrals mechanism is in place in both the districts. A separate register for referrals is maintained at all the facilities visited. In Khammam, follow up of referral cases is being done by ASHAs while no such follow up mechanism is observed in Adilabad. All the UPHCs are indenting through e-Aushadhi platform and receiving through Central Drug Store. Buffer stock of Medicines and consumables are available at UPHC. Essential list of drugs and consumables for UPHCs @50,000 per month is being supplied by the procurement agency TSMISDC.

Outreach Services

The outreach activities are being conducted by the ASHA & ANMs; micro plan was found with them. 58% of the sanctioned UHNDs have been conducted so far while only 25% of special outreach sessions were covered. UHNDs are mainly conducted on every Wednesday at AWC, and are managed by a SN, ANMs, ASHAs, AWW and MAS members. In Adilabad, monthly calendar of outreach activities was displayed at the UPHC. Special Outreach camps are conducted in Khammam, the camp is managed by 1- Gynaecologist, 1- General Physician accompanied by Staff Nurse and ANM. Special Outreach register is maintained at the UPHC by the ANMs.

Community Processes

72% of the sanctioned ASHAs have been selected and oriented on NUHM Programme at IIHFW, Hyderabad. ASHAs and ANMs are monitored by Community Organizer (Public Health Manager) placed in each UPHC. MAS groups are formed by MEPMA, existing Self-Help groups of NULM are linked to NUHM program. MAS bank accounts are opened but grants are not yet received by MAS groups. It was observed that there are common signatories for bank accounts for 2 or 3 MAS groups.

Quality

Urban Health Nodal officer of the district is also nodal officer for District Quality Assurance committee. The first DQAC meeting was conducted on 8th October, 2017; meeting minutes were present. Baseline Assessment of 69 UPHC as per NQAS have been completed, the report for which have been shared. 17 UPHCs were nominated for state certification in the month of January 2018 may be applied for NQAS and in the month of March 2018 may be applied for National Assessment. Proposing 114 UPHCs for Kayakalp award. External assessment would be completed by January and by the end of March, award winning UPHCs would be declared.

Innovations

Piloted community based NCD screening to determine disease burden and improve early detection and preventive and pro-active care for NCD cases. This screening includes Diabetes, Hypertension, Oral Cancer, Brest Cancer, Cervical Cancer and Prostate Cancer. Selected Karimnagar city for this pilot since it has NDC cell for referral linkages. All the UPHC ANMs and ASHA were trained on NCD screening and management including technical and operational protocols.

Public Private Partnerships

Electronic-UPHCs on pilot basis were established in Rasoolpura of Secunderabad Cantonment Board and Shadnagar of Rangareddy district. These centres were equipped with medical equipment, Doctor, Paramedic, Lab Technician and Pharmacist. Main concept was using telemedicine in providing the primary health services and capturing vital measures like height, weight, BMI, BP, Glucose etc. Facility equipped with diagnostics like Otto scope, Derma scope, stethoscope and ECG. Facility also conducts outreach services, special outreach camps and UNHDs.

Finance

Overall fund utilization of UPHC is only 38%. RKS has been constituted for 80 UPHCs in Rest of Telangana and 112 UPHCs in GHMC. All are ensured with opening balances and 192 RKS accounts have been mapped into PFMS. Separate bank accounts with NUHM as sub-account have been formed in all the District Health Societies.

UTTAR PRADESH

Planning and Mapping

GIS mapping for the facilities at State level has not been initiated. Mapping of slums and vulnerability assessment at district level has not been done.

Catchment area of UPHCs was not clearly demarcated and the staff was not aware of its catchment population.

Institutional Arrangement & Programme Management

UP state is divided into 18 divisions and each division has 1 NUHM consultant for about 5-6

districts. At district level there is 1 NUHM Nodal officer supported by 2 urban-coordinators and 1 Data cum account assistant, constituting DPMU. Regular convergence meeting at district level was found missing. NUHM had no linkages with Medical College; also the college has not adopted any Urban Health training Center. The Community Medicine and Psychiatric department were oriented and expressed their willingness to take up activities under NUHM, with support from some additional faculties as the mental health department was found grossly understaffed (with only 2 faculty managing the department).

Infrastructure

Kanpur Nagar has 49 functional UPHCs but there were no UCHCs for a population of 6.4 lakhs. The city has identified 11 UPHCs as cold chain points and these are called Mother UPHCs. Each mother UPHC is supplying vaccines to 6-7 associated UPHC. In Kanpur Nagar only 29% UPHCs (14 out of 49) are functional in government building, while the rest 35 are rented at rate of 16,500 per month including electricity. Out of the total 49 facilities, RKS has now been formed for 20 facilities and still under progress for the rest. 13 facilities have also opened their accounts but fund transfer to them is yet to be initiated.

Human Resource

More than 96% positions under service category were filled and functional. An all staff training under NUHM and its components was to be started.

Service Delivery

The facilities were functional from 9 am to 5 pm. General services at the UPHC were routine OPD, ANC check-ups, immunization, diagnostic services, outreach and immunization. NCD screening was not being done at the facility and opportunistic NCD cases were referred to district hospital or medical college with no follow up. 9 out of 49 UPHCs have been identified as delivery points and have established labour rooms which will start functioning shortly. All the complicated and un-manageable cases were referred to either Government district hospital (12-15 km away), Medical College (12 km away) or community health centres (which is 10 km from the UPHC). The patients were referred through the printed OPD slips. Though the facility is maintaining a referral record for all the referred cases, but the diagnosis or reasons for referral were found missing from the records. This can severely affect the quality of "follow-ups" especially for the high risk pregnancy cases.

Outreach Services

97% of the total 336 sanctioned UHNDs, have been conducted so far. Weekly UHNDs are conducted by ANMs and ASHAs on Wednesdays while special outreach camps were conducted monthly by MOs, staff nurses, pharmacist and LT. Most special outreach camps do not involve any specialist services because districts are finding difficulty in arranging specialist for INR 3000. Hence facilities at both Kaushambi and Kanpur are conducting specialist camps with regular MOs. In some rare cases OBGYN is available for the specialist camps. ANMs are facing difficulty in identifying sites for conducting outreach/UHNDs. Few of them conduct at AWCs but most AWC in urban areas are not functional, because of which ANMs use open spaces of schools/temples OR their own houses for conducting sessions. It was found during interviews that females don't feel comfortable getting ANC check-ups in open places and are reluctant to attend UHNDs since there is no privacy.

Community Processes

The number of ASHAs and MAS were found to be very less as compared to the GoI population norms. For example a facility in Kanpur Nagar called Gujjaine UPHC had 8 ASHAs and 6 MAS catering to a catchment area of more than 65,000, all being vulnerable slum population. It was further observed that though 65% positions of ASHAs are filled at district level, only 50% of them were currently functional. Out of the total functional ASHAs, 84% have been trained but they are not provided with drug or HBNC kits as of now. 48% of total 457 sanctioned MAS were constituted, out of which only 13% have been trained so far.

Quality

There is no internal or external quality assessment at any facility. District needs to nominate facilities for quality certification. Patient feedback mechanism and complaint box was missing. The Bio-Medical waste management was not found in place. Though the color coded bins were present at all the facilities but waste segregation knowledge among the staff was compromised. Also the partially segregated waste is collectively dumped in the Municipality vehicle, as the facilities are not registered with pollution board, and there is no MoU with any agency at district level, for collection and disposal of segregated waste.

PPP

PPP is signed with Sight Saver Organization, operating through Vanshidhar Netra Sansthan, for providing an eye-specialist to conduct fixed day eye check-ups at the UPHCs.

Finance

Since RKS formation was pending till March 2017, the remaining balance of 24, 75,000 as on 31st March 2017 is proposed as committed amount for 2017-18. Further in the absence of bank account, facilities have not been able to utilize their operational expenses and out of the total remaining balance of 22.29 lakhs as of 31st March 2017, district has proposed to commit 9.37 lakhs for 2017-18. Out of the total 49 facilities, RKS has now been formed for 20 facilities and still under progress for the rest. 13 facilities have also opened their accounts but fund transfer to them is yet to be initiated. All the payments of service providers and ASHAs is through PFMS however the facility is not registered under it.

UTTARAKHAND

Planning and Mapping

Slum mapping was earlier conducted by NULM, which is still being followed by the State for NUHM. GIS mapping of facilities has not been initiated but GIS coordinates are available with the State. The vulnerability mapping and assessment (city, ward and slum level) is under process.

Institutional Arrangements and Programme Management

The posts of State Urban Manager and State Urban cum Accounts Manager under SPMU are still vacant since December 2015 and June 2016 respectively. None of the urban DPMUs is functional in the State. Under CPMU, 3 City Urban Health Managers and 1 Urban Health Consultant along with 4 Urban Health Accountants are functional. Immunization Task Force is in place at State level and for 6 cities. The due list and micro plan is prepared by the ANMs in consultation with the Public Health Manager at the UPHC level. An orientation meeting was held with ULBs in 2015-16. There has been no meeting held at State level for convergence with SBM and NULM. No comprehensive state plan to ensure convergence hence coordination between ULBs, WCD, Water and Sanitation and State/District Health Department at grass root was found poor.

Infrastructure

The MOU between PPP partner and the Government mentions that it is the overall responsibility of PPP partner to select the rented building for operationalizing UPHCs. All the 39 UPHCs are functional in the rented buildings within slum locality. Rent for individual UPHCs varies from ₹ 15,000 to 25,000. Biometric device was linked to salary accounts. CCTV cameras & Wi-fi were installed and operational in all the UPHCs. Branding of the UPHCs was poor. HMIS data is not being regularly reported by the facilities running under PPP mode.

Besides the UPHCs, there are 12 Health Posts still functional in Dehradun operating from 8 am to 2 pm and caters to a large population with an average OPD of around 10 to 15 per month. A total of 18 Health Visitors and 19 ANMs are in position in these Health Posts. There is provision of ILR and Deep Freezer in each of the 12 Health Posts. Hence, only immunization services are delivered. None of the Health Posts has Medical Officer or Pharmacist in place. Since there is no pharmacist available, procurement of medicines is not done. PPP partner is not responsible for operating Health Posts. RKS have not been constituted at any of the UPHCs across the State as PPP partner is mainly responsible for running and undertaking activities under NUHM.

Human Resource

Each UPHC has 100% HR in place. Each UPHC is equipped with 1 MO (FT), 1 SN, 5 ANMs, 1 LT, 1 Pharmacist, 1 PHM, 1 Watchman cum Sweeper and 1 Ward Aaya. There was no data to analyze the performance of HR. Hence it was very difficult to understand the utilization of UPHC functionality under PPP mode. None of the visited facility has HR policy in place. Along with the approved HR, the PPP partner has an additional staff of 4 which include 1 Project Coordinator, 1 IT-MIS-Coordinator, 1 Accountant and 1 Data Entry Operator (DEO). This group of 4 members caters to a cluster of UPHCs in their area.

Service Delivery

UPHCs under PPP mode across the State are operating from 9 am to 5 pm, with no evening OPD. The service delivery across the visited UPHCs mainly focused on RCH and immunization services. Average OPD per facility ranges from 50 to 60 per day. Registers on OPD were maintained but OPD diagnosis was not recorded. The UPHCs perform around 24 laboratory tests such as Haemoglobin, urine albumin, urine sugar, blood grouping etc. on an average in-house. As per the MOU, drug procurement is done by the PPP partner. But, due to non-availability of generic drugs from the government supply, branded drugs are being purchased from outside. There was no record of referrals made from the UPHCs to the higher facility as no formal referral and follow-up mechanism is in place.

Outreach Services

UHNDs are held on Mondays or Saturdays between 10 am to 4 pm, the micro plan for which is prepared by PHM. These are conducted by ANMs at the AWC with support from ASHA and AWW. Immunization services are being provided in the facility on every Wednesday and Saturday. Services provided under UHND include ANC, immunization, detection of malnourished children and family planning counseling to the beneficiaries. The MOU mentions conducting Special Outreach camps every month for each UPHC. However, nothing is reported in the HMIS.

Community Processes

NUHM has 579 urban ASHAs and 750 MAS in place, trained on NUHM Orientation Module and Modules 6 and 7 by State and CPMU. Payment of urban ASHAs is verified through PPP partner and payment is made manually by CMO office. Around 180 ANMs have been trained. Out of 750 MAS, 33% have been trained on Orientation Module. Therefore, the bank accounts are opened only for them. ASHA drug kits and HBNC kits are not available for urban ASHAs.

Quality

UPHCs under PPP mode have not undergone any baseline assessment on Quality Assurance. State Quality Assurance Committee (SQAC) is formed at the State level and it includes State NUHM Nodal Officer. No Quality Assurance training on NQAS has been organized standards by the State.

PPP

NUHM in Uttarakhand works with this model of PPP. A total of 39 UPHCs out of 40, are operational under PPP mode. MOU with PPP partner is initially signed for one year but can be extended to a period of 3 years depending on the performance of the PPP partners on evaluation.

Finance

All UPHCs are charging ₹ 10/- for registration, valid for 15 days, for APL patients. There were no charges for BPL patients and pregnant women. The collected user charges are divided in two parts - 50% are routed through Treasury while the remaining 50% go to NUHM account of CMO. Approximately ₹ 25 to 30 Lakh are lying unused in the NUHM account for the past 2 to 3 years.

WEST BENGAL

Planning and Mapping

The listing and mapping of urban slums has been done .The process of GIS mapping is still going, it has been completed for the UPHCs visited. The 2 UPHC visited has already completed listing and mapping of urban slums. No evidence of vulnerability

mapping was noticeable. Also the display of IEC materials at UPHC is not adequate.

Institutional Arrangement and Programme Management

NUHM is being implemented through Municipal Corporation & ULBs in the State; through bodies like Kolkata Municipal Corporation (KMC) and State Urban Development Agency (SUDA) which directly interface with the Ministry of Health and Family Welfare. 89 ULBs are sanctioned under NUHM. The information flow mechanism is from the Ministry to KMC and SUDA, who in turn coordinate with ULBs assigned under their areas. Good coordination was observed between State NUHM cell, DPMU and ULBs in the state. There is strong focus of Municipality on Urban Health.

Infrastructure

92% of the UPHCs are functional out of a total of 459 sanctioned for the State. Rogi Kalyan Samiti is not formed at any of the UPHCs.

Human Resource

64% positions in DPMU and 70% positions in CPMU are filled. Percentage of filled clinical staff at the UPHCs is 66%, para-medical is 45% and support staff is 62% filled. As half of the sanctioned positions are vacant especially from the of paramedical staff, services can be seriously affected. In P. Medinipur we visited Ghatal and Medinipur UPHC where no ANM and shortage of full time MOs was seen.

Service Delivery

RCH services were available in the UPHCs. Most ANC in urban slums is provided through weekly UHNDs at AWCs and Maternity Homes. All basic registers were maintained at UPHC and online HMIS reporting was followed (Paschim Medinipur). Various OPD slips were in use at the UPHCs, however no referral slip were found. All drugs and consumables items were present in the facilities. The UPHC uses SIMS portal to indent drugs and other supplies from vendor. No outpatient clinics during evening hours in the State. All the National health programs are not implemented through UPHCs.

Outreach Services

The State has acute shortage of ANM and GNM due to this, the outreach services are severely hampered. Although microplans are in place, insufficient number of UHNDs being held (In Kharagpur Municipality out of planned 5760 only 150 organized) and insufficient outreach activities being conducted (In Medinipur Municipality out of a target of 108, only 29 special outreach camps held)

Community Processes

The district level training of the Honorary Health Worker/Urban ASHAs is underway in PPP mode in P.Medinipur. The 1st batch of 23 HHW/Urban ASHAs training commenced on 6th November 2017. 1200 HHW/Urban ASHAs have been approved for KMC but many of them are getting older and retiring. On an average 200-300 HHW will retire over the next 1-2 year. The main challenge is to fill the vacant positions and State has no plans in place for recruitment of new urban ASHAs. MAS formed in both the districts have their accounts opened. Most of the local SHGs have been adopted as MAS (Paschim Medinipur) and their district level TOTs conducted; but in D. Dinajpur trainings need to be expedited. Out of target of 11709 MAS for the State, only 4748 MAS have been formed.

Quality

None of the UPHC visited practiced Kalyakalp or NQAS for quality improvement of their facilities. We suggest to roll-out the quality programme in KMC run UPHCs (144) since they are better staffed and functioning well.

Public Private Partnership

HHW/Urban ASHA training is being conducted under PPP mode currently.

Finance

Percentage of utilized funds is 23.06% against the sanctioned RoP of 228.96, however their utilization upto second quarter was 52.80 crores.

NAGALAND

Mapping

The identification of slum and mapping has been completed with support from the Urban Development Department for all 4 cities/towns. The process of identification of vulnerable population is under process, the State Health Department is doing the vulnerability mapping with help of its health workers. The GIS based mapping data for slum area and vulnerable population for all 4 cities/ towns covered under NUHM has been covered with support of State NVBDCP Dept. All the facilities in urban areas are reporting through HMIS. The mapping of these facilities is under process.

Programme Management

The Programme Management staff is in position in all the 4 cities/towns. The clinical and para-clinical staff are all in place except for 1 vacant position of Pharmacist at District level. The UPHC, Kohima has 1 lady MO (Part-time) in position which is not approved position, this initiative was taken owing to high case load of female patients. Orientation training has been successfully imparted to all programme management, clinical and para-clinical staff at state and district levels for 1-2 days. Training for ULB/ Municipality members has not been conducted. The establishment of convergence linkages with other departments such as SBM, Urban development, WCD etc is under process in the state.

Infrastructure

In the state, 5 UPHCs in total are functional, out of which only 2 in rented and 3 UPHCs in Government buildings respectively. Untied grants have been released to all the facilities. Rogi Kalyan Samitis (RKS) have been formed in all the health facilities. Regular meetings of RKS need to be held in all the urban health facilities and minutes of the meeting needs to be recorded. Out of the 5 newly approved UPHCs, civil works for 3 is completed while 1 is pending and 1 just started.

Human Resources

All the clinical and para-clinical staff is in position. The UPHC, Kohima has 1 lady MO (Part-time) in position which is not approved position, this initiative was taken owing to high case load of female patients coming for delivery.

Service Delivery

It was observed in visited health facilities that the basic primary health care services provided were RCH oriented, focus needs to be integrate with the disease control programme activities (i.e NVBDCP, NCD, RNTCP, IDSP, NOHP, NTCP, NMHP etc) leading to comprehensive primary care. ILR & Deep freezer were properly maintained. Family planning methods like IUCD insertion are being conducted in the facility. Essential equipments such as X-ray, USG were not available. Drugs & Consumables were being purchased on indent basis from state as well as from NUHM funds also. The computerized system was not followed for registration, medicines indent/purchase through online system. During the visit registers were found i.e. OPD, integrated RCH, laboratory registers, immunization etc. Beside these accounts book consisting the untied grant register and ledger book.

Community Processes in NUHM

Under community processes, 41 ASHA has been sanctioned 38 ASHA are in position whereas out of 98MAS sanctioned 74 MAS formation have been done. Orientation training for all the selected MAS in position has been completed as per GoI guidelines. ASHA have been imparted induction training as well as Mod 6 & 7 training. ASHA drug kits have been distributed to all ASHA. Average ASHA incentives received was ₹ 1000 per month but ASHA do receive regular payments. In urban areas ASHA are nominated by ward panchyats and selected by ASHA selection committee. The state has flagged it needs for additional ASHA requirement which will be finalized after vulnerability mapping is completed.

All the 74 MAS formed have Bank Accounts opened. The untied fund has been transferred to the MAS accounts for utilization for community activities. But it has been observed that MAS requires hand holding for effective utilization of funds. 327 MAS monthly review meetings have been conducted and MAS have been involved in National Deworming Day, Intensified Diarrhoea Control Fortnight, UHND etc. It was observed that though MAS have been formed

and working but still the community linkages needs to be strengthened . The state needs to involve the existing AWWs with support from ANM and ASHA to improve the community linkages.

Outreach Services

With regard to outreach services 413 UHND and 59 Special Outreach camps have been conducted in whole state. The special outreach camps are conducted in the presence of MOs/SN/LT/ANM. The requirement for Specialists in Special Outreach camps is of utmost importance for addressing different health issues of the community.

Quality

Quality assurance committee at state and district levels has been formed. The induction training of the QA team is in process. The UPHC, Kohima will be first facility to go for Quality Assurance Assessment which is under process. The Grievances Redressal mechanism is not in place for UPHCs. IEC/BCC activities in urban health have been done especially for RCH and Disease Control Activities.

Finance

Total fund Sanctioned in FY 2016-17 is ₹ 4.45 Cr, the utilization is ₹ 2.71 cr. The utilization certificate and audit report have been submitted. Unspent balance is ₹ 6.90 crores against allocation.

HARYANA

Planning and Mapping

GIS mapping has been completed for all the identified cities (28) under NUHM. It was informed that this mapping later provided major inputs for planning of health facilities in urban areas. Vulnerability mapping however, is initiated only in four cities and State needs to expedite the process. Haryana State Health Resource Centre is assisting the state in undertaking vulnerability assessment.

Health Infrastructure

Majority of UPHCs are functioning in rented buildings with functional RKS in all UPHCs.

Human Resources

While the staff at the level of SPMU is in place, there is a 60% vacancy at the level of DPMU (of the post of City Urban Health Consultants). There is 34% of shortage of Medical officers in urban PHCs of Haryana. In Gurugram, 8 post of MOs are vacant out of 18 sanctioned posts. It was observed that the UPHCs were managed by pharmacist(s) and staff nursesin the absence of medical officers. The orientation training on NUHM is completed for 90% of the recruited staff. Additional trainings on Immunization, RTI-STI,IMNCI,NSSK and NQAS have also been provided. The NUHM staff was observed to be deputed at district hospital in Gurugram and this has affected the service provision at the UPHCs.

Service Delivery

A good range of ANC, PNC and referral services were observed to be provided by the UPHCs. 10 UPHCs are operational as delivery points providing Intra partum services. PMSMA activities were being organized at the UPHCs. Immunization services, Intensified Diarrhea Control Fortnight, activities under Mothers Absolute Affection (MAA) program, Micronutrient Supplementation Program(MSP), Pulse Polio, National Deworming Day, are being carried out in all the UPHCs that were visited. Family planning services: Counseling, provision of contraceptives (including IUCD insertions) and referral for tubectomy/vasectomy was observed at the UPHCs that were visited. 145 ANMs have been trained in Adolescent Health and these ANMs are providing counseling services to the adolescent age groups in the UPHC catchment areas.

Besides NPCDCS services like OPD, diagnostic services (Blood Glucose testing) and free medicines are being provided to patients with Hypertension, Diabetes Mellitus etc. at the UPHCs. Further, specialist consultations are being provided during Special Outreach Camps and through referral to Civil Hospitals. Urban ASHAs of district Gurugram have been trained for NCD screening.

All Urban PHC(U-PHCs) are being included in the online RNTCP NIKSHAY Portal as Peripheral Health Units (PHI) and monthly reporting regarding Presumptive TB cases are being referred and diagnosed in nearest DMC/CBNAAT center.

26 high load U-PHCs have been identified for opening of new microscopy centres in U-PHC which can improve TB case detection. Joint monitoring and supervision by NUHM and RNTCP officials are being undertaken for improvement in field outreach, mapping of slums in NIKSHAY, Private sector mapping and performance of public as well as private health facilities for TB case notification.

HIV/AIDS

HIV testing facility is available in 60 UPHCs and 2 UCHCs(FRUs) under NUHM in the state. Counselling services are being provided by the medical officer and the Staff nurse at the UPHC.

NLEP

Training of Urban ANMs are being conducted at all the districts for screening of patients for Leprosy. IEC/BCC activities are also being carried out.

Outreach Services

Special out-reach Urban health camps (health mela) were observed to be well planned in Gurugram. In many instances such outreach camps were observed in partnership with resident welfare associations/ ULBs. 500-700 beneficiaries were observed to be attending these camps.

Community Processes

Against the required strength of 2676 ASHAs, there are 2472 urban ASHAs (92%) in position. However, a high dropout rate was observed in urban ASHAs (particularly in Gurugram). In total 30 urban ASHAs dropped out of the total 122 urban ASHAs enrolled across various districts. The knowledge of ASHAs was observed to be satisfactory. Currently urban ASHAs have been trained till round 3 of module 6-7. On an average each ANM is catering to about 10,000 urban population and each ASHA caters to about 1500-2000 slum population which is as per NUHM norms. However, additional burden owing to maternity leaves and drop-outs is affecting their performance. Currently the State does not have a MAS platform and it may plan for MAS formation for improved community participation.

Quality Assurance Activities at UPHCs

Baseline Assessment of 47 Urban Primary Health Centres as per NQAS has been completed by the State. Of these, 10 were selected for quality certification and 1 UPHC (UPHC Krishna Nagar Gamri, district Kurukshetra) has been certified for NQAS by the State Quality Assurance Committee. Further, UPHC Krishna Nagar Gamri has also been nominated for the National Level Assessment and Certification. In FY 2017-18 (as per RoP), 5 more UPHCs have been approved for Quality Certification.

The baseline assessment of 14 UPHCs have been completed and 2nd assessment after gap closure have been done in 8 UPHCs. Also, UPHC Harivihar in District Faridabad, UPHC Adarsh Nagar and UPHC Quilla Mohalla in District Jhajjar and UPHC Jatwara in District Sonepat has scored more than 60% after 2nd assessment.

Finance

State share of NUHM has not been released.

MAHARASHTRA

Planning and Mapping

GIS mapping has been carried out in Mumbai Corporation. For rest of the state-urban areas including Parbhani and Warda, manual mapping has been done. State needs to take up the vulnerability mapping to understand the status of slums particularly vulnerable or a particular slum and each household in the slum.

Institutional arrangements and Programme Management

State has 1 megacity, 9 corporations above 10 lakhs population, 8 corporations above 5 lakhs population, and 63 councils. NUHM is implemented through corporations and councils. Corporations directly report to State Health Society and Councils report to Civil Surgeon or District Health Officer of the district. Parbhani has a dedicated NUHM team with active leadership from Municipal Commissioner and Medical officer incharge. However, there were coordination issues in district Wardha between NUHM-ULB and

Civil Surgeon team. There is a 31% shortage of staff at SPMU, 60% at CPMU (Rest of Maharashtra) and 44% CPMU (Mumbai Corporation)

Instrastructure

State has functional 37 UCHCs out of total 45. Rest of UCHCs are under construction. The total number of UPHC's functional with minimum staffing & service package is 413. Total target of UPHC is 513. Rests of the UPHCs are under construction. The total population of Municipal Corporation of Greater Mumbai (MCGM) is 1.25 crores with 40% non-slum population. MCGM is divided into 7 zones under which there are 208 health posts. State has incurred low expenditure on infrastructure i.e. only 18%. Total number of infrastructure works approved under NUHM is 584 and out of which 211 has been finished. 78% of the funds under renovation has been spent and expenditure under new construction is 75%. In MCGM, out of the 61 approved facilities under NUHM for civil repairs, administrative approval was taken up by corporation for 56 sites. Work has been completed for 31 facilities and not started in 6.

Human Resources

State has a total of 3798 in position HR against total of 6189 which is 61% of the total position. Maximum vacancy is for full time medical officers, part time medical officers, ANMs, SNs and LT. MCGM has an in position HR of 841 against total approved 1031 which is 82% against the total. However, there are 90 (100%) vacant Part Time MOs, 65 Staff Nurses (36% vacant positions). Other corporations also have shortage of doctors. E.g. Thane Municipal Corporation has 23 vacant Part Time MO against 25 approved positions, 84 Staff Nurses against 85 approved, 24 LT against approved 25 LT. Team was informed that the vacancy of medical and para medical staff is because of low remuneration.

Service Delivery

OPD and immunization services were being provided by UPHCs. Municipal Corporation Hospital was cold chain point with 2 vaccinators in position and was supplying vaccines to all the UPHCs. OPD timings for urban facilities are from 9:00 am to 1:00 pm and 3:00 pm to 6:00 pm. Convergence with National Health Programmes was found missing. In Parbhani, dedicated gynecologists were visiting UPHCs on every 9th for ANC checkups under PMSMA.

Municipal Corporation hospital, Parbhani and UPHC Bene Compound of MCMG was conducting lab investigations (Hb, RBS, MPROT, UPT, complete urine) and (Routine, sputum test, dengue, malaria etc. No diagnostics or lab facility available at other UPHCs. Local purchases for drugs were being made at UPHCS. No central purchasing has been done for last 2 years.

Outreach Services

Outreach services are being conducted for immunization sessions/UHND. ANMs have dedicated areas and are conducting sessions every Tuesday and Thursday. At UHND, there were Complaints of non-provision of immunization services despite coming to AWW center along with the Immunization card of the child. AWW informed the team that she was told to provide immunization services to the newborns of same area and not the ones who come from another place to deliver (daughter in law and not the daughters). In Wardha major problems were seen in recruitment of doctors for UPHCs, being conducted by the Municipal Council. Lack of coordination of ULB with CS was reported as a challenge.

Community Processes

In Maharashtra, 7675 ASHA have been engaged against the target of 9565 and induction training has been provided to 2336 ASHA. No ASHA was provided with HBNC kits. In district Parbhani, 25 ASHA have been engaged against the target of 71. Induction training has not been started in the district and is planned for end of month. In Wardha, all ASHAs have been engaged and a few batches have been trained in induction module. Engaging MAS, and training is outsources to NGO SNEHA. However, since inception, only 1038 against the target of 17200 have been formed in the state. No MAS has been formed in Parbhani so far. MAS have been constituted in Wardha recently. Mumbai has link workers named Community Health Volunteers (CHVs). They get fixed honorarium of ₹ 5000 per month and engaged for last 20-25years. ASHAs are being engaged now in place of CHVs.

Innovation

Dilaasa is a centre that identifies domestic violence and physical abuse including rape, burns and fall victims, to provide legal counselling, psychosocial support services to the survivors of domestic violence, to integrate and ensure sustainability of services. There are 11 such centres under NUHM, HR and equipment support has been provided under NUHM.

Quality

No internal assessment has been initiated for UPHCs.

Finance

RKS constitution and registration for urban facilities is delayed. So far, 278 RKS has been registered out of total 602 RKS. Bank accounts at 187 facilities have been opened. For districts of Warda and Parbhani, no RKS has been constituted against 2 councils UPHC and 8 Corporation UPHCs respectively.

MEGHALAYA

Planning and Mapping

GIS mapping of the slums & health facilities has been done while preparing city plans. Vulnerability mapping to identify the most vulnerable groups under NUHM is also carried out in Shillong city.

Program Management Staff

Deployment of the staff has been done at State and District PMU level. 1 position of District UH consultant is vacant.

Training and Capacity Building

Orientation & training of the Programme Management Staff & medical Officers has been done. Two days orientation cum training of MAS has also been conducted in East Khasi Hills. Status of training of each staff is found at Bishnapur UPHC. UASHAs are found to be trained till 6 & 7 modules in the visited facilities.

Human Resources

Most of the staff approved under NUHM is shifted from urban RCH. Positions of 100% FT MOs, SN and ANMs have been recruited and functioning. While 94% positions of LTs and 84% pharmacist are in place.

Service D.elivery

Citizen Charter and available drugs are displayed at Umsohsun UPHC and Bishnapur UPHC. Apart from RCH services, there is a clear existence of vertical programmes like RNTCP, IDSP etc. Registers are well maintained by ANMs and Laboratory Technician. ANM at Bishnapur UPHC was able to demonstrate a match between the data in HMIS report and in registers. Planning of outreach camps and UHNDs were found at the district level. Considering the local needs, UHNDs at some places are conducted during evening hours also. Supply of drugs and consumables is through district drug store only. Local purchase is also being made by MO. There is no Rate contract available for such purchase. It is observed that the owner of the premises of UPHC, Demseiniong has given notice to vacate UPHC. District Administration may take necessary action to pursue the owner or find another location in the vicinity only.

Public Private Partnership

Demseiniong UPHC is closely working with “Lam Jingshai”, an NGO addressing issues of Vulnerable groups especially Sex workers.

Community Process

ASHA and MAS are adequate in number in Shillong city. Out of 75 sanctioned, bank account of 58 MAS has already been operational. As per the interaction with a MAS member, they have got ₹ 5000/- last year and this year as well. Fund is utilized for procuring Dustbins and other such activities determining the Health. ASHAs are getting payment through PFMS.

Outreach Services

The outreach services are the platform to interface with community for strengthening the entire gamut of services including RCH services. As per the discussion with district UH consultant, there is difficulty in getting Specialist doctors for attending special outreach camps.

सिटीजन चार्टर

चिकित्सालय रोगी के रूप में आपके अधिकार

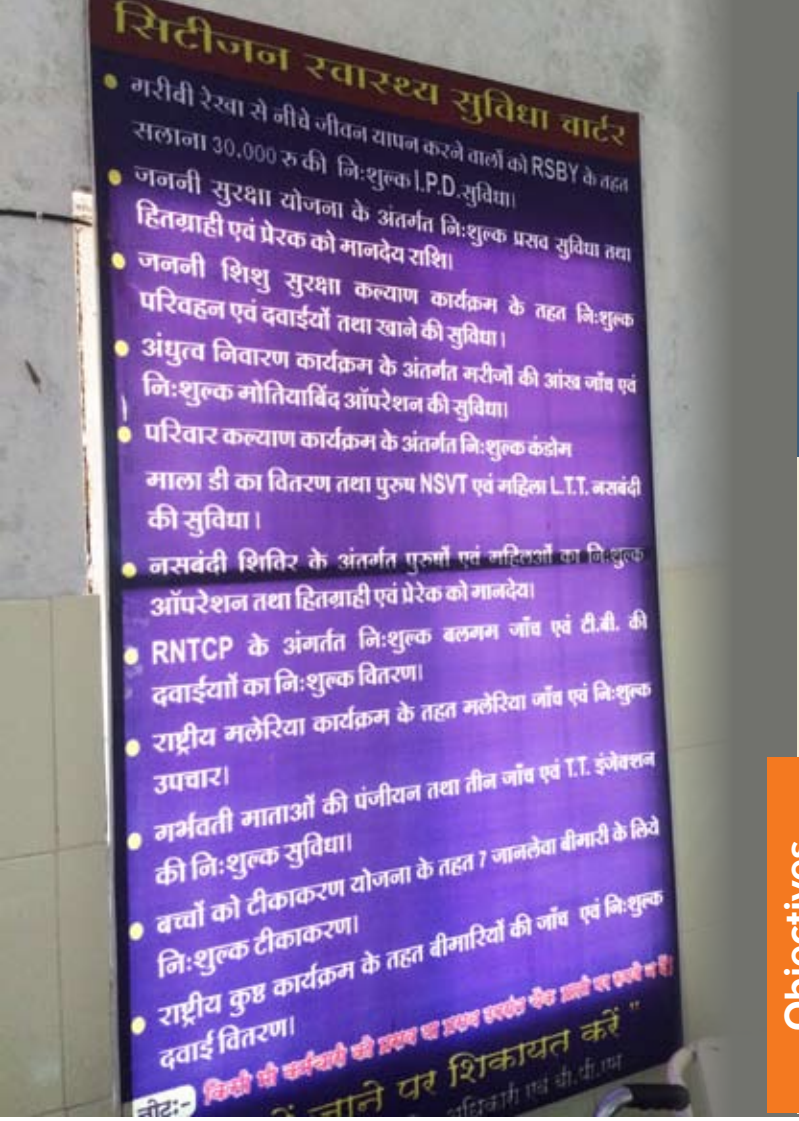
1. प्रचलित गुणवत्ता मानकों के अनुसार उचित चिकित्सकीय परामर्श एवं उपचार प्राप्त करने का अधिकार।
2. चिकित्सालय द्वारा प्रदान की जाने वाली स्वास्थ्य सेवाओं सुविधाओं एवं उनके निर्धारित शुल्कों की जानकारी होने का अधिकार।
3. रोगी के इलाज, उपचार, रोग निदान की सम्भावित प्रस्थितियों उपचार में संभावित आशंकाओं, रोग निदान के उचित विकल्पों तथा अन्य चिकित्सा पद्धतियों के बारे में स्पष्ट विवरण एवं जानकारी प्राप्त करने का अधिकार।
4. उपचार हेतु संदर्भित औषधियों के नाम सामान्य प्रभाव तथा सम्भावित दुष्परिणामों की जानकारी प्राप्त करने का अधिकार।
5. किसी प्रकार के औषधि, परीक्षण तथा उपचार को लेने अथवा न लेने का अधिकार। इस दशा में प्रतिफल की जानकारी होने का अधिकार।
6. द्वितीय चिकित्सकीय परामर्श प्राप्त करने का अधिकार।
7. रोगी के आत्म सम्मान, व्यक्तिगत गोपनीयता, धार्मिक तथा सांस्कृतिक मान्यताओं को आदर करने का अधिकार।
8. रोगी की परिस्थितियों एवं उपचार से संबन्धित चिकित्सकीय सूचनाओं को प्राप्त करने का अधिकार।
9. रोगी से संबधित उपचार एवं चिकित्सकीय गोपनीयता की सूचना प्राप्त करने का अधिकार।
10. चिकित्सालय से संबन्धित शिकायतो को उचित माध्यमों के द्वारा दर्ज कराये जाने का अधिकार। दर्ज शिकायत पर न्यायपूर्ण एवं शीघ्र कार्यवाही प्राप्त करने का अधिकार।
11. उपचार के दौरान किसी भी प्रकार के चिकित्सकीय अनुसंधान/परीक्षण कार्यक्रम में हिस्सा लेने अथवा न लेने के निर्णय का अधिकार।

चिकित्सालय रोगी के रूप में आपके उत्तरदायित्व

चिकित्सा उपचार रोगी एवं चिकित्साकर्मी के मध्य एक साझा कार्य है जिसे चिकित्सालय में उपलब्ध वातावरण के अन्तर्गत ही पूर्ण किया जा सकता है।

1. रोगी अपने चिकित्सक अथवा चिकित्सा सहयोगी को सभी महत्वपूर्ण प्रर्याप्त सूचनायें अवश्य दें। आपकी पिछली बीमारी, किसी भी प्रकार की एलर्जी, वर्तमान स्वास्थ्य की दशा अथवा अन्य महत्वपूर्ण विवरण आपके सही उपचार में सहयोग देते हैं।
2. यदि आप सुझाये गये उपचार एवं इलाज की योजना से सहमत हैं तो कृपया चिकित्सक द्वारा बताये गये निर्देशों का भली भाँति एवं मनोयोग से पालन करें।
3. चिकित्सालय के नियमों, अन्य रोगियो तथा चिकित्सा सहयोगियों के अधिकारों के प्रति सहानुभूति दिखायें एवं इनका पालन करें। मरीजों एवं तीमारदारों से संबन्धित आचारसंहिता का पालन अवश्य करें।
4. आगन्तुकों से मेल-मिलाप एवं पूर्व निर्धारित कार्यक्रमों की सूचना चिकित्सालय को यथा समय उपलब्ध करायें।
5. चिकित्साकर्मियों से गलत सूचना, चिकित्सा प्रमाण पत्र एवं प्राप्ति रसीद से संबन्धित विवरण बनवाने एवं उनका प्रयोग अवैधानिक है।

चिकित्सा अधीक्षक
सामु० स्वा० केन्द्र लोहाघाट
चम्पावत



TOR 12

GOVERNANCE AND MANAGEMENT

Objectives

- Review the institutional structure for management, capacity building and monitoring, operations of district health societies, SIHFW, supportive supervision mechanism, planning process at various levels.
- Review the convergence measures and extent of convergence at various levels.
- Assess the accountability mechanisms and their functionality and effectiveness.
- Review the implementation status of various regulations (CEA and PCPNDT) in the state.
- Examine the PPPs and outsourcing agencies entered into the states, their monitoring and evaluation mechanisms, quality of service provided, agreement/MoU signed and find out is there any duplication of functions.

National Overview

States and UTs have reported establishment of SPMUs, DPMUs or associated structure in states such as Assam, Karnataka, Odisha, Uttar Pradesh, Uttarakhand, Nagaland, Haryana and West Bengal. However, the Programme management structure remains relatively weaker at block level. Decentralized planning process is a core system strengthening instrument of NHM which is not robust in many states, however few states such as Assam, Bihar, Chhattisgarh, Nagaland and Odisha have initiated this process.

Coordination with urban local bodies remains a challenge, while Punjab, Chhattisgarh and Karnataka have established collaboration with concerned ULBs. In all visited states the role of State Training Institution e.g. SIHFW/CTI/RHFWTC is still not defined and limited to capacity building which is also not happening at full pace, due to lack of adequate and competent faculty.

Intra-sectoral convergence is limited to WCD and Education department for RBSK and WIFS programme in states like Assam, Bihar, Chhattisgarh, Karnataka, Odisha, Nagaland, Uttarakhand and Punjab. Uttarakhand reported integration of ASHA, AWW and ANMs at Village level meetings like VHSNC.

All the visited states reported the presence of 104 health helpline except at Meghalaya and Haryana; among all Bihar is the only state where state government has passed Act on grievance redressal namely “Lok Sikayat Nirvachan Adhiniyam 2016” by assembly of Bihar. Registration of grievances is very low due to inadequate IEC in most of the states. In most of the states time bound escalation & solving

is also lacking. Chhattisgarh and Nagaland are the only visited states where PC&PNDT has not been implemented yet.

Key Findings

Institutional Structures for Management, Capacity Building and Monitoring

All the mandated structures and institutions prescribed under NHM e.g. SHM, SHS, DHM, DHS and RKS/HMS are in place in **Assam, Karnataka, Odisha, Uttar Pradesh, Uttarakhand, Nagaland, Meghalaya, Haryana** and **West Bengal**. Most of the bodies meet as per the norms except the mission level bodies at below district level. **Telangana** SHM and DHM have included representation from urban development and urban local bodies. In **Uttar Pradesh** besides NHM, there are 3 autonomous bodies that work in the state to support namely State Innovations in Family Planning State Agency, Uttar Pradesh State AIDS Control Society and Uttar Pradesh Health System Strengthening Project.

Urban Development directorates, ULBs and related officials and experts in state/district health mission/ societies are present in Chhattisgarh, Karnataka, Nagaland and Punjab, adequate no. of meetings held in the states at district and state level. While Karnataka was only state where meetings held at taluka and block levels.

Decentralized planning process is a core system strengthening instrument of NHM which is not robust in many States and has almost come to a standstill. Planning process is perceived as planning for NHM funding mostly whereas it was envisaged that the planning of health should be the reflection of community needs and experts input. While States such as **Assam, Bihar, Chhattisgarh, Nagaland** and **Odisha** have initiated planning from block level, and resources allocations are based on decentralized planning, this was not seen in **Jharkhand, Manipur, Punjab, Telanagan, Uttar Pradesh, Uttarakhand, Meghalaya, Haryana** and **West Bengal**. Even a decade after implementation, decentralized planning and allocation of financial resources based on plans from district and sub district levels, is yet to take place.

Supportive supervision, maintenance of records and feedback mechanism is weak in all the visited states.

States such as **Assam** (though weak), **Chhattisgarh** (achieved 82% of their target), **Jharkhand, Karnataka, Punjab** and **Uttar Pradesh** have identified Medical colleges, Public health institutes and some development agencies for imparting trainings of state/divisional and district level officials in the state in NHM programmes in coordination with SIHFW. While in **Uttarakhand** the role of medical college is limited as referral point for tertiary care and in **West Bengal** despite the presence of several medical colleges and school for Public Health, there was no specific attempt at partnership for capacity building or research. SHSRC is functioning as limited technical support to NHM in Chhattisgarh only. In Uttarakhand, there is limited linkage of medical college with the State health department for further implementation of NHM.

Convergence Measures

Intera-sectoral convergence between health sector and non-health sectors was found in states like **Assam** (WCD, PHED, Education, PRI), **Bihar** (Education, ICDS), **Chhattisgarh** (Education, WCD), **Karnataka** (Urban Development), **Odisha** (WCD, PRC, education), **Punjab** (ICDS, Education, PRI, Sanitation dept), **Telangana** (WCD, DRDA-IKP, RD, PRI, Revenue dept, Education, MEPMA), **Uttarakhand** (ICDS, Education, DPRO, water & sanitation, electrical dept, mahila mandals, Judiciary

and border security force), **Nagaland** (social welfare, education, ICDS) However, convergence was not observed or very limited convergence found in **Jharkhand, Uttar Pradesh** and **West Bengal.**

Regular meetings with the above mentioned sectors are happening only in few states i.e. **Assam, Chhattisgarh, Karnataka, Odisha, Punjab, Manipur** (meetings happening at administrative level only). Intra-departmental convergence for particular RBSK program, school health, WIFS and MHS was happening in a proper way in all the visited states except in **Assam** and **Uttar Pradesh**.

Integration at the village level (VHSND) between ANMs, ASHAs, MPWs and AWWs was observed in few states i.e. **Assam, Bihar, Chhattisgarh, Karnataka, Odisha, Punjab** (measures to address nutritional issue at community level is missing), **Telangana, Nagaland** and **Uttarakhand**. However, weak/minimal convergence observed at **Uttar Pradesh** and no provision of AAA convergence present at **Manipur** and at **Meghalaya.**

Uttarakhand state has adopted an innovative method of carrying out "nukkad natak" using ANMs as actors for raising awareness about health issues.

Accountability

Accountability measures like Social audits or Jan Sunwais were in place in **Bihar** (take place every week), **Uttar Pradesh** (but not regular) and **Uttarakhand** (only one meeting held in 2017) whereas in **Chhattisgarh**, Jan Darshan and Chhattisgarh social audit units being set under department of Panchayat and Rural Development but social audits of healthcare system has not been conducted till date. States like **Assam, Meghalaya, Haryans** and **West Bengal** do not have any provision to enable accountability of service providers to community.

Citizen's charter display for various entitlements, schemes and helpline was found at all visited public health facilities and AWW centres of states i.e. **Odisha, Punjab, Uttar Pradesh, Uttarakhand, West Bengal** (but not uniform and strategically placed) except at **Assam** and **Karnataka.** Awareness about NHM schemes and citizen charter among public is limited/satisfactory.

Grievance Redressal system in the form of 104 toll-free health helpline was present at **Assam**, **Bihar, Karnataka**, **Punjab**, **Uttar Pradesh** and **Uttarakhand** except in **Haryana** and **Meghalaya.** However, in **Chhattisgarh** the system was placed on the name of "Jan Darshan" (online portal to lodge their grievances) and every year "Gram Suraj Abhiyan" or "Nagar Suraj Abhiyan" take place where DC organizes a camp for addressing grievances of people. **Bihar** is the only state where state government has passed Act on grievance redressal named "Lok sikayat Nivaran Adhiniyam 2016" by Assembly of Bihar, this act has given legal power to community to complain any public servant to respective authority and authority should ensure time bound compliance of all grievances. However, Facility level Grievance regressal mechanism like complaint boxes were mostly absent in the facilities visited in Bihar

Regulation

States like **Assam, Jharkhand** and **Uttarakhand** have adopted the central **Clinical Establishment**

act and notified its rules as well as the appropriate authority however, state specific CEA has been formed and enacted in states like **Bihar, Chhattisgarh** ("Chhattisgarh State Upcharyagriha Tatha Rogopchar Sambandhi Sthapanaye Anugyapan Adhiniyam, 2010 (No. 23 of 2010)"), **Karnataka** (Karnataka Private Medical Establishment Act), **Manipur, Nagaland** (Nagaland health establishment Act), **Telangana** (Telangana state allopathic private medical care establishment act 2002 and rules 2007). CEA has yet not been introduced in **Uttar Pradesh, Haryans** and **Punjab** but a state level regulatory bill is under process in these states. States are attempting to align these Acts with the key features of central CEA, 2010.

All public facilities of the visited states have been registered and following online mode for registration (**Assam, Chhattisgarh** and **Jharkhand**) while states like **Manipur** and **Telangana** are following offline mode for registration.

PC&PNDT act is being implemented in **Assam, Bihar, Jharkhand, Karnataka, Manipur, Odisha, Punjab, Telangana, Uttar Pradesh, Uttarakhand, Haryana** and **West Bengal,** while in Chhattisgarh PC&PNDT cell were found to be grossly incomplete and mapping of ultrasound machines has not been done completely. In Nagaland the PCPNDT is limited to registration of ultrasound machines. However, not a single case prosecution reported in **Assam, Bihar** and **Jharkhand** reason behind this needs focused attention. Poor Maintenance of "G", "F" forms and no display of Mandatory wall posters declaring no sex determination found in **Manipur** and **West Bengal**.

Public Private Partnerships and Outsourcing

There is no PPP Cell at **Chhattisgarh** State however, a nodal officer for PPP was appointed, Chhattisgarh state government has planned to cover housekeeping of civil hospital and MCH wing, free diagnostic service, BMWM, BMEM under PPP mode. Provision of routine monitoring was present in Chhattisgarh.

In **Odisha** few NGOs like Paribartan, Pushpak and Gopobondhu are working in favor of achieving NHM's outcomes under PPP mode. An effective management system includes a local steering committee was there for the routine monitoring and evaluation.

In **Punjab** there was no instance of PPP as a whole but number of outsourcing and activities under CSR was observed like under RBSK private hospitals are empanelled for the surgery of cleft palate, dialysis centre donated by an NGO, free checkups for AWW workers and school children at private empanelled hospitals etc.

Uttar Pradesh state government has outsourced housekeeping and MBWM for all district and state level health facilities. State has extended very limited scope for PPP as lack of KPI, deliverables along with monitoring for performance are weak.

PPP are being implemented throughout the Uttarakhand state includes screening health camps (Chikitsa Suvidha Apke Dwar), 108 ambulance services (GVK EMRI) and operationalization of UPHCs. However, state has operational issues due to less-monitored contracts despite adequate provisions being built in the tender.

West Bengal has outsourced several key functions like security, Diet, transportation and some diagnostic services (USG and selected laboratory tests). PPP are used for performing surgeries for children diagnosed with congenital heart diseases under RBSK programme. Poor quality of contract drafted for monitoring, quality of services and payment of services was observed.

Recommendations

Activate District Health Mission and leverage the existing structure to contribute to the mission objectives. Each issue and action taken should have a person responsible and it needs to be pursued till the time it is implemented/resolved.

- Meeting of state and district health mission needs to be undertaken regularly with focus on policy decisions and required actions to improve accountability and outcome under NHM.
- Systematic exercise may be undertaken to conduct Gap analysis of availability of infrastructure in public health facilities and gaps filled up to ensure compliance to IPHS norms over a period of time. State may set targets of number of new health facilities to be made compliant to IPHS norms while ensuring continuity to IPHS compliance of existing IPHS compliant facilities.
- States may include of district and block PMU in every step of planning and implementation. They should agree on plans and jointly monitor. VHSN Committee may be involved in planning process.
- Operationalize State Training Institution e.g. SIHFW/CTI/RHFWTC urgently, by adequate staff strengthening & transparent selection of high quality faculty. The state also needs to plan for exposure visit to other better performing states for the PMU staff.
- Enhance more collaboration across departments. E.g. encourage Medical colleges to take a lead role in NUHM, engage with Skill India Initiative to train and get technician, physiotherapists etc. The State may strengthen joint reviews and monitoring with all allied departments (e.g. WCD, Education, PRI etc.) which would provide better insights and suggestions and improve performance in the long term.
- HMIS reports needs to be verified by MOIC before uploading on HMIS portal.
- There should be a strong supportive supervision from District level for proper implantation of NHM Programmes. Targets for visit and time bound ATR need to be given & monitored at every level.
- State and District health societies should invite all concerned within the department and among various departments so that decision taken has wider acceptability, avoid duplication and has better ownership. This helps in implementation.
- Decentralized health action plan involving Panchayats, Block and District should be initiated on priority.
- There is no record of medicines prescribed to a patient. As such there is no control system for dispensing of drugs. A proper system should be evolved whereby the drugs distributed may be checked against prescription. System of prescription audit may be institutionalized.
- Social Audit and Jan Sunwais should be institutionalized at all the levels, especially at the district level.
- PCPNDT committee may take action to zero down on the blocks where the sex ratio is below average. Interdepartmental and interstate coordination meetings need to be more frequent.
- Regulatory acts in the line of Clinical Establishment Act need to be enacted as soon as possible in order to provide the poor people a quality medical service with minimum OOP expenditure and harassment.
- State needs to have a transparent transfer and recruitment policy with a defined timeline of posting at various levels. Tenure of service shall be fixed for specialist in any facilities for example 3 years for specialist in hard to reach areas with incentive and 5 years for soft areas. The transfer policy should be innovative and based on pointing system so that the chances of interference would be minimum.
- DISHA committee should be formed for better inter-sectoral and inter-departmental convergence with different departments and elected representatives of District like MPs and MLAs.

- Key Performance Indicators (KPIs) should be built in PPP contracts and these should be closely monitored to enable accountability while ensuring timely payment.

Recommendations Pertaining to the North Eastern States

- Identifications of most vulnerable SCs and provide additional incentives, house rent, etc. to Staff staying there.
- Tenure based transfer posting policy for MOs and other key staff working in difficult and remote locations in order to maintain the morale and improve efficiency and delivery of services.
- Issue of mobile/internet connectivity in these remote areas need to be taken up with Department of Tele-communications, GoI at the senior most level from the State Government.
- Issue of non-opening of zero balance bank accounts and delay in opening of bank accounts for beneficiaries need to be taken up with the Department of Financial Services, GoI at the senior most level to facilitate PFMS/DBT transactions.

State Findings

ASSAM

- Poor monitoring is common. Instances are faulty BP monitors giving false reading leading to wrong treatment and faulty weighing scales recording incorrect weight of pregnant women. No follow up of DHS meeting decisions. Incomplete entries/wrong entries in MCH registers with no MCTS no.s (but surprisingly HMIS data reflected s complete and updated)
- Instructions of DHS were not implemented and a staff was not paid for 16 months.
- The directorate and the NHM continue to function as parallel structures. The problem persists at the district level and below too. NHM PMUs concentrate more on RCH and health systems issues, and are not well informed about the DCPs and NCDs. The Medical Officers and other staff still see the programs as verticals and integration required at the level of implementation in the facilities is absent.
- Usage of data/information for planning or programme evaluation is limited. No capacity building measures have been taken in recent years to strengthen their analytical abilities.
- Role of Urban Local Bodies in implementation of NUHM is restrictive, largely due to the fact that among the subject matters where devolution of powers have been effected, health is not one.
- The State is currently not conducting any Social audits or Jan Sunwais.
- Although state has adopted the Clinical establishment Act and has notified its rules as well, the fact that private practice by medical officers and the specialists is quite rampant.

BIHAR

- Key stakeholders such as PRIs, Women and Child Development authorities, Urban Development authorities, are not adequately involved in the making the PIP.
- Under PCPNDT, committee has been constituted for the looking in to the matter; however, no complaint has been found register at the PHC level.
- CEA has been adapted by the State. However, at the District level, District Cell/Nodal Officer for the CEA has not been appointed as yet.

CHHATTISGARH

- State has Reconstituted DISHA committee in all 27 districts.
- Collaboration with SHSRC, EU, WHO, UNICEF, JPHIEGO, HLLFFT, De-worm The World, Nutrition International, Power Grid for technical support.
- NHM is having good coordination with Directorate, Health services, SIHFW and Chhattisgarh State Medical Supply Corporation.

No meeting of SHM has been held during 2017-18 till date.

- EC of State NHM has devolved financial powers to DD (Rs.50000), CMHO (full power under NHM budget) and BMO (full power for NHM budget) as per district ROP subject to approval of DC as per rules. Also, power has been delegated for recruitment as mentioned in TOR 6.
- Joint Director at Commissionarate level do programme review for concerned districts.
- Collaboration has been made with Medical College at Raipur for capacity building and funds have been provided to the college for establishing (i) Facility Based New Born Care Unit (ii) Sub-unit of State IDSP Surveillance Unit (iii) MDR TB ward. The College has also been accredited under JSY scheme for institutional delivery.
- The PSM Department of Rajnandgaon Medical College have linkage with District Health Authorities for visits of their students to Urban PHCs.
- MoU has been proposed for collaboration with Sathya Sai Hospital, New Raipur under RBSK for treatment of identified Paed. Cardiolodgy cases.
- SHSRC support in Implementation of Comprehensive Primary Health Care (setting up Health and Wellness centres in Korba district, training of the Service providers, established working as ASHA Resource Center), developing sickle Cell services, capacity Building of Rural Medical Assistance (10 days training on curative component of RCH, CD and NCD).
- SIHFW organized an International Summit for State Health Policy in October 2017 and are preparing the final draft.
- For menstrual hygiene programme the State Health authority - EU has given CAPEX of ₹ 3.5 crore which was to be utilised for installation of vending machines in school but till date the Dept. of School Education has not initiated anything on this issue.
- Under CEA, there was no mapping and list of services available in the private establishments except what they declare in their form. During discussion, the district authorities informed that private service providers are finding the provisions of the Act/Rules and SoP made thereunder as not realistic and the requirement are impossible to be fulfilled. This results into submitting application for registration which is granted provisionally for six months and later on the establishment applies for lower capacity (for 20 bedded establishment) whereas actually the establishment runs 50 beds.
- District authorities are accrediting Private hospitals/Nursing Homes for JSY, FP and RSBY. State Government has fixed the package rates for the treatment and the utilisation of private services in RSBY which is good.
- There is no PPP Cell at State level. However, there is a nodal officer for PPP and as stated above the State Government is planning for a PPP model.

JHARKHAND

- In both the districts Programme Implementation Plans, Policy formulation is not based on authenticated data and there is no use of HMIS for such activities. There is lackof devolution of powers to CHC and PHC in respect of infrastructure maintenance and hiring of operational staff etc.
- In Pakur it has been observed that all development partners are working in silos and convergence has not been observed among development partners.
- 183 applications under CEA provisionally approved. Workshops are being held to disseminate information about CEA Act.
- DPMU and SPMU are functional however shortage of staff is there. Block level Programme management units were not formed which is leading to poor documentation of NHM activities at block level.

KARNATAKA

- Various meetings at different levels happens regularly like Zilla Panchayat level), District Health Mission Meeting, District Society Meetings, District Level medical Officer meeting, District Level all supervisors' meeting, Taluka Level Meeting, PHC level Meetings and PHC level Aroyga Raksha Samity (ARS) quarterly meetings etc.
- Private sector institutions are supporting the health department in all national programmes like MR campaign, National Immunization Day, Pradhan Mantry Surakshith Matruthva Abhiyana (PMSMA), Eye, Dental, Mental health camp and also they involved in IEC Activities to motivate and increase awareness to public.
- In spite state has identified a nodal officer for supportive supervision but it is still moderately weak.
- Citizen charters were not displayed in the health facilities visited. Complaints/Suggestions box were not visible at all facilities visited.
- From 1994 PC & PNDT Act has been initiated. So far 48 cases have been booked, out of which 35 cases have been closed and 13 cases are pending in court. At the districts visited, the PC & PNDT Act implementation was not satisfactory and infact in the District Hospital cum Medical College (RIMS) itself the mandatory forms and SOPs were not implemented.
- Instead of the Clinical Establishment Act, in Karnataka, Karnataka Private Medical Establishment ACT (KPME) is implemented at State and District level.

Concerns

- Bottom up planning process is not seen in true spirit
- Review meetings held regularly but not result oriented
- Supportive supervision is weak and the quality of supervisory visits, documentation and action taken is a concern. Individual driven programmes were seen wherein certain excellent programme officers/consultants are able to drive the implementation of the programme.

MANIPUR

- NHM follows bottom up planning. Financial powers have been delegated to various levels and integration with Directorate is done Director Health and Family Welfare Services is additionally Mission Director NHM.
- Planning process needs to be strengthened by forming need assessment and technical committees which is presently done through individual files put-up by concerned programme officers.
- Under PC&PNDT, there were 117 ultrasounds done in the state and 60 inspections have been done with 1 raid. Inspection resulted that district level and the state level, ultra sounds were not registered with the appropriate authority in the district hospital at TEMEL LOND, CHC and RIMS.
- The registration of clinical establishments is offline and 169 establishments have been registered. There are 5 staff with hardware available at the state level, no dedicated staff at the district level, no workshops/trainings have been held with stakeholders either at the state or the district level. On the whole, the implementation of Clinical Establishment Act needs strengthening.
- CSR is limited to procuring 11 ambulances from Power grid Corporation of India. CSR for improvement in service delivery/infrastructure/ equipment could be explored.

ODISHA

- Under PC&PNDT, State Supervisory Board (SSB), State Advisory Committee and District Advisory Committee have been constituted. 938 facilities have been and 97 applications of registration have been rejected by appropriate authorities since the inception of the Act. 65 cases filed since the inception of the Act against owners and doctors. 3 doctors

convicted and 1 owner. 20 appeals disposed u/s 19 of the Act.

- ASHA, AWWs, ANMs together prepare Monthly plan and implement activities in the sub-centre, VHND and immunization clinics.
- Public Private Partnership has been going on since 2006-07; 33 rural PHCs and 25 urban PHCs are being run by NGOs under PPP mode; External agency is employed to evaluate the performances before giving extension; NGOs are managing MAA GRUHA, Arohya plus, PHC management in KBK + districts (in most inaccessible and remote areas).
- **The NGO – paribartan** (registered in 1999) has been working in programs namely "arogya plus" manages Mobile Health Unit. **NGO - pushpak** (registered in 1994) has been managing "maa gruha" (home away from home for the pregnant mothers to ensure institutional delivery), working under Arogya Plus and **NGO - gopobondhu society** (registered in 1997) has been partnering with NHM in managing 3 PHCs, 3 MAA GRUHAs, 1 Arogya Plus and also for ASHA Training (by making their training venue available and also by providing all training logistics).

PUNJAB

- A separate Punjab Health System Corporation exists which is the nodal agency for health infrastructure up gradation and maintenance of equipment. However district level monitoring is not satisfactory. Supportive supervision mandated to be on quarterly basis. However, quality of supervision is poor.
- There is devolution power to the districts and to the blocks. However the effectiveness of such decentralisation needs to be evaluated and monitored. Government Medical Colleges are integrated in providing services through certain special state initiatives like Hepatitis C free treatment scheme(MMPHCRF), latest treatment facility through Cancer Control Programs in government medical colleges and also creation of Cancer Registry in Medical College Patiala, involvement of Medical Colleges in MDRs.
- Citizens 'Charters are placed in the facilities, these also require to be uniformly made bilingual. Many of the facilities don't have any suggestion box installed in prominent and easily accessible places. However there are CC TV monitoring in the CC and above levels.
- PCPNDT Act- Mapping of all the Ultrasound machines have been done. GIS mapping of the public sector has been completed. Training Programme of the stake holders has taken place. PCPNDT committees in place in both districts but need activation. 1533 USG machines have been registered under PC&PNDT Act in the State. Out of this 849 have been suspended and registration for 109 have been cancelled; Court cases U/section 20-155 (93 disposed, 31 conviction, 31 pending); toll free number is 104. Free treatment of girl child up to the age of 5 at the Medical colleges is being done.
- There is no instance of public private partnership as a whole. But number of out sourcing and activities under CSR has taken place like Under RBSK- private medical institution has been empanelled for tertiary care treatments due to Cleft lip/palate and RHD, Dialysis centres under PMNDP on CSR, Private Laboratory has been empanelled under MMPHCRF for specialised tests for hepatitis C patients, Under MMPCRK, cancer patients are provided with free treatment at empanelled private hospitals and Tata Medical Centre Mumbai has collaborated to provide a state of art cancer care facility at Bhathinda.

TELANGANA

- Health department works in coordination and collaboration with various line departments to conduct VHNDs, VHNSCs, UHNDs, Grama sabha, General body Meetings, Parent Teacher Meet at schools and RKS meetings.
- 88 Registered facilities under PC&PNDT in the Khammam district, in which 86 are Ultra Sound Centres and 02 are IVF Centres. 77 Inspections have been conducted by District Appropriate Authority in financial year 2017-18. Since inception 02 Court Cases has been filed in the District Khammam. Total 27 PC&PNDT Centres are registered in Adilabad District, in

that 05 Government Institutions and 22 Private institutions.

UTTAR PRADESH

- Gaps still exist in utilization of HMIS/MCTS data for planning. The District requirements are still not reflected into the district plans.
- The state has a monitoring structure in place but the frequency of visits by the officials is very regular. Also, these visits are not comprehensive and do not cover all the programs.
- Feedbacks and reviews of these monitoring is also not shared, and a week intra departmental coordination has been observed in both the districts.
- Involvement of medical colleges and schools of public health is very limited under NUHM.
- Convergence is limited at various levels. NUHM and civil society organizations coordination was not there.
- Suggestion boxes are available for redressal of grievances at CHC, DH and at DM office in Kaushambi.
- Monitoring of PCPNDT and its implementation is in place at all levels. State has adopted Rajasthan model for tackling the issue of sex selection through Mukhabir Yojna following which two successful decoy operations were conducted in Agra and Meerut.
- Limited scope of PPPs and lack of key performance indicators and deliverables along with monitoring for performance at various levels through systematic reviews on regularity of services is required.
- Frequent transfers of specialists' upto 9 in seven years in Kanpur Dehat and 6 MOs in one year in Kaushambi District.
- Non-constitution of DISHA committee in the State for better coordination amongst public, different departments of the Government and elected representatives of State i.e. MP, MLA

UTTRAKHAND

- The SHM is chaired by the Chief Minister while the DHM is chaired by the Chairman of Zila Parishad/Zila Panchayat. SHM carries out Video Conference with CMOs of the Districts on 2nd Thursday of each month.
- District level plans are discussed at State level during annual meetings prior to finalizing State PIP, but active use of HMIS/MCTS data for planning at various levels has not been in place.
- Supportive supervision mechanism is not institutionalized at any level. However at the district level, programme review is held on 1st day of every month by the CMO and minutes are recorded.
- In Udham Singh Nagar, close coordination between the block level and the MO placed at PHCs was observed.
- The medical colleges are being used as referral point for tertiary care. However, there is limited linkage with the State health department for further implementation of NHM.
- Only one case was registered for violation of PCPNDT Act in the year 2017 in each of the two districts visited, which suggests more rigorous monitoring of existing and new centres.
- PPP are being implemented throughout the State. These include - Screening Health Camps, (Chikitsa Suvidha Aapke Dwar), 108 ambulances – GVK EMRI and operationalization of UPHCs.

WEST BENGAL

- The State and districts have evolved a rigorous review process. Each week the Principal Secretary holds a video conference with the CMOs of all districts. This is a new initiative, and has replaced the monthly meetings held at the State level.
- West Bengal is supported by UNICEF and WHO for specific interventions at State level. Despite the presence of several medical colleges and schools of public health, there is no specific

attempt at partnership for capacity building or research.

- At the District Health Society level, the convergence with school Education and Public Health Engineering Department is strong, a key requirement given progress such as the RBSK and the urgent need for improved drinking water supply, particularly in D. Dinajpur with is endemic for fluorosis.
- The State has instituted patient satisfaction surveys at a few DH and SDH. Such a survey for both in patients and out patients was being undertaken in the SDH Gangarampur. For OPD satisfaction for the period of September 2017, about 54% rated the services as poor and 43.4% as average. There is need to standardize such surveys mechanisms.
- The RKS receives untied fund, RSBY and Swasthya Saathi. In SDH Balurghat, it was observed that RKS fund is being used for purchase of drugs and payment for diagnostic services too.
- Under the PC & PNDT Act, all facilities registered and new provisions of Rules are being implemented in D. Dinajpur, but not in P.Medinipur. In both districts, the submission of monthly report to the District Appropriate Authority was found to be irregular. The F1 form record were not available in P. Medinipur and were incomplete in Dakshin Dinajpur.

NAGALAND

- Regular district review meetings being held at state level. Regular supervision and training by the state officials. Regular communications and updates by the state to the districts.
- Regular supportive supervision is done by both the state/District officials. Yes, technical updates presented during the review. Supportive supervision conducted as per the need basis. Reports not uploaded in the portal. After every visit the reports are shared with the district and block level officials.
- DISHA Committee – The officials are not aware.
- The officials are working according to their tradition and culture.
- They officials are not maintaining and producing appropriate documents for verification and record purposes.
- E-mail and other modern advancements are not provided to all the sectors.

MEGHALAYA

- Lack of supportive supervision mechanism for monitoring the functioning of DH/CHC/PHC/SC etc.
- Lack of awareness about PCPNDT Act amongst the service provider.
- Inter-sectoral convergence needs to be strengthened
- Field visits to be focused and Action Taken Report to be followed with.
- Extremely bad un-motorable roads in the South Garo Hills district making service access very difficult. The public transport system is nonexistent
- Mobile network is very poor throughout the South Garo Hills district, making referral transport unviable.
- Electricity supply and water supply erratic and irregular. SCs do not have provision for electricity and water supply in South Garo Hills
- SC at Balpakram is in dilapidated condition and may collapse
- Banking services very poor, refusing to open zero balance accounts, branch only at District Headquarter, hence many beneficiaries are unable to open bank accounts in South Garo Hills
- At South Garo Hills because of the remote unconnected locations without any amenities, it is very difficult for staff to reside.

HARYANA

- It was also observed that although the funds are transferred from State to District level under appropriate programme head; thereafter the funds are disbursed from district level to SDG/CHC/PHC through a common pool. This has resulted in a peculiar situation wherein

at implementation level i.e. SDG/CHC/PHC the utilisation of funds from common pool is above 80% in some cases, while at state level the utilisation per programme is showing 30% progress. This prevalent system made it difficult to evaluate the performance of any particular schemes of NHM at the district level.

- There was delay in issue of district wise ROP during 2017-18. The ROP for the State of Haryana was issued in the mid of July, 2017. While it was observed that the district wise ROP for Gurgaon district was received there only in the end of October, 2017.
- Delegation of financial powers at State and District level has been made. Payment through PFMS portal and AADHAR based payments to ASHA and ANM nurses have been initiated. PFMS implementation is increasing across the board right from State/District/PHC/CHC level and can be termed satisfactory. Linkage with AADHAR for payments and other activities is also being implemented quite successfully. The State Government has implemented software for monitoring availability and supply of drugs right upto the SDG/CHC/PHC level which is an excellent system.
- Supportive supervision: There are coordination issues between the nodal division at the state level, concerned departments to whom reports have been sent for action, the Medical Officers who have undertaken the visits and the health facilities which have been visited.
- The Districts Authorities have reported about non setting up of PNDT Cell in the District and lack of legal support and experience to conduct raids. At the State levels the officers reported import of second hand USG machines and mobile size USG machine as challenge in implementing the provision of the Act.
- The resources are thinly spread across various health facilities as it was found that there has not been increase in the number of health facilities complying with IPHS norms during 2017-18 over the previous year.

STATE POSITIVES AND CHALLENGES

REVIEW TEAM

GOALPARA TEAM	NALBARI TEAM
Ms Limatula Yaden, Director NHM I, MOHFW	Dr Partha Jyoti Gogoi, Sr. RD, DGHS
Dr Sunil Gitte, JD, ROHFW	Ms Indu Capoor, AGCA Member-PFI
Ms Mona Gupta, Health Lead, TSA, Deloitte	Ms Indhu S, Consultant, CH, MOHFW
Dr Shamim Mannan, Consultant, RNTCP, MOHFW	Mr. Gautam Chakravarty, USAID
Ms Asmita Jyoti Singh, Senior Consultant, NHM, MOHFW	Mr. Prasanth Subramaniam, Senior Consultant, PHA, NHSRC
Ms Jenita Khawairakpam, Consultant, MH, MOHFW	Ms Vandana Chaudhary, US, NUHM, MOHFW
Kishore Mogulluru, Consultant, ADB	Dr. Mrigen Kumar Deka, Consultant, NVBDCP, MOHFW
Samina Parveen, IIPH, Shillong	Dr. Mital Shah, UNICEF
Ms Ima Chopra, Consultant, NHSRC	
Mr Bamaiya, AD, Ministry of AYUSH	

POSITIVES

Over the course of previous CRMs, positive observations have been received in the following areas:

- Empowerment of ASHAs in delivering community based services
- Significant results in malaria reduction
- Efforts at HR reforms, including creation of Rural Health Practitioners
- Efforts to reach difficult areas through initiatives such as boat clinics

The 11th CRM has again commended state for its efforts in ensuring access to health services (including monthly services in the difficult riverine areas/char areas), ensuring adequate non-specialist HR at most health facilities, ensuring availability and provision of free drugs to patients, and initiating free essential diagnostics services. The 11th CRM team has particularly appreciated the mandatory testing of finance HR on GFR and financial guidelines; this has had positive impact on maintenance of finance data.

	DISTRICTS/INSTITUTIONS VISITED	
TYPE OF FACILITIES	**GOALPARA**	**NALBARI**
District Hospital	Goalpara Civil Hospital	Civil Hospital Nalbari
Community Health Centre	Lakhipur CHC, Dudnoi FRU	Mukalamua FRU, Deerapara Thihu, Baghamaui
Primary Health Centre	Agya, MCH Nayapada, SD Model Hospital Ambari Bazar	Kamakurchi, Morua BPHC, Gograpar BPHC, HA Model Hospital, Dalulakal
Sub Centre	Hashdoba (DP), Rakhyasini	Aranganor, Kharkhariyal, Khatikuchi, Bilapar
Other	Boat Clinic, Aanganwadi Fataripara, Tea estate Simitola, Schools (Dudhnoi High School, Simitola).	Boat Clinic, Aanganwadi Dalalakal, 104, Sagar Kuchi, School (Sagar Kuchi)), Katuriya village
Lenga Sub Centre, North Gauhati block of Kaamrup district		

Urban Health facilities visited include Guwahati – Dhirenpara CHC, Ulubari UHTC, Sarabhati UPHC, Goalpara – Goalpara UPHC and interaction was also held with Commissioner, Guwahati Municipal Corporation.

CHALLENGES

Persistent challenge for the state- as reflected in previous CRMs- has been its relatively higher infant and maternal mortality rates. The current CRM has also highlighted implementation of JSSK as a cause of concern (particularly provision of diet and referral transport). Quality of care during ANC has also been highlighted as a cause of concern.

Some other concerns and areas of improvement include the following:

- A need to have a patient feedback on actual availability of drugs at health facilities
- Ensuring that teething troubles in Free Diagnostic Initiative are addressed particularly those related to reducing reporting time on tests, ensuring sample collection during post OPD hours and assessing OOPE on diagnostics.
- Ensuring that all SHCs with a team of Community Health Officer and ANMs are included in Health and Wellness Centre plans.
- Prioritizing completeness of data with an aim to ensure continuity of care, rather than for data-policing.

REVIEW TEAM

BHOJPUR DISTRICT	MADHEPURA DISTRICT
Dr. Sumita Ghosh, DC(MH-I), MoHFW	Dr Amarendra Mahapatra, Scientist E, ICMR
Dr. Narendra Goswami-Consultant MH, MoHFW	Dr A K Bagga, Scientist E, ICMR
Dr. Mayank Sharma, Consultant, MoHFW	Dr Nisha Singh, Consultant, PHP, NHSRC
Dr. Prayas Joshi, MoHFW	Dr Ashalata Pati, Consultant, MoHFW
Sh. A K Singh, MoHFW	Ms. Pallavi Gupta, Consultant, RCH.
Mr Arindam Saha, NHSRC, MoHFW	Dr Mobassir Husain, Consaltant (VC), NVBDCP, MoHFW
Dr. Shibu Balakrishnan, RNTCP consultant, WHO-Kerala	Mr. Gyanish Kumar, FMG, MoHFW
Mr. Bijit Roy- AGCA	Ms. V K Bhalla, US, NRHM I, MoHFW
Dr. Mahendra Pal, Research Officer, MoAYUSH	

POSITIVES

- The incentive for Girl child admission in SNCU is a commendable initiative to ensure a healthier girl child. Also, despite of the HR constraints, the number of programs are being implemented well.
- The model of Universal Access to TB Care of involving private practitioners in Patna is an effective strategy and may be expanded to other cities.
- State has started the roll-out of Bridge Programme in Community Health for six students and is in the process to select 50 candidates to be enrolled in the January 2018 session of Bridge Program.
- State is progressing well towards Kala Azar elimination. Development Partners like CARE India, Kala-CORE, WHO, BMGF are providing good support for Kala-azar elimination program.
- There is good planning under National Programme for Control of Blindness across the state and particularly the NGO involvement for monitoring of cataract surgeries.

	DISTRICTS/INSTITUTIONS VISITED	
TYPE OF FACILITIES	BHOJPUR	MADHEPURA
District Hospital	Arrah	Madhepura District Hospital
Sub District Hospital	Jagdishpur	
Regional Hospital	Sandesh, Sahar, Jagdishpur	
Primary Health Centre	Sandesh, Jagdishpur, Bihia	Singeshwar, Kumarkhand, Murliganj, Ghameria.
APHC	Korri	Rahta
Urban Primary Health Center	Gausganj, Maulabag	
Sub Centre	Akhgaon, Chilhaus	Bairbanna, Sarohpati, Jorgama
Mobile Health Team		RBSK, Murliganj
Government School		Kumarkhand
Community Interaction		Kumarkhand

ANM Trainning School, Arrah, Community interaction.

CHALLENGES

- Bihar has highest OOPE on drugs in public health facility i.e. ₹ 1808 per person against national average of ₹ 291.
- Most patients who could be managed by providing primary health services were being referred to higher facilities and medical colleges thereby increasing patient load at secondary and tertiary care settings.
- Lack of HR and non-functional equipment are the major barriers to effective functioning of blood banks in the state. There is huge gap between demand and supplies of blood in the state - Requirement is around 8 lakh units whereas the collection is only 1.5 lakh units per year.
- Yet, Biomedical Equipment Maintenance Programme (BMEMP) is yet to be initiated in the state.
- More than 60% of the staff were not trained in the key essential trainings of SBA, NSSK, RKSK, and PPIUCD in both districts.
- Organization of service delivery is variable. There was one District hospital in each visited district functioning as FRUs. Other facilities provide basic health services without having staffing pattern appropriate to the health facility nomenclature.
- Overall cleanliness of health facilities needs to be ensured along with provision of adequate waiting areas for patients.

CHHATTISGARH

REVIEW TEAM

DHAMTARI	BIJAPUR
Dr. Sushma Dureja, DC(AH), MoHFW	Dr. Ranjana Garg, AC (NUHM), MoHFW
Dr. Anup Anvikar,Scientist F, ICMR	Ms. Renuka Patnaik, FP Const, MoHFW
Dr. Ajay Patle,Sr. Consultant, PHP, NHSRC	Mr. Deepak Kumar, AH Const,MoHFW
Mr. Ugramohan Jha, HMIS consultant, MoHFW	Dr. Prairna Koul, AH Const,MoHFW
Dr. Jyoti Baghel, MH Consultant, MoHFW	Dr. Rajeev Pathak, Consultant, RNTCP
Mr. Manoj Jha, JD, NIPCCD, MoWCD	Dr Sanjay Tiwari, Consultant, NVBDCP
Ms. Shanti Negi, US(F), MoHFW	Dr. Shalini Varma, UNDP
	Ms. Seema Upadhyaya, AGCA Secretariat, PFI

POSITIVES

- State has demonstrated the ability to ensure availability of essential drugs at health facilities using online indenting mechanism and doorstep delivery up to PHC level, effective ambulance services, completion of civil works and filling-up HR vacancies in the visited state.
- The CRM team also observed well-functioning RMNCH+A services, including good ANC coverage, availability of IFA, Calcium and Deworming tablets and vaccines under UIP, functional cold chain. Operationalizing 100 sub centers as Health & Wellness Centers in Korba district and increase in PPIUCD, PAIUCD insertions and male sterilization are also commendable.
- State did well in the Communicable & Non communicable Disease Control programs. The state reported a decline in malaria cases as well as deaths, implementation of community based diagnosis and treatment of malaria, involvement of private health care providers and chemists in TB notification, community awareness about Leprosy, shift from camp approach to routine cataract surgeries at DH level and effective integration of RNTCP with NUHM are also praiseworthy achievements.

	DISTRICTS/INSTITUTIONS VISITED	
TYPE OF FACILITY	DHAMTARI	BIJAPUR
District Hospital	DH Dhamtari	DH Bijapur
Civil Hospital	Kurud	
CHCs	Nagri, Gujra, Kurud, Birgaon	Bhopalpatnam, Gangloor, Bhairamgarh, Usoor
PHCs	Bhakara, Keregaon, Kandel, Shihava, Chataud, Sirri	Modakpal, Madeed, Awapalli, Basarguda, Elmidi
SHCs	Arjuni, Simra, Koliyari, Shivani Kala, Bazar Kurud, Raide, Khadpattra	Nameed, Murdanda, Madeed, Tumnaar, Murkinar, Minganchal, Janga
NUHM	UPHC Gudyari	UPHC Khokhopara
School	Higher Sec. School Shivani Kala	Kanya Residential School Gangloor, Kanya Residential School Murkinaar
Villages/Training Centre/Drug Ware House	Arjuni, Shivani Kala, Drug warehouse	Murdanda, AWC Chintakosh, AWC Mingachal, VHNC meeting Tumnar, VHND Ithampur, Haat Bazaar Mathwada, Haat Bazaar Gangloor

CHALLENGES

- There is an urgent need for a targeted focus on certain areas. Despite measures taken to address HR gaps there still remain shortage of specialists and medical officers. Also, the HR like LTs and counselors were found to be underutilized due to irrational posting apart from some other clinical HR possessing deficient skills. Further, despite approval for bio-medical equipment maintenance initiative, it has not been operationalized and many critical equipment, were found non-functional. Biomedical waste management system also needs immediate attention with adherence to protocols and training of staff.
- In RCH, despite high ANC coverage, absence of line listing of high risk and severe anemia cases was found. The districts visited lacks USG services and the facilities need to implement proper labour room practices. The exclusive MCH wing for delivery care in Nagri was found under-utilized. In UIP instances were observed where new-born administered 10 times the required dosage of Vitamin K while zero dose of vaccine was not provided below CHC level in labor rooms in Dhamtari District. State also needs to ensure follow-up for PPIUCD and IUCD.
- Further, RKSK is poorly implemented with no AFHCs established till date, blue IFA supplies to schools irregular and peer education Programme not rolled out in Bijapur district.
- Implementation of various initiatives in communicable diseases also require attention by way of sharing of disease data by private facilities for analysis and action under IDSP, using malaria microscopy instead of relying solely on RDTs, poor knowledge about national drug policy for Malaria even among MOs in Bijapur district, high percentage of loss to follow-up among TB patients, etc.
- Despite screening of population for Hypertension and Diabetes, no database of NCDs is maintained in Bijapur, leaving large lacunae in ensuring continuum of care for NCDs.
- Furthermore, despite functional UPHCs and out- reach mechanisms under National Urban Health Mission other than RNTCP, all national Programme were not yet integrated in urban service delivery. Regarding health services data, I am happy to note that all facilities are reporting data on HMIS. However, existence of multiple reporting systems in the State was found leading to duplication of efforts and wastage of resources in addition to disparate data being reported through different channels.
- In financial management, while the Statutory Audit Report for Financial Year 2016-17 is yet to be submitted, the Concurrent Audit Reports of the districts should be reviewed and acted upon. It was found that the prescribed accounting practices are not being followed in maintenance of cash registers and untied funds were found to be withdrawn in full without supporting documents.

MEGHALAYA

REVIEW TEAM

SOUTH GARO HILLS	EAST KHASI HILLS
Dr. Teja Ram, DC(FP), MoHFW	Sh. B.S. Murthy, Director, MoHFW
Sh. B. K. Datta, DS (RCH), MoHFW	Dr. J.N. Srivastava, Advisor, NHSRC
Dr. Neha Dumka, Consultant (CP), NHSRC	Dr. S.D Mazumder, Sr. Regional Director
Dr. Meena Som, Health Specialist, UNICEF	Dr. Pranay Verma, DD, NCDC
Dr. Vaibhav Ghule, Sr. Technical Advisor, The UNION	Dr. Mushtaq Ahmad Dar, National Coordinator, RMNCH+A, Govt. Of J&K
Ms. Tushita Mukherjee, Project Coordinator, Prayas	Dr. Nisarg Desai, Consultant-Public Health Policy & Planning, MoHFW
Sh. Mantu Kumar, Consultant-Finance, MoHFW	Ms Jahnabi Hazarika, PHFI-IIPH, Shillong

POSITIVES

- State has ensured access to health services, implementing Meghalaya Maternity Benefit Scheme and ASHA Benefit Scheme, Biomedical Equipment Maintenance and initiating an Innovative model of Pink Taxi for drop back under JSSK.
- Partograph is being used in most of the delivery points visited.
- Peer Educator Programme has been initiated in the state, 30 ANMs have been trained for peer educator training so far and 180 peer educators have been selected.

	DISTRICTS/INSTITUTIONS VISITED	
TYPE OF FACILITIES	EAST KHASI HILLS	SOUTH GARO HILLS
District Hospital	Ganesh Das MCH Hospital, Civil Hospital, Shillong	Civil Hospital, Baghmara
CHC	Pynursla, Sohiong, Sohra	Chokpot
PHC	Smit, Jatah, Pomlum	Silkigre, Rongara, Moheshkola, Siju
Dispensary	Shastri Memorial	Mahadeo
UPHC	Demseiniong, Bishnupur, Umsohsun	--
SC	Thinroit, Umlympung, Mawkdok, Mawtawar	Mitapgre, Kenigre, Dambuk Aga, Balpakram
AWC	Mawkdok-1, Pynursla 'B'	Rongrakgre
Others	Reid TB Hospital, MIMHANS, RIHFW, Blood Bank, State & District Drug ware house, MMU	Panda Village, Rongrake Viilage, Siju Govt. School, MMU

CHALLENGES

- While the State is striving to make progress in all the areas, there is an urgent need for targeted focus on areas such as High out of pocket expenditures on drugs, diagnostics as state has not followed the free drugs policy.
- State has no proper fund flow mechanism to ensure timely payment of incentives to ASHAs & overall implementation of single window payment mechanism was not implemented.
- The line listing of high risk pregnancies is variable across facilities and no action is being taken after identification.
- High Home deliveries has been reported in the state however, home distribution of Misoprostol is inadequate.
- Display of the Essential drugs list is lacking at the facilities and the blood bank in FRUs in HPD is non-functional.
- Under RMNCH+A, new family planning methods and Newborn Action Plan have not been rolled out. Skill based capacity building of staff in all delivery points needs to be focused.
- The Disease Control Programme continue to operate as vertical programs. But reporting for Communicable Diseases and IDSP needs to be strengthened. In RNTCP, data reporting in NIKSHAY needs to be adhered. Regular feedback and follow-up mechanism needs to be in place.
- State to undertake assessment of All DHs & CHCs against National Quality Assurance Standards & develop Time-bound action plan for closure of the gaps.
- Untied fund is integral part of health facility functioning; therefore the timely release of fund has to be taken care. State to ensure on timely VHSNC and RKS meetings for active community involvement has not been released.

JHARKHAND

REVIEW TEAM

PAKUR	EAST (PURNI) SINGHBUM
Dr. Dinesh Baswal, DC, Maternal Health, MOHFW-	Dr. Suresh Mohammed, World Bank
Dr Nobhojit Roy, Advisor, Public Health Planning, NHSRC	Sh. Sanjay Kumar, DD (MCTS), MOHFW
Dr. Gandham Buliya, ICMR	Sh Vinod Kumar, US, PMSSY, MOHFW
Ms Seema Joshi, DD, HMIS, MOHFW	Dr. Parminder Gautam, Sr. Consultant, QI, NHSRC
Dr Sanjay Arora, RNTCP, Jammu	Sh Amit Mittal, Consultant Fin (IDSP), MOHFW
Sh Daman Ahuja, Programme Manager, AGCA Secretariat, PFI	Sh Sanjay K Gupta, Consultant, NVBDCP, MOHFW
Sh Vishal Katharia, Consultant, Child Health, MOHFW	Ms Srutidhara, Consultant, NUHM, MOHFW
Dr Tarun Sodha, Technical Officer, NRU-IPE Global	Sh Vijay Paul Raj, USAID
	Dr Neha Naik, Consultant, MOHFW

POSITIVES

- As has also been reported in the previous CRM reports, the community processes of the state are well established. The front-line workers of the state i.e. the ASHAs/Sahiyas are trained, informed and are carrying out their functions well.
- Nutrition Rehabilitation Centres (NRCs) have been well established and maintained across the state. These Malnutrition Treatment Centres (MTCs) have been appreciated by the earlier CRMs also.
- The state has reported decreasing trends of communicable diseases like malaria and Japanese Encephalitis (JE). This is also evident from the State Level Disease Burden report that has been recently released. Malaria contributed to 1.7% of the DALYs in 1990, which has reduced to 0.5% in 2016.
- The state has launched Night Immunization van in East Singhbum city for vaccination of missed out children in the streets in urban areas.

	DISTRICTS/INSTITUTIONS VISITED	
TYPE OF FACILITIES	EAST SINGHBUM	PAKUR
DH	Sadar Hospital	Sadar Hospital
SDH	Ghatsila	NA
CHC	Baragorah	Litipara, Maheshpur, Pakuria, Pakur Sadar
PHC	Kaladogra, Karadubah, Ramchandernagar	Sahargram, Dharampur
SC	Surmuhi, Amainagar, Karadih west, Sundernagar, Pagadah	Chatkam, Dharampur, Rolagram, Narayangarg, Anjana, Nagarnavi, Jikerhati,
UCHC	Mango	
UPHC	Laxminagar, ChotaGovindpur	
Villages	Karadubah, Dhushra, Pagadah	Badgaon, Beechpahari, Anjana, Nagarnavi

CHALLENGES

- Lack of sufficient human resources along with their limited capacities. Irrational deployment of the HR has further aggravated the shortage.
- Lack of basic amenities, like electricity, at the health facilities. Need of a mechanism for proper disposal of bio-medical waste needs to be emphasized.
- Integration of the Disease Control Programmes with the NHM system. Regular feedback and follow-up mechanism on outbreaks by District Teams needs to be in place. Involvement of Private sector in TB notification needs to be focussed.
- The Quality and completeness of HMIS data is a major concern, it was noticed that there was no quality checks of data before being uploaded on HMIS.
- Implementation of Biomedical Equipment Maintenance Programme should be taken up by the state on priority.
- Weak referral transport system was reported by the visiting team.

HARYANA

REVIEW TEAM

BHIWANI	GURUGRAM
Dr. Sila Deb, DC, Child Health & Immunization, MOHFW	Ms. SunitaSharma, Director, NHM –IV, MOHFW
Dr. Neha Parak, Consultant, RNTCP, MOHFW	Dr. Chinmoyee Das, DADG, MOHFW
Dr. Hariprakash Hadial, Lead Consultant- MH, MOHFW	Dr. Sonalini Khetrapal, Health Specialist, ADB
Ms. Eeena Lamba, UNDP	Ms. Ratna Khare, SPM,UP
Shri Nishant Sharma, Consultant, HRH, NHSRC	Shri Manoj Keertani, Programme Assistant, NHM II, NGO Division, MOHFW
Shri Sunil Kumar, Consultant Fin (NLEP),MOHFW	Dr. Madhusudan Yadav, Sr. Consultant, PHP, NHSRC
Shri Bikramjit Choudhary, US	Dr. Adil Shafie, Consultant, NUHM, MOHFW
	Dr. Neha Parak, Consultant, RNTCP, MOHFW

POSITIVES

- Excellent efforts in mitigating time to care, in terms of physical access to health facilities, comprehensive range of specialist services at District hospital including 24x7services of SNCU, Blood Bank, and emergency.
- Comprehensive plan to start DNB courses.
- Dialysis services at Gurugram with good rate of utilization
- Co-location of AYUSH services at most PHCs and cross referrals at all levels, leading to an increase in the possibilities of integrated care.
- Operationalization of multiple e-platforms aimed at maintaining Electronic Health Records (e-upchar), tracking of maternal and infant deaths (MIDRA), backtracking anemia cases (ATM), and GIS mapping for all the slums.
- Mobilizing CSR funds to improve access to ambulances.

DISTRICTS/INSTITUTIONS VISITED

TYPE OF FACILITIES		FACILITIES VISITED
District	**Gurugram**	**Bhiwani**
District Hospital	Civil Hospital, Sector 10 General Hospital	GH Bhiwani
Sub District Hospital	Sohna	BawaniKhera, Sivani
Community Health Center	Pataudi, Ghanghola	Loharu, Gopi
Primary Health Center	Bhondsi, Bhangrola, Badsahpur	Jui, Dadrigate, Barwa
Urban Primary Health Center	Omnagar, LakshmanVihar, Chauma	
SHC	UnchaMajra, Silani, Dausa, Bhangrola	Gopi, Umarvas, Baliyali

CHALLENGES

- Acute shortage of manpower (doctors, Staff nurses, pharmacists) at sub-district level and lack of quality supervision.
- Inaccessibility to safe abortion services at the sub-district level.
- Delay in selection process of candidates for Bridge Programme and coordination with IGNOU for accreditation of training sites.
- Intra-district transport support to children screened under *Rashtriya Bal Swasthya Karyakaram* (RBSK) so as to improve follow-up compliance.
- Awareness generation specially for referral transport for JSSK benefits.

UTTARAKHAND

REVIEW TEAM

CHAMPAWAT	UDHAM SINGH NAGAR
Shri Alok Kumar Verma, Director (Stats), MoHFW	Dr A S Chauhan, Director -Finance, NACO
Dr Honey Arora, Consultant (NUHM), MoHFW	Shri Arpit Singh, Consultant, NHM – Finance, MoHFW
Dr N Arlappa, Scientist E, ICMR	Ms Neha Agarwal, Consultant, PHP, NHSRC
Dr. Raman Kataria, JSS Bilaspur	Ms PoojaChitre, Consultant (Maternal Health), MoHFW
Dr Ravi Kumar, AV, SPO, Jhpiego	Dr Sandhya Ahuja, Consultant, NHSRC
Shri Sarangadhar Nayak, US (NHM-IV), MoHFW	Dr UmeshTripathI, Consultant, RNTCP
Dr Vinay Bothra, Senior Consultant, NHSRC	

POSITIVES

- Creation of Uttarakhand Chikitsa Seva Chayan Board for avoiding delays in recruitment of doctors
- Regular review of HMIS data
- PFMS implementation has been scaled up across the state.
- The CRM team particularly noted with appreciation for functioning of 104 call centre with its active role in RBSK and RKSK initiatives.
- Functional District Quality Assurance Committee (DQAC)

	DISTRICTS/INSTITUTIONS VISITED	
TYPE OF FACILITIES	**CHAMPAWAT**	**UDHAM SINGH NAGAR**
District Hospital	District Hospital (Champawat), Coronation District Hospital (Dehradun)	JLN District Hospital (Rudrapur)
SDH	Tanakpur	Kashipur
CHC	Lohaghat (Champawat), Vikasnagar (Dehradun)	Kichha (FRU), Khatima, Sitarganj, Gadarpur
PHC/BPHC	Pati, Barakote	Nanakmatta, Kalakhera
UPHC	Khera (Udham Singh Nagar), Transit Camp (Udham Singh Nagar), Bhagat Singh Colony (Dehradun), Deep Nagar (Dehradun)	Rampura (Udham Singh Nagar)
Sub Centre	Sub Centre and SAD Sipty Sub Centre Chandni	Shirpur, Bichhua, Ratanpur Fullia, Gadarpur
School	Jawahar Navodaya Vidyalaya Latoli and Kanya Uchch Prathmik Vidyalaya	Rajkiya Prathmik Uchch Kanya Vidyalaya
UHND/AWC/VHSNC	AWC Khera, Sanjay Nagar/UHND Khera	UHND Sitarganj
Village	Sipty, Barakote	Danpur
Health Post	Dalanwala (Dehradun)	
ANMTC Centre	-	Gadarpur

CHALLENGES

- Rational deployment of human resources and capacity building of staff.
- Ensuring free drug and diagnostic services including display of Essential drugs list.
- Implementation of Biomedical Equipment Maintenance.
- Operationalizing the various projects undertaken under Public Private partnership.
- Under-utilization of ambulance services and inactiveness of Medical Mobile Units in field due to lack of funds.
- Equipping the urban ASHAs with ASHA drug kits and HBNC kits under National Urban Health Mission.
- Grievance Redressal Mechanism was not in place. Awareness about Mera Aspataal too was found to be low among the staff and beneficiaries alike.
- Delay in the payment of incentives to ASHAs.

KARNATAKA

REVIEW TEAM

DISTRICT RAICHUR	DISTRICT CHITRADURGA
Dr. M. K. Aggarwal- DC, UIP, MOHFW	Dr. Ravi Kumar,
Mr. S. Natarajan –DS (CCD/VBD)	Dr. P. K. Srivastava- JD(NVBDCP), MoHFW
Dr. Raghuram Rao- DADG(TB), CTD	Dr. Joydeep Das –Sr. Consultant, RRCNE
Dr. Dilip Singh Mairembam-NPO, WHO	Dr. R. P. Saini -Sr. Cons-RCH, NHM
Dr. Deepa Prasad-UNFPA	Mr. Smarajit Chakraborty-AGCA
Mr. Pradip Kr. Pal- US(Dental Health)	Mr. Rahul Govila-FMG, NHM
Ms. Bhanu Priya Sharma-Consultant, NHM	Mr. Narendra Patel-Consultant, HMIS, MoHFW
Ms. Isha Rastogi-NUHM-Finance, NHM	
Mr. Syed Mohd Abbas-Consultant CP, NHSRC	

POSITIVES

- State has opted for bidding of specialist to attract human resources in its difficult areas.
- State has developed the health infrastructure with an effective Time to Care approach in both districts.
- In most of the facilities visited, services for maternal health, child health and immunization were found to be functional and adequate. Labor rooms in 24X 7 PHCs and CHCs were well equipped with availability of trained Staff Nurses having adequate skills.
- Comprehensive Primary Healthcare (CPHC) is being piloted in Mysore and Raichur Districts in a very systematic manner. A total of 105 Sub Centers are being upgraded to Health & Wellness Centers (HWCs) in the pilot phase.
- ASHAs were observed to be performing well in the state with ASHA incentives being regularly paid through PFMS. Non-monetary incentives like Sim card, umbrella, bags are also being provided.

	DISTRICTS/INSTITUTIONS VISITED	
FACILITIES	**DISTRICT RAICHUR**	**DISTRICT CHITRADURGA**
District Hospital	Raichur Institute of Medical Sciences	Chitradurga
Taluka Hospital	Deodurga	Challakere, Molakalmuru
CHC	Arkera, Mudgal	Rampura
PHC	Ballatagi, Sirwar, Gurgunta, Masarkal, Gaboor	Pandrahally, Chikkajajur, Imangla, Bedareddy Halli Laxmisagar Vijiapura
Urban PHC	Harijanwada, Zaheerabad, Ragimangedda	Buddha Nagar
Sub-HC	Jagtagal, Mudgal, Gudihaal, Devarbhupur	Ashoka Siddapura, Hireemmi Ganur
Slums	Harijanwada urban slum	Gauriammanhalli Village, Banjigere village, Venketeswar barawane urban slum
Others	▸ District Training Centre ▸ District Drug warehouse ▸ District Health Office ▸ Taluka Office, Raichur ▸ Pvt Practitioners & Pvt Chemist	▸ District Training Centre ▸ District Drug warehouse ▸ District Surveillance Office ▸ District VBD Control Office
Bangalore	BBMP, Azad Nagar Urban PHC, 13-D Cross Padarayanpur (MAS)	

CHALLENGES

- Implementation of JSSK should be prioritized, particularly the element of referral transport.
- Facility specific EDLs must be ensured so as to ensure benefits of Free Drugs Initiative.
- There is a need to expedite implementation of Biomedical Equipment Maintenance Programme as non-operational equipment were observed during CRM visits.
- Continued orientation of providers should be undertaken to improve reporting of Dengue and Chikungunya cases.
- RKS/Arogya Raksha Samitis need to be monitored for regular meetings and their decisions must be assessed.
- In view of increasing burden of NCDs, the state needs to prioritize recruitment and effective roll out of various programs under NPCDCS.

MAHARASHTRA

REVIEW TEAM

WARDHA DISTRICT	PARBHANI DISTRICT
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Ms. P.A. Mini, Dir, PMSSY	Dr.Jyoti, AD, IDSP
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Ms Sweta Roy, Deloite	Dr.Sushant Agrawal, Consultant, NHSRC
Sh. Arun Srivastava, Advisor - QI, NHSRC	Ms.ArpanaKullu, TISS
Dr. Vipin Garg, Lead – Cons – JSY&DBT	Dr. Prashant Kumar, SP - UNICEF
Dr. RanjanPrusty, IIHMR	Dr.Nitahsa Kaur, NUHM
Mr. Prithvi Prakash, M&E (could not attend)	Mr. VivekSinghal, Cons, HMIS.
Mr. SatyajitSahoo, FMG	Dr Vinay Kumar, Programm Manager
Mr. KrushnaSirmanwar, Consultant, NHM	Mr. Ajay Prakash, RNTCP

POSITIVES

Over the course of previous CRMs, positive observations in the following areas:

- Infrastructure development,
- Human resources reforms,
- Involvement of PRIs and community-based monitoring,
- Integration of AYUSH services,
- Improving access in difficult regions and utilization of services.
- Use of IT for improving transparency
- Improved range of free drugs and diagnostics
- Implementation RCH, Ambulance services, RNTCP and ASHA trainings
- Context specific local initiatives

The 11th CRM has also observed positive findings related to significant progress in National and State certified NQAS facilities, availability of free drugs, and rapid response from 108 ambulance services. Further, satisfactory implementation of RCH services in terms of standard Labour rooms protocols, antenatal screening for GDM, Hypothyroidism, RTI/STI, syphilis and HIV-AIDS, and establishing the mechanism of institutionalization of Maternal and Child Death Review is reported. Local context specific initiatives - such as “Prakalp Prerna” to prevent farmer’s suicide at District level- continue to be taken up in the State.

	DISTRICTS/INSTITUTIONS VISITED	
FACILITIES/ COMMUNITIES	NAME OF FACILITIES VISITED PARBHANI	NAME OF FACILITIES VISITED WARDHA
District Hospital	Civil Hospital, Women Hospital, Ortho Hospital, Eye Hospital	District Hospital, MCH wing MGMIS Sewargram
Sub District Hospital	SDH Gangakhed, SDH Selu, RH Palam,	SDH Hinganghat, Arvi SDH, RH Pulgaon, Rh Seloo
Primary Health Center	PHC Mahatpuri, PHC Rani sawargaon, PHC Kolha, PHC Manwat	PHC Morangan Kho, PHC Burkhoni, PHC Dahegoan, PHC KharanganaMorangana, PHC Alipur, PHC Sahur
Urban Primary Health Center	MC Hospital, UPHC Khaja colony, UHP Verma Nagar,	UPHC Hinganghat, UPHC Wardha
Sub Centre	SC Harangul, SC Hadgaonpawde, SC Golda, SC Khandali, SC Moregaon	BagholiSubcenter, Kurzhadi fort, Sonegaon Abaji, Badgaon kale, Taroda, Yesambha
VHND/AWC/UHND	AWC Boti, UHND Bharat Nagar, AWC Hadgaonpawde, AWC Kolha	Pawagaon, Tarasavangaon,
Villages/Urban slums	Moregaon, Urban Slum	
Mumbai Corporation	UPHC Bene Compound, SNCU Mahim	

CHALLENGES

- Postings and utilization of laboratory technicians and performance monitoring of contractual staff were reported as some HRH challenges in previous CRMs. However, rational posting of human resources, including specialists, is now emerging as an area of concern. For instance, it was observed that observed that OBGY specialists were posted at PHC or CHCs where there is no Anesthetist/LSAS trained doctors. Institutionalizing performance appraisal and competencies assessment remains a pending agenda.
- All previous CRMs have hinted on need for capacity building of finance personnel in peripheral health facilities, better management of cash books and utilization of untied funds. The 11th CRM also recommends that State may conduct systematic financial training in maintaining books of accounts, fund management and PFMS training for DBT to beneficiaries.
- Need for strengthening facility and community services under urban health Programme and NCD services have been highlighted by past few CRMs. The 11th CRM recommends improving coordination with Urban Local Bodies, and effective roll out of facility-based screening.

MANIPUR

REVIEW TEAM

TEAM – IMPHAL WEST	TEAM – TAMENGLONG
Dr Bina Sawhney, Additional DDG, DGHS, MoHFW	Dr Chaman Prakash, Additional DDG, DGHS, MoHFW
Dr Jayram M, Registrar Academics, PHFI	Dr K C Meena, Deputy Director (ISS), NVBDCP, MoHFW
Mr D P Awasthi, Programmer (Statistics), MoHFW	Dr Suresh S, Deputy Registrar, PHFI, Bangalore
Dr Babasaheb Tandale, Scientist E, NIV, Pune	Dr Prashant Soni, Consultant Child Health, MoHFW
Dr Suryavanshi, Assistant Director, RARIMCH, Nagpur, MoAYUSH	Dr Rajesh Kumar, Asstt. Professor RBM, NIHFW
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Mr Abhilash Philip, Associate director, PSI	Mr Saurabh Raj, Programme Manager, AGCA Secretariat, PFI
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Mr Tushar Mokashi, Consultant HCF, NHSRC	

POSITIVES

- The state ensures low OOPE when compared to other NE states.
- AYUSH and Dental services were also found up to the mark and MMUs deployed under CHCs were also found to be functional.
- Facilities visited were found clean and well maintained with 24x7 water supply in the labour room except CHC Sekmai.
- Home Based new-born care is running well and ASHAs interacted were found to have good knowledge on HBNC.
- All the cold chain points were well maintained with appropriate job aids and trained Cold Chain Handlers with successful Implementation and functioning of EVIN (Electronic Vaccine Intelligence Network). Temperature loggers have been installed and are successfully recording and transmitting real-time temperature data.
- "PMSMA" being practiced in most of the facilities in both the districts.
- Colour coded bins for biomedical waste management were found in all the visited facilities except a few.

	DISTRICTS/INSTITUTIONS VISITED	
TYPE OF FACILITIES	IMPHAL WEST	TAMENGLONG
Medicall College/District Hospital	RIMS Hospital	DH - Tamenglong
Community Health Centres	Wangoi and Sekmai	Nungba
Primary Health Centres	Mekola and khurkhul	Noney
Urban Primary Health Centres	Langoltarung and Mantipukhri	
Sub Centres	Naorem, Samusang, Awang Wabagai and Phumlou	Akhui
Villages	Awang Wabagai, Therni, Govindragramam, Naorem	Akhui, Muktikhullen

AREAS FOR IMPROVEMENT

- The government facilities are accessed, the average OOPE for outpatient care (Rs.1855), Inpatient care (Rs. 8363) and Child Birth (Rs. 8019) indicate poor implementation of various initiatives under NHM and the majority of OOPE was incurred on purchasing medicines (50%), followed by transport (16%) and diagnostics (13%).
- Referral protocols were followed but documentation needs improvement.
- The ambulance service is deficient due to lack of adequate number of ambulances in the state and the hilly terrain coupled with bad roads calls for innovative solutions for reaching the people living in hard to reach areas.
- In 24x7 PHCs all the delivery cases are referred to the CHCs/RIMS/JNIMS due to lack of skills and training of the Medical officers and staff nurses.
- X-ray, ultrasound and ECG machines are not available at most of the places but not being utilized while Blood Bank services are not available in most of the facilities.
- Biomedical waste management was not being practiced in most of the facilities.
- There is no SNCU, NBSU and NRC in both the districts except RIMS (NICU).
- All the visited facilities in district Tamenglong including DH has the policy of rotation of staff nurses in the hospital and hence no staff nurse is exclusively dedicated for labor room.
- There are urgent needs of trainings of recruited staff on SBA, NSSK, IUCD, PPIUCD, Biomedical waste Management and AEFI.
- The facilities lacked inventory management systems and had no policy to deal with the short expiry drugs/reagents, etc and there is no classification for storage of drugs, no essential drug list, Bin card system segregation of Schedule H drugs.
- There is no central oxygen supply with no oxygen concentrator in all facilities including NICU RIMS.
- It has been observed that State has not implemented “PCPNDT Act”.
- Wrong practice of keeping every new-born baby under Radiant warmer is being followed in most of the facilities.
- With regards to TB, case notification rate is very low - 84 per 1 Lakh Population. Not all CBNAAT co-located with ART centers, No DR TB centres in Tamenglong district and notification from Private sector not reflected in NIKSHAY. H1 scheduled drugs yet to be implemented and lack of complete sensitization of stakeholders on daily regime was observed.
- The National Programme on Palliative care is yet to be implemented despite approval in RoP 2017 (Rs 175 Lakh).
- The fund absorption capacity at the healthcare facilities is weak and has led to blocking of scarcely available funds. Denying payments due to non-linkage of Aadhar to bank accounts is currently being practiced and should be avoided. (e.g. JSY/JSSK beneficiaries, ASHAs, NHM Staff).
- With regards to NUHM, the facility visited has no electricity supply for past two years. In spite of strong presence of ASHA’s and MAS at ground level it was difficult to mobilize patients to UPHC as the location of UPHC was close to a Territory centre (RIMS). The staff and MOIC were unaware about the guidelines under NUHM which led to absence of key documents to be maintained under UPHC. No branding of NUHM incorporated into the system.

NAGALAND

REVIEW TEAM

KIPHIRE	WOKHA
Capt. Kapil Chaudhary, Director, NHM	Dr. Yashpal Sharma, Registrar, Govt. Medical Collage, J&K
Dr. Padam Khanna, Sr. Consultant, NHSRC	Dr. Suresh Dalpath, DD, Haryana
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Dr. AmolPatil, Tech Officer, PATH	Dr. Ankur Yadav
Shivam Jain, Consultant, Finance	Dr. Selvarajan, Research Officer, MoAYUSH

POSITIVES

- State has a strong commitment in provisioning of health services which is reflected in dedicated and qualified health functionaries, well equipped infrastructure and interventions like screening of all pregnant women for HIV, Hep B, Malaria, VDRL etc.
- In Kiphire district, all the blocks are notified as Open Defecation Free (ODF).
- Health facilities are well maintained, IEC material displayed in health facilities and reach of services to people is also adequate.
- Full routine immunization is working well, with good cold chain maintenance and vaccine storage
- Labour room well maintained and well utilized. Staff is knowledgeable on active management of third stage of labour and immediate newborn care.

	DISTRICTS/INSTITUTIONS VISITED	
TYPE OF FACILITY	KIPHIRE	WOKHA
District Hospital	Kiphire	Wokha
CHC	Pungro and in Kohima Viswema	Sanis, Bhandari
PHC	Kiusam, Amahator, Sitimi	Baghty, Chukiting, Englan
Sub Centres	Phuvkiu (Chomi), Singrep, Phelungre, Samphure	Wokha village, Longmatra, Merapani, Meshangpen, Chudi
MI Session	Pokhpur village	
Church meetings	Kiphire Town Baptist Church with four other church leaders	Wokha Town Baptist Church with nine other church leaders
VHSNC/AWC	Pokhpur AWC	

CHALLENGES

- NHM funds released by GoI to the State during FY 2016-17 had not been received completely by State Health Society.
- ASHAs have not received incentives since Oct'16 in Kiphire district and since March'17 in Wokha district.
- None of the districts visited had received their ROPs/budget sheets for planning and implementation of various activities at their level.
- Services offered by all public facilities are mainly focused on OPD services, adequate IPD care services were found lacking, especially in Kiphire.
- There is an urgent need for targeted focus on certain areas like, implementation of free diagnostic services –patients are still paying even for basic laboratory and radiological tests e.g. Hb estimation in Kiphire district.
- Further, X-ray and ultrasound services are non-existent in both the districts. Drug supply in these districts is very irregular. Further, blood services were also found lacking.
- Despite JSSK, mechanism for pick-up and drop-back facility for pregnant/delivered mothers and sick infants is yet to be institutionalised.
- Community & facility level investigations for MDR & CDR is lacking
- No microplan for RBSK mobile health teams.
- No planning of services to be given by Medical Mobile Units (MMUs).
- Open Vial Policy is not in practice affecting immunization and the staff lacks knowledge of new Family Planning methods introduced under NHM.
- Mentoring and monitoring protocols are not in place, which leads to deteriorated quality of data affecting its completeness, correctness and timely updating of records in HMIS and MCTS.
- State has implemented bio medical equipment maintenance initiative; however, the facility level staff still lacks knowledge on how to use the services.
- Despite training of the staff, NCD screening is yet to be initiated.
- NUHM implementation in Tuesang and Mokokchung requires special attention.
- Establishment of Grievance Redressal System, compliance with legal & statutory requirement under the PC & PNDT Act, NOC for fire safety and convergence with other departments need to be in place.

ODISHA

REVIEW TEAM

KEONJHAR DISTRICT	MALKANGIRI DISTRICT
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Dr. Goutam Rakshit, AD, MoAYUSH	Ms. Shikha Yadav, Sr. Consultant, Adolescent Health, MOHFW
Sh. Vindesh Kumar Singh, Consultant, Procurement & Finance, MOHFW	Dr. Rakshita K Sareen Consultant, NHM, MOHFW
Dr. Priyadarshini, SPM Bihar, PFI	Dr. Amrita John Consultant, MH, MOHFW

POSITIVES

Over the course of previous CRMs, positive observations have been received in the following areas:

- Improved utilization of facility-based services
- Continued strengthening of community-based initiatives and PRIs
- Convergence with other programs such as ICDS and various community based organizations
- Robust functioning of Rogi Kalyan Samitis, VHSNC/VHND platform and ASHA programme
- Continued focus on innovations

The current CRM has also made positive observations on State's efforts towards looking at out of box solutions. Some of these include, use of District Mineral Fund for engaging specialist services, and disease specific initiatives such as SAMPoorNA and DAMAN. Convergence efforts through platforms such as GKS (in rural areas) and WKS (in urban areas) have been highlighted too.

	DISTRICTS/INSTITUTIONS VISITED	
TYPE OF FACILITIES	MALKHANGIRI DISTRICT	KEONJHAR DISTRICT
District Hospitals	DHH Malkhangiri	DHH Keonjhar
SDHs	Balimela (Area Hospital)	Anandpur
CHCs	Mathili, Kalimela, Pandripani, Korukonda	Ghatgaon, Salipur, Mahanga, Harichandanpur, Telkoi
PHCs	Padmagiri, Govindapalli, Tumsapalli	Jagmohanpur, Kalapat, Rebanapalaspal, Sirigida
Sub Centre	Tumsapalli, MPV-22, PV-66, Markapali	Srigada, Binjhabahal, Nardangipendhi
Other facilities	ANMTC Jeypore, ANMTC Rayagada,Pandripani, Sevashram, MV-83 Village, Nursing Directorate, Nursing Council, Comphrehensive Skill Lab, State drug ware house and district, drug ware house	ANMTC Keonjhar, ASHA Training Site
Urban Areas	Jayporeguda MAS	UPHC-Keonjhar & IRC Village Nayapalli, Bhubaneshwar, UCHC-BMC Hospital Bhubaneshwar, ChilipokhariBasti, MAS members,Ward No. 58-Bhubaneshwar, MAA Mangalya MAS.
Villages/VHSNCs	MPV-37,Kalimela,MV70,MV-64,MV-22,MV-83,MPV (Malkangiri Protected Village)	Telkoi(Adakata Village and MHU site RBSK Mobile team site Adakata), Kantabahal, Golaband, Jagmohanpur, Pitanali
AWW	Kalimela AWC (MV-70), Kendargumpha, Potteru Village 22, MV 83, MPV 37,Pujari Munda Mini AWC	Adakata,Karanja,Nandhara

CHALLENGES

Slow completion rate of infrastructure, quality of maternal and child care in health facilities, shortage of human resources for disease control Programme related to malaria and rational posting of human resources in general have been highlighted as areas of concern over the years. The current CRM too recommends focussing on proper architectural design of MCH wings, appropriate follow up mechanism for high risk pregnancies, regular JSY payments and implementation of guidelines for standardization of labour rooms. On human resources, the State is recommended to integrate Training Management Information System (TMIS) and Human Resources Information System (HRIS) for better monitoring of postings. Place based incentives to attract HR in difficult areas and work towards a human resources policy are also a step in the right direction.

Some further areas of focus for state includes ensuring improved implementation of National Free Dialysis program. NQAS certifications and strengthening grievance redressal mechanisms.

PUNJAB

REVIEW TEAM

LUDHIANA	KAPURTHALA
Dr. Basab Gupta, DC NUHM, MoHFW	Dr. Sher Singh, Jt. Director, NVBDCP, MoHFW
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Mr. Bhaswat Das, NHSRC	Dr. Biswajit Das, Director, MoHFW
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Ms Amita Chauhan, Consultant, NHM, MoHFW	Mr. Satish Kumar, US, MoHFW
Dr. Aishwarya Sodhi, MH Division, MoHFW	Dr. Mangla Sood, Asst Professor, HP
Ms. Madhurima Bansal, Consultant, HMIS Division, MoHFW	Mr. Samarendra Behera, GM PSI
Mr. Navdeep Gautam, SPM, Punjab	Ms. Pallabi Gohain, Inf. Manager, MoHFW
	Mr. Harikrishnan, Finance Div, MoHFW

POSITIVES

- Most of the health facilities have good infrastructure with adequate waiting space. All the facilities are well connected enabling easy transport and referral services.
- JSSK services have been well implemented for both pregnant women & sick infants. Drop back from facility to the home has been provided to all the beneficiaries reported.
- Incentives were being paid on regular basis for conducting home visits. ASHAs are making additional home visits for LBW and SNCU discharged babies.
- State has rolled out daily regimen in all 22 districts with effect from 30th Oct 2017.Almost 95% of TB patients are tested for HIV.
- 100% achievements in cataract operations was reported
- State is having very good infrastructure for De-addiction and Rehabilitation Centres
- Despite there being lack of sufficient HR at all levels, the available Doctors & staff are dedicated and working in adverse conditions to best of their capability.
- Cashless health insurance scheme called Bhagat Puran Singh Sehat Bima Yojana for Blue Card Holders (BCH) families in Punjab to provide health insurance up to ₹ 50,000/- per family per year.
- Mapping of all the Ultrasound machines under PC & PNDT act has been done.
- Adequate HR and transfer policy, availability of specialists at the Dialysis units, Display of Facility specific EDL, free diagnostic services were observed.

	DISTRICTS/INSTITUTIONS VISITED	
TYPE OF FACILITIES	LUDHIANA DISTRICT	KAPURTHALA DISTRICT
DISTRICT HOSPITAL	Ludhiana	Kpaurthala
SD HOSPITALS	Jagraon& Khanna	Phagwara
CHC	Hathur; Pakhowal&Dhelon,	Tibba & Kalsanghian
URBAN CHC	Vardhaman; Giaspura Colony	
PHCs	24*7 PHC Mansooran:Block PHC Malaudh&Chowkiman	24*7 PHC Dhilwan; Maqsudpur & Paramjitpur
URBAN PHC	Salem Tabri; Model Town (Khanna), Model Town (Ludhiana), Giaspura Colony	RaikaMohalla
Sub Centers	Hathur – 1 &2; PandherKhedhi; Kulhad, Gudhe, Dhelon&Malaudh	Ibrahimwal; Raipurpirbux; Jallowal; Pandori Jagir; Kheerawali
URBAN HEALTH KIOSK	Metro Road, Sanjay Gandhi Colony	
OUTREACH	Salem Tabri, Metro Road	Mehtabgarh
OTHERS	VHND-BhuntriAnganwari Centre; Community Interaction in 2 villages, in Ghude&Pakhowal and I slum; School Visit –RBSK Team; Drug Rehab Centre-Jagraon, DC Ludhiana	Community Interaction in Chogawan and Jalowal villages

CHALLENGES

- Under RMNCH+A, reorganization of labor rooms as per MNH norms, skill based training of manpower and rational deployment of trained HR needs to be initiated.
- Anganwadi and School Health Programme should integrate life style diseases and behavioral change communication.
- Involvement of private sector in TB notification needs to be improved.
- NMHP needs to be rolled out from the community level to check on the increased number of cases of Drug-addiction.
- State to carry out Convergent activities with Swacch Bharat Mission and National Urban Livelihood Mission. Outreach camps for improved immunization coverage and nutritional programs in urban areas need to be conducted.
- Delay in transfer of funds from Treasury to State Health Society of 31 days to 238 days during 2016-17.

TELANGANA

REVIEW TEAM

DISTRICT KHAMMAM	DISTRICT ADILABAD
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Mr. Ajit Kumar Singh, Consultant, NHSRC	Smt. Alka Ahuja, DS, NACO
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Sh. Amit Kumar, DD, e-Health	Ms. Srilekha, Project Officer IT, UNDP
Dr. Abhishek Gupta, Sr. Consultant, NHM	Ms. Sinimol K.J, Consultant, NHM
Dr. Shilpy Malra, Consultant, NUHM	Dr. Princy Joseph, Consultant, RCH
Ms. Saranga Panwar, Consultant, Burn and Trauma	Dr. V. J Rao, TA Team, ADB
	Sh. Yogesh Chandra, FMG (NHM)

POSITIVES

- Good emergency referral transport facilities- 104-Ammovadi (referral transport services for pregnant women) and 108 Emergency services and Bike ambulance and Hearse vans are available day and night.
- Good progress in District Hospital strengthening activities. There is increase in the OPD, IPD, Delivery care, C-section & Surgeries at the district hospital.
- State has initiated free diagnosis services in all public health facilities in all 31 districts under the NHM.
- Intensive ANC schedules and identification of high risk pregnancies followed at all levels.
- The State has formed Public Health & Specialist cadre
- KCR kit- mother and kid care items are provided to newborn babies and their mothers to ensure financial assistance to mothers from poor households.

	DISTRICTS/INSTITUTIONS VISITED	
TYPE OF FACILITIES	KHAMMAM	ADILABAD
District Hospitals	District Hospital, Khammam, District Tuberculosis Centre Office (DTCO) Khammam, District Health Society, DM&H Office briefing and discussions	RIMS Medical College, Adilabad
CHCs	Madhira, Nellakondapall	Utnoor, Boath
PHCs	PHC- (Wyra (Awarded Best PHC, 2016) and Singareni)	PHCs- Bazarahathnur, Indiravelly, Shyampur, Sonala, Dantenpalli, Bheempur
UPHC	Mamillagudem,Mustafanagar, Srinivasnagar	Khurshidnagar, Puthibowli, Shantinagar
SC	Seethapuram, Thatipudi, Madira	Heerapur, Pullimadugu, Shyampur, Sonala, Dantenpalli
Community Interaction	Thatipudi, Seethapuram, FGD with ASHAs and ANMs	
Slums	Ramanagutta, Vikalanga colony	
Anganwadi Centers	Sambhaninagar	Puthibowli
OTHERS	UHND, Sambhaninagar	SNCU- RIMS, Adilabad; Utnoor, DEIC – RIMS, Villages – Sundarnagar, Puthlibowli, Eshwarnagar, Indiravelly, Chinthalpori, Pardi-B, FGD- with ASHAs- UPHC,AWC(Urban)

CHALLENGES

- AERB guidelines, Fire Safety norms, Airborne Infection control norms and grievance redressal mechanism need to be in place.
- Availability of Blood Storage Unit to be ensured at all CHC FRUs.
- Under RMNCH+A, PMSMA – specialist services to be made available in all CHCs/PHCs.
- Focus on other spacing and temporary limiting methods to be emphasized. Case sheets with Partograph to be maintained below DH as well.
- Reporting for Communicable Diseases and IDSP needs to be strengthened.
- Involvement of Private sector in TB notification need to be improved.
- State need to ensure HR Manual & policy is as per NHM norms and implement HRMIS.
- Biomedical waste management mechanism need to be in place.
- State to provide regular payments of JSY & JSSK, conduction of RKS meetings. RKS audit need to be done as per NHM guidelines.
- Delay in providing ASHA incentives under RNTCP, NVBDCP was observed which need to be taken care of.

UTTAR PRADESH

REVIEW TEAM

KAUSHAMBI	KANPUR DEHAT
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Prof. Manish Chaturvedi, Professor, NIHFW	Sh. Venkatesh Roddawar, Consultant, CTD, MoHFW
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Sh Akhilendra kr. Trivedi, Consultant (Trng), MoHFW	
Mr. Anil Gupta, Consultant, PHP, NHSRC	

POSITIVES

- Initiatives on hiring of specialist on regular as well as contractual basis, from open market through open bid with performance-based payment mechanism
- Referral services under JSSK have shown improvement with an average reporting time of 25-30 minutes.
- Dakshata lab and Nurse Mentors are a big resource for mentoring of paramedical staff.
- Early initiation of breast feeding, Exclusive breast feeding and skin to skin contact and practices followed
- Provision of Ultrasonography of pregnant women on PPP mode at 50 high delivery load facilities of 40 districts initiated
- New incentive for Maternal Death reporting by community of ₹ 1000/has been initiated. IEC in newspaper and FM channels has started.
- New Initiatives like Hausla sajhedari under Family planning where private providers (surgeons) have been empanelled with the state to improve access to family planning services in the population and to decrease the unmet need.

	DISTRICTS/INSTITUTIONS VISITED	
TYPE OF FACILITIES	KAUSHAMBI	KANPUR DEHAT
Medical College	-	GSVM Medical College, Kanpur
District Hospital	Combined District Hospital	Combined District Hospital
CHC	Kara, Kaneli, Chail	Pokhriya, Rasulabad
PHC	Sarswa, Manjhanpur, Shajadpur	Sarwankhera, Sikandra, Razdaan
Health Sub Centre	Myohar, Sadipur	Arhariyamau, Shonda, Pindarthu

CHALLENGES

- The State needs to focus on provision of comprehensive primary health care, non-operational Jan Aushadi stores and Amrit Stores in districts, high OOPE against diagnostic services (and line listing of services), operationalization of dialysis units in district and implementation of Bio Medical equipment maintenance
- State reported very low comprehensive full ANC coverage, Line listing of High Risk Pregnancies is not being maintained at all health facilities provision of HIV & GDM screening service lacking in the field, labour room staff lacks knowledge and skill on Essential Newborn care practices and resuscitation, most of the FRUs were without functional Blood Storage Units.
- The Disease Control Programmes continue to operate as vertical programmes. State to initiate Central packing unit (DRTB Drugs) and C & DST laboratories. Involvement of Private sector in TB notification is very low. Underutilization of CBNAAT machines. National Mental Health Programme not initiated at District level. State to establish NCD clinics (missing in both the Districts).

WEST BENGAL

TEAM COMPOSITION

PASCHIM MEDINIPUR	DAKSHIN DINAJPUR
Dr. Zoya Ali Rizvi, AC, ARSH, MoHFW	Dr. Rajani R. Ved, ED, NHSRC
Dr. R K Das Gupta, JD, NVBDCP	Dr. R.K.Hazra, Scientist E, ICMR
Dr. Satyajit Sen	Dr. Alka Gupta, SPO, QA, Gov. of H.P
Prof. T. Bir, NIHFW	Dr. Somashekhar, NTI
Dr. Shampa Nag, Project Director, Caritas, India	Dr. Anisur Rahman, Manager, Save the Children
Mr. Kumar Vikrant, ADB	Dr. Alok Ranjan, TISS
Dr. Manas P Roy, DADG, MoHFW	Ms. Pumani Kalita, NHSRC
Ms. Sumitha Chalil, Sr. Consultant, NHM	Ms. Tajinder Kaur, FMG

POSITIVES

- Good access to public health services and high case load (OPD/day average: 300 at block level and 500 at district hospital) at the public health facilities. No stock-out for most of the essential drugs at all the health facilities visited.
- Well trained ASHAs were found, demonstrated potential to be engaged in areas such as NCD screening/follow-up, Blindness control, RBSK, Elderly care, VBD, etc.
- Good ANC coverage and early registration was observed, Labour room protocols were followed and HIV testing was done for all ANC beneficiaries.
- All TB patients were also screened for co morbidity (HIV).
- NCD clinics functional at DH and SDH level. There was a good example of convergence between NCD and geriatric clinics
- The Basic book of accounts were maintained properly and as per the norms at district and state head quarter.
- The District Health Society meets regularly and takes key decisions as required.
- Convergence with AWW and ICDS is well established
- DMHP running well, however linkages with the De-Addiction programme needed.

	FACILITIES VISITED	
TYPE OF FACILITIES	PASCHIM MEDINIPUR	DAKSHIN DINAJPUR
DH	Medinipur MCH	DH Balurghat
SDH	SDH Kharagpur, SDH Ghatal	SDH Gangaram
CHC/BPHC/RH	RH Dantan, RH Hijli, RH Dwarigeria, BPHC Vidya Sagar	RH Tapan Block, RH Kushmandi
PHC/UPHC	UPHC Sarathpally II, Ghatal	Ramparachachara, Samjhia (24*7)
HSC	SC Satkui, SC Matkapur, SC Bhabhanipur, SC Bhadutala II, SC Barameshya, SC Dandipur	Mandapara Ramparachachera, Ananatpur, Bishnupu, Aminpur, Balapara, Saralam: Ajimatpur, Kartaba, Azmadpur, Kuchila, Thakurpur, Mallencha, Kumarganj
School	Dantan Bhagabat Charan HS, Dandipur Manmatha Vidya Mandir SS	Kardaha High School, Samaspur LP School
Village & AWC	Manikadagar, Kharagpur, Bhabhanipur, Bhadutala II, Mohulbari, Dandipur	Mohakgram, Mandapara, Vishnupur, Anantpur, Vishnupur, Kalshi, Kawli, Dikul, Korai Chenchara, Chakrabhigu, Hajarabari, Tejihar

CHALLENGES

- Lack of primary health care services and concerted effort at preventive and promotive activities leading to overcrowding of facilities even with adequate HR, lab facilities and free drugs.
- Irrational use of antibiotics by ANMs at sub centre level without prescription by doctor.
- Besides JSSK, no dedicated free transportation, even for emergency cases as MI/Stroke/RTA etc.
- No informed consent of the beneficiary and lack of follow up for retention of PPIUCD.
- No implementation of newer guidelines (Inj Genta/Inj Dexa/Ca supplementation, point of care, Syphilis testing, Gestational Diabetes Mellitus) under RCH
- PMSMA not seen, partographs not maintained uniformly despite SBA trainings
- Poor monitoring of immunization sessions; stock out of IPV & DPT reported, irregular outreach sessions for immunization along with poor management and monitoring of vaccine storage.
- WIFS Pink yet not available in schools and AWCs
- No functional DEIC leading to poor follow up of referrals (besides CHD/Club foot/Cleft Palate which are followed very aggressively)
- Private facilities under IDSP are not reporting
- Both the selected districts are low endemic for malaria; so the 4 deaths in 2017 should have been averted. This may be due to the fact that ASHAs are not empowered as per National drug policy for Malaria diagnosis and treatment.
- State Internal Evaluation for TB needs a restart (regular monthly monitoring of the district level RNTCP staff) and procedural delays in release of funds from State HQ may be avoided
- Sources of drinking water including Tube wells contaminated with fluorine.
- COTPA not fully implemented in the State
- Supportive supervision needs strengthening at all levels of administration
- The overall fund utilization is low across the State especially for the NCD programme which is only 2.61%. This may be because funds are released pool-wise and not activity-wise
- State needs wide implementation of PFMS with proper training and 100% DBT payments.
- VHSNC funds routed through P&RD; limiting the ability of health system to engage communities for action on social determinants

Note

NATIONAL HEALTH MISSION
Ministry of Health & Family Welfare
Government of India
Nirman Bhavan, New Delhi