National Rural Health Mission

# Second
# COMMON REVIEW MISSION
November-December 2008

## Report











NATIONAL RURAL HEALTH MISSION
MINISTRY OF HEALTH & FAMILY WELFARE

SECOND

# COMMON REVIEW MISSION

REPORT

NOVEMBER-DECEMBER 2008

**NATIONAL RURAL HEALTH MISSION**
Ministry of Health & Family Welfare
Government of India
Nirman Bhawan, New Delhi

Ministry of Health and Family Welfare
Government of India, Nirman Bhawan,
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डॉ अन्बुमणि रामदास
Dr. ANBUMANI RAMADOSS

At the outset, I would like to thank all the members who joined the 2nd Common Review Mission in November – December 2008 for the useful insights they have provided on how the National Rural Health Mission is doing in 13 states. We are encouraged by their finding as far as seeking services from public systems are concerned.

Public systems have started providing more outpatient care, inpatient care, institutional deliveries, drugs, diagnostics, emergency ambulance service, etc,. we have also noted the points made regarding improving the quality of services in manystates.

2. The NRHM has focused on communalization and innovations in human resources engagement. Over 80,000 doctors, nursed and paramedics besides 6.40 lakhs ASHAs have link workers been added to the systems of health care in the country. We have challenges in expanding medical and nursing education with reforms in the coming years we hope to make possible expansion of medical and nursing education without compromising on excellence and quality.

3. It was a great learning experience for me to sit through the presentation made by CRM team on their finding. I am sure that the State Government representative have taken these in the right sprit and would like to improve the performance of the health systems in State even faster in the years to come. NRHM is nothing short of a social revolution in provision of health care services. Posterity will judge its contribution to improving the health indicators of our country

(Dr. Anbumani Ramadoss)

श्रीमती पनबाका लक्ष्मी
Smt. PANABAAKA LAKSHMI

सत्यमेव जयते

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MINISTER OF STATE
FOR HEALTH AND FAMILY WELFARE
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February, 2009.

I am pleased to see the findings of the 2nd Common Review Mission of National Rural Health Mission which visited 13 States in November-December 2008. NRHM is a flagship programme of the UPA Government and our Hon'ble Prime Minister has encouraged us to provide accessible, affordable and accountable quality health service in rural areas. The NRHM has been trying to do that successfully and the results of these efforts will definitely translate into better indicators of health care in our country.

The NRHM has set in motion a series of reforms in States that will help improve the quality of health services to poor people in remote areas. A very large number of innovations have taken place and I am sure these innovations will lead to better services across the country.

NRHM is a unique partnership with State/UT Governments and I must say that the support of the State Governments has been a key factor in the success of this programme. We will continue to work with the States to further enable the achievement of goals and objectives of this flagship programme.

Panabaaka Lakshmi
(PANABAAKA LAKSHMI)

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The National Rural Health Mission has promoted large scale innovations across the States to provide quality health services to people in remote areas. These innovations have been welcomed by the States as they provide a platform for local health action. The Common Review Mission is an important institutional arrangement to validate the work of NRHM in the field. The best of experts from outside the Government as well as from the Government traveled intensively to two districts in the selected 13 States and spent a full week in trying to understand the difference that NRHM had made. The Report of the 2nd Common Review Mission of NRHM undertaken in November-December 2008 has tried to do this in a very evidence based way. We are glad to learn from the insights of experts that the programme has contributed towards increase in outpatients, inpatients, institutional deliveries, drug and diagnostic availability emergency transport etc.

Health is a complex sector which requires the partnership of diverse professionals, civil society etc. NRHM has tried to involve civil society and public health experts in a range of its interventions. The CRM is part of this overall culture of transparency, openness and partnership with all concerned citizens. It is through the useful inputs of a wide variety of professionals that we are able to steer on the right path. There are a large number of challenges which the CRM has identified for further action in order to improve quality of services. I take this opportunity to thank all members of the CRM for having given us very useful insights in moving forward towards the goal of providing affordable, accessible and accountable quality health services for our rural areas.

Naresh Dayal

**(NARESH DAYAL)**

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# M E S S A G E

The Annual Common Review Mission is a very important event in the calendar of the National Rural Health Mission. It is an opportunity for the Mission to get an independent feedback from experts and civil society representatives on how the Mission is doing. NRHM values the suggestion and recommendations of independent reviewers as it is based on the conviction that good and credible public systems must eternally subject themselves to external assessments. There are other quantitative and MIS based systems of assessing performance in States. The Common Review Mission is an opportunity for a qualitative assessment of progress based on intensive field visit and interaction with the functionaries and community representatives over a two week schedule. The intention of covering two districts in 13 representative States during each Mission is to ensure an objective assessment of progress. A multi disciplinary team comprising of public health experts, civil society representatives, central and state government functionaries, development partners etc., provides an opportunity for learning from the observations of experts.

NRHM was launched in April 2005 by Hon'ble Prime Minister Dr. Manmohan Singh. Its detailed Framework for Implementation, that provided for flexibility and large scale sector reform with additional resource, was approved in July 2006. In its short journey (Public health challenge in India is a marathon and not a sprint!), the NRHM has initiated large scale innovations and reforms. It is a completely new way of approaching field level problems where States lead the process for change. The Programme Implementation Plans of States, based on decentralized District Plans, form the basis for approvals after an intensive process of the appraisal and dialogue. This ensures optimal prioritization and ownership of the State. Large scale innovations are an outcome of this space that NRHM provides for fresh thinking in the health sector. NRHM does not come up with solutions without understanding the ground level problems. By providing for community institutions at all levels, NRHM promotes flexibility with local level accountability.

The thrust of NRHM on human resources and united funds with local institutions has resulted in better services to the people. We are confident that we have to continue to follow the paradigm shift that NRHM has initiated, from distrust to trust, from inflexibility to flexibility, from narrow vertical efforts to broader horizontal preparedness of facilities. NRHM is based on the premise that a fully functional platform for health care at all levels, from the village to the district level, will have positive consequences for all health sector programmes. It is only by addressing a wider set of mortality and morbidity factors that impair people's life, that it would be possible to provide affordable, accountable and accessible health care in rural areas. The wider determinants of health are very crucial and that is why NRHM has tried to promote a non – medicalized perspective on health that respects preventive and promotive health as well. Water, sanitation, women's empowerment, education, literacy, are all critical for better health outcomes.

We would like to thank all the experts who gave us their valuable time and ever more valuable insights on how to make the NRHM even better. We would like to assure them that we take the recommendations in the right spirit, and in partnership with the States, we do try and ensure that the suggestions are acted upon.

I would like to thank all who made it possible to organize the Common Review Mission. In particular, I would like to thank Mr. Amarjeet Sinha, Dr. Tarun Seem and their teams along with the NHSRC for making the Mission possible.

**(G.C. Chaturvedi)**

# CONTENTS

# ABBREVIATIONS

| | |
|---|---|
| AMG | ASHA Mentoring Group |
| ANC | Ante-Natal Care |
| APHC | Additional Primary Health Center |
| ANM | Auxiliary Nurse Midwife |
| ANMTC | Auxiliary Nurse Midwife Training Centre |
| ASHA | Accredited Social Health Activist |
| AYUSH | Ayurveda, Yoga, Unani, Siddha, Homeopathy |
| BAM | Block Account Manager |
| BEmOC | Basic Emergency Obstetric Care |
| BPM | Block Programme Manager |
| BPMU | Block Programme Management Unit |
| CEmOC | Comprehensive Emergency Obstetric Care |
| CHC | Community Health Centre |
| CMHO | Chief Medical and Health Officer |
| CRM | Common Review Mission |
| DFID | Department for International Development (UK) |
| DH | District Hospital |
| DHAP | District Health Action Plan |
| DHS | District Health Society/Director Health Services |
| DLHS | District Level Household Survey |
| DOTS | Direct Observation Therapy – Short-course |
| DPM | District Programme Manager |
| EDL | Essential Drug List |
| EmOC | Emergency Obstetric Care |
| EMRI | Emergency Medicine and Research Institute |
| FMG | Financial management Group |
| FRU | First Referral Unit |
| FW | Family Welfare |
| GNM | Graduate in Nurse and Midwife |
| GOI | Government of India |
| Hb | Haemoglobin |
| HMIS | Health Management Information System |
| ICDS | Integrated Child Development Scheme |
| ICTC | Integrated Counseling and Testing Centre |
| IDSP | Integrated Disease Surveillance Project |
| IMEP | Infection Management and Enviroment Protection |
| IMNCI | Integrated Management of Neonatal and Childhood Illnesses |
| IMR | Infant Mortality Rate |
| IPHS | Indian Public Health Standards |
| IT | Information Technology |
| JBSY | Janani Bal Suraksha Yojna |
| JDS | Jeevan Deep Samiti (RKS) |
| JNU | Jawaharlal Nehru University |
| JSY | Janani Suraksha Yojana |
| KBK | Kalahandi-Bolangir-Koraput (districts of Orissa) |
| KHSDP | Karnataka Health Systems Development Project |
| LHV | Lady Health Visitor |
| LLFS | Life-Line Fluid Store |
| LSAS | Life Saving Anaesthetic Skills |
| LT | Laboratory Technician |
| MCHN | Maternal and Child Health, and Nutrition |
| MMR | Maternal Mortality Rate/Ratio |
| MMU | Mobile Medical Unit |
| MNGO | Mother NGO |
| MO | Medical Officer |
| MOHFW | Ministry of Health & Family Welfare |
| MSG | Mission Steering Group |
| NABH | National Accreditation Board for Hospitals and Healthcare Providers |
| NCD | Non-Communicable Diseases |
| NDCP | National Disease Control Programmes |
| NFHS | National Family Health Survey |
| NGO | Non-Government Organisation |
| NHSRC | National Health Systems Resource Centre |
| NIPI | Norway-India Partnership Initiative |
| NPCB | National Programme for Control of Blindness |
| NLEP | National Leprosy Eradication Programme |
| NRC | Nutritional Rehabilitaion Centre |
| NRHM | National Rural Health Mission |
| NSV | Non-scalpel Vasectomy |
| NVBDCP | National Vector Borne Disease Control Programme |
| OPD | Out Patient Department |
| PHC | Primary Health Centre |
| PIP | Programme Implementation Plan |
| PIU | Programme Implementation Unit |
| PMU | Programme Management Unit |
| PPP | Public Private Partnership |
| PRI | Panchayati Raj Institution |
| PTS | Pregnancy Tracking System |
| RCH | Reproductive and Child Health |
| RDK | Rapid Diagnostic Kit |
| RKS | Rogi kalyan samiti |
| RMRS | Rajasthan Medicare Relief Society |
| RNTCP | Revised National Tuberculosis Control Programme |
| ROP | Record of Proceedings |
| RSBY | Rashtriya Swasthya Bima Yojana |
| SC | Scheduled Castes |
| SDH | Sub Divisional Hospital |
| SDP | State (Gross) Domestic Product |
| SHC | Sub Health Centre |
| SHG | Self Help Group |
| SHRC | State Health Resource Centre |
| SHSRC | State Health Systems Resource Centre |
| SIFPSA | State Innovations for Family Planning Services Agency |
| SIHFW | State Institute of Health and Family Welfare |
| SPMU | State Programme Management Unit |
| SNCU | Sick Neonatal Care Unit |
| SRS | Sample Registration Systems |
| TBA | Traditional Birth Attendent |
| TFR | Total Fertility Rate |
| TNMSC | Tamilnadu Medical Services Corporation Limited |
| TSP | Tribal Sub Plan |
| TT | Tetanus Toxoid |
| UC | Utilisation Certificate |
| UNOPS | United Nations Office for Project Services |
| VHND | Village Health and Nutrition Day |
| VHSC | Village Health and Sanitation Committee |
| WHND | Ward Health and Nutrition Day |
| WHSC | Ward Health and Sanitation Committee |

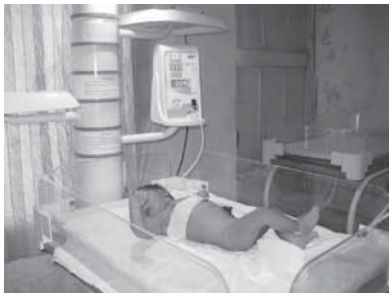
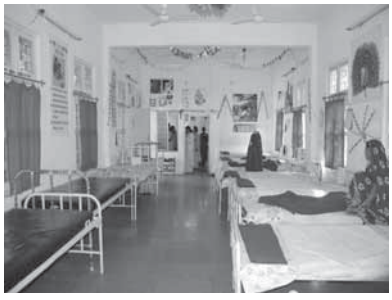
# EXECUTIVE SUMMARY









# EXECUTIVE SUMMARY

The Second Common Review Mission of the National Rural Health Mission was held in November-December of 2008, 43 months after the formal launch of the programme and 27 months after the Framework for Implementation was approved by the government. A total of 67 persons- eighteen officials of the central and state governments, 19 public health professionals from academic and technical institutions, 17 public health activists from civil society and 13 representatives of development partners participated in the mission. The Mission was divided into 13 teams and each team visited more than ten facilities in a minimum of two districts in a state. At each of these sites, the Mission interacted extensively with the community representatives, service providers, and officials. Thereafter the teams held discussions with the concerned state officials and submitted the state reports. These state reports have been summarized in this national report along with an analysis of general trends across states.

The Mission studied changes in 19 parameters. In this report the findings have been summarized under four main headings. The most important of these is improvement in service delivery and facility functionality focusing on the NRHM's promise of guaranteed services. The other headings are human resource development, improvements in management and strengthening of community processes.

## KEY FINDINGS OF THE MISSION

1. The most important finding is a general increase in utilization of public health services, reflected in increase in number of outpatients, and in-patients, a sharp increase in the institutional deliveries and greater utilization of ancillary services like diagnostics, referral transport etc. This increase is seen across states. Though Janani Suraksha Yojana is a major driver of this increase, other factors like more nurses and doctors put in place, better availability of drugs and improved cleanliness and above all, the increasing will to revive public health systems are becoming the dominant contributing factors.
2. The increased utilization is not uniform across all facilities in all states. In six states, all of them high focus, despite an overall increase, the increase at PHC level (the facilities meant to follow the norms of one per 30,000 population), is modest or absent. And in a few of these six states, increases in service even at the sub-center level have been compromised by the focus on developing CHC or block PHC (i.e. with the norm of one per lakh population) . This has occurred because of a conscious policy to utilize scarce human resources optimally by pooling them to viable levels at few centers, rather than spreading them thinly. Or this has occurred because of core sub-center services being transferred to higher levels, with little plans for those who are still unable to access the higher health facility. In most of these states with secondary centers getting overcrowded and reeling under the pressure of institutional deliveries, attention for revitalizing the primary health center is required
3. All states have seen substantial increase in number of service providers deployed. There is now an increased awareness of sub-critical densities of human resource in the public health system, a legacy inherited from the nineties, as one of the critical reasons for the poor performance of the public health system. Along with this, some states have substantially revised and improved the key dimensions of their workforce management policies whereas other states, though seized of the issues, have yet to push through the minimum necessary changes for ensuring a motivated workforce from whom performance can be demanded. One important development is a range of incentives given to the staff across states to improve the availability of workforce in hitherto underserved areas. There is a concern that the major part of the increases in workforce are contractual and sustainability beyond the sanctioned NRHM period would be a problem, especially where states have not fully owned the essential nature of such expansion and planned for it in the state budgets.
4. Expansion of paramedical, nursing and medical education is occurring in all states and there are plans for a major acceleration of this. Lack of faculty, institutions and resources seriously hamper this expansion. In many states almost all recruitable staff available in the open market has been taken in- and unless the pool of new recruits is sharply increased, further improvements even in service delivery would become critical. This is most important in the poorest performing states where existing human resource density is extremely low, and all these NRHM driven increases have not been enough to catch up even with the pre- NRHM levels of human resource availability in the high performing states.
5. Quality of care and preparedness of facilities have improved. However states with better baseline like Kerala, Tamil Nadu and Maharashtra have been in a position to make quicker use of untied funds and strengthen the state and district planning process for addressing these issues. Though there have been significant improvements in infrastructure, drugs, diagnostics, sanitation and hygiene, dietary arrangements etc in the high

focus states, the rapid increase in utilization, especially the rise of institutional deliveries tends to outpace the relatively much slower rate of expansion of infrastructure, human resources and supplies. Addressing this would require even more flexibility in funding, along with better management structures at the state and district levels.

6. Induction of management, IT and accounting skills in a major way at every state and district level has improved the management of programme significantly. The flow of funds has been streamlined with computerization of accounting and bank transfers of funds at most levels. However states have shown very varied progress in setting up institutions that are needed to improve the management and drive the process of architectural correction. This is particularly a problem in the area of procurement and logistics (where Tamilnadu Medical Services Corporation {TNMSC} is a national benchmark), in infrastructure development (where the Gujarat PIU is a benchmark), in the area of technical assistance (the planned SHSRCs) and in the area of training institutions (the SIHFW equivalents and the pyramid of institutions below them).
7. The ASHA programme has expanded at the grass root level to cover all the high focus states except Himachal Pradesh and Jammu and Kashmir, and is now being expanded to cover the entire nation. The ASHA has emerged as an enthusiastic community health worker whose effectiveness and live contact with the public health system is sustained through the JSY and her role in the village health and nutrition day/ immunization session. Most states are working towards improving their support systems, quality and frequency of training, regularizing payments, refilling drug kits, providing for special referral support and expanding the incentive package. As these steps come into place, the programme can be expected to pick up and provide a much higher level of outcomes. Most other dimensions of community participation- the village health and sanitation committee, the community monitoring programme, the public participation in *rogi kalyan samiti* and district health societies are showing good potential but in many states it is too early to comment as they are only in the take-off stage. There is a scope for increasing the participation of NGOs in the ASHA programme and in strengthening other community processes.
8. Systemic inadequacies are affecting all vertical programmes, the most important of these being the poor density of functional health facilities and consequent low human resource density in the low performing states. In addition, immunization continues to be affected by poor logistics. The efforts at integration could be strengthened especially by using the district plan process to address the systemic and programme linkages.
9. Most of the planning for fully functional facilities or achieving IPHS norms focuses on the RCH components. Other health care needs like management of acute illnesses (so critical to disease control programmes), trauma, and non communicable diseases are not as yet getting the importance due to them in planning, resource allocation, human resource planning or in monitoring. There is a need for high performing states to show the way forward in these areas. There is a need for these states to develop models of integration of these concerns that could cover up to 80% of morbidities, into the district plan.
10. Hospital Development Societies are in place in all the districts, divisional and block hospitals and in most of the PHCs. These societies are functional and are an effective vehicle for untied funds and to some extent for improved facility level management and this has substantially contributed to improving quality of services. Much needs to be done however to make them

more conscious of their role in safeguarding equity, along with quality of services, and to reduce their image as merely being a vehicle for user fees. The problems of user fees are not properly understood by both facility level service providers and these societies. However problems like lack of exemptions for the poor, non utilization of certain services and exclusions do exist and were evident to the visiting mission teams.

11. Decentralisation in terms of devolution of governance powers to *panchayats* continues to be a challenge. However progress has been made in involving *panchayats* in the structures of the mission - VHSCs, hospital development committees and in district health societies. Capacities for district planning have improved substantially but the process is hampered by lack of information about the resource envelope available against which the district plan is made and failure of states to release moneys to the districts according to the approved district plan and to use the district plan as the instrument of programme review.
12. A wide variety of non governmental partners have been involved in providing the services or strengthening the programmes. Mostly, they are not-for-profit agencies who are reaching out to underserved areas through different contracting arrangements. In a few states like Bihar there is outsourcing of ancillary hospital services to local agencies and individuals against a standardized agreement. Though these are all useful supplements to the public health system, there is no generally replicable model that has been seen in the states visited. In all the cases of partnership, even where a reputable not-for-profit group is involved, there is a need to have an independent monitoring mechanism in place. In addition, a careful assessment and construction of financing arrangements should be made such that services are appropriately budgeted and sustained and for all these, there should be sufficient capacity at the district and state levels.

## RECOMMENDATIONS

1. Work with states to finalise a clear nomenclature for the different facility levels and their hierarchical relationships to each other. This is a major constraint in planning, financing and monitoring.
2. Work with states to contextualize IPHS guidelines in order to plan and set meaningful annual targets for improvement in a phased approach to reach the goal at every facility level. The states also need to contextualize the guidelines so that service priorities under IPHS reflect the epidemiological profile in each state.
3. Renew attention on strengthening the PHC. In most states this would be based on achieving the IPHS norms in human resources for PHCs, but in states with a human resource crunch, alternative human resource management strategies based on multi-skilled paramedics would be needed.
4. Improving the quality of care and comfort of stay for the in-patients in the public hospitals especially at the secondary level, through clean toilets, fresh linen, and a friendly environment. Over time move to a system of ensuring quality improvement in all public health facilities.
5. Mainstreaming AYUSH, and not merely mainstreaming the AYUSH provider: Provide users with a greater choice of services by having the provision of AYUSH services, and not use the providers as additional allopathic curative care providers.
6. Where an AYUSH doctor is being used as a substitute for an MBBS medical officer, this should be in addition to their providing services of the AYUSH system, with enough medicines,

equipment and other support to do so. In such situations, there is a need to specify through standard protocols the level of allopathic care that can be provided by them and provide them with training and a legal framework to deliver such care.

7. There is a need to urgently strengthen the ASHA support system. This includes a state level resource team capable of developing further state specific materials, well trained and supported district and block level teams of facilitators and a system of monitoring. Streamlining of payments also needs attention and its base widened by allowing a larger number of activities to be included for incentives.
8. Enhance community participation, especially representatives of user groups in the hospital development committees (*rogi kalyan samitis*), and transform their image from being a vehicle of user fee collection into an organization charged with addressing equity and quality issues.
9. Activate the village health and sanitation committees and strengthen facilitation systems for this. In particular NGOs could play a major role.
10. Simplify the current process of community monitoring, broad base the programme participants and upscale it for a wider coverage.
11. Improve coordination between the health mission and the directorates in the states. Simultaneously, increase training and support inputs to directorate staff so that they are able to participate and eventually lead in the process of change and revitalization of public health systems.
12. Work with state governments to start immediately three management and support organizations/ arrangements with minimum design specifications – one for procurement and logistics, another for infrastructure and the third for technical assistance (the SHSRCs).
13. Improve the quality of public health management through development of a public health sector management cadre, expansion of public health education including in-service skill training and improved human resource development policies for health administrators.
14. Make improvements in workforce management policies, one of the cornerstones of good governance in the states and support the states to evolve and implement commonly agreed policies in this regard.
15. Assist and support states to draw up and implement plans to revitalize their SIHFWs or equivalent organization and other training institutions so as to ensure that in-service skill upgradation meets the quality and pace required for improving service delivery.
16. Assist and support states to draw up and implement state specific human resource development plans to ensure expansion and quality of medical, nursing and paramedical education, so that the needs of the public health system are prioritized and met within the shortest possible time.
17. Build a national plan linked to the above to take on the responsibility of developing faculty and quality assurance systems for this rapid expansion in medical, nursing and paramedical education.
18. State spending on the human resource component should expand, so as to slowly take in the new positions being created under NRHM. This is essential for sustainability, better work force performance and as part of the commitment to increased public health expenditure. A wider and innovative set of incentives, not only monetary, must be tried out and institutionalized for attracting and retaining skilled personnel in difficult areas.
19. Link district plans to resource envelopes available for districts and also develop the practice of revising the plan document after sanction, based on fund allocation and local priorities.

20. Develop the district plans further so that they are used to rationalize infrastructure and human resource and financial resource deployment to match utilization patterns of different facilities and areas, while ensuring that basic resources are equitably provided to all.
21. There is a need to ensure, that there is a proportionate allocation of funds and expenditure for accelerating non *Janani Suraksha Yojana* (JSY) dimensions of RCH that would prepare the facilities for all round provision of quality services, especially addressing other dimensions of women's health, neonatal care and meeting the felt needs of contraception.
22. The NRHM's emphasis on human resource development should take into account the needs of the disease control programmes. There are shortages of staff even in key district level management positions. Integration of disease control programmes and IDSP in the district plan in a technically meaningful manner is essential for improved outcomes in many programmes, especially in vector control.
23. While immunisation programmes have been given attention in states with regards to outreach and fixed day immunization services, gaps in availability of vaccines and issues in cold chain management seem to have adversely affected progress in the current year.
24. Progress beyond planning for RCH service delivery in primary and secondary facilities and plan for addressing emergencies, acute illness and even chronic illness at all levels. This can be achieved through the development of appropriate referral linkages, human resource development and deployment strategies in such a way that all the facilities within a district become like parts of a single functional unit. High performing states on RCH parameters should take the lead on this.
25. Improve the flexibility of fund allocation to facilities within a district and to districts within a state so that funds flow to facilities and districts which use them the best. This is essential to expedite useful absorption of funds. However funds needed for a minimum level of functioning must be ensured to all facilities and equity considerations within regions are to be kept in mind so that places already suffering from lack of human resources and sanctioned facilities are not further deprived.
26. Engage the private sector to provide services in thematic and geographic areas where the public system is deficient by working out packages that are cost effective and transparent and subject to good monitoring practices.
27. Develop HMIS systems and capacities so that action can be taken on information derived from data analysis at the facility and at the sector, block and district levels. The main challenge is the development of district level systems and capacities for use of information. The other major challenge is to be able to collect information from the private sector as well.

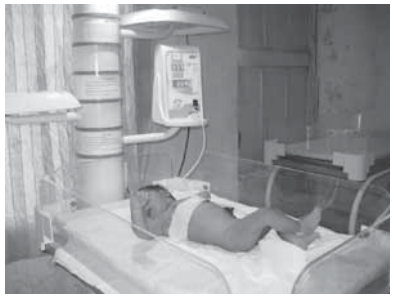
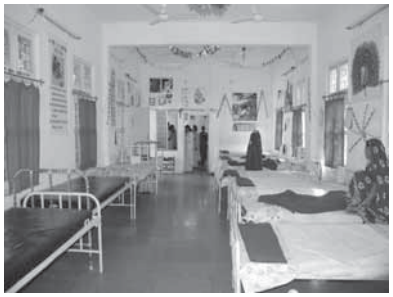
# SECOND COMMON REVIEW MISSION REPORT









# SECOND
# COMMON REVIEW MISSION
## REPORT

## BACKGROUND

The National Rural Health Mission (NRHM) was launched on 12th April 2005, to provide accessible, affordable and accountable quality health services that would reach even the poorest households in the remotest rural regions. The detailed Framework for Implementation that defined the strategy by which this goal would be approached was approved by the Union Cabinet in July 2006. This Common Review Mission, the second one, is an assessment of the progress during the last one year. To put greater emphasis on the states with the more unsatisfactory health indicators, 18 states were classified as special focus States.[1] This Common Review Mission covers 9 of these 18 states and 4 of the other 11 states.

1 The high focus states are the 8 states of the North-east- Assam, Sikkim, Tripura, Meghalaya, Mizoram, Manipur, Nagaland and Arunachal Pradesh; the eight low performing states of Bihar, Madhya Pradesh, Uttar Pradesh, Rajasthan, Orissa, Jharkhand, Chhattisgarh, and Uttaranchal; and the two states of Jammu & Kashmir and Himachal Pradesh. The NRHM is also being implemented in the remaining 'non-high-focus states'.

The National Rural Health Mission represents a major departure from the past, in that central government health financing is now directed to the development of state health systems rather than being confined to a select number of national health programmes. There are many considerations behind such a shift. This shift is important for improving the structure and functioning of public health systems because all national health programmes taken together cover only a small proportion of the morbidities – in the range of about 20 to 30%. Another reason for this shift is because investment in health systems development is essential for good results even for national disease control and RCH programmes. For investment in health funding to impact on health equity and on poverty, larger funds have to flow for health systems to those very states whose ability to raise resources internally are most limited and who have a greater burden of poverty and inequity and, therefore, a greater burden of disease to bear. While the state governments bear the responsibility of planning and providing the health services in their state, the NRHM is expected to facilitate the strengthening of health systems and infuse new energy through support from the centre.

The NRHM framework represents a conscious decision to strengthen public health systems and the role of the state as health care provider. The NRHM also recognises the need to make optimal use of the non-governmental sector to strengthen public health systems and increase access to medical care for the poor. There has been concern on whether such an approach is pragmatic given the poor record of performance of the public health systems. The NRHM framework is built on an understanding that low and declining public investment in health care and the many structural problems in the way the public health system has been organised are the main reasons why it has been functioning poorly, and therefore this must be addressed through increased public expenditure and through architectural correction of the public health system. Given the uneven growth of the private sector, its current situation in terms of regulation of quality and pricing of services as well as the issues of access to the poor, provisioning of services through the public sector and the public health care providers remain the mainstay of public health policy.

The NRHM is, therefore, about increasing public expenditure on health care from the current 0.9% of the GDP to 2 to 3% of the GDP in an effective manner so as to strengthen the public health services. The corollaries of such a policy directive are not only an increased central government budgetary outlay for health, but that the states also make a matching increase – at least 10% of the budget annually, including a 15% contribution into the NRHM plan, and that the center-state financing ratio shifts from the current 20:80 to at least a 40:60 ratio in this plan period. Another important corollary is that the state health sector develops the capacities to absorb such fund flows. This is why a process of reforming and strengthening the state health systems needs to go hand in hand with the increase of fund flows.

The other core objective of the NRHM, which is also central to reviving trust in the public health system, is the responsibility of creating what the framework calls "fully functional health facilities" within the public health system. Whether it is a sub-centre, or a PHC, a CHC or a district hospital, the NRHM framework spells out a service guarantee expected of that level, and promises to provide the resources and assistance needed by states to close that gap. The outcome most expected from the Mission is that each facility is able to fulfill this guarantee.

The "architectural correction" of the public health system envisaged by the NRHM, so as to deliver

on these two core objectives that would lead to the goal of "equitable, affordable, effective, quality health care", is organised around five pillars, each of which is made up of a number of overlapping core strategies.

a. **Setting Norms and Standards and Achieving Service Guarantees:** The first of these pillars is the setting of norms and standards for public service health delivery which match the notion of service guarantee outcomes and putting in place a mechanism of monitoring and support to ensure that this is reached. Once the norms and standards are in place, the challenge lies in identifying facility wise gaps in infrastructure, human resource, equipment, drugs and supplies and above all in service outcomes. And then the challenge is to ensure that states are seized of this task and build roadmaps to close these gaps. Gaps in infrastructure require an efficient mechanism of completing civil works in time with quality. Gaps in equipment can be addressed relatively easily. Gaps in drug supplies need an adequate drug procurement and distribution system. Gaps in human resource require expansion of educational programmes plus workforce reforms and innovations. The NRHM has put in place a set of Indian Public Health Standards for each of the facilities from Sub-centre to District Hospital with service guarantees at each level. Most states have completed facility surveys to identify the gaps and are seized with the task of closing these gaps. The Common Review Mission itself represents the apex of a pyramid of monitoring and evaluation strategies meant to assess and ensure movement on this path to attain fully functional health facilities. In addition, the NRHM framework assures the states that the center would contribute substantially to the financial and technical resources needed for states to close the gaps.

b. **Innovations in human resources development for the health sector**: The central challenge of the NRHM is to find definitive answers to the question of ensuring adequate recruitment and retention of workforce for the public health system and adequate functionality of those who are recruited. Breaking a vicious cycle where poor performance of the workforce has justified poor attention to solving the fundamental problems of human resource development, the NRHM lays downs a minimum human resource requirement for each facility level and follow up to ensure that states agree to a roadmap to close these gaps. The most important outcome of this is the dramatic increase in the number of nursing and allied staff being brought into the system. The contractual appointments and local recruitments to immediately fill the gaps as well as ensuring local residency, incentives for staff working in hitherto underserved areas, and the use of multi-skilling and multi-tasking options are examples of innovations that seek to find new solutions to old problems. Expansion of professional and technical education and increasing access of weaker sections to such education are also core strategies.

c. **Increasing Participation and Ownership by the Community** (also referred to as communitisation): This is sought to be achieved through an increased role of PRIs in the ASHA programme, village health and sanitation committees,and through increased public participation in hospital development/ management committees. The district health societies, the district and village health planning efforts, the special community monitoring initiative and the greater space for NGO participation are also envisaged to contribute towards enhancing the inclusion of community perspectives in decision making.

d. **Improved Management Capacity:** The approach adopted is of professionalising management by building up management and public health skills in the existing workforce, supplemented

by inculcation of management personnel into the system. Another major component of this is the creation of institutional capacities for improved management in the form of functional programme management units, strengthened directorates of health services, strengthened and outcome oriented state institutes of health and family welfare that would ensure that the workforce in every facility has the necessary skills to deliver its service guarantees, and the creation of state health resource centres that would act as strategic planning and technical assistance units and as managers of change. Increased decentralisation in management, public participation and accountability in the management through participatory decision making structures, like the hospital development committees and the district health societies, is another major strategy for improving the functioning of public health system.

e. **Flexible Financing**: The central strategy of this pillar is the provision of untied funds to every level – the village health and sanitation committee, sub-centre, PHC, CHC and district hospital. Even the strategy of providing a resource envelope to each district and state, which the district/state has to use against an approved plan that it develops, is an unprecedented level of financing flexibility. Financing packages for demand side financing and various forms of risk pooling, where money follows the patient, are also major strategies declared by the NRHM. The *Janani Suraksha Yojana* is one major, almost overwhelming, example of the demand side financing option, so much so that in many places, the NRHM is being identified with it. But the challenge of the NRHM is to be able to build more comprehensive packages that would ensure efficient allocation of funds within the public health system and address equity concerns for the entire range of preventive and curative care needs.

Since operationalising these measures involved wide-ranging administrative mechanisms to be set up, the initial years of 2005-06 and 2006-07 were start-up years, requiring steps to be devised and put in place at central and state levels. 2007-08 was the first year of full implementation, and 2008-09 led to its further strengthening. Continuing and concurrent review of planning and implementation processes has been considered crucial for such a mission that involves a large degree of flexibility and constant innovation.

## MANDATE AND METHODOLOGY OF 2ND COMMON REVIEW MISSION

The Common Review Mission (CRM) was set up as a part of the Mission Steering Group's mandate of review and concurrent evaluation. The last two years - 2007 and 2008 - have been crucial for the implementation of the NRHM, as many of the plans and strategies of the NRHM were rolled out in the states. The first Common Review Mission was undertaken in November 2007 with the task of assessing progress of the NRHM in thirteen states relating to the core strategies and the central areas of concern stated in the NRHM Framework for Implementation. It was able to provide considerable clarity on the main areas of progress and key constraints that the NRHM was facing.

Now, in the third year since its launch and after two completed years of implementation (since the approval of the NRHM framework), the 2nd CRM is an opportunity to undertake detailed analysis of how successful and how implementable are the strategies of the Mission. It is also an occasion for collating and documenting the evidence to support or question the effectiveness of different strategies in different contexts. Thus, the 2nd CRM was undertaken with the following overall mandate:

1. To review the changes in health system under NRHM through field visits and spot examination of relevant records.

2. To document evidence for validating the key paradigms of NRHM including decentralization, infrastructure and HR augmentation, communitisation and others,
3. To identify the key constraints limiting the pace of architectural correction in the health system envisaged under NRHM
4. To recommend policy and implementation level adaptations, which may accelerate achievement of the goals of NRHM.

## MEMBERS

Each State team was composed of six members comprising the following:

1. Two Government Officials *(Any two out of the following)*
   a. Officials of the MoHFW, GoI
   b. Officials of state health departments (Health Secretary/ Mission Director/Director of Health)
   c. Regional Directors of Health & Family Welfare
2. One Public Health Expert (either of the following)
   a. Non-official member of Mission Steering Group of NRHM
   b. Non-official member of Empowered Programme Committee of NRHM
   c. Advisor or Senior Consultant of NHSRC
3. One Representative of Development Partners
4. Two Representative of Civil Society *(Any two members from the following)*
   a. Representative of Civil Society Organisations
   b. Representatives of Advisory Group on Community Action
   c. Representatives of ASHA Mentoring Group

Each team identified a team leader and a rapporteur. While the team leader was to provide overall guidance, the rapporteur was to be the point of contact for the team and coordinate the authoring of the report of the team.

Since each team member had to spend almost 8 days on this mission, it was difficult to commit the time of so many senior persons for so long. The final list of 67 persons who made it to the mission team is provided along with the state summary reports.

## STATE COVERAGE & TIMELINE

The 2nd CRM was conducted in two phases, one from 25th November to 5th December in 9 out of 13 states, and the other from 16th to the 21st of December in another 4 states. This was necessitated by the assembly elections in 4 of the selected states.

The 2nd CRM selected the following thirteen states with a view to provide a representative picture of the progress made.: Assam, Bihar, Chhattisgarh, Orissa, Rajasthan, Tamil Nadu, Karnataka, Kerala, Madhya Pradesh, and Uttar Pradesh, Jharkhand, Maharashtra, Mizoram, The first ten of these states were also covered during the 1st CRM.[2]

The entire group assembled in the committee room at Nirman Bhavan, New Delhi, for a briefing chaired by the health secretary Shri Naresh Dayal on 25th November for the states covered in phase 1 and 15th December for phase 2. After a detailling of the terms of reference of the mission, the various divisions in the Ministry briefed the participants on the components of NRHM that they were guiding - providing them the copies of guidelines that the center had sent the States and the information they had about the progress of the programme. They also shared some of their concerns and made suggestions on what the CRM could review during their field visits.

2 The 1st CRM had covered the states of Andhra Pradesh, Assam, Bihar, Chhattisgarh, Orissa, Madhya Pradesh, Gujarat, Jammu and Kashmir, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh and West Bengal.

On the second day of the mission, there was a one-day briefing by the state officials at the state headquarters. During this briefing, detailed presentations were made by the state officials on the strategies adopted and activities undertaken under NRHM in the state.

On the third day of the Mission the team was divided into two groups and each group was to visit one or two districts. The two districts were selected by the CRM team in consultation with the State mission directorates. The visit to the district lasted two to three days and the appraisal was done using a broad protocol that indicated the minimum number of each type of facility that should be visited and the 19 key aspects that should be covered.

After returning from the districts, the teams held further interactions with the state team and civil society members. Detailed discussions within the teams resulted in draft reports of the main issues and these reports were presented at a meeting of the key officials of the state, usually in the presence of the secretary or the mission director. The reports have subsequently been finalized through email consultations between the team members. Some members submitted individual notes on their observations and recommendations as well. The findings and recommendations of all the state reports have been consolidated in this report and these would be placed before the entire mission team at the national consultation. All the state reports will be available on the NRHM website, as was done for the previous CRM.

The previous CRM had reported on 24 parameters and this time they have been combined into the 19 key aspects of the health service system listed below:

i. Assessment of the case load being handled by the Public System at all levels
ii. Preparedness of health facilities for patient care and utilization of services
iii. Quality of services provided
iv. Utilisation of diagnostic facilities and their effectiveness
v. Drugs and Supplies
vi. Health Human Resource Planning
vii. Infrastructure
viii. Empowerment for effective decentralization and flexibility for local action
ix. ASHA
x. Systems of financial management
xi. HMIS and its effectiveness
xii. Community Processes under NRHM
xiii. Assessment of non-governmental partnerships for public health goals
xiv. Systems in place for outreach activities of Sub-centre
xv. Thrust on difficult areas and vulnerable social groups
xvi. The preventive and promotive health aspects with special reference to inter-sectoral convergence and effect on social determinants of health
xvii. Effectiveness of the disease control programmes including vector control programmes
xviii. Performance of Maternal Health, Child Health and Family Planning Activities seen in terms of availability of quality of services at various levels
xix. Assessment of programme management structure at district and state level

The progress in the states on these 19 key aspects was to be reviewed against the timelines set for NRHM as well as the Programme Implementation Plans (PIPs) for 2007-08 and 2008-09 of the respective states. The findings on these 19 aspects are organized under four broad heads in this report--Service Delivery & Facility Functionality, Human Resources, Improving Management Systems, and Community Processes. A summary of the findings on each of the parameters across the states and the key strengths and challenges before each state are also presented.

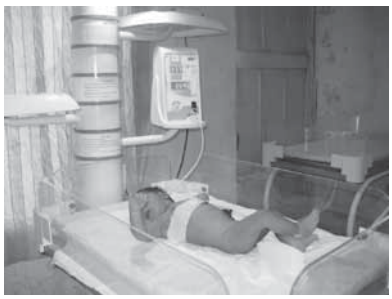
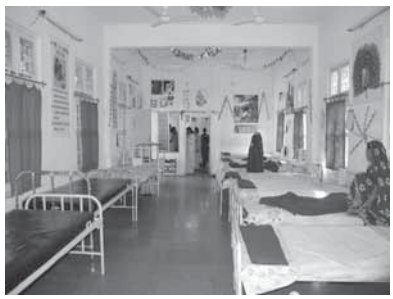
# FINDINGS OF THE COMMON REVIEW MISSION









# FINDINGS

## OF THE COMMON REVIEW MISSION

### NATIONAL OVERVIEW: GENERAL PATTERNS

The findings of this CRM have to be understood in the context of processes of institutional change, and therefore refer to comparisons with observations made during the last CRM wherever possible.

a. There is a continuing progress in 2008 under NRHM in all the states included in the review, in terms of improved utilization of services and better functioning of facilities as well as in community processes, human resources for health, flexible financing and improved management.

b. The general trend found by the previous CRM, towards increasing share of services provided by the public health sector and improving their access and quality, has continued. While the earlier CRM had expressed doubts about progress in increased utilization of services in some states, this CRM observes that there is progress in the pattern of increasing utilization across all states. The earlier CRM could not be certain whether in some states the increased utilization was merely a direct JSY effect or due to the new initiatives under NRHM. However, this CRM notes that though JSY remains a key driver of increased utilization, the patterns of increased utilization now clearly show an increase in general outpatient attendance and inpatient occupancy and in much of diagnostic services as well, and the increase has been well beyond what the JSY contributes to.

c. The variations in roll out across states observed last year persist, though there is some degree of making up for time lost by some of the relatively low performers. The trend of each state rolling out different programme components at different rates continues, and this could be a problem, particularly in low performing states where some components have yet to begin- mostly due to state level governance and management constraints. States that had better baselines and similar programmes in place had been quick to take off on NRHM strategies, and have now added several innovations to further strengthen their services. (Integration of NRHM funded health systems strategy with State health systems development programmes under bilateral donors has been insufficiently studied by the Mission, but there appear to be areas of synergy as well as discordance, and necessary as well as avoidable overlaps).

d. A broad categorization on the basis of achievements in strengthening of service delivery at all levels of facilities[1], shows that 3 patterns have emerged: In 6 states all levels have been strengthened (Kerala, Karnataka, Maharashtra, Rajasthan, Mizoram, Uttar Pradesh); in another 6 states the secondary level facilities (CHC or block PHC) have been strengthened but PHCs (additional) remain weak (Orissa, Bihar, Assam, Chhattisgarh, Madhya Pradesh and Jharkhand). In one state i.e. Tamilnadu, the PHCs and secondary level facilities have been strengthened but the sub-centre services have got relatively weakened. In the 6 states with additional PHCs, the improvement in sub-centres is varied. It is worth noting that there are state specific contexts and rational explanations for each of these patterns, which are explained in the next section. But it also needs to be emphasized that there are epidemiological, sociological and experiential bases for insisting on improvements in service delivery at all these levels, and while partial improvements could be a stage in the process, the commitment to improvement at all levels needs to be reiterated.

e. The increase in attention to functioning of public health systems along with the infusion of funds has led to many bottlenecks, almost accepted as inevitable in public systems, receiving renewed critical attention. The Common Review Mission itself, given its sweeping mandate and broad based composition and comprehensive public health systems' focus, could prove a turning point for the way health systems are perceived. The mandate of the common review mission as a systems approach linked to horizontal integration at state and district levels, has led to highlighting a much wider level of problems than merely programme specific reviews would have. The final report is only one part of the CRM's outcomes. The CRM has become a systematized process of dialogue between center and state, between public health experts and civil society and public health administrators, between

1 Sub-centre and PHC as primary; CHCs, SDH and DH as secondary level.

policy makers at national and state capitals with programme implementers at the district and facility levels. The final report is able to capture only a part of the richness of this dialogue as represented in the sum of all central and state level presentations, district tour reports, state mission reports and submissions on special issues made by individual members. Even all these documents taken together capture only a part of the entire dialogue that takes place. Though there are serious concerns about the NRHM becoming a stand alone vertical programme built around a set of new players, the major trend is of increasing integration of the new skills with the existing structures and increasing attention to cross cutting systemic improvements that would impact favourably on all programmes.

f. The strengthening of public health management is still in its early stages but even the modest improvements that have been made can be seen to be paying dividends, with better flow of funds and better utilization of NRHM funds by the states. Areas of improvement that are seen across the states are in induction of management, IT and accounting skills at district and block levels, better financial management, largely due to computerization of accounts, and electronic transfer of funds through e-banking. The CRM also notes that there are many areas of management improvement where the NRHM has made path breaking policy advances but their impacts are not yet visible due to the time it takes to roll out these strategies. At least some of these impacts should however be visible in time for the next mission. These include creating management organizations for better procurement and logistics, and for infrastructure development, institutionalizing concurrent audit, rolling out the new HMIS reform package, strengthening the SIHFW and putting in place the SHSRCs.

g. There has been an increase in budgetary allocation from the state treasury indicating an increasing ownership by the states. There has also been a better utilization of funds in many states--facilitated by the increase in personnel deployed for financial management. However, absorption of funds remains a challenge. In most states three factors seem to correlate with poor fund expenditure. One of these is governance issues which include stand offs between directorates and state missions, delays or non attention to building up enough state level management structures especially for procurement and infrastructure, for technical assistance, and lack of tenure of key officials. The second is a poor density of facilities and service providers. And a third would be the highly varied utilization pattern for all the untied funds on flow. Thus, though flexible financing is a great move forward, unless flexibility is further increased to be able to spend more on facilities and districts with greater turnover of services and resources, the large patches of untied funds in a few select facilities/districts/states could slow down the rate of expenditure of the entire programme. Evolving strategies to deal with this would be a major challenge in the coming year where increased demand for resources may co-exist with poor ability to submit utilization certificates. On the one hand additional funds need to be channelized to areas of high demand within districts, between districts and across states, and on the other hand sufficient resources must reach areas of poor absorption to act as drivers of change so as not to lose sight of equity considerations.

h. Several core steps for overcoming crucial human resource constraints have been operationalised and the results of some of these steps are already becoming evident. The message of the IPHS norms on human resources is beginning to sink in. The most heartening feature is that state after state has reported substantial additions to the numbers of service providers- especially of nurses and doctors. Not only are we now talking of filling up contractual slots available under NRHM but also the posts under the non plan component of state

budgets which have been lying unfilled for so long. In some states it is almost as if an informal freeze on recruitment and indeed on the public health system which had been put into place in 1992-has finally been revoked. The states in the North are now running out of doctors, nurses and paramedics available for recruitment in the general pool and further accretions are going to have to wait for the newly revived nursing training schools and the new medical colleges to turn out new graduates.

i. Meanwhile, under the increasing scrutiny for systemic bottlenecks for poor quality of public service performance, many states notably Bihar, Orissa etc have gone in for revising the service conditions of their workforce and have begun thinking of career paths for their staff. Though in most states the depth and range of such workforce management policies is insufficient to meet the requirements, overcoming the mindsets of the past is not easy, and the fact that the states are seized with these issues must in itself be seen as a major gain.

j. The ASHA programme has continued to expand on the ground, and given the increased space for community participation it provides, the programme is vibrant. Though there has been considerable progress on removing some of the constraints noted in the earlier CRM, there is still much that remains to be done. The *Janini Suraksha Yojana* has kept her in close linkage with the health system, giving the time and space for other support systems to be established. As these systems come into place in the coming year, the programme would be strengthened and yield further measurable outcomes. Other Community processes, especially the village health and sanitation committee and the community monitoring programme are in variable stages of take off, but are clearly evident on the ground in all states. NGO participation is largely in the community monitoring and MNGO programmes. Initial reports on Community Monitoring show that a new approach is being successfully piloted. The MNGO programme, which is functional in some states, is under review as an outcome based national scheme. A few states are making effective use of NGOs for the ASHA programme and there is scope to expand this. The *rogi kalyan samiti* has been successful as a vehicle for untied funds and for flexible local management, but as a vehicle of community participation in management, it is yet to get going fully.

k. There are some areas where the challenges have not yet been addressed sufficiently. One of these is to go beyond RCH prioritized services in the definition of fully functional health facilities. This could be justified in the low performing states where addressing high maternal and infant mortality rates and high total fertility remains unfinished on the agenda. However, even in the high performing states, the development of systems for and the integration of management of non communicable diseases into primary and secondary level care remains insufficiently addressed or even conceptualized into the NRHM framework. Considering that acute illness and trauma also needs urgent attention and that social protection of the poor requires public provisioning of services in these non RCH areas in all states, there is a need to build comprehensive facility development and human resource development approaches to match these goals.

l. The other major challenge that remains to be tackled is one of effective decentralization. The *Panchayat* has a role in the village health and sanitation committees and some states have provided Panchayats an effective role in the district health society and the *rogi kalyan samiti.* A greater role in governance of health facilities remains elusive and for the most part there is no consensus on this across states. The other frontier of decentralization, the district plan has also advanced further with greater capacity for the same developing in most states. The challenge is now to

make the district plan an effective tool of organising the health system as a single multifunctional district level network. For this, one needs to base district planning on information (provided before planning) about the resource envelope available to it, and more pragmatically provide for a post sanction implementation-planning stage with provision for greater flexibility of moving resources to respond to needs and utilization patterns within an agreed plan.

## NATIONAL OVERVIEW: KEY AREAS OF THE HEALTH SYSTEM

The findings of the CRM on 19 key areas are presented here under 4 heads. Some have been consolidated from the state reports as such, while others are re-organised, so as to avoid repetition of overlapping and cross-cutting themes. We have attempted to present the major findings as the teams have reported them, however consolidation of findings from such extensive reports will always leave room for some issues getting less attention than a state specific situation warrants.

### TOWARDS ACHIEVING SERVICE GUARANTEES

Under this head we bring together findings from all the key areas relating to the changes in service delivery and facility functionality and in the utilization and quality of health services. Issues related to equity and attaining the expected standard of services receive specific focus here.

#### *Assessment of the case load being handled by the Public System at all levels*

There is a general increase in utilization of services after implementation of NRHM, which was observed last year and has further improved since.

In the high focus states, i.e. those with weaker performance earlier, the increase has been dramatic. For instance, from Assam the team reports that: "NHRM represents a 'revolution' in terms of improving access of the rural poor to health care. According to one community informant, NRHM has already made a huge difference compared to the pre-launch situation, which was described as 'the near zero supply of services and immunizations'."

Data such as the following has been repeatedly presented from state after state: "Increase in OPD cases from 7,93,727 in 2005-06 to 8,80,339 in 2006-07 and to 10,05,247 in 2007-08."

Varying patterns of increase in utilization were found among the primary and secondary level facilities across the states. The non-high focus states, those performing better even earlier, showed that there has been an increase at all levels of services, as in Maharashtra and Kerala. The increase has been marked at all levels even in some high focus states such as Rajasthan. However in Tamil Nadu, though there has been an increase at various levels, the shift in utilization has been more markedly to the PHCs as compared to other levels and sub-centres and ANMs (called the VHNs in that state) have lost out in terms of their role in service delivery.

In states such as Orissa, Bihar and Chhattisgarh, the increase has been relatively greater at secondary levels such as CHCs, Sub-district and District Hospitals and at the cost of the primary levels. "It is well evident from the community interaction that OPD services and normal delivery is an increasing trend in many CHCs and SCs. However this trend is not seen in PHC facilities. OPD services and institutional delivery in many PHCs has gone down…."

The analysis about reasons for increase in utilization has also been varied across the states. Some of the reasons given are reported below:

- "due to better availability of services, better infrastructure and 24x7 availability of services."
- "main reason for this is the improved human resources deployed."
- "The institutions where doctors are coming regularly particularly in CHCs the increase in indoor patient load is quite encouraging."
- "the decentralisation, responsiveness to local needs, paradigm shift in health system management and availability of untied funds have improved the facilities and their credibility among members of the public. JSY, community mobilization by ASHA, and proper referral transport have contributed to a large extent in increasing the case load. However greater patient load has been noted in the district and sub-divisional hospitals and CHCs as compared to PHCs and Sub-centres. It was observed that there was a total dependence on the government health system in the absence of a significant private sector."
- "Basic reason for increase in inpatient load at PHCs and CHCs is increase in institutional deliveries partly due to JSY and also because of upgradation of the quality of the infrastructure, clean toilets, water availability, inverter for alternate source of electricity, free meals and also due to feel good factor generated by the beautification of the centres and hospitals and their surroundings."

Maternal and Child Health Services in Madhya Pradesh

The lack of increase at certain levels and in some facilities was attributable to the policies adopted by the state. In Bihar the understanding was- since in every place there is a situation of near collapse, it would make sense to start by prioritizing improvements in the main block PHC (CHC), i.e. strengthening of secondary level as a priority over the primary level facilities. By concentrating available resources in these areas quick improvement was observed. But now, as CHCs reel under the pressure, there is a rethinking on how to revitalize the sector level PHCs. This is the same situation in Orissa and Jharkhand, though Jharkhand is not yet seized of the issue. In Chhattisgarh the lack of additions to nursing staff at the PHC level may be the main constraint- in a context where most PHCs are anyway being managed by non-MBBS providers.

The impact of JSY on services at different levels varies. It has, for example led to decrease in services by ANMs in terms of conducting deliveries in several states, and where the PHCs were not geared up, this has led to overcrowding in the CHCs and District Hospitals.

In other states where strengthening of SCs has received attention, the OPD care and deliveries have increased even at SC level. For example Maharashtra reports that "Definite improvement seen in the outpatient load of Sub-centres, PHCs and Rural Hospitals (CHCs). 24X7 Block PHCs are offering outpatient, emergency and institutional services. Sub-centres are regularly doing deliveries. (A separate labour room built from the State budget has increased the numbers)."

In several cases, the facility is under-utilised due to irrational positioning of too many facilities too close to each other. "In-patient load at the Sub-district hospitals is below optimum due to comparatively less efficient facilities available (it was reported that demand for services was not there due to the

presence of a 24X7 PHC nearby. It was informed that the State had been proposing to shift the Sub-district Hospital at Bhor to an area in the same district where it was required)." The use of the district planning for rationalizing the use of resources- infrastructural and human - within the districts would help in achieving this objective.

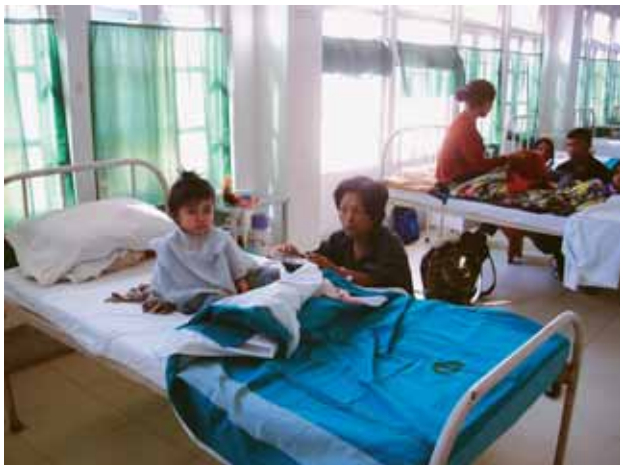
### *Preparedness of health facilities for patient care and utilization of services*

The facilities at all levels are getting strengthened in several ways. However one important observation is that given human resource constraints, improvements in service delivery at facilities which are considered to be of greater priority are often at the cost of services at the other facility levels- since the same limited human resource is shifted around.

**District hospitals**: In most states these have been the strongest in terms of infrastructure and posting of doctors including specialists, since the health personnel prefer postings here, and the hospital caters to the local middle class as well as the poor. In several states, their infrastructure has been strengthened by health systems development projects of the World Bank from the 1990s. However there is a huge variation in terms of their quality. Several states, including some of the 'high focus' states, are now in the process of obtaining Quality standards certification for their district hospitals from either the NABH or the ISO.

"District hospital at Bahraich is clean and well maintained. The ambience of the campus is good including plenty of greenery and also comprises of a committed team. There has been improvement in health facilities during the last one year. The hospital is in process of accreditation by NABH. Bed occupancy rate is more than 100%."

"District Hospital Serchhip has got a new trauma wing and blood bank building, but the DC of Serchhip made a strong case for undertaking renovation of the main hospital building. In Civil Hospital Aizawl and Champhai District Hospital the initial stage of upgradation project has begun."



In-patient care in Mizoram

On the other hand, in some districts, the district hospitals have barely reached the level of services of a PHC or CHC. In other places, there are district hospitals which function minimally despite a large infrastructure, due to shortage of personnel, or mismanagement and poor performance of the personnel posted there.

"In obstetric care the quality is seriously hampered by lack of nurses and midwives- The ratios are extremely adverse with only 13 nurses to staff 60 beds with over 100% occupancy and the heavy outpatient…. and only two nurses in a labour room that could have upto 50 deliveries per day."

**Community Health Centers**: The CHCs, that have been conceptualised as the first point for provision of specialist medical care, overlapping between primary and secondary level services, are later entrants in the chain of facilities starting in the 1980s. They were developed by upgradation of PHCs as well as by creating new facilities and this process is still continuing. Since the upgradation processes have been undertaken at different points of time and to varying degrees, the nomenclature has tended to

get muddled. Block PHC, Upgraded PHC, Sector PHC, just PHC or PHC (New) are terms that have been variuously used in different states to denote a facility that provides primary level services and is the first point of contact with a doctor. Some of these are on their way to being strengthened in terms of infrastructure and human resources to move to the higher level services of a CHC. In several states the CHC is well established as a provider of secondary services, but in others it is known by various terms: Block PHC, Upgraded PHC, just PHC, Referral Hospital, Rural Hospital. In all situations, there is a shortage of personnel, especially the specialists who are not joining the public services, and staff nurses who are not being produced in adequate numbers, and few have reached the IPHS.

"Some CHCs have less than 30 beds. However, owing to increased load due to the JSY, additional wards are being constructed..."

"CHC lacking in specialist manpower, non-functional OT – referrals to District Hospital"

"Uttar Pradesh has two types of PHCs. The PHCs situated at block headquarters are called block PHCs which are currently catering to about 1 20 000 to 1 50 000 population. In the districts we visited, these PHCs are run by MO I/C and an AYUSH LMO. The third MO is not posted. These PHCs function as 24x7 facilities. Mostly deliveries are conducted by the Staff Nurse and ANMs of the attached SC. The laboratory facility is grossly underutilized as only basic clinical investigations are carried out. Eventually all block PHCs will be converted into CHCs. Construction work is in progress."

The First Referral Unit (FRU), a terminology originating from the RCH-I programme, requires a certain set of services linked to maternal health services with commensurate equipment to be available at a facility—the minimum being a set of 3: facilities for conducting caesarian section, blood storage/banking, and a neonatal care unit. The CHC, sub-divisional and district hospitals are the ones that are in a position to provide these services. Since the CHC is also defined under IPHS to have all these features, one could see this as a parallel terminology to the CHC. These three definitions of the FRU are anyway the most challenging aspects of raising the CHC to IPHS standards, and therefore there are few if any CHCs which could become FRUs without simultaneously achieving or being in a position to achieve IPHS standards. However, the review shows that in several cases, designating facilities as FRUs by the state is more a 'statement of intent' rather than actually having ensured all the 3 minimum criteria being met. What was evident was the effort to move towards fulfilling them, but the road map was not always clear or even thought out. One team observed that the licensing of blood bank/ storage had also been done on the intent rather than on the actual availability of the requisite equipment and human resources at the facility .

**Primary Health Centres**: This facility which is meant to provide the first interface with a doctor offer comprehensive promotive, preventive and curative services, and provide supervisory support to personnel at further peripheral levels-- the sub-centre, the village health workers (now the ASHA) and the anganwadi centres – is receiving attention on a priority basis in some states such as Tamil Nadu and Rajasthan.

In other states, it tends to suffer because of priority given to the CHC level and the District Hospitals. The doctors and ANMs are shifted from the PHCs to the CHCs and DHs in order to operationalise the curative services at the secondary level, taking the basic medical care further away from the villages, and to the neglect of preventive primary care. The concept of pooling from where this practice originated also implied running the PHC with paramedical staff and providing for the medical officer to visit daily or thrice a week during office

hours. But often, especially in Jharkhand, the withdrawal of staff from the PHC to the CHC was not linked to these two measures and this was leading to a net reduction of peripheral services. Now as the CHC level services picks up, the attention shifts back to restarting up the PHCs. The supervision of sub-centres and village level work as well as disease control programmes meant to be performed by the PHC personnel have also suffered due to the shortages of personnel at this level.

The great variation in preparedness of PHCs across states and within states is also depicted in the terminology that has come into use for this level of facilities: Additional PHC, PHC (new), mini-PHC, PHC etc. These need to be differentiated from block PHC, main PHC or just PHC denoting potential or putative CHCs. These two sets differ in terms of the population coverage norm to be followed, number of doctors, staff nurses and ANMs sanctioned, number of beds, as well as the supervisory duties expected from it. They also represent the process of incremental development of the facilities. What are called PHCs in Tamil Nadu are functioning at the level of CHCs in other states.

In Uttar Pradesh '24x7 PHCs' represent the conversion of facilities that were barely functional in the day for a few hours thereby limiting the range of services they could provide and the level of trust they could invoke in the community, to facilities providing round the clock services,. For this they had to ensure the availability of at least an ANM or Staff Nurse round the clock along with a doctor at least on call, thereby not only having arrangements for conducting deliveries at night but also increasing the range of other emergency services and other indoor care they could provide.

PHCs in Bihar have been revived and are to be upgraded to CHCs while the Additional PHCs are to play the role of PHCs. The PHC (New) in Orissa are upto a decade old, but had generally been under-resourced and under-uitilised and are only now being resuscitated with posting of Medical Officers and/or AYUSH doctors on a contractual basis under the NRHM.

In several cases, the placing of facilities too close to each other has meant that the inputs for strengthening are wasted since utilization remains low.

In a number of states, there is an effort to outsource management of the (additional) PHCs to make them functional. Bihar leads in this. The first round effort did not succeed and now a second round effort is going on. This has also been tried, but in a limited way in Orissa and in Uttar Pradesh and Rajasthan. In the latter states, the outsourcing is done only where there is an NGO which offers special advantages - a niche strategy – but not as such meant for general replication. "The SDH, Sagwara is functioning very well and attracting increasing case-load. It is a unique model of PPP (through charity and managerial participation) but may be difficult to replicate. However, this has also meant meager case-loads at adjoining PHCs. An analysis of 'C to E' forms reveal that many minor cases are being treated at Sagwara and the DH, Dungarpur, which can adequately be treated at CHCs and PHCs. Minor ailments constitute a large load at these institutions, much of which can be tackled at SCs, PHCs and CHCs."

Primary Health Centre in Madhya Pradesh

**Sub-Centers:** The sub-centres have received a face-lift in all states, and are providing RCH services through an ANM, but the MPW (M) is a missing cadre in the facilities visited. In several states, an additional ANM has been recruited, often without fulfilling the NRHM's requirement of filling the MPW (M) post first, and with no role specification or division of work between the two ANMs.

A sub-centre of Maharashtra

"It has been observed that most of the SCs are giving better services than in the past because of the availability of untied fund and their proper utilization. In most of the SCs visited, it was observed that basic materials including pediatric ambu bag, delivery tray, table with mackintosh sheet, boiler, AD syringes, needle cutter etc. were functional. General level of cleanliness in SCs is good except where it is functioning from a rented building. Another good initiative is the availability of functioning telephone connection at SCs. It has been reported by the community during group discussion that the team work between ANM, *Mitanin* and AWW is exceptionally encouraging. However, problems in water supply and electricity bill payment are reported by the SCs."

"Sub-centre buildings, even the rented ones, were observed to be satisfactory. They were equipped with labour table and other basics, but were hardly in use, either due to non-residence of the ANM, or because of referral to CHCs/hospitals under JSY. MPW (M) was not posted in any of the sub-centres visited, affecting the provision of basic curative care and the disease control programmes."

However, in some states the maternal health services of the ANM have been weakened by the JSY and the shift of site of deliveries to the higher level facilities.

## QUALITY OF SERVICES PROVIDED

Quality of services can be assessed against objective indicators of the efforts at strengthening the facilities and services, as well as the indicators of impact on health of the population. Or it can be viewed in terms of satisfaction of the users, and the provider's assessment of their work and working conditions. The CRM was not designed to assess the impact on health status, and it may be too early in the roll out of the NRHM to expect such an impact, but it was able to examine the changes/improvements in parameters that contribute to quality. It also reflected on perceptions of the users and providers of services.

**Patient satisfaction**: Patient satisfaction was in almost all places very positive. In some settings, the recent memory of a complete lack of services and the current changed situation was upper most in people's mind. In the other settings where services were available and had been in use even earlier, there was an appreciation of the improvement in quality of the physical surroundings, the availability of doctors, drugs and a more woman friendly environment.

**Provider satisfaction**: Provider satisfaction was more qualified, but even then on the whole it was very positive. There was a strong and positive sense of change, of things having been achieved, of their being able to deliver more services. There was a lot of dissatisfaction with the service conditions and payments at all levels and with different issues

related to support services. One recurrent expression was "the work load has increased so much but there is little improvement in staff or facilities to manage the increased workload."

However, wherever, "no substantial improvement in physical infrastructure was seen, the doctors and nurses also commented about the need for better infrastructure. On the other hand, the local community, including the patients gave a mixed response. While they did acknowledge the improvements in infrastructure, they felt that the quality and range of services were still inadequate."

The CRM teams in almost all the states observed some improvement in the levels of cleanliness, provision of waiting space for patients, etc. but cleanliness of toilets was still wanting. The team also noticed the need for attention to procedures for registration, patient flow and information through appropriate signage, waste disposal and other aspects crucial for a patient friendly facility. The shortage of human resources and thereby not being able to deliver the expected services was also noted as an issue of quality. Of course, wide differences were evident through the reports in terms of quality of infrastructure and functional processes of the facilities, as reflected in the following quotes:

"All facilities were well maintained with proper cleanliness, disposal pits constructed (using RKS funds) – paramedical and group D staff trained in IMEP at District Hospital."

"Overall some improvements have been made in the services like cleanliness, waste collection, electrification and water supply, but are inadequate. While there were extra sweepers appointed from untied funds and maintenance grants, there is still scope for improvement in the cleanliness of toilets and availability of water supply in some hospitals. Many hospitals have colour coded bins supplied but the practice of segregation of hospital waste at source is not practiced by all the staff."

"The infrastructure is old and requires repairs. New building is under construction. OPD patient load is very high, institutional delivery load is also very high. Drug supply is adequate. However the PHC has only 4 beds which require to be augmented, and there is no referral transport service available. Laboratory services are inadequate. Bio-medical waste management facility is available."

"There are many facilities below the district level which are not as per the recommended norms and nomenclature viz. State Dispensaries, Subsidiary Health Centres and Mini-PHC. Block PHC is the administrative unit for health activities of the block. Availability of specialists was not as per norms. At one CHC, Surgeon, Physician, Pediatrician and Radiologist were not available while 2 Gynecology & Obstetric specialists, 2 Anesthetists and 1 Dental Surgeon were available. At another CHC, Dental surgeon was available but dental chair was not available. Here, there were no facilities for sterilizations and MTP. At a District Hospital, eye surgeon was available but not doing eye surgeries due to lack of facilities."

Patient waiting area in Kerala

The efforts for improving services have been made through regular staff, contractual staff as well as through contracting out the services. The arrangements differ widely across states, especially with regard to the terms and conditions of the private providers of the outsourced services. "There

is a systematic effort to provide generator support, pathology diagnostics, X-ray (and soon ultrasound as well), and services like ambulance, laundry, diet, cleaning and sanitation, and monitoring,by outsourcing each of them. This has kick-started strengthening of all these services, and today they are available either from the outsourced person or from the facility's own resources in the majority of facilities visited."

The fear expressed by one of the teams seems to echo the general finding in the high focus states that, "given the problems of the past, expectations of providers and even of the public had been set at very modest levels. The system is in danger of stabilising at this low level of expectations and outputs, and even as one appreciates the effort that has gone in to reach this level, there is a need to set the benchmarks higher. There is much more that needs to be done, if the increased patient load and utilization of services was to result in increased outcomes."

## UTILISATION OF DIAGNOSTIC SERVICES AND THEIR EFFECTIVENESS

Significant improvement in diagnostic services was observed, even in the high focus states. While this was across all levels of facilities, the degree to which diagnostic technologies had been made available at the primary level varied widely across the states. Those with well endowed PHCs presented a picture that was unimaginable in others:

In Maharashtra, "All 24X7 PHCs are having labs providing basic facilities; semi-auto analyzer and special services like ECG and X-ray; DHs have facilities for ECG, X-ray, ultrasound with CT-Scan. These services are available at reasonable user cost. The pregnancy diagnostic kit for early diagnosis of pregnancy, urine test for albumin and sugar, test to rule out anaemia (checking the hemoglobin level) and diabetes and the pregnancy induced hypertension were also available in these facilities." In Tamil Nadu, the diagnostics are at a level that it seems to require an examination of the extent of their rational utilisation in all facilities, "The Block PHCs are provided with Scan and all the 235 upgraded PHCs are provided with ultra-sonogram, X-ray, ECG and Semi auto analyser."

In the high focus states, despite the shortages of Laboratory Technicians in some states, they have worked out mechanisms for ensuring services: "There was an effective pooling of lab technicians from malaria, TB and HIV/AIDS programmes for efficient handling of investigations and diagnostic workload in the DH/SDH/ CHC level. Blood banks at the DH are functional with a lab technician. However basic infrastructure is often found lacking, such as water supply and registers for lab technician are not in place. …Lab facilities are not available at PHC (N). X ray facility is not available at Sub divisional hospitals and CHC levels."

Laboratory services at PHC

"The state has made sincere effort to improve access to quality diagnostic services through public private partnerships. Outsourcing models have been developed to contract-in private providers for offering clinical laboratory as well as X-ray services from the premises of public hospitals and PHCs.

While these innovations are noteworthy and are in the right direction, some operational constraints were noted during the field visits." The shortcomings included the private providers' reluctance to set up laboratories in PHCs, the overlap of both public and private in some settings, and the lack of basic quality protocols as well as bio-medical waste management practices in both public and private laboratories visited.

User charges are still being taken for diagnostics in most states, though generally below the market rates. Families Belolw Poverty Line (BPL) are exempt from the user charges.

## DRUGS AND SUPPLIES

All states report significantly better availability of drugs and other consumables as compared to the situation in the past. The availability of drugs was also displayed on the wall of DH/CHCs/ PHCs as a measure to improve confidence of the public. But medicines and other consumables are still found to be inadequate in many facilities since the increase in supplies has not been commensurate with the increase in patient load. Also logistics systems are slow to develop and there are frequent out of stock of high volume drugs, in a situation where patient attendance and therefore drug utilization is constantly rising. In the high focus states, putting in place a district warehouse for drugs with a trained storekeeper and a demand responsive system of drug distribution remains a priority.

"Inadequate budget for the drugs (Rs.1 Lakh for CHCs, 0.5 lakh for Block PHC & 16000 for PHC (N)) have resulted in the burden of out of pocket expenditure on patients, including expenses for emergency surgery and treatment." "Despite steep increase in state expenditure on pharmaceuticals during the past few years, the per capita public expenditure on pharmaceuticals (around Rs. 8 per capita) is too low compared to about Rs 49 per capita (USD 1) recommended by WHO."


Availablity of drugs at facility

In states where the system strengthening is still in take off stage, like in Jharkhand the existing picture presents the contrast: "There is shortage of drugs and other supplies at most of the health facilities including district hospitals. At all the places patients have to purchase I/V drip sets and sutures. Inj. Magnesium sulfate and the MVA kits were not available at PHC/CHC/FRU. Ayurvedic drugs are not provided for use by Ayurvedic Physicians and these doctors were found to be prescribing only allopathic drugs. Supplies of Dental consumables are poor. At one place Dental X-ray Unit was available but X-ray films were not available."

Generic Drugs were found to be "available in institutions (PHC/CHC/DH) through Cooperative Store and LLFS – 30-50% cheaper than MRP." In many states, the *Rogi kalyan samitis* are providing free medicines to the BPL families. But access to essential drugs mainly requires increasing the list of essential drugs supplied in the facility and making outside prescription unnecessary.

## AYUSH SERVICES FOR FACILITY FUNCTIONALITY

Almost all the CRM States have started with collocation of AYUSH practitioners in PHCs, CHCs and DHs except in Bihar (where the AYUSH infrastructure is still weak in the public sector) and Kerala (where the state has more AYUSH facilities than modern medicine). Some states have reached high levels of co-location like Maharashtra and Rajasthan whereas others have done so very partially such as Assam and Jharkhand.

Panchkarma facility under AYUSH services in Chhattisgarh

However, at least in Orissa, Maharashtra, UP and MP, the CRM teams have observed that the AYUSH doctors are working as an arrangement for 'substitution' of the allopathic doctors rather than as 'co-location. In Orissa, the mobile health units are also being managed by AYUSH doctors. Almost all the states with co-location reported that the AYUSH drug supply is inadequate and none of the report mentions the presence of AYUSH paramedics.

## SYSTEMS IN PLACE FOR OUTREACH ACTIVITIES OF SUB-CENTRE

The regular schedule of household visits by an MPW, male or female, has not been in place for a number of years. There seems to be a number of reasons for this. Firstly, there is absence of male MPWs, who had been withdrawn since the nineties; secondly, the sub-centres have to attend to high population coverage and thirdly, the Pulse Polio drives are reported to take up as much as a 100 days of their time in some states. The emphasis under the NRHM is, therefore, on an increase in outreach activities through the ASHA who is the main plank for home visits and through the Village Health & Nutrition Days organized at the ICDS *anganwadi* centres where the family comes to the outreach center and meets the ANM on a fixed day every month. Both these strategies are working reasonably effectively, though in many states the VHND is primarily an immunization session and ANC clinic where ASHA, AWW and ANM come together.

"Fixed VHNDs at the *Anganwadis* are increasing ANC registrations, immunization, growth monitoring & nutrition counseling activities. 6 Mobile health units are in place managed by AYUSH doctors."


Outreach services through mobile medical unit in Madhya Pradesh

In Tamil Nadu, there is a different trend with the sub-centre beginning to lose out in service delivery, and the ANM becoming more a mobiliser than a care provider, "The lone VHN (ANM) at the SHCs is pre-occupied with mobilisation of women for ANC, PNC, Immunisation programmes at PHCs and transportation of pregnant women

to the PHC for delivery. The ANMs are further engaged in the school health and adolescent health programmes and are left with hardly any time for domiciliary visits and other outreach programmes of SHCs. The outreach programme VHNDs at *Anganwadi* Centres is not visible in any of the districts visited." However the understanding is that now the health seeking behavior of the public requires that a doctor needs to be available even for immunization services- and reportedly this is the situation in Kerala also. This may be the reason why the state of Kerala has preferred the ASHA who is a mobiliser than to have a second ANM. This needs to be explored further and the implications of this need to be understood for the high performing states which are still far short of 100% immunization coverage and seeing reversals in the immunization programme,

## THRUST ON DIFFICULT AREAS AND VULNERABLE SOCIAL GROUPS

States have identified the 'difficult areas' as either the ones that are 'hard to reach' because of the terrain and poor communication infrastructure or the ones with a high proportion of population from the 'vulnerable groups'. The identified vulnerable groups are the tribal populations, Scheduled castes and families Below Poverty Line. Mobile medical units, creating higher density of facilities for better coverage, and giving the personnel 'difficult area allowance' are some of the measures to ensure services in these difficult areas and to the vulnerable groups. Some of these initiatives have been taken up under the NRHM and some were already part of the regular services and have received additional support from the NRHM.

"Tribal Area Sub-Plan (under the treasury, outside the NRHM) has substantial effect in the tribal areas with additional funds for construction of Sub Centres and also additional salary support for the 2nd ANM. Most of the Sub Centres in Dungarpur (TSP district) has two ANMs."

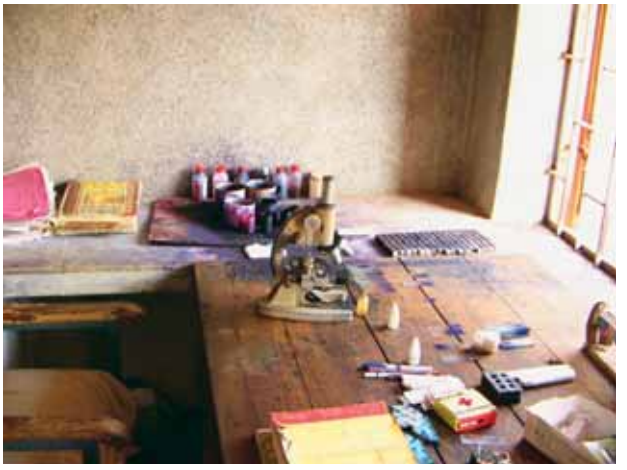
"The KBK districts are clearly identified as underserved districts and special provisions have been made to strengthen the services, such as special incentives for health staff serving in KBK plus districts. A few 'hard to reach' areas in other districts too are managed by NGOs under PPP. However, all districts need to map the most vulnerable pockets and ensure convergent services for them."

In the non-high focus states, several NRHM schemes were not applicable for the entire population but operationalised only in the difficult areas. For instance, in Maharashtra, "in the beginning the ASHAs were only for the tribal areas. The schemes for the difficult areas included multi speciality training on priority basis for the nurses and doctors posted in tribal and extremism affected areas, separate batch of girls for nursing schools from tribal areas with higher stipend (twice of the regular), Rs. 1000/- pm higher payment to nurses in tribal areas and Rs. 1500/- pm higher payment (both contractual and regular) working in extremism affected Nagpur Division. The monthly payment of ANMs vary according to the location of the sub center; in rural area sub-centre the payment is Rs. 7000/-, in naxalite area sub-centres it is Rs. 7500/ and in unreachable Sub-centres it is Rs. 10,000/-."

## EFFECTIVENESS OF THE DISEASE CONTROL PROGRAMMES INCLUDING VECTOR CONTROL PROGRAMMES

Operationalisation of the disease control programmes has been strengthened by the improvement in the service system as a whole. The various programmes are also interacting with and supplementing each other in some aspects, such as use of Lab. technicians across programmes. The shortage of personnel at various levels is leading to other innovations

as well, for instance for anti-malaria activities in Orissa, "Time taken for reporting of positive cases of malaria by the laboratory is three weeks to one month, since there is a gross shortage of Laboratory Technicians. LTs were also allocated to the State by GoI from the Malaria budget. There are problems in finding candidates who are trained in malaria testing (MLT). Hence the state has decided to select the candidates and train them in Malaria Microscopy and rename the post. The state may consider opening institutions for the training of LTs to meet the emerging demand for LTs at the sector level PHCs…..The posts of MPW (M) are vacant and contractual appointment is underway, which is expected to result in improvement in surveillance and delivery of treatment to the patients.



Malaria Diagnostic services in Orissa

ASHAs, who have received additional training as per the state's needs, are facilitating the detection of Malaria/TB/Leprosy cases. They make blood slides for malaria and give them to the ANM. In the case of TB and Leprosy, they are familiar with the symptoms and signs and counsel the suspected cases to go for medical help. Similar human resource problems are being faced even in states such as Tamil Nadu, "There is no shortage of laboratory chemicals at the microscopy centres as well as sub-district hospitals. The case detection rate and the availability of Laboratory Technicians are of concern in tribal and underserved areas. There is acute shortage of male Health Workers and the services of available 400 NMS can be utilised for implementation of DCPs. In most of the upgraded PHCs, alternate arrangements are made for taking x-rays, ECGs and other routine investigations. The ICTC technicians are also providing additional support."

Micro-plan using GIS mapping in Bihar

The Revised National Tuberculosis Control Program is doing well in all the states, with adequate detection and cure rates. It was thought that some attention is required now for improving detection rates, especially focusing on unreached groups and spatial pockets,

> "The RNTCP is reported to be doing well as per programme parameters. However, the fact that this is a mountainous area with many areas unreached is an indicator that the state needs to be looking actively for uncovered groups and areas, and not go by nationally-determined indicators of performance."

State specific problems are being dealt with as a priority, for instance Kala-azar in Bihar, sickle-cell anemia in Maharashtra and non-communicable diseases in Kerala. "The supply of anti KA drugs has improved in Bihar where Kala-azar contributes to 80% of nation's disease burden. Inconsistency in

treatment protocols and non familiarity of treating doctors with the current program treatment guidelines are major concerns in this program."

The IDSP is working in some states, with start up of data entry and collation on-line from the field and laboratories. Use of the data to track disease patterns and outbreaks is yet to begin in any appreciable way. "The State and district level IDSP is being strengthened, with appointment of data entry operators, data managers and district surveillance officers in place. However, the Rapid Response Team needs to be further strengthened for outbreak investigation and for further action. The P, S and L forms are being routinely submitted. However, issues with data validation and feedback for prompt action still remain to be addressed at various levels. The State and District labs still need further strengthening."

## PERFORMANCE OF MATERNAL HEALTH, CHILD HEALTH AND FAMILY PLANNING ACTIVITIES SEEN IN TERMS OF AVAILABILITY OF QUALITY OF SERVICES AT VARIOUS LEVELS

Maternal and child health services have moved at a varying pace over the period of the NRHM. In all states, there has been a continuing increase in number of deliveries conducted in institutions. Institutional deliveries have increased in the 13 states included in this CRM. This is evident from the visits made and confirmed by the changes in the DLHS data for these states. Institutional strengthening for this has also happened in varying degrees.

However, the same degree of attention has not gone to child health initiatives. The unmet need for contraception also raises issues about performance of basic services by facilities.

### *Maternal Health*

Preparedness for Institutional Deliveries: The facilities providing the services for increased institutional deliveries vary across states, as already discussed. Where the primary level facilities are not geared up, all the delivery cases are reaching the secondary level facilities--the CHCs (or their equivalents which are being termed PHCs in some states), SDH and DH—which face severe over-crowding, shortage of beds and therefore inability to keep the mothers for 48 hours post-partum. They are also not able to provide the services for mother and child that are possible if full use is made of the opportunity provided by a mother and new born being with the health system.

Facilities available for institutional delivey in Assam

Ante-natal care has been strengthened by the early identification of pregnant women by the AWW and ASHA. However, the quality of ANC remains a challenge. The Orissa team observes "the ANMs at Sub-centres are now working mainly as 'ASHA managers' and data providers for the HMIS, at best providing some ANC and contraceptive services. Even the quality of ANC services is severely limited by the fact that in most cases, neither weight gain, BP nor Hemoglobin are being monitored. Only prophylactic dose of IFA is being given with no

one receiving the therapeutic dosage. Institutional deliveries are happening at the CHCs and above, since the PHCs do not have MBBS doctors or Staff nurses. The most vulnerable, the tribal families still depend upon home deliveries which the ANMs are NOT conducting. This is evident in the data provided at district level, and at the sub-centres visited. Dai training has been discontinued but the home deliveries are being conducted by the dais (TBAs). In this way, a 'de-skilling' of ANMs and no support for dais is likely to weaken the service delivery system at the peripheral level, especially for the more vulnerable sections who are unable to travel to institutions at a distance, despite JSY support. Mechanism for linking of TBAs with ANMs needs to be evolved to make the skills of ANMs reach the underserved areas / population groups."

In states where all round facility strengthening has happened, the ANMs are performing deliveries at sub-centres, homes and PHCs. ANC and as an activity is receiving limited attention in some of these states, but as in Tamil Nadu and Maharashtra, ANC is utilised as an opportunity to build rapport with the mothers and their families, introduce them to the delivery facilities in the public sector, and provide all the requisite care.

The deliveries conducted in SCs are considered institutional deliveries only if they have facilities as per IPHS. The PHCs upgraded with 3-4 ANMs/SN for provision of 24x7 maternity services often lack the medical backup and so, "in order to meet the short fall of doctors at these PHCs, particularly Lady Medical Officer (LMO), the mission has decided to recruit 428 lady doctors from Indian System of Medicine for posting them at the 24x7 facility and give them adequate training in EmOC."

In settings where the ANC contact with the health system had been satisfactory and the facilities have been made woman friendly, it was reported by the CRM team that, "During the interviews with the recently delivered women in the health centers and hospitals, it was evident that they prefer to stay for 2 to 3 days in the health facility for normal deliveries".

Post-natal care has been a relatively neglected area, with mothers going home within a few hours of delivery, as reported from most states. This is the period when both mother and neonate are at high risk of morbidity and when a large part of the infant and maternal mortality occurs. "The mission found that the operationalisation of block level PHCs and the increased focus on additional PHCs were providing a platform from which access to maternal health, child health and family planning services had been expanded."

The payments for JSY are being made in time in some states, but mothers face much delay in others. Referral/emergency transport for pregnant women was observed to have been operationalised in most states, thereby actively facilitating the women's access to institutions for delivery. In some states, it was observed that the private institutions empanelled for deliveries under JSY, do not provide adequate care for the new born or keep records of the child's health.

There has, reportedly, been an increase in incomplete abortion coming to institutions, attributed by the MOs to misuse of Misoprostol by unqualified practitioners. This is an observation that is a cause for concern, since both women's morbidity and maternal mortality may increase. The expansion of safe abortion services is also slow.

## Child Health

The teams found that the monthly Village Health & Nutrition Day (VHND) was being conducted in most states at the AWC with the involvement of the ASHA, ANM and the VHSC, and operationalising the AWC as a major site for child health related activities for pre- school-going age and the school health programmes can impact on the school-going age group. These points provide for inter-sectoral convergence on child malnutrition, illness or disability detection and immunization. It also provides opportunities for interaction with mothers. However, in some states the VHND strategy has not yet taken off, and in some others, it helps only in the implementation of the immunisation programme. "The immunization programme has reached the people through sub-centre/AWC level and appears to be operating well. Fixed weekly immunization days are being held in AWCs and sub-centres… However, other child health interventions are not consistently emphasised, and supplies (including ORS) are not uniformly available in all the centres visited." Even the new born corner was not found in most of the facilities conducting deliveries.

Nutritional Rehabilitation Centre (NRC) in Madhya Pradesh

The focus on, and skill development for, dealing with childhood illnesses is envisaged through the IMNCI, but the planned training is largely for the ANM and it is too slow to make significant impact. Nutrition Rehabilitation Centres (NRC) are being set up in some states for the grade III and IV malnourished children—"The NRCs in the District Hospitals visited were excellently run and maintained. This is a very encouraging endeavour to tackle the issue of malnutrition in the area".

However, the numbers do not match the level of need as per NFHS data on malnourished children, so as observed by one team, "The State has initiated the setting up of Nutrition Rehabilitation Centers in 2 districts, but a more comprehensive approach is needed, integrating preventive, promotive and curative nutrition interventions." The rolling out of facility based care at the PHC and CHC level is also too slow and too varied across the states. There is need for a composite planning, linking the IMNCI training for home and facility based care, SCNU, ICDS and NRC as well as the maternal services.

A systems approach to maternal and child health could try to take all the strategies at the sub-center into one single training package and at the PHC into another single package and at the CHC and district hospital into a third single package and then build training and support strategies based on this, rather than introducing so many different packages at so many different rates across the state. However child health has benefitted from the large increase of ASHAs and nurses in the system as almost all of them are geared to provide some services to the sick child.

## Family Planning

The assessment of progress in family planning services was mixed. One heartening development was that achievements in NSV are impressive against targets and with rising coverage. This needs

to be sustained with more mobilization efforts as in absolute terms NSV is only still a small part of overall sterilizations. Male participation in family planning needs to be promoted further, and the MPW (M) may be a vital cadre for this. Tubectomy figures in some states seem to be declining. Even where it is increasing, the increase is nowhere near the type of increase being seen for JSY. Much of the problem could be on the supply side, as fixed day per week sterilization is not yet achieved in many centers. However in contrast to the last visit more facilities have reported this to be happening.

Family Planning Camp in Madhya Pradesh

The ANM seems to remain the mainstay of the contraceptive services for spacing methods. "All centres have a list of eligible couples. There is a very high uptake of the oral pill as evidenced from the NFHS-3 (10% of ECs) and the DLHS-3 (12%)." "Large number of women are on the oral pill records of health workers, but the quality of service is wanting. Counseling is cursory, and an extra pill packet is not given (to prevent stock-out at the level of the user); drop-outs are not methodically contacted. Going by the records, it is possible that several women run out of pill supplies." "IUD insertions are being done by all ANMs, while there is an increasing use of oral pills without any monitoring of side-effects."

### *Infrastructure*

There has been a face-lift of a large number of facilities in all states, with extensions, repairs and maintenance works. This was observed in the high focus and non-high focus states. For example the mission to UP observes,that there has been excellent improvement during the last one year in terms of clean, green and well maintained district hospitals and CHCs due to committed team and District Magistrate,. Very spacious HSC buildings, generators and inverters are available and in Tamil Nadu, all the PHC premises have a new look as most of the civil works were completed including provision of toilets, water supply and uninterrupted electricity including generators. The PHCs are well equipped with ILR, Deep Freezers, Sterilisers, Autoclaves, Semi/Auto analysers, Calorimeters, emergency lights, water filters etc. The PHCs are having patient's privacy by provision of curtains, cots, mattresses in good condition. The linen supplies were inadequate as three sets are provided per bed and during the rainy season these supplies are inadequate.

In some states, quality of civil works leaves a lot of scope for improvement and delays are reported in undertaking or completing projects. Most states have set up or are in the process of setting up an infrastructure or construction wing in an attempt to facilitate rapid infrastructure development. A few states still do not have an infrastructure development plan. Shortages of electricity and water supply still afflict facilities in many states but generators obtained through the RKS funds have helped.

Systems of referral/emergency transport have been developed in most states but a few still do not provide for this facility of access to life-saving services. There is also a constraint of transport for field workers and for the supervisory tasks of MOs.

## Equity Issues

Several initiatives have been taken by the states for the poor and the marginalized groups. Waive of user fees and free supply of medicines is one of the prime strategies being adopted to ensure access of services to the BPL families in all the states. As long as user charges and inadequacy of drug supplies exist, this measure is essential. However, since evidence from various parts of the world has shown that user fees act as barriers to access health care by the poor, women and girls as well as other marginalized groups, its effectiveness needs to be assessed to ensure equity. Almost every state mission has observed this problem in the persistent user fees and the impact on access it has.

The mission from Bihar reports, "In the district hospital, user charges for most of the services are found to be generally high and are even comparable with private hospitals. All BPL cardholders are excluded from user charges. However for those poor who do not carry a BPL card, the decision for exclusion is made at the level of civil surgeon on case-by-case basis. One would wonder how many poor could access civil surgeon's office to avail of such benefits."

> "There is a need to do more here especially in giving exemption in user fees, more so for the outsourced services. No user fee is charged from BPL families. Despite this and the JSY, institutional deliveries amongst SC/ST are less than those amongst others and deliveries were found to be largely performed by TBAs. Since travelling distances to access services is more difficult for these sections of society, strengthening sub centers and PHCs will contribute to equity in access and availability of health services."

Mechanisms for social insurance are being put in place to some extent but are in too much of a flux for the teams to observe their benefits. In Rajasthan, which had an effective mechanism, it was found that, "Social protection scheme includes Rajasthan *Swasthya Bima Yojana*, which involved premium subsidy being provided from NRHM, and government hospitals being reimbursed by the state insurance department for free treatment given to BPL card holders. This scheme was stopped after the launch of RSBY under the Ministry of Labour, under which smart cards are printed, but the scheme is presently non-functional with no payment made to the Insurance Company (ICICI-Lombard). Meanwhile the GoR launched a comprehensive social insurance scheme, which included health (called *Bhamashah* scheme) but that was also stopped because of the issue of non-compatibility of cards (with software support from Infosys) with the RSBY software. So, presently the health insurance for protecting the poor from catastrophic expenditure is non-functional."

The CRM team found that "one of the commendable achievements of Tamil Nadu state is the low out of pocket expenses incurred by rural in-patients (Rs.637) in comparison to Rs. 2610 in Karnataka, Rs.2170 in Andhra Pradesh and Rs.2174 in Kerala. The accessibility of facilities and service is very good in the plains for the rural, BPL and SC population. The services in the tribal areas are provided through MMUs and the residents have sought for daily availability of VHNs and weekly visits by MOs."

## Reflecting on the IPHS

Finally, there is also the issue of imperatives of the high goals set by the IPHS. While it may be possible for some non-high focus states to meet these standards, they seem to be skewing the service structure by making the states shift personnel to where the gaps are more as per the IPHS norms, i.e. by shifting the staff away from the primary and to the secondary level facilities. While there is a rationale

for making 'at least some facilities fully functional' if not possible to do so for all, the moot question is whether the quantum of human resources required by the IPHS is essential for ensuring the basic service provisioning or is some of it useful for further improvement of quality and effectiveness only after the basic service provisioning is in place.

Thus, there is an obvious need for rationalisation of health facilities in all the states, but more so in those with major constraints. This includes consideration of the spatial distribution of facilities, human resources and skills as well as equipment against the service guarantees expected for each and every village and residential clusters within villages. The processes of decentralized planning and implementation within the health service system must lead to such a rationalization. Now that the planning and management systems are gearing up, and the medical officers too are getting involved in decentralized planning for the Block/District/State Action Plans annually, such steps will have to be part of the next phase of the NRHM if further gains are to be obtained and the gains are to be sustained. Of course, this would have to supplement the ongoing efforts at facility strengthening.

Facility strengthening is happening due to the improvements in infrastructure, infusion of health care providers, the support from availability of funds at all levels and improved fund flow, better data management and availability, as well as enhanced community mobilization and facilitation of access to services.

## HEALTH HUMAN RESOURCES

A large number of health personnel have been added to the public health system under the NRHM. This has been the single most important system strengthening process, since in the previous decades, although infrastructure development projects such as the Health Systems Development Projects, and programmes for service delivery such as the RCH-I, had been undertaken but there had been little infusion of human resources. If anything, there had been a depletion of some health cadres, such as the MPW (M) and the need for operationalising the new infrastructure had enhanced the human resource gaps, such as of specialist doctors and nurses. The NRHM brought renewed attention to the issue and requirements were identified in terms of numbers of various professionals and para-professionals, based on the vacancies in the already sanctioned posts as well as new estimates for reaching the IPHS specifications. Skill sets were also identified as needing renewal, reorientation or development de novo. The CRM has once again highlighted the progress made on this front in the last two years.

ANM Training Centre in Chhattisgarh

The CRM has also found that the human resource gap still remains the single most important challenge in strengthening the public health system and meeting the NRHM goals. Medical professionals available in the country, especially specialists, are not joining the public services. In some specialities, such as anaesthesia and psychiatry, very few professionals

are being produced in the country. Nursing colleges are far short of requirements, and ANM-Training Centres have been non-functional for about a decade in several states, leading to non-availability of staff nurses and ANMs for recruitment. Paramedical personnel such as Laboratory Technicians are again too few in number, or are not trained and registered as per standards. Few of the cadres have an orientation or training in public health planning and management.

All states have taken steps in the last two years to deal with this problem, for meeting service needs in the immediate and for long-term outputs. The results were evident: even in a well functioning health system such as Kerala--"Many doctors, specialists and nurses have been employed in hospitals, CHCs and PHCs under the NRHM on a contractual basis and they have added to the services in these centers."

In the high focus states, most SCs have two ANMs, the second ANM being recruited under TSP by the state government. The second ANM is generally located at an underserved area and not at the Sub-centre itself. These are positive developments. All facilities had pharmacists and lab technicians.

Consultants desired under SHRC are in place, and also SPMU, DPMU are functional. Strengthening of District PMU is in progress and establishment of Block PMU is proposed. One Block Accounts Manager is in position.

This situation has come about through a number of initiatives for recruitment, improving working conditions and attracting personnel to the public services, in-service and pre-service trainings for multi-skilling and multi-tasking of the present personnel as well as producing more health personnel.

### Recruitment

The procedures for recruitment have been simplified. This includes delegation of powers for local contractual appointments, appointment of retired nurses on contractual posts, power of appointment given to the Taluka Health Officers and medical superintendents and walk-in interviews. The Rural Medical Officer (RMO) cadre has greatly increased the availability of MOs at PHC level and this is a positive step. The introduction of Compulsory Rural Service for MBBS and post-graduate doctors is a major step in providing health care services in rural areas.

### Improving service conditions

The emoluments of cadres have been enhanced through several mechanisms. A 'hardship allowance' Rs. 1000/- to nurses in tribal areas, Rs. 1500/- (both contractual and regular) for those working in extremism affected division and Rs. 1500/- additional payment to doctors working in extremism affected division have been introduced.

"Entry level post for doctors upgraded to Jr. class - I, specialist pay increased form meager Rs. 150/- to Rs. 3000/- per month. The additional allowances that are being offered to doctors are as follows; for those serving in KBK districts at the rate of Rs. 8000/- at block level and below and Rs. 5000 at district level, for contractual doctors18,000/- instead of 12,000/-. and Post-mortem allowance of Rs. 500/- per case. A proposal for restructuring of cadre of doctors for creating better promotional avenues is under active consideration. A rational transfer policy for doctors is also being formulated."

"The state (Tamil Nadu) has standardized the rules and regulations for appointments, transfers and promotions through annual counseling".

### *Pre-service education/training, In-service Training & Multi-skilling*

The capacities of existing training institutions in terms of number of students have been enhanced and new colleges/centres are being set up. Under PPP, all nursing schools are going to increase their capacity. They would be provided beds from SDH/DH and PHCs and fees of Rs. 25,000/- would be given as loan to students entering into 5 year bond and girls from tribal areas joining these nursing schools would get a monthly stipend.

"Three new medical colleges have been set up. Additions have been made in the under-graduate curriculum e.g. the IMNCI".

"Multi-specialty training is given on a priority basis for the nurses/doctors posted in tribal and extremism affected areas".

With multi-skilling of health care providers, one of the limitations has been the poor retention of skills and performance based on the training. A process of review followed by modifications in the selection procedure of in-service candidates for the training has resulted in better retention and performance, for instance in the case of LSAS in Orissa - 1st batch, the: selection of trainees was done by the CDMOs and the retention and performance of trainees were low. For the 2nd batch, applications were sought from in-services doctors and the retention was better but still low. For the 3rd batch, the applications were sought for specified FRUs, they were interviewed and counseled for selection of those interested. The retention and performance review will include giving an honorarium if found to be practicing LSAS.

However, many of the multi-skilled personnel like EmOC, LSAS trained doctors are not able to perform due to various inherent systemic reasons.

There is also a shortage of training faculty and an added problem of the trainers being transferred frequently. The frequent transfers can adversely affect a district since the district would lose trainers. In Dungarpur, 2 of the 4 Master Trainers of IMNCI have been recently transferred and this is severely affecting their training schedules.

## WORKFORCE MANAGEMENT ISSUES

The CRM teams have highlighted several workforce management issues that states need to address in designing and operationalising HR measures:

**Appropriate postings and transfers:** Poorly planned transfers lead to non-functioning of human resource due to compulsions caused by personal reasons. *At Kuttichal PHC there was only one doctor since doctors were said to be refusing to work in the area. However, according to the doctor, his wife who is also a doctor is posted in another district. A proper . coordination in postings will be helpful in this kind of situation.*

Rational/transparent transfer and postings policies & procedures need to be formulated and operationalised.

**Clear role definition:** Within the system and for each person at a facility, there is need to define the roles and responsibilities, *"There is lack of clarity on division of roles between the two FHWs and the one or two MHWs posted at a sub-centre. Outreach village or home visits do not appear to be regular or as per a defined beat programme".*

**Career progression opportunities: Career progression pathways and options need to be built in to the system.** *"A system of bridge courses to upgrade ASHA to AWW to ANM to Graduate Nurse and to Postgraduate Nurse should be set up*

*as an incentive for better performance and for career progression.*

**Rationalised and equitable emoluments:** While planning for incentives and salaries, entire staff in the hard areas needs to be considered at the same time, *"ANMs under TSP are contractual and drawing hardship allowance under NRHM in tribal/desert areas. Contractual LTs (under RCH II) are not drawing a hardship allowance. The allowance is not available to DPMs and BPMs either. These 'anomalies' were reported to the CRM."*

**Training policy and planning:** The teams noted the need for a comprehensive training policy and infrastructure to enable ongoing training and re-training of personnel. *"There is no system of nursing in-service education for the state as a whole. This is the appropriate time to set it up while the state is developing its human resources at a rapid pace."* For the trainings that are planned e.g. SBA, IMNCI etc., it was observed that the number of personnel for whom trainings are planned was grossly inadequate. Also, the same personnel are often required to undertake a large number of trainings, posing problems in a situation of constrained human resources.

**Integration of contractual staff and regular cadre:** mechanisms for integrating the new contractual appointees into the state health services will be required to sustain the progress made under NRHM.

## COMMUNITY PROCESSES IN THE NATIONAL RURAL HEALTH MISSION

The National Rural Health Mission continues to expand the extent and quality of community involvement. Significant progress has been made in addressing many of the gaps identified in the first Common Review Mission Report.

### *The ASHAs*

The flagship of community participation is undoubtedly the ASHA programme. Emboldened by its welcome in the high focus states of the NRHM, the programme was extended to cover all states in October 2008. Of the 13 states visited by the CRM, nine were high focus states with the ASHA programme well in place. In the 3 high performing states of Karnataka, Maharashtra and Kerala, the ASHA programme is limited to tribal areas. In only one state i.e.,Tamil Nadu, is the programme yet to be initiated. In every one of the high focus states visited by the team, ASHAs have been met with and the programme has been assessed in some detail. The reports are unanimous in their appreciation of the work being done by ASHAs, the enthusiasm shown by the ASHAs and their potential.

Training of ASHAs in Orissa

The Assam report states "The ASHA programme has created a ground for NRHM in the state, they are the face of the NRHM, are visible and have an audible presence, with their dresses, umbrellas, radio and JSY contact. They will now be given cycles, which will give them a visible presence on rural roads. ASHAs are verily the wheels of NRHM in the hinterland."

The progress on some parameters which relate to what the system should do for supporting ASHAs are not uniform and there are some constraints. Thus as far as training is concerned, ASHAs in Chhattisgarh, Orissa, Assam, Rajasthan and Madhya Pradesh have either completed their 4 modules or are on the 4th round of training which is about 15 to 19 days of training (much more in Chhattisgarh). The states of Uttar Pradesh, Bihar and Mizoram however lag behind with only 7 days of training given to the ASHAs.

The payments for ASHA are reported as regular in Orissa, but in most other states, there is a 3 to 6 months delay. The problem seems most acute in Jharkhand and Chhattisgarh.

Except in UP and Bihar, in all the states drug kits have been procured and distributed,. This is very good progress since the last year when only one state had done so. However the challenge now is to refill the drug kits as and when they get exhausted- which means a very good system of procurement and logistics and expanding the funding for this component both from central and state budgets. More information on patterns of usage and financing would be essential as also the task of improvement in logistics.

The other area where there is slow, though steady improvement is in the support structure. The district community mobiliser/coordinator is in place in Chhattisgarh, Orissa and Uttar Pradesh . Appointments are in process in Madhya Pradesh, Rajasthan, Jharkhand and in Bihar it is yet to be brought into the agenda. Sub-district facilitators are in place in Chhattisgarh and in process in other states. A state level resource center providing support is critical, but has been established in only three of the nine high focus states visited- Chhattisgarh, Orissa and Jharkhand. There is a considerable need for urgency in this area since as shown by experience, without such a support, it is difficult to sustain outcomes from the programme. The Madhya Pradesh team states "there is hardly any recognition or consideration of ASHA support by state health department, and it was very much felt by the team during their interaction with officials from SHCs, PHC, CHC and district health systems."

One very encouraging feature reported from many states is a variety of support and encouragement activities like presentation of sarees, umbrellas, radios or cycles to ASHAs by the NRHM. In Assam a radio programme specifically beamed at ASHAs also provides support.

### *Village Health and Sanitation Committees*

As far as the Village Health and Sanitation Committees are concerned, the programme has moved forward steadily. The most time consuming step in forming these committees is the issue of order at the state level, stating the terms of formation of these committees. Once this step is completed, the VHSCs are rolled out and the funds are transferred – the entire process taking a few months after that. This stage has been reached in Kerala, Karnataka, Maharashtra, Tamil Nadu, Mizoram, Chhattisgarh, Orissa and Uttar Pradesh. In Jharkhand, Rajasthan, Madhya Pradesh and Assam, the VHSCs are formed and the programme is at the stage of fund transfer. In Bihar the snag is at the state level as the enabling order is still to be issued. There is not enough information on what the funds have been used for across the states but where funds have reached and guidelines are in place, preliminary reports suggest that the money is well spent on a variety of local necessities- most often related to drinking water or drainage.

### *Rogi Kalyan Samitis*

The other major challenge is in increasing the role of communities in management, through different instruments of decentralization. Of these, the most universal and most functional are the hospital development societies. This is functional in all states, though the role given to the elected *panchayat* varies. In some states they had become solely a vehicle for collecting user fee. Under the NRHM, the process of these societies as vehicles to provide space for communities in governance and management and as a vehicle for improved facility level decision making was emphasized. Till now, much of the energy had gone into registering them and making them functional. Now the mission *notes* that these hospital societies need to focus on providing more space for user participation and making the societies more equity conscious and less user fee dependent. As a rule where untied funds are given to a functional RKS and basic guidelines are in place, these united funds get utilized well. This was the case in most of the states.

Rennovation of facility in Kerala

The core challenge of communitisation is the issue of health facilities being placed under the *panchayats* -only Kerala and Karnataka have such a situation in place. All the others are able to involve *panchayat* leaders in all the four above steps- selection of ASHA, use of untied funds at the sub-center, the village health and sanitation committees and the RKS- but this involvement stops short of actually reporting to them or being paid by them. In Bihar the *panchayat* leadership role in the RKS is being stepped back and in Assam it is being headed by local MLA.

The involvement of NGOs in NRHM varies. In most states they participate in the MNGO scheme, the ASHA scheme and in capacity building for VHSCs. The effectiveness of the MNGO scheme needs to be studied further and though missions mention MNGOs in different roles, the scheme itself does not draw attention. One special form where community participation and NGO involvement is very visible is in community monitoring. Of the states visited, where community monitoring had taken place and there was a positive response to it was in Assam, Karanataka, Rajasthan and Chhattisgarh. Though the potential for replication is not clear, some reports suggest, "community monitoring can be beneficial if kept simple." There is possibly a need to persist with this and work on further approaches as well as a limited scaling-up to fully understand the potential of this component.

In conclusion, the NRHM has brought the role of public participation in the health sector center stage and multiplies the forms and intensity of community participation. This has no doubt contributed to better utilization of services and better health awareness. The process of decentralization and public participation in governance however remains a challenge.

## IMPROVED MANAGEMENT

This has four distinct components: the induction of management skills and the strengthening of existing management capacity, the building of better financial management systems, and putting

in place a robust health management information systems, the creation of structures for professional public health management and technical assistance. We consider below each of these:

## INDUCTION OF MANAGEMENT SKILLS

Every state that is visited by the Mission, had put in place a team of contractual staff with management qualifications for programme management (the district programme manager) and with IT qualifications for data management and with financial qualifications for financial management. Only Tamil Nadu which has a health administrative cadre had not done so, and Kerala had used these positions for putting in place officers identified as more dynamic, from within the medical cadre itself. One advance in this year over the previous is the coming into position of contractual block management staff in Assam, Bihar, Chhattisgarh, Jharkhand, Karnataka and Kerala,

In most states, these cadres were performing well and had made themselves invaluable. There was still the problem of integration of the contractual management staff with the regular staff of medical administrative directorate - but the problem is now articulated as a change that needs to come in the directorate. The need for this contractual staff inputs is no longer in question. The coordination of the directorate with the state mission directors' office has now become the central management challenge. There is no doubt that in terms of sustainability and technical quality of the programme and even for effectiveness, personnel with management functions under the directorate need to be better oriented, better qualified and better supported to play a leadership role. But it is also clear that without the induction of new blood, the stimulus to change the old styles of functioning, and move to a measurable performance output mode of functioning is unlikely to occur. The deliberations of the National Workshop on strengthening public health management (held at Puducherry) therefore have an immediate relevance for this discussion. The consensus arrived in that workshop could inform the way management in the state directorates and in the districts are to be strengthened.

The CRM also points out that given the contribution of the contractual staff, more attention should be given to their human resource management- both in skill development and also in performance review and incentives and increments in compensation packages.

## SYSTEMS OF FINANCIAL MANAGEMENT

There are four key dimensions of improvement in financial management.

One of them is the addition of financial staff, especially at the block and district levels. This has happened across the states. With NRHM, the simple recognition has come that to handle the vast volume of accounting at the district and block and even sub-block levels, a large number of persons with accounting skills have to be inducted- and the lack of this was a critical bottleneck.

The second change promoted successfully by NRHM is the e-transfer of funds to district level and increasingly further down to block and facility levels. This is a move that creates substantial time savings and transparency.

A third major area of improvement is in the introduction of concurrent auditing. Here progress has been slow. States like Madhya Pradesh, Kerala, Karnataka, have made strides in this- but the other states continue to lag behind in this and would perhaps need more support and persuasion to be able

to put this in place. Monthly financial reporting has started and is seen in most of the states reported and even this should be computerized and web-enabled in the coming year.

But the fourth is the core improvement- the actual increase of expenditure with timely submissions of audited statements and utilization certificates so that fund flow is streamlined. Despite considerable increase in systems across the 13 states, it may be noted that the poorest states- Bihar, Uttar Pradesh, Jharkhand and Chhattisgarh continue to have a poor absorptive capacity for funds- though it is precisely these states that need to sharply expand their public expenditures on health.

## HMIS AND ITS EFFECTIVENESS

Progress in HMIS was assessed at a time when a major changeover of the system had just been initiated. What the CRM has picked up were largely the current state of affairs and the need for a paradigm shift.

Almost all state teams reported that the analysis and use of information is very weak. In most states, data collection however is going on and though there is much improvement in quality needed, this is not the central problem. In many states computers are available in block level and in all states they were available at the district level. In states like Kerala, Maharashtra and Tamil Nadu they were available at the PHC level also. Some states had started entering data into the web-portal, but at the time of visit, most of the states had yet to do so. It was thus clear that of all the many problems that HMIS faces, the central, most widespread and persistent problem is the poor analysis and use of large quantity of data that is on flow and secondary to this is the problem of validity and reliability of data.

This poor use of data, noticed by all teams, is also related to design features. Firstly, the use of indicators, instead of raw data elements generates "information" as different from "data" and this facilitates the use of this information. Secondly the systems should be able to support data analysis and display at every level, including the level of data entry. It should also have in built feed back systems, as tools of programme management and improving data quality. And thirdly it emphasizes the need for capacity building and the need for coordination at the periphery between the IT specialist, the public health practitioner and the demographer.

One other issue raised was that data usually bypassed the sector PHC and was aggregated only at the block level. The need for training staff on this was noted by all. Persisting multiple formats was reported by a few teams. Potentially this could be a major area of improvement in the coming year and the spin-off effects of this turn key improvement on all aspects of programme management could be immense- if we get it right.

## INSTITUTIONS OF MANAGEMENT AND OF CHANGE

The other major thrust areas in management are the need for special vehicles for management of procurement and logistics, an institutional structure to manage infrastructure development, a revitalization of the state institutes of health and family welfare to lead the in –service skill development and the state health systems resource center to drive forward the process of architectural correction.

Over a year of striving, what seems to have been achieved is a broader understanding of why such organizations are needed. However in terms of really

getting them going on the ground- the progress has been decidedly modest.

### Procurement and Logistics Organisation

The TNMSC model, in principle has been accepted as the benchmark for an effective procurement and logistics system. In this period, Kerala has also gone in for such a system and Karnataka has made some major changes in this direction. Madhya Pradesh has declared an existing agency- the Laghu Udyog Nigam as deemed to be its procurement agency, but this agency is not coordinating logistics which, though an improvement, falls far short of the requirements. Orissa has set up a state drug management unit which streamlines some aspects of procurement. Though many other states have committed to making such an institutional change, few have actually done so. The benefits of a TNMSC like system for improved governance and decreased wastage, for better availability of drugs and supplies, for a higher per capita public expenditure on drugs, and a reduced out of pocket expenditure for the poor patient at the public hospital are well acknowledged and documented facts. The urgency is to push harder for this fundamental change in other states as well.

### Infrastructure Management Organisation

In many states serious crisis of poor expenditures relates to money locked up in infrastructure development. This is further compounded by the problem of poor quality of civil work and the failure to make water and electricity arrangements as part of the same development costs. There is evidence to show that a separate cell or unit charged with this task had organized this work with greater efficiency and speed. In this period Bihar and Madhya Pradesh has created such a cell and Karnataka and Kerala have created engineering wings within the health department. Given the huge gap in crucial health infrastructure there is a need to put such a system in place and other states would need to give this much greater attention.

### State Health Systems Resource Centers and SIHFWs

This is another key management strategy of the NRHM. This is an area where there has been partial progress. Many states have recruited consultants for providing in house technical assistance in many areas. Others have created centers for some of the functions- like Jharkhand has created an outsourced *Sahiyya* resource center and Orissa has constructed a community processes management unit within the SPMU. However no state, except Chhattisgarh has a full fledged state health systems resource center in place. The CRM identified many areas where states require technical assistance - in improving the quality of training, in better quality of district and state planning, in planning for child health more effectively, in building up drug distribution systems, in designing BCC programmes, in quality assurance programmes, in human resource planning, in building up health management systems etc. Though these can be initiated with the help of external consultants and agencies, there is a need to build up technical capacities within the state to sustain and develop these programmes further. If there is no self reliance built up in technical capacity, the long term sustainability of public health systems would be compromised. There is also a need to institutionalize such technical capacity in an institution that the state supports so that there can be an institutional capacity with institutional memory of the planning and development process. This is distinct from the role of the SIHFW, though these institutions can be co-located. There is also a need to strengthen SIHFWs in most states, and this area indeed would need a special review.

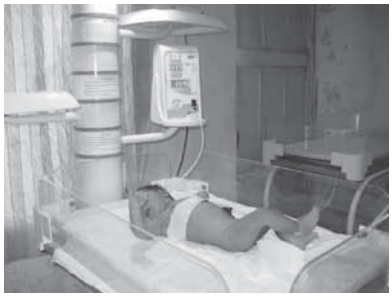
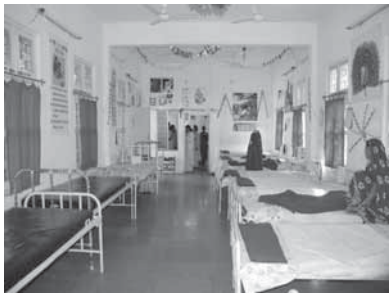
# RECOMMENDATIONS OF THE SECOND COMMON REVIEW MISSION









# RECOMMENDATIONS
## OF THE SECOND COMMON REVIEW MISSION

1. **Standardizing Nomenclature:** Work with states to finalise a clear nomenclature for the different facility levels and their hierarchical relationships to each other. This was not an issue earlier, but now with central funding flowing to states to meet the norms and a monitoring system where this relationship is critical, confusion on names would be a major constraint in planning, financing and monitoring. One aspect of this is defining a sub-center as being embedded in every PHC and CHC, PHC in every CHC and district hospital, to look after the outreach activities of the section where the facility is situated. This would alter calculations of requirements for number of facilities and for staff at the co-located higher level facilities, while continuing to distinguish the outreach services and the services provided in the facility premises.
2. **Contextualising IPHS:** Work with states to contextualize IPHS guidelines so as to be able to plan and set meaningful annual targets for improvement at every facility level to reach the goal of service guarantees in a phased manner. Contextualisation

should also mean review of guidelines to ensure that service priorities reflect the epidemiological profile of each state.

3. **Revitalizing the sector PHCs:** Some states such as Rajasthan and Tamil Nadu have shown that it is possible to place Medical Officers at PHCs. Others could attempt to reach this stage but, to begin with should at least ensure that the paramedical and nursing personnel placed there are multi-skilled to provide primary level curative care along with their preventive tasks and also arrange for a visiting doctor. Pooling of medical officers at the CHC (block PHC level) should not become a reason for collapse of the sector PHC which is essential for the provision of many services.
4. **Quality Improvement:** Improving the quality of care and comfort of stay for patients in the public hospitals especially at the secondary level, through clean toilets, fresh linen, and a friendly environment. Over time, move to a system of ensuring quality improvement in all public health facilities.
5. **Mainstreaming AYUSH, and not merely mainstreaming the AYUSH provider:** The main purpose of bringing AYUSH services to the mainstream facility is to provide users with a greater choice of services. But using an AYUSH service provider to provide non-AYUSH services defeats the purpose and needs to be restricted, even where the provider may be willing to do so.
6. **AYUSH providers in allopathic care:** Where an AYUSH doctor is being used as a substitute for an MBBS medical officer, there is in addition to the above, the need to specify through standard protocols, the level of care that can be provided by them and to give them the training and the legal framework to provide such care.
7. **Supporting the ASHA:** There is a need to urgently strengthen the ASHA support system. This includes a state level resource team capable of developing further state specific training material, well trained and supported district and block level teams of facilitators and a system of monitoring. Streamlining of payments is still to be done in many states as also the base widened by allowing a larger number of activities to be included for giving incentives.
8. **Pro-Poor RKS:** Enhance community participation, especially representatives of user groups in the hospital development committees (rogi kalyan samitis), and transform their image from being a vehicle for collection of user fee into an organization charged with addressing equity and quality issues. This requires a greater awareness of the limitations and problems of user fees and a greater willingness to exempt the poor or where needed completely eliminate all but the most token forms of user fee.
9. **Getting VHSCs going:** Expedite the activation of village health and sanitation committees and strengthen facilitation systems for this. In particular, NGOs could play a major role in this.
10. **Community Monitoring:** Simplify the current process of community monitoring, broad base the programme participants and expand the areas covered by this process. Ensure serious consideration of the findings and issues raised; also view it as a process of dialogue with the community rather than as a threat.
11. **Coordination at the top:** Improve coordination between the health mission and the directorates in the states. Also increase training and support inputs to directorate staff so that they are able to participate and eventually lead in the process of change and revitalization of public health systems.
12. **New Institutions:** Working with state governments to start 3 management and technical support organizations/arrangements of minimum design specifications – one for procurement and logistics, another for infrastructure and the third for technical assistance (the SHSRCs). National workshops with groups of states with similar institutional context to help them design organizational structures most suited to their situations would be useful to move this process along.

13. **Professionalising Management:** Improving the quality of public health management through the development of a public health sector management cadre, expansion of public health education including in-service skill training and improved human resource development policies for health administrators.
14. **Improved Workforce Policies:** Make improvement in workforce management policies, as one of the cornerstones of good governance in the states and support states to move to evolve and implement commonly agreed policies in this regard. A state watch on the performance of different indicators of good governance would be a useful supplement.
15. **Revitalising SIHFWs and Training Institutions:** Assist and support states to draw up and implement plans to revitalize their SIHFW/equivalent organization and other training institutions in the states so as to ensure that in-service skill up gradation meets the quality and pace required to improve service delivery.
16. **State Specific Human Resource Plans:** Assist and support states to draw up and implement state specific human resource development plans to expand with quality medical, nursing and paramedical education, such that the needs of the public health system are prioritized and met within the shortest time possible.
17. **National Plan for faculty development:** Build a national plan linked to the above to take on the responsibility of developing faculty and quality assurance systems for the rapid expansion in medical, nursing and paramedical education. This would be a very valuable support for the low performing states and it would need assistance from the high performing states, catalysed by the center.
18. **Workforce Management:** State spending on the human resource component should expand, in order to slowly take in the new positions being created under NRHM. This is needed for long term sustainability. In addition, better work force policies are required to be established for increasing the range of incentives, both monetary and non-monetary, that are needed to draw and retain skilled human resources in under-serviced areas. The states' commitment to increase public health expenditure makes this possible.
19. **Resource Linked District Plans:** Build on the district plans by linking district planning efforts to a better understanding of resource envelopes that are being made available to each district. Also, on a more pragmatic level, states need to develop the practice of revising the plan document after the national sanction, for implementation. Based on the national sanction, the state sanction to the districts should be decided using the district plans. This revised post sanction district plan should then be placed in the public domain as well as used by the districts to guide action.
20. **District Plans to rationalize resource allocation:** Developing the district plans to rationalize infrastructure, human resource and financial resource deployment to match utilization patterns of different facilities and areas and fulfill the service guarantees is necessary to meet the objectives of NRHM.
21. **Systems Strengthening for RCH:** There is a need to increase budgetary allocation to core system development issues, even for maternal health. Though much has been done to prepare the facilities for the JSY inrush, the rate of increase of JSY has outpaced all of this. Much of the funds get absorbed in the Janini Suraksha Yojana. There is a need to ensure that there are proportionately adequate funds allocated and spent on non JSY activities of RCH that prepare the facilities to deliver quality services. There is also a need to focus on preparedness of facilities for providing neonatal care and meeting felt needs of contraception. . Expanding facilities and human resource to meet the increased load of the most vulnerable becomes a national emergency.

22. **Immunisation:** While immunisation programmes have been given attention in states with regard to outreach and fixed day services, gap in availability of vaccines and issues in cold chain management seem to have adversely affected progress in the current year. Lack of minimum required facilities and human resource densities also contribute to limiting progress in a significant way.
23. **Going Beyond RCH:** Progress beyond planning for RCH service delivery in primary and secondary facilities and plans for addressing emergencies, acute illness and even chronic illness in the primary and secondary health care facilities Through the development of appropriate referral linkages and human resource development and deployment strategies, all the facilities within a district can become like parts of a single functional unit. In states which are high performing on RCH parameters, this should emerge as the immediate priority, but even in other states this is necessary to provide considerable social protection for the poor from the increasing costs of care and also to increase the effectiveness of all disease control programmes.
24. **Integration of Disease Control Programmes:** Low human resource densities due to failure to create adequate facilities, failure to create adequate number of posts in sanctioned facilities and failure to fill up vacancies have all taken a toll on disease control programmes. The NRHM's emphasis on human resource development should take the needs of the disease control programmes also into account. Currently, there are vacancies even in key district level management positions. The integration of disease control programmes in a technically meaningful manner that could lead to improved outcomes remains a challenge. This could be addressed for many programmes through district plans, especially for integrated vector control and control of water-borne diseases. Every effort should be taken to further integrate disease control programmes and IDSP into the NRHM for these systemic and programmatic reasons, convincing the divisions of the technical merits of such a decision. This has not yet happened at district and often even at state levels.

25. **More Flexibility to Flexible Funding:** Improve the flexibility of fund allocation to facilities within a district and to districts within a state so that funds flow to facilities and districts which use them the best. This is essential to expedite useful absorption of funds. However when going into such flexible financing, there is a need to ensure that the funds needed to reach a minimum level of functioning are not .compromised and equity considerations within regions are kept in mind- so that places already suffering from lack of human resources and sanctioned facilities are not deprived even further.
26. **Engaging with the Private Sector:** Engage with the private sector to provide services in thematic and geographic areas where the public system is deficient by working out packages that are cost effective and transparent and subject to good monitoring practices. The experience so far has been very mixed. This review shows a multitude of good partnerships with motivated, largely not for profit institutions, but there are few examples of any link with the commercial private sector that could be recommended for nation-wide replication.
27. **Information for Action:** The main challenge is to develop HMIS systems and capacities so that action can be taken on information derived from data analysis at the facility and at the sector, block and district levels. This would also increase the validity and reliability of data collected nationally. The development of the national web-portal and the rationalization though important milestones, must be seen only as initial steps. The main challenge is in the development of district level systems and capacities for use of information. The other major challenge is to be able to collect information from the private sector as well.

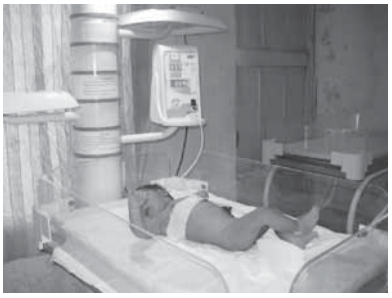
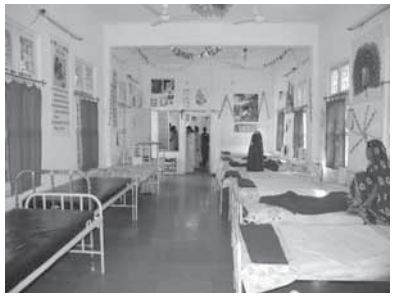
# STATE REPORTS IN BRIEF









# STATE-WISE KEY THEMATIC AREAS

## THEME-I:

## ASSESSMENT OF CASE LOAD BEING HANDLED BY THE SYSTEM AT ALL LEVELS

| | State | Key Findings |
|---|---|---|
| 1. | Assam | NRHM is a revolution in access to health services. It has made a huge difference. Significant increase in institutional births and outpatient visits. Significant increase in IPD cases as well. Evening OPD started in many places. |
| 2 | Bihar | The increased utilization of services is reflected in increase in number of persons utilising every type of service that is available – outpatient care, in patient care, institutional delivery services, emergency services, surgical services, lab services, etc. Every Block has a 24X7 facility with at least 6 doctors and nurses. Close monitoring facilitates service guarantees. High case load in Block PHCs and District/Sub District Hospitals. Additional PHCs still to be made operational. |
| 3. | Chhatisgarh | OPD services and normal deliveries show increasing trend in Health Sub Centres and CHCs. No increase in PHCs due to shortage of doctors and nurses. Well functioning CHCs with regular attendance of doctors is increasing the number of indoor patients as well. District Hospitals have increasing case load. Uneven performance in family planning services. |
| 4. | Jharkhand | Evidence of increased case load at the Block PHCs in spite of unsatisfactory basic infrastructure and hospital beds at that level. Increased in patient load in District Hospitals. Slight fall in OPD attendance in one of the District Hospitals perhaps due to better functioning of Block PHCs and Sub Centres. *Sahiyyas* very active. Institutional deliveries yet to pick up on a very large scale. In patient care also picking up with more functional facilities. |
| 5. | Karnataka | Institutional deliveries have increased from 60% in 2005 to 79% in the current year – perhaps on account of JSY and State Government's initiatives like Madilu (post natal care kits for BPL patients), Prasuthi Ariake (ANC benefits for BPL), etc. Many NRHM initiatives are recent. OPD attendance suggests a substantial increase in case load at PHCs. District and Taluka Hospitals have high case load. FRUs are under utilized. |
| 6. | Kerala | Outpatient case load is good in all hospitals, CHCs and PHCs. State data suggests that OPD cases have shown increase in 2007-08. Number of inpatient cases varies across districts and facilities. Inpatient cases can increase if full range of services is provided. Not all CHCs are providing 24X7 services. Wide variation among facilities and their load. Need to focus on non-communicable diseases (diabetes, hypertension etc). |

| | State | Key Findings |
|---|---|---|
| 7. | Madhya Pradesh | NRHM represents a revolution. There is a significant increase in IPD and OPD case load at health facilities. JSY has increased the credibility and confidence of the people in the government health institutions. There are trained and skilled manpower to support health facilities at many institutions. Khargone, a tribal district, has reached 71% institutional deliveries. Increase in OPD and IPD has been so significant that a decision to increase bed strength by 6000 beds has been taken in the State. |
| 8. | Maharashtra | Definite improvement seen in the outpatient load of Sub centres, PHCs and Rural Hospitals (CHCs). 24X7 Block PHCs are offering outpatient, emergency and institutional services. Sub Centres are regularly doing deliveries (labour room construction has increased numbers). Increase in in- patient load is for deliveries and other services, due to JSY and also due to facility upgradation, clean toilets, availability of water, inverter for alternate source of electricity, free meals and also due to feel good factor generated by the beautification of the centres with NRHM funds. Sub District Hospitals need improvement. . |
| 9. | Mizoram | Overall IPD/OPD attendance appears to be the same over the last three years. Presence of regular Medical Officers has made positive impact on IPD/OPD in PHCs. Few deliveries at Sub Centres. ANM is conducting home deliveries.. Increase in institutional delivery at PHC/CHC after JSY. Utilization of delivery facility at District Hospital has gone up but up gradation is not commensurate with the increased load. |
| 10. | Orissa | NRHM has transformed public health service delivery in the State. The decentralization, responsiveness to local needs, paradigm shift in health system management and availability of untied funds have improved the facilities and their credibility among members of the public. JSY, community mobilization by ASHAs, and proper referral transport have contributed to a large extent in increasing the case load. However, greater patient load has been noted in the district, sub district hospitals and CHCs as compared to PHCs and Sub Centres. Increased number of deliveries, OPDs and bed occupancy reported from the districts visited. PHCs (sector level) are weak and providing limited services. |
| 11. | Rajasthan | Increase in institutional deliveries. Almost all PHCs reporting institutional deliveries. Some Sub Health Centres are also conducting institutional deliveries. Well performing Health facilities attracting increased case load, cases of malnutrition and large number of non communicable disease cases as well. |
| 12. | Tamil Nadu | Since the inception of NRHM, case load at the PHCs has increased remarkably – daily OPD by 17% and inpatients excluding deliveries by over 100%. The average OPD attendance is 60 to 230 in the PHC. Discharged two days after deliveries and diet is supplied through SHGs. The SDHs and DHs are well equipped. |
| 13. | Uttar Pradesh | NRHM has infused a new life into the flagging health sector in UP. Huge upsurge in institutional deliveries. Sub Centre has only one ANM but active in most places. OPDs are also showing increasing trend because of better maintained facilities. District Hospitals very well maintained. Some CHCs have also started providing surgical services. Increase in 24X7 PHCs. |

# THEME-II

## PREPAREDNESS OF HEALTH FACILITIES FOR PATIENT CARE AND UTILIZATION OF SERVICES

| State | | Key Findings |
|---|---|---|
| 1. | Assam | While human resource has increased, there is a still a long way to go in fully preparing facilities for all kinds of morbidities. Physical infrastructure and availability of ambulances have improved. Blood storage arrangement not functional in many First Referral Units. Family Planning services need more attention. Basic diagnostic tests being done – need to provide for a larger range of test services. Need for better equipped emergency rooms. Shortage of drugs. Need to expand range of services on Village Health and Nutrition Day. |
| 2. | Bihar | Patient satisfaction was very positive in almost all the places, – the recent memory of a complete lack of services and the current changed situation being upper most in people's mind. Assessement by the providers was more qualified, but even then, on the whole, very positive: 'The workload has increased so much but there is little improvement in staff or facilities to manage the increased workload.' The system is in danger of stabilizing at low levels of expectation and outputs. Increase in services has occurred up to the Block PHC level. Additional PHCs still a big challenge – functioning, but very poorly, more like a sub centre with an outpatient dispensary. |
| 3. | Chhatisgarh | Improvement has taken place in Health Sub Centres, CHCs and District Hospitals. PHCs are the weakest link. CHCs not providing First Referral Unit services in most places. Improvement noticed in untied grants, infrastructure, equipments, drug supply, water supply, contractual staff etc. Unsatisfactory utilization of ambulance services. Lab facilities functional with minimal services. Large human resource shortages and irrational placements affect preparedness of facilities.. |
| 4. | Jharkhand | *Sahiyya*s have been trained up to third module and have drug kits with them. ANMs are in place at the Sub Centres with basic facilities like BP equipment, stethoscope, etc. Immunization through VHNDs is a priority. Availability of medicine at Block PHC and District Hospitals has improved leading to higher case load. Doctors on contract, besides the regular doctors at PHCs and Additional PHCs. Many of them are providing service 24X7 in spite of adverse housing facility in remote areas. Poor infrastructure is a serious concern. While large scale new construction has started under NRHM and with the Finance Commission grants, it will take some time before they are all completed. |
| 5. | Karnataka | Concerted efforts to improve the health facilities with the funds available from different sources. Availability of untied funds has made a significant difference in the preparedness of health facilities at all levels. While facilities are well equipped, utilization of services is not very high in PHC/CHC. |
| 6. | Kerala | Uneven preparedness of facilities leading to uneven utilization rates. Assured services can reduce congestion in higher order facilities. |

| State | | Key Findings |
|---|---|---|
| 7. | Madhya Pradesh | Facilities do not have staff as per Indian Public Health Standards' norm. District Hospitals are adequately staffed. The Specialists at CHCs and blood storage facilities need priority attention. Janani Express vehicles in all FRUs help in referral transport. Lab services available in all facilities. Keeping in view the sudden increase in patient load especially under JSY scheme, the infrastructure in terms of staff and other facilities are under a great strain and this is adversely affecting the quality of service and has reduced attention to other programmes. Mobile Health Units are doing well. |
| 8. | Maharashtra | Extremely committed health functionaries in coordination with public representatives have been able to deliver good quality services. 30% of the PHCs have reached IPH Standards. Nurses, doctors and specialists have been appointed. Well stocked drugs and consumables, laboratory facilites for conducting diagnostic tests. Water quality checking at Sub Centres. Blood storage facility in IPHS, PHC and CHC. |
| 9. | Mizoram | Medicos and Para medics available at all levels – except Specialists. Young doctors in position, appear confident and capable of handling most conditions. Need to utilize the time of health workers at Sub Centres in a better way. District Hospitals better equipped. Some equipment are not fully utilized. Lack of Specialist manpower at CHC. All PHCs well equipped in lab facilities with regular tests being done. Rapid Diagnostic kits with ASHAs but not with health workers. All facilities well maintained with proper cleanliness, disposal pits constructed ( using RKS funds) – paramedical and Group D staff trained in IMEP at District Hospital. |
| 10. | Orissa | Urgent need to up grade infrastructure. Inadequate budget for drugs leading to out of pocket expenses. Utilization of untied funds, maintenance grants and RKS grants to improve preparedness of health facilities was very impressive in both the districts. 1153 AYUSH doctors at PHCs and CHCs to provide OPD services. Substitution rather than co location in the absence of the MBBS doctor in PHC (N). |
| 11. | Rajasthan | Sub Centres getting prepared for institutional deliveries with labour rooms. Good institutions attracting high load. Large number of surgeries in District and Sub District Hospitals. Significant number of non communicable diseases are being identified and treated at primary and referral levels. PHCs and CHCs handling larger case load and prepared to do so. All PHCs have an MBBS doctor and 40% have an AYUSH doctor as well. |
| 12. | Tamil Nadu | The PHCs, Block PHCs, upgraded PHCs, Sub District Hospitals and District Hospitals are adequately equipped for the routine works and emergency situations. All the facilities are provided with adequate number of specialists, doctors, nurses, VHNs, pharmacists, lab technicians, and other support personnel on regular, service placement or contract basis. The PHCs, SDH, and DH are able to meet the requirements for lab investigations, x-ray, ECG, ultra sonogram, etc. All Sub Centres and PHCs are provided with requisite drugs and other supplies. Need to improve quarters at PHCs. |
| 13. | Uttar Pradesh | While cleanliness has improved, shortages of nurses, doctors, specialists hamper preparedness to deliver quality care. Rationalization of posting and stable tenures are needed for preparedness to improve further. Need to focus on expansion of nursing services. Sub Centes and PHCs have started using untied grants. More than half of the ASHAs are very active in the community. Village Health and Sanitation Committees have been set up though getting the cooperation of PRIs is proving to be difficult in many areas. |

# THEME-III

## QUALITY OF SERVICES PROVIDED

| State | | Key Findings |
|---|---|---|
| 1. | Assam | Substantial improvement in infrastructure. Need for further improvement in quality and range of services. Wards were patient friendly with clean linen, sufficient lighting and clean toilets. Segregation of waste with deep burial. Complaints about CHCs have reduced as they are functioning well. |
| 2. | Bihar | Over 100% bed occupancy in District Hospitals. Lack of nurses and mid wives hampers quality of care. Mamta programme for women volunteers is an innovation to meet the nursing shortages in hospitals. Addition of more trained and well supported nurses into the system would be the single most important step that could be done to improve the quality. Lack of beds and nurses in Block PHCs. Excellent outsourced ambulance service helps in shifting patients. Conversion to 30 bed PHCs is needed on a priority basis wherever more than 5 deliveries take place every day. Standards of cleanliness would require substantial improvement. In all the facilities visited, there are efforts to improve amenities – lighting, wiring, water supply, patient waiting halls, toilets, drainage, etc. but these are rather sporadic. Need to use untied funds at all levels. There is a systematic effort to provide generator support, pathology diagnostics, x-ray and soon ultrasound as well and services such as ambulance, laundry, diet and cleanliness and sanitation services. Need to monitor outsourcing arrangements more effectively to ensure full compliance to agreement |
| 3. | Chhattisgarh | Health Sub Centres are giving better services than in the past, thanks to untied funds and their proper utilization. Functional telephones at all Health Sub Centres. *Mitanin* help desk in health facilities is a good initiative in bringing poor households to facilities. CHCs and District Hospitals provide bed nets to protect the patients from mosquitoes. Infection control measures have started but pits are provided only in a few places. |
| 4. | Jharkhand | Block PHCs are basically six bed hospitals with very modest basic features. New buildings will take a little time for completion. OP services have improved due to availability of medicines. Contract doctors have improved availability of human resources. There is shortage of nurses. Sub Centres are quite well equipped though own building is a constraint. *Sahiyyas* are active though performance based payments are not timely. |
| 5. | Karnataka | The availability of Staff Nurse and Medical Officer has increased. Drugs are mostly available. Quality Assurance thrust in Tumkur leading to efficient use of untied funds. Untied funds being used imaginatively for client convenience – TV, Plants, CD players, waiting halls, etc. More attention needed for the maintenance and cleanliness of toilets. The access to School Health programme is improving |
| 6. | Kerala | Wide variation in the quality of services among similar types of institutions related to motivation, commitment and skill of the head of the facility. PHC buildings have been renovated. TVs and DVD facilities in many hospitals in Wynad district. There is display of list of medicines at facilities. Need to monitor services from the point of input versus services. |

| State | | Key Findings |
|---|---|---|
| 7. | Madhya Pradesh | NABH accreditation for District Hospitals is under way. Quality assurance is receiving attention in the system. |
| 8. | Maharashtra | Sub Centres well equipped with infrastructure and equipments and untied funds. Hospitals becoming women friendly. Clean and well equipped labour rooms. Waste management satisfactory. *Panchayat* representatives are involved. |
| 9. | Mizoram | PHCs and Sub Centres are well managed. Cleanliness is good. District Hospital needs improved facilities. |
| 10. | Orissa | Overall some improvements have been made in the services like cleanliness, waste collection, electrification, water supply but are inadequate. While there were extra sweepers appointed from untied funds and maintenance grants, there is still scope for improvement in the cleanliness of toilets and availability of water supply in some hospitals. |
| 11. | Rajasthan | Most institutions have received a face lift with the untied funds of NRHM. Toilets were clean and functional and many CHCs had functional power back ups. CHCs are still not able to provide Caesarean section service. Blood storage is an issue. No or limited surgeries at CHCs. Waste segregation and facility level disposal are being done at most institutions; pits were found to be constructed and in use; bio medial waste was being brought back from outreach sessions. |
| 12. | Tamil Nadu | Almost all facilities are well maintained and upkeep of facilities is of satisfactory levels. Family Health Clinics in all 385 Basic Emergency Obstetric Centres thrice a week. |
| 13. | Uttar Pradesh | Nursing cadre shortages hamper quality of care. Women are not staying in facilities 48 hours after delivery. While improvements in cleanliness and basic infrastructure have improved the quality of services, far greater thrust on nursing services is required. |

# THEME-IV

## UTILIZATION OF DIAGNOSTIC FACILITIES AND THEIR EFFECTIVENESS

| | State | Key Findings |
|---|---|---|
| 1. | Assam | Range of diagnostic services available at various levels has improved substantially. Much more needs to be done to improve the technical skills of the Lab. Technicians. |
| 2. | Bihar | Diagnostic services through PPPs. Outsourcing by contracting in private providers. Private partner not showing that much interest in operating at the Block level. Non availability of regular Lab technicians. Inadequate attention to quality and biomedical waste management. |
| 3. | Chhatisgarh | The laboratory facilities are functional at District Hospitals and CHCs, but not functional in PHCs due to lack of manpower. Pregnancy testing kits and rapid diagnostic kits are available in most facilities. Convergence of lab services of RNTCP, general health services and vector borne diseases. |
| 4. | Jharkhand | TB Programme Lab Technicians at a number of Block PHCs. Integration of lab services is taking a little time. Diagnostic centres being established in District Hospitals. Modern equipments procured or in the process of being procured. |
| 5. | Karnataka | There are seven Regional diagnostic labs under the Karnataka Health System Development project. Lab Technicians are largely in place with adequate equipments and reagents. X- ray and ultra sound at Taluk Hospital. Lab investigations for ANC not available at PHCs. No RTI/STI testing. Utilization of diagnostic equipments by ANMs at Sub Centre is low. |
| 6. | Kerala | State has appointed Bio Medical Engineers to ensure that the equipments are in working condition. Overall the equipments are good. |
| 7. | Madhya Pradesh | In most of the facilities only one Lab Technician is available for doing all the investigations for all the programmes. |
| 8. | Maharashtra | All 24X7 PHCs are provided with labs. for basic tests, along with semi auto analyzer, ECG and X ray facilities. Services at reasonable user cost. 30 Public Health Lab services for water quality monitoring, industrial waste/effluents examination, etc. |
| 9. | Mizoram | Diagnostic facilities available but not as per Indian Public Health Standards. Need for proper maintenance strategy for equipments. Need to build strong accountability of suppliers at purchase stage |

| State | | Key Findings |
|---|---|---|
| 10. | Orissa | There was an effective pooling of Lab Technicians from malaria, TB, HIV/AIDS for efficient handling of investigations and diagnostic workload in the DH/ SDH/CHC level, integrated across programmes. Lab facilities are not available in PHC (N). |
| 11. | Rajasthan | Lab services suffer from shortage of staff. Rapid Diagnostic Kits for malaria, IDD kits and hemoglobin testing kits available with ANMs. Pregnancy testing kits available with ANMs and ASHAs. |
| 12. | Tamil Nadu | The essential investigations are available in all PHCs, Sub District Hospitals and District Hospitals. The Block PHCs are provided with scan and all the 235 upgraded PHCs are provided with ultrasonogram, x-ray, ECG and semi auto analyzer. Blood storage facility in 20 PHCs by TANSACS. |
| 13. | Uttar Pradesh | Lab Technicians are available for basic tests. Need for better coordination and convergence among all the programmes. |

# THEME-V
## DRUGS AND SUPPLIES

| State | | Key Findings |
|---|---|---|
| 1. | Assam | Less than satisfactory in 2008-09. Medicine availability in 2006-07 and 07-08 was better. Supplies expected to improve from December 2008 onwards. |
| 2. | Bihar | Improved supply of essential drugs is the most notable achievement by the State and this has significantly contributed to the increased use of public facilities noted during the past few years. The new rate contracting system and enforcing the presence of distribution depots of the suppliers within the State through which the districts place orders, has tremendously improved the availability of essential drugs at public facilities. At least 15 drugs were available in most of the PHCs. Sub Centres are without drugs. Local procurement was allowed to meet stockouts. Per capita expenditure on drugs is Rupees 8 after steep increase. Needs to be increased substantially with improved availability of drugs at Sub Centres as well. Logistic systems need to be fully operationalized. |
| 3. | Chhatisgarh | State level e- procurement is in place. Some delays in supplies. Proper mechanism for receipt, storage and indenting of drugs. Need for warehouses at district level. Availability of drugs is satisfactory. Occasional replenishment of stock is done by Jeevan Deep Samiti. *Mitanin*s got drugs but delays in replenishment. There have been recent efforts to streamline equipment management. |
| 4. | Jharkhand | Rate contract system with funds being released to PHCs. Availability has improved considerably at all levels. *Sahiyya*s have also been given medicine kits but arrangement for replenishment is not in place. Essential drug list and standard treatment protocols have been prepared for the state. |
| 5. | Karnataka | A State Drugs, Logistics and Warehousing Society has been established that acts as an official procurement agency to meet all requirements of health and family welfare department. Indents collected at beginning of the year. Rate contracts after call for tenders. 14 Drug warehouses in the State. 14 more taken up for construction. Use of untied funds to procure drugs, in case of shortage, has helped. A very sound procurement system with very few stock outs. Need for review of drug list to make it more rational. Replenishment of ASHA drug kit needs attention. |
| 6. | Kerala | Setting up of the Kerala Medical Services Corporation, in operation from April 2008 is a major step. The process of procurement and distribution of medicines and supplies has been streamlined. Computerization, pass book system and essential drug list have been established. Systematic and regular testing of all batches of medicines. Need to standardize the indenting procedure. Need to increase storage space. |
| 7. | Madhya Pradesh | The State has developed a drug policy. TNMSC model is being implemented in the State. Separate drug cell has been formed and Laghu Udyog Nigam has been appointed as procurement support agency. Procurement through e – tendering has reduced cost of supplies and improved quality. Distribution of procured medicines and materials is done through outsourced warehouses. 21 warehouses are under construction with NRHM funds. |

| | State | Key Findings |
|---|---|---|
| 8. | Maharashtra | Drugs and supplies are in abundance in the Sub Centres, PHCs and in CHCs. They are well stocked in newly made racks and cupboards with proper marking for easy retrieval. Vaccines are also available (except measles) and in proper condition stored in IPL and deep freezer. |
| 9. | Mizoram | Based on indents, medicines are centrally procured and distributed. There are shortages. Need for effective inventory management. |
| 10. | Orissa | Most of the health facilities had drugs and pharmaceuticals available as per allocations but the budget per facility is inadequate and needs to be enhanced. A State Drug Management Unit has been set up for procurement of medicines and this has improved timely procurement and availability. However, mechanism for transparency and need based distribution of drugs to districts/facilities is yet to be put in place. Emergency drug tray was found to be adequately stocked in most of the facilities. |
| 11. | Rajasthan | Generic drugs available in Hospitals and other facilities at 30-50% lower than MRP through cooperative stores. List and price of generic drugs displayed in all facilities. ASHAs are provided with drug kit. Replenishment from Sub Centre. Indenting needs to be timelier to prevent stock out situations. Shortage of high costly antibiotics for weeks. Injectables and fluids show no stock out. |
| 12. | Tamil Nadu | TNMSC is a role model supply system. It is very effective in ensuring adequate supplies of drugs and other routine supplies of all health facilities. EC Pills and IUDs are not available. |
| 13. | Uttar Pradesh | While drugs are available, the allocation of drugs is very less compared to the need on a per capita basis. There is a need to increase the drug budget and develop sound system of logistics, inventory management and forecasting. Preparation of essential drug lists and use of generic drugs need to be encouraged alongside efforts to set up TNMSC like corporation for procurement and logistics of drugs and equipments. |

# THEME-VI

## HEALTH HUMAN RESOURCE PLANNING

| State | | Key Findings |
|---|---|---|
| 1. | Assam | There are shortages of doctors and para medics and efforts have been made to rationalize through regular posting and by contractual appointments. Incentives have been worked out for the contractual staff but there is resentment among the regular doctors – need for incentives for regular staff and for career progression. Need to rationalize placement of ANMs. There are many ANMs at higher level institutions. Need for cadre review of doctors and paramedics to retain good human resource. |
| 2. | Bihar | The availability of human resources has increased substantially in Health Sub Centres, PHCs, DHs and Medical Colleges. Shortage of Specialists, Nurses and Lab Technicians still exist. Very innovative new cadre rules have been approved for doctors with well defined career progression. Contractual appointment policy is in place. Need to improve and expand nursing education as a top most priority. |
| 3. | Chhatisgarh | Chhatisgarh has serious human resource shortages. Lack of rational and transparent transfer policies and postings further aggravate the problem. Recently there was an effort to post Rural Medical Assistants in difficult areas from the 3 year course students. Large scale shortages of Nurses, Lab Technicians, Para medics and Specialists. |
| 4. | Jharkhand | Large scale shortages of Specialists and Nurses. Efforts have been made to rationalize postings of Specialists at Block, Sub District and District Hospitals. Need to create Specialist cadre and undertake rational and transparent policy of transfers and postings. Gradation list not yet prepared in Jharkhand state leading to lack of transparent criteria in key postings of doctors. State needs to look at Bihar's new cadre rules and create a similar system. The schools for ANM and Nursing need further strengthening with increase in intake. Jharkhand has a tradition of nursing services and women workers migrating in search of work. Nursing will improve skill levels of migrant women workers. 1200 doctors being recruited through the Jharkhand Public Service Commission. Appointment is in final stage. |
| 5. | Karnataka | Reasonable availability of Medical doctors, para medics and nurses in facilities visited. Contractual appointment of Specialists, Doctors, staff nurses, ANMs and Lab Technicians has been made to meet the shortfall.. In service MBBS doctors have been trained in Emergency Obstetric care and life saving anesthetic skills and posted to designated FRUs. Signs of improvement in availability of HR. ANM Training Centre needs attention. Cadre management and service conditions of doctors are issues to be resolved. |
| 6. | Kerala | Various categories of human resources have been added on contract under NRHM and this has further improved services. Medical Officers as DPM working well. Compulsory Rural Service for MBBS and Specialists is a good step. NRHM Coordinators not integrated into health system. More rational system of deployment needed. |

| | State | Key Findings |
|---|---|---|
| 7. | Madhya Pradesh | There are large scale shortages of Specialists and Nurses in the State. Contractual support structures for programme management are in place at the State and the district level. The block level structure is being put in place. |
| 8. | Maharashtra | Several steps to improve availability of Nurses. Second ANMs are provided. MPW Male already there. Shortage of Anesthetists. Need to rationalize posting of Specialists to ensure service guarantees. Capacity of government nursing schools has been developed. Decentralized appointment on contract. Multi specialty training is needed on a priority basis for nurses posted in tribal and extremist affected pockets. Higher payments in tribal and naxalite areas. |
| 9. | Mizoram | Availability of doctors and nurses has increased due to contractual appointment under NRHM. Shortages of Specialists persist. Increased staffing of Lab technicians leading to increase in service availability. 2 ANMs posted in Sub Centres. Need for in service nursing education. Need to invest in mobility of non doctor supervisors as well. |
| 10. | Orissa | Shortage of MBBS doctors, Staff Nurses, Specialists and Lab Technicians plague public health services. The State has taken several immediate and long term initiatives to meet this HR crisis. 3 new Medical Colleges have been set up in the private sector. Cadre reforms and up gradation of entry level post of doctors as Junior Class –I plus allowances in difficult areas are likely to attract more doctors. Cadre restructuring is under active consideration. Multi-skilling going on. There is a proposal for setting up 8 GNM Schools and 13 ANM Training Centres. |
| 11. | Rajasthan | Shortage of Specialists at FRU/CHC. The Rural Medical Officer cadre has greatly increased the availability of MOs at PHC level. Shortage of Lady MOs. Multi-skilling under progress – needs to be utilized better. Posting of 2 ANMs in tribal areas is a very good development. Very few refresher courses for ANMs. Need for synergy among training institutions. |
| 12. | Tamil Nadu | During the last two years 4263 nurses have been appointed on contract basis in the rural health centres. Life saving Anesthesia skills imparted to 106 MBBS doctors who are posted back to Block PHCs. All VHNs are given mobile phones. Cadre reforms to promote posting in rural areas. HR position is satisfactory. |
| 13. | Uttar Pradesh | Human resource is the real challenge in UP. Huge shortage of Nurses and Specialists. Some rationalization is improving the availability of services of Anesthetists and Gynecologists. This alone will not be enough. Need to expand nursing and medical education services on a large scale. Some District Hospitals could be considered for up gradation in to Medical Colleges in a time bound manner. Three year courses as in Assam and Chhatisgarh could be considered. |

# THEME-VII
## INFRASTRUCTURE

| | State | Key Findings |
|---|---|---|
| 1. | Assam | While lot of buildings have been constructed or are under construction, there is a need for greater rationalization of capital investments in order to ensure full utilization. While facility surveys have been completed, the up gradation is often not based on felt-needs. |
| 2. | Bihar | Infrastructure wing under the State Health Society has been created. Progress on construction is tardy. The State is exploring options for faster pace of construction and maintenance. Quality supervision of construction is weak. |
| 3. | Chhatisgarh | Unsatisfactory infrastructure. PWD and Chhatisgarh Infrastructure Development Corporation are constructing the buildings. Lot needs to be done. Many Sub Centres are in rented buildings. Many new construction works are under progress. |
| 4. | Jharkhand | A very unsatisfactory infrastructure. Large scale construction has been taken up in the last six months which will take a few more months for completion. It is likely to improve the infrastructure position. Block level PHCs need up gradation into 30 bedded CHCs on a priority basis. Accommodation for doctors and nurses also needs priority attention. |
| 5. | Karnataka | State is pooling infrastructure resources from different sources. Impressive physical lay out of PHCs/Taluka Hospitals, and newly constructed Sub Centres. Need to focus on quality of construction in a few places. Facility Surveys undertaken and gaps identified. Engineering Cell of Health Department is doing the construction. |
| 6. | Kerala | Building and equipment infrastructure coming from many sources. Engineering wing of NRHM, Kerala, is responsible for planning and monitoring. Equipment bought should be audited for their utilization. A State wide emergency ambulance system needs to be established. |
| 7. | Madhya Pradesh | Infrastructure Wing has been established under the Health Department and large scale construction works have been undertaken. 1747 Sub Centre buildings, 193 PHC buildings, 101 CHC buildings, and 7 District Hospital buildings are under construction at present. |
| 8. | Maharashtra | Excellent construction of new infrastructure and repair/upgradation of the existing infrastructure. Gardens and landscaping. Staff Quarters in good condition. |

| | State | Key Findings |
|---|---|---|
| 9. | Mizoram | Construction cell in NRHM Directorate is over stretched due to the volume of work. Need for assessing the requirement of engineers. Local people's committees may be involved. |
| 10. | Orissa | Huge backlog of construction activities under NRHM and State funds. A separate engineering unit was set up last year. Work allotted to 8 Government PSUs. Progress unsatisfactory. Need to prioritize Health Sub Centre construction along with ANM's residential quarter. |
| 11. | Rajasthan | Good progress in construction. Emphasis on construction of residential quarters at PHCs/CHCs is a positive step. Out of pocket expense for referral transport. |
| 12. | Tamil Nadu | All the PHC premises have a new look as most of the civil works have been completed. Need to improve residential quarters. Need for an infrastructure division within the health department, as PWD has many other responsibilities. |
| 13. | Uttar Pradesh | Infrastructure in District Hospitals, CHCs and PHCs has vastly improved in the last few years. There is a lot more to be done. Construction is going on at many places. A large number of Health Sub Centres need new building or repair. Site selection for PHCs must be near habitation to ensure their optimal use. Large gaps in infrastructure need to be addressed on a priority basis. |

# THEME-VIII

## EMPOWERMENT FOR EFFECTIVE DECENTRALIZATION AND FLEXIBILITY FOR LOCAL ACTION

| State | | Key Findings |
|---|---|---|
| 1. | Assam | 20,309 VHSCs formed. Started late due to PRI elections. Need for capacity building. *Rogi kalyan samitis* in most places. Good community participation in programmes. Village Health and Nutrition Days have attracted community participation. |
| 2. | Bihar | *Panchayats* are represented in the RKSs and the District Health Society. Involvement of *Panchayats* in NRHM is still not a priority. RKSs have been formed and are functional. VHSCs not formed as yet. Block Health Manager and Data Assistant working under the RKS. District Health Society meets regularly and proceedings are well maintained. |
| 3. | Chhatisgarh | Good participation of *Panchayati Raj* Institutions in the decentralization agenda. VHSCs are constituted under the umbrella of the PRIs. *Jeevan Deep Samitis* in facilties. Good use of untied grants in 2008-09. PRIs need to be made more active in *Jeeevan Deep Samitis*. |
| 4. | Jharkhand | *Panchayat* elections have not been held in Jharkhand since 1978. There are no elected PRIs. Therefore NGOs have been enlisted in selection of *Sahiyyas* and in the constitution of the Village Health Committees. Wherever the NGO selection has been a good one, the performance of the *Sahiyyas* and the Village Health Committees has been good. In other places, poor selection of NGO has hampered local processes. In the procurement of drugs, untied grants to local institutions, has helped in the process of decentralization. |
| 5. | Karnataka | PRIs are on board. Members of *Panchayats* as members of Arogya Samitis. CEO of Zila Parishad in District Health Society. All facilities from the Taluka downwards are funded through the *Panchayat* system. Indifference to health among *Panchayat* members as perceived by doctors, is leading to delayed decision making. Good use of untied funds at all levels. District Health Society meets regularly. |
| 6. | Kerala | Ward Health and Sanitation Committees have been operationalized. Untied, annual maintenance grants and RKS funds being regularly used to upgrade facilities and services. PRIs are part of RKS and are involved. *Panchayats* are involved in the running of Sub Centres. |
| 7. | Madhya Pradesh | VHSCs being formed and accounts being opened, but not fully operational as yet. RKS in all facilities. Untied funds being used under direction of ANM. Need to improve the involvement of the Sarpanch. |
| 8. | Maharashtra | Excellent involvement and cooperation of PRIs. VHSCs are fully functional. Untied funds used for cleanliness and beautification. SHGs are involved in providing meals in PHCs. ANM is providing meals to delivery cases at Sub centre. RKS meetings are held regularly. Sarpanch, members of VHSC, Gramsabha, and employees of health *panchayat* and ICDS involved in the preparation of Village Health Plans. |

| State | | Key Findings |
|---|---|---|
| 9. | Mizoram | Village Health and Sanitation Committees operationalized in all villages. Active involvement of youth, women and senior citizen groups in activities such as awareness for malaria, improved sanitation, etc. Need for regular meeting and monitoring of financial progress. RKS is operational with active involvement of Village Council members. Good use of untied funds. District Health Society meetings are not regular. |
| 10. | Orissa | Untied funds at different levels have contributed significantly to addressing local needs effectively and towards empowerment of local action and convergence. 11774 VHSCs set up (Gaon Kalyan Samiti). The NGOs are supporting the process. PRIs, women's SHGs and ICDS AWWs are being involved in the functioning of RKS, GKS and in the health system. |
| 11. | Rajasthan | Untied funds being utilized at all levels – the pace of utilization needs to increase. RMRS formed at all levels. VHSCs formed but their money is still with the Sub health Centre. Need to make VHSCs more active. |
| 12. | Tamil Nadu | VHSCs established for 12,618 villages and 2540 town *panchayats*. VHSCs meeting regularly and the record of discussions are maintained. Untied funds well utilized. Patient Welfare Societies in PHCs. Active District Health Missions. Need for empowerment of DMHOs. Community monitoring in a few facilities. |
| 13. | Uttar Pradesh | PRIs are involved but health functionaries complain of non – cooperation in many places. Village Health and Sanitation Committees have been set up under the umbrella of PRI. Sub Centres have joint accounts operated by ANM and Sarpanch. |

# THEME-IX

## ASHA

| | State | Key Findings |
|---|---|---|
| 1. | Assam | 26,225 ASHAS have completed Module IV training. ASHA programme has created a good ground for NRHM and ASHAs are visible and have audible presence. JSY work popular. Most of them earned less than Rs. 10,000 in one year. Medicine kits provided but no arrangement for replenishment. Popular weekly radio programme for ASHAs. |
| 2. | Bihar | ASHA programme is in place and the ASHAs are almost without exception, enthusiastic and functional. In most facilities they were seen in the labour rooms and maternity wards with the patients they had accompanied. Delays in performance based payments. Training for 2-4th module is delayed. ASHA programme is doing well in spite of the constraints. Succeeding due to local innovations. The Muskaan programme and the JBSY provide specific task for ASHAs. |
| 3. | Chhatisgarh | 60,000 *Mitanins* in Chhatisgarh, trained and deployed in every hamlet and are active in the field. Wide appreciation of *Mitanin*s' role in society. Comprehensive support structures in place. *Mitanin* help desks in all CHCs and District Hospitals. High degree of skills and competence among *Mitanins*. Irregular replenishment of drugs. Competition with ANMs for family planning incentives. |
| 4. | Jharkhand | The *Sahiyyas* of Jharkhand have been selected by NGOs, through Village Health Committees. They have done three modules of training. Good modules have been developed in the local contexts. Medicine kits have been made available to them. *Sahiyya*s see themselves as a representative of the local community and not as an administrative assistant of the ANM. This has helped in keeping their community links strong. Performance based payment processes need streamlining. |
| 5. | Karnataka | 2150 ASHAs are in place in C category districts. Well designed training programme for ASHAs. ASHAs have ID cards. Need to create support systems for ASHAs. More communication material needed for ASHAs. |
| 6. | Kerala | 8435 ASHAs in place. Selected by *Panchayats*. ASHAs are confident and aware of the NRHM programme. Performance based payment made regularly. Need to increase performance based payment criteria. Regular drug kits still to be provided. |
| 7. | Madhya Pradesh | ASHAs are effective and knowledgeable. Accompanies JSY cases. Training by resource persons at the district level. ASHAs are involved in making blood smear slides in fever cases. Incentives not worked out for malaria work. There are some issues of relationship among ASHAs/AWWs/ANMs. Need for more NGO involvement in the ASHA programme. |

| | State | Key Findings |
|---|---|---|
| 8. | Maharashtra | ASHAs are working in tribal areas. Third module training is going on. ASHAs are well motivated and enjoy the confidence of the community. Block level ASHA libraries established in three Blocks. |
| 9. | Mizoram | ASHAs are active. Rapid Diagnostic kits for malaria provided to them. Facilitate community leadership. |
| 10. | Orissa | 34,252 ASHAs selected. Induction training completed for all. 48% of ASHAs have completed up to fourth module. ASHAs are provided with drug kits. Posters providing details of payments to ASHAs are displayed in all facilities. ASHAs were found to be rooted in the community, highly motivated, and the competence and skills were good. Good team work with women SHGs and AWWs. Playing a role in nutrition and women's empowerment. |
| 11. | Rajasthan | ASHA *Sahyoginis* are working under the ICDS programme and their involvement in institutional deliveriesis low. Closely linked to *Aanganwadi* Workers. The involvement of ANMs with ASHAs needs strengthening. 15 day training for ASHA *Sahyogini* – State may like to assess need for change. |
| 12. | Tamil Nadu | Not implemented in Tamil Nadu as yet. |
| 13. | Uttar Pradesh | More than half the ASHAs are very active in the field. The community knows them and uses their support in seeking health services. Two rounds of training have been completed. Performance based payment criteria needs to be widened to include a larger number of activities for performance based payments. Training needs to be speeded up. Role clarity vis-a-sis ANM and AWW will help. ASHA is a key person in the Village Health and Sanitation Committees. |

# THEME-X

## SYSTEMS OF FINANCIAL MANAGEMENT

| | State | Key Findings |
|---|---|---|
| 1. | Assam | The capacity of the State to utilize funds made available to it under various components of NRHM has consistently increased. Good State level leadership and active role of District Health Missions. Need to improve financial record keeping. District PMUs have good data. Need to strengthen capacity at State level. Civil works and tender process take a little time and therefore fund utilization is often delayed. |
| 2. | Chhatisgarh | Though State Health Society account is opened, many disease control programmes still operating through old accounts. The 15% State contribution for the NRHM not yet transferred to State Health Society but the process has been initiated. Audit of 2007-08 completed. Core banking is from District to Block level. Slow progress on approved activities in 2008-09. |
| 3. | Jharkhand | Vacancies at the Block and district levels have been filled up Efforts to strengthen the state level set up has also been made. Financial performance has improved and levels of expenditure has picked up with large scale construction activity. |
| 5. | Karnataka | Delegation of administrative and financial powers to SHS and DHS in February 2008. Accounts with SBI and SBM. FMG constituted. Electronic transfer of funds from State to district. Single audit report in the State. Concurrent audit in place in 6 districts. |
| 6. | Kerala | Ebanking facility across the State. The facility is operational, and allows for transparency, audit and speedy operations. ASHAs given electronic cards for financial transactions. |
| 7. | Madhya Pradesh | Expenditure reporting found to be satisfactory. Monthly Audit of District Accounts and reporting by e-mail has helped. Use of computers in PHCs. Substantial increase in utilization of funds. |
| 8. | Maharashtra | Societies have merged. SPMU and DPMUs are functional. Block Monitoring Committee in place. FMG at State level providing guidance to field units. Timely reporting of financial statements. |
| 9. | Mizoram | System of financial management in place with specific personnel at various facilities. Delays in JSY payments. |
| 10. | Orissa | Increased pace of utilization of funds. Financial reporting is timely. Transfer of funds through e-banking. Financial guidelines under NRHM disseminated to all districts. |

| State | | Key Findings |
|---|---|---|
| 11. | Rajasthan | Finance team strengthened at all levels. Electronic transfer of funds up to Block levels. Monthly financial reporting from blocks to districts, districts to states has been initiated. Tally software has been introduced but use is at nascent stage. |
| 12. | Tamil Nadu | E transfer of funds to districts. Untied grants released to all. VHSC members need to be trained regarding accounting procedures. |
| 13. | Uttar Pradesh | DPMUs have been established recently. Block and PHC level staff strengthening needed for better financial management. E – transfers to districts with the support of SBI. Need to further streamline processes of reporting and their timeliness. |

# THEME-XI

## HMIS AND ITS EFFECTIVENESS

| | State | Key Findings |
|---|---|---|
| 1. | Assam | Data system is weak. Post 2005 the Data Manager at the district handles a lot of data. Information is collected but rarely analyzed. State has partially operationalized the web based district data system. |
| 2. | Bihar | Data Centres at state, district and block levels through an. outsourced system. Daily information is made available. Cellphone connectivity has also been established. Holds everyone in the system responsible. A little over intrusive but then it serves the purpose. |
| 3. | Chhatisgarh | Data generation through Block level, bypassing PHCs. New formats being used in the State level reporting. Most of the programmes retaining vertical reporting format. Feedback mechanism not in place to improve the MIS process. Sub Centres have up to date records. |
| 4. | Jharkhand | While basic data is being collected manually, its analysis and utilization varies. Need to create a strong HMIS for monitoring the performance of facilities, especially surgical procedures at Block level facilities. |
| 5. | Karnataka | Detailed State proforma. Web based system introduced in one district. HMIS needs to be harmonized with NRHM needs. Need for training the staff. |
| 6. | Kerala | The current manual HMIS is not meeting the need. The State is in the process of developing new HMIS. Need for Nodal information officers at each level. CHCs and PHCs have computers. |
| 7. | Madhya Pradesh | HMIS operational. Need to make it more effective with capacity building at all levels. |
| 8. | Maharashtra | Very well functioning web based HMIS formats, user friendly software for data entry, analysis and report generation at different levels and trained health staff in use of software database are the features of the State HMIS. |
| 9. | Mizoram | HMIS data being collected. Not stable as yet. New staff deployed. |
| 10. | Orissa | Comprehensive HMIS reporting formats have been introduced since April 2007. Need to improve quality of data. Feedback to PHC and Sub Centre needs to be strengthened. |
| 11. | Rajastha | Integrated HMIS is in pilot phase covering RCH, IDSP and NDCPs. Data validation built into the system. Testing phase is over. To be expanded State wide in 2009-10. |

| | State | Key Findings |
|---|---|---|
| 12. | Tamil Nadu | Has good MIS. Computers in PHCs. |
| 13. | Uttar Pradesh | Weak area in UP. Data is collected but not adequately analysed at the right level. Efforts needed to ensure that the new web based HMIS takes deep roots early and facilitates analysis at each level. |

# THEME-XII

## COMMUNITY PROCESSES UNDER NRHM

| | State | Key Findings |
|---|---|---|
| 1. | Assam | Need greater support and capacity building. RKS functional. VHSCs constituted. PRIs involved at each stage but greater efforts at capacity building are needed. NGO sector needs to be involved more effectively. |
| 2. | Bihar | While access to services at Block PHC has considerably increased, the formation of community process institutions like the Village Health and Sanitation Committees, Sub Centre level committees, etc, is still pending. *Rogi kalyan samitis* have been formed in most health facilities. |
| 3. | Chhatisgarh | 92% VHSCs already constituted and accounts with the joint signature of *Mitanin* and *Panchayat* Secretary has been opened. Low utilization of funds so far. Monthly Village Health and Nutrition Melas are being held. *Mitanins* working in tandem with ANM, AWW, SHGs, etc. Community monitoring has been initiated. |
| 4. | Jharkhand | Largely led by the NGOs through the *Sahiyya* programme. Large presence of NGOs has helped. *Rogi kalyan samitis* have been formed. Sub Centres are utilizing their untied grants. |
| 5. | Karnataka | Community monitoring through VHSCs in four districts, with support from Karuna Trust. Need for more effective systems of monitoring. Simplify village report card. Evidence of PRI members having a say in use of untied funds. |
| 6. | Kerala | Ward health and Sanitation Committees meet regularly and maintain minutes. *Panchayats* provide fund for electricity, medicines and glucometer. Need to orient *Panchayat* members about NRHM. |
| 7. | Madhya Pradesh | Satisfactory involvement of the local communities and PRIs in RKS and other institutions. ASHAs are effective. Indicates useful selection criteria. |
| 8. | Maharashtra | 7887 ASHAs in tribal areas. ASHA selection in other areas has started. Support mechanism for ASHAs in place. VHSCs established in 82 % villages. Maximum utilization of village health funds is on providing safe water supply and thereafter on Village Health and Nutrition Day. |
| 9. | Mizoram | ASHA is in place everywhere. 7 day training. Need for refresher training. ASHA mentoring group has met only once. Needs to meet more often. VHSC operational in every village. Need to involve other than health department functionaries. |

| State | | Key Findings |
|---|---|---|
| 10. | Orissa | Community processes are strong. ASHA selection, role of PRIs in Gaon Kalyan Samitis (VHSCs) and RKS, Village Health and Nutrition Days have all created platforms for community action. |
| 11. | Rajasthan | Begun involving VHSCs in micro planning. Involvement of community representatives in management structures needs to be further increased. NGO invovlement is weak. |
| 12. | Tamil Nadu | Community participation through VHSC, RKS, etc. |
| 13. | Uttar Pradesh | PRIs are involved. RKSs have been set up. VHSCs have been set up. Need for training of PRI/community leaders to improve their contribution in decentralized management of health system. |

# THEME-XIII

## ASSESSMENT OF NON–GOVERNMENTAL PARTNERSHIPS FOR PUBLIC HEALTH GOALS

| | State | Key Findings |
|---|---|---|
| 1. | Assam | NGOs are involved in Boat Clinics – doing very well. NGOs in community monitoring programme. There could be greater involvement. |
| 2. | Bihar | The State has a number of PPPs. It has very little NGO involvement at present. The mother NGO programme is not operational. Efforts to run APHCs through NGOs have not been very successful so far. |
| 3. | Chhatisgarh | State Health Resource Centre is playing a key role in community based health sector reforms. Playing a creative capacity building role in many areas. Large scale NGO partnerships in the *Mitanin* programme, blindness control programme, MNGOs and FNGOs for RCH. NGO Jana Swasthya Sahyog is running a very good hospital in Bilaspur district. |
| 4. | Jharkhand | Sahiya programme and Mobile Medical Units have made use of NGO presence. MMUs are run by *Vikas Bharati*. Doing very well with wide coverage. |
| 5. | Karnataka | Large scale involvement of NGOs. 49 PHCs outsourced to NGOs. |
| 6. | Kerala | Few NGOs are involved. Community monitoring is not formally introduced. |
| 7. | Madhya Pradesh | Need to further increase in NGO involvement. |
| 8. | Maharashtra | Large scale involvement of NGOs in programme. MMUs by NGOs. Training and capacity development through NGOs. Community monitoring through NGOs. NGOs are working for TB/ HIV/AIDS. |
| 9. | Mizoram | Active village level involvement of youth, women and senior citizens through VHSC. MMUs provided to some NGOs. Mother NGO scheme to strengthen government efforts. Young Mizos Association and Mizo Women's Association are active. |
| 10. | Orissa | Good NGO participation in NRHM activities. Involved in ASHA training, community processes for setting up of GKS in a campaign mode, referral transport and management ofa few PHC (N) as a PPP arrangement, PRI sensitization, organizing health melas, etc. 17 MNGOs and 88 FNGOs cover 2891 villages in 22 districts under the MNGO programme. |
| 11. | Rajasthan | Clearly spelt out NGO and PPP policy in the State. EMRI ambulance service, MMUs, social marketing of sanitary products as examples. |
| 12. | Tamil Nadu | Donations to hospitals as PPP. Many local initiatives. |
| 13. | Uttar Pradesh | Very few partnerships. Need for building detailed criteria that facilitates NGO involvement. PPPs being proposed for Medical Colleges. |

# THEME-XIV

## SYSTEMS IN PLACE FOR OUTREACH ACTIVITIES OF SUB CENTRE

| State | | Key Findings |
|---|---|---|
| 1. | Assam | Some of the Sub Centres in the State were found to be functioning very well with a resident ANM, high quality buildings and good use of untied funds. There are variations across centres. Many Sub Centres are in rented buildings. Non resident ANM in many places. Need to speed up the construction of sub Centre buildings 108 Ambulance system operationalized in a few districts. The Male Worker is needed at the Sub centre level. |
| 2. | Bihar | ANMs are in place in Sub Centres. Untied funds given but not yet utilized. Need more confidence to spend. Engaged in the Muskaan programme. |
| 3. | Chhatisgarh | Besides VHNDs, biannual child health months have led to significant increase in coverage of outreach services. While ambulances are available, their utilization for referral cases was low. |
| 4. | Jharkhand | Sub Centres are doing better than in the past. VHCs are getting active and funds have started reaching them. Mobile Medical Unit has expanded access in remote areas. |
| 5. | Karnataka | Streamlined outreach through fixed monthly out reach plans. VHNDs getting institutionalized. Mobile Health Units operational in KHSDP. EMRI planned for emergency ambulance service across the State. Health Workers(Male) are being trained.. |
| 6. | Kerala | WHNDs are regularly observed. IEC materials are innovative and well displayed. Sub Centre kit supply needs to be regular. EC pills not available. JPHNs need periodic training to cover all aspects. |
| 7. | Madhya Pradesh | Village Health and Nutriton Days effective. Sub Centres are doing outreach services. Need to widen land include larger public health challenges as well. |
| 8. | Maharashtra | Fixed day services in village for iummunization. Village Health and Nutrition Days. |
| 9. | Mizoram | VHNDs held regularly – more educational rather than service function. MMU operational under District Hospital. |
| 10. | Orissa | Fixed Village Health and Nutrition Days are increasing ANC registrations, immunization, growth monitoring and nutrition counseling activities. Mobile Units are in place. Second ANMs have been provided for outreach activities in remote areas. Absence of MPW Male limits the activities. |
| 11. | Rajasthan | Coordination with AWW is good as Sahayogini is an ICDS functionary. VHNDs held regularly. |
| 12. | Tamil Nadu | 100 Mobile Medical Units with 100 doctors on contract. 63,715 camps were held in 2007-08. Effective school health programme. |
| 13. | Uttar Pradesh | Sub Centres need the MPW male and the second ANM. The load on a single ANM is heavy. Fixed day services have started with good results. Mobile Medical Units to improve outreach services yet to begin. |

# THEME-XV

## THRUST ON DIFFICULT AREAS AND VULNERABLE SOCIAL GROUPS

| State | | Key Findings |
|---|---|---|
| 1. | Assam | Special efforts are being made to address health needs of tea estate workers and people living in tribal and char areas. Need for a robust plan. There is the challenge of attracting good human resource in remote areas. |
| 2 | Bihar | Exemption from user fee needed for the poor. |
| 3. | Chhatisgarh | Chhatisgarh has difficult areas. Proposal for creation of a Rural Medical Corps with special pay to address remote area needs is waiting for Cabinet approval. Rural Medical Assistants have already been posted in tribal areas. |
| 4. | Jharkhand | Tribal areas with large parts facing active Naxal issues. Difficult working conditions for doctors and para medics. Many of them are providing service in these difficult areas. Untied funds has helped them to activate the health facility and make it clean. VHSCs and *Sahiyyas* have helped in improving the outreach services. |
| 5. | Karnataka | 219 PHCs identified as remote. Additional financial incentives to doctors and staff nurses. Priority to C category and tribal districts is commendable. |
| 6. | Kerala | Tribals form 1.14% of State population. ASHAs in tribal areas. Sickle cell anaemia project targeted at tribal population. Comprehensive Health Care Scheme for tribals provides for full reimbursement. |
| 7. | Madhya Pradesh | Mobile Health Units in tribal areas has helped. Need for more focused attention. More direct publicity of free services for the BPL/SC/ST needs to be highlighted. |
| 8. | Maharashtra | Tribal area focus in ASHA programme. Additional financial incentives for tribal and naxal areas. MMUs in difficult areas. |
| 9. | Mizoram | Mizoram has difficult and remote areas that need special initiatives. Perhaps efforts like NGOs managing remote PHCs ( as tried out in Arunachal Pradesh) could be tried out in Mizoram. |
| 10. | Orissa | Needs to be more pro-actively sought and encouraged. Special provisions for KBK districts. |
| 11. | Rajasthan | Tribal Sub Plan provides for additional funding in difficult areas. 2 ANMs in difficult areas. |
| 12. | Tamil Nadu | Accessibility and availability of services is very good. Good outreach through MMUs. |
| 13. | Uttar Pradesh | Need to expand outreach services through camps. More nurses and Male Health Workers needed in the field. |

# THEME-XVI

## THE PREVENTIVE AND PROMOTIVE HEALTH ASPECTS WITH SPECIAL REFERENCE TO INTER-SECTORAL CONVERGENCE AND EFFECT ON SOCIAL DETERMINANTS OF HEALTH

| State | | Key Findings |
|---|---|---|
| 1. | Assam | Newly elected *Panchayat* members provide an opportunity for convergence. Road map for their capacity building is needed. Need for more involvement of health department functionaries in inter sectoral convergence. |
| 2 | Bihar | Nutrition rehabilitation programmes have begun. Emphasis is on the Vitamin A campaign. |
| 3. | Chhatisgarh | AYUSH co-location has not happened as yet. Intra health sector convergence across programmes and facilitie is also an issue in Chhatisgarh. |
| 4. | Jharkhand | VHNDs are popular. Rapid Diagnostic kit for malaria has helped. ANMs have these kits. |
| 5. | Karnataka | Good convergence with NACP-III and ICDS in VHND. Water quality monitoring being undertaken. PPP for vector surveillance. |
| 6. | Kerala | WHNDs are regularly observed. United funds of WHSC used for source reduction and vector control. The absence of malaria, filarial, dengue and Chikangunya this year may indicate success of such activities. |
| 7. | Madhya Pradesh | Greater community led action needed for preventive and promotive health. |
| 8. | Maharashtra | School Health Programme (353 teams at Taluka level) in coordination with education department, geriatric scheme implemented in cooperation with volunteers from Kishori Shakti Yojana and senior citizens attending the sessions at Aanganwadis and doing exercise, constitution of VHSCs in partnership with the water and sanitation committees, VHSC funds for improvement of amenities in Aanganwadi Centres, safe water supply, RKS funds being utilized for drinking water facility, viable partnership with ICDS through ASHAs in tribal areas, 438 Child Development Centres to treat Grade III and Grade IV malnutrition, partnership with Public Health Labs for water quality testing, are all an affirmation of the convergence in the State. |
| 9. | Mizoram | Measures of vector control are good with involvement of VHSCs. Convergent efforts in the VHNDs. Need for dental services. |
| 10. | Orissa | NRHM implementation has clearly contributed to better linkages of health staff with ICDS, Total Sanitation Campaigns and Self Help Groups. The team work of ASHAs, AWWs and ANMs in organizing the Village Health and Nutrition Day is a good platform for convergence. |
| 11. | Rajasthan | Need for greater coordination. |
| 12. | Tamil Nadu | Good coordination at the field level. |
| 13. | Uttar Pradesh | School Health Programme and Saloni programme for adolescent girls has been started. The Village health and Sanitation Committee can also greatly enlarge preventive health thrust. Need for systematic capacity building. |

# THEME-XVII

## EFFECTIVENESS OF THE DISEASE CONTROL PROGRAMMES INCLUDING NVBDCP

| | State | Key Findings |
|---|---|---|
| 1. | Assam | Thrust is on RCH. Gains in disease control programmes are incidental. Malaria cases and deaths have reduced mainly due to use of rapid diagnostic kits and insecticide treated bed nets. ASHAs are trained in use of Rapid Diagnostic Kit and in blood slide making. TB and leprosy programme reported to be doing well. No district level laboratory under IDSP. |
| 2. | Bihar | Disease control programmes are now with the Directorate. In the absence of adequate financial delegation the programme has slowed down. Technical protocols need to be more widely discussed. Supply of anti kalazar drugs has improved. Inconsistency in treatment protocols. Need for doctors' orientation on programme treatment guidelines. Only one round of spray for vector control. Social mobilization of communities needs to be speeded up. Case detection less than 50% for TB. Cataract surgeries are not being regularly undertaken in District Hospitals. No shortage of leprosy drugs reported. IDSP is just starting. |
| 3. | Chhatisgarh | Section wise GIS mapping for malaria. 1,55,620 bed nets distributed in 2007. Rapid Diagnostic Kits distributed in Bilaspur and Dhamtari. *Mitanin*s are trained in using Rapid Diagnostic Kits and in making blood slides. Vacancy of MPW Male affecting Malaria surveillance. District Malaria Officers and Inspectors are not in position even in areas with high malaria incidence. Poor monitoring of NLEP. Inequitable and insufficient distribution of eye surgeons. |
| 4. | Jharkhand | TB programme has picked up and services are available. Rapid Diagnostic kits have helped in timely detection of falciparum cases. In patient cases of malaria seen. |
| 5. | Karnataka | Good progress on the disease control programmes. API has reduced and deaths are low. Convergence of NVBDCP, TB and HIV/AIDS noticed at PHC/CHC level. Vision centres are functional. IDSP working very well. |
| 6. | Kerala | Commendable that State has set up an innovative programme for the community to manage terminal illness. Use of NGOs/Volunteers for pain and palliative care is commendable. |
| 7. | Madhya Pradesh | Thrust on RCH activities. Need for wider public health focus to cover all disease control programmes as well. |
| 8. | Maharashtra | Well run. Good coordination with NRHM. Rapid diagnostic kits and other testing facilities available. ASHAs in tribal areas taking blood slides of malaria. RNTCP has linkages with all ICTC and ART centres. |
| 9. | Mizoram | Malaria control programme is effective. Fever and malaria cases have come down. RNTCP doing well. Blindness control programme is less active because of lower awareness. |

| State | | Key Findings |
|---|---|---|
| 10. | Orissa | High incidence of malaria but no District Malaria Officers. Absence of MPW Male makes it difficult. MPW being appointed on contract. Time taken for reporting cases by laboratory is three weeks to one month. Insecticide treated bed net is useful but in short supply. GKS needs to be actively involved in the vector control activities. |
| 11. | Rajasthan | Malaria areas well provided with active search and malaria drugs. Rapid Diagnostic Kits being used in PHCs but not by ANM/ASHA. TB detection and cure rates above the targeted levels. IDSP formats in use at District/CHC/ FRU levels. |
| 12. | Tamil Nadu | Working very well. |
| 13. | Uttar Pradesh | Still functioning separately. Need for integration. Need for improvement in the Malaria control programme and detection of TB cases under RNTCP. |

# THEME-XVIII

## PERFORMANCE OF MATERNAL HEALTH, CHILD HEALTH, AND FAMILY PLANNING ACTIVITIES SEEN IN TERMS OF AVAILABILITY OF QUALITY SERVICES AT VARIOUS LEVELS

| | State | Key Findings |
|---|---|---|
| 1. | Assam | Large number of new born care centres at PHCs. Utilization still low. Institutional births have gone up to 60% from 37% before NRHM started. Home births need attention as well. Percentage of children receiving full immunization has increased. |
| 2. | Bihar | Access to maternal, child and family planning services has expanded. However, unmet needs remain high. The Muskan Abhiyan for immunization and institutional deliveries seems to have worked well. |
| 3. | Chhatisgarh | Institutional deliveries yet to catch up. More needed to be done on child health. Nutrition not a priority as yet. |
| 4. | Jharkhand | JSY yet to pick up. Institutional deliveries are slow to pick up even though ANC registration has increased. More confidence needed in the health facility and its service guarantee. Sub Centre deliveries are taking place. |
| 5. | Karnataka | PHC and Taluka Hospitals have shown improvement in physical infrastructure to deliver RCH services. New born care needs attention. SBA training, MTP and LSAS need quality assurance. Training of EmOC and LSAS for Medical Officers has shown good progress though coverage needs to be widened. Special efforts to simplify BPL certification have helped. E-banking has improved efficiency of JSY payments. Improvement in immunization coverage is visible. Maternal deaths are being investigated. |
| 6. | Kerala | PHCs, CHCs and Taluka Hospitals are providing services for family planning. Only few CHCs are providing 24X7 delivery services. Public awareness of JSY and immunization is satisfactory. |
| 7. | Madhya Pradesh | Substantial increase in institutional deliveries. Efforts made in child health as well. Improvement in family planning services. |
| 8. | Maharashtra | Significant increase in institutional deliveries, good quality facilities and cleanliness contributes to popularity of the public system. Simultaneous attention to maternal and child health needs as also to malnutrition is needed. Pregnancy testing kits are available in Sub Centres. |
| 9. | Mizoram | ANC done regularly at all facilities. Incidence of low birth weight is very low. Need to improve new born care facilities in CHCs and PHCs. Regular immunization at all centres. High off take of oral pill for family planning. EC pills not available. Young doctors trained in mini lap providing services at PHC/ CHC. Quality of IUD services could be improved. . |

| State | | Key Findings |
|---|---|---|
| 10. | Orissa | PHC strengthening needs to be emphasized for preventive and curative services. Thrust has been largely on CHCs/SDH and DHs. 61% of all institutional deliveries in 2007-08 were JSY supported. Major gains made. Quality of maternal care needs immediate attention. Discharge within few hours of the delivery. 341 institutions that have been selected for 24X7 services need to be operationalized on a priority basis. FRU operationalization needs to be given priority. Childhood illness care at primary level needs strengthening. Nutrition Rehabilitation Centres are in place in two districts. Contraception performance has improved marginally. NSV achievements are impressive. There is an increase in incomplete abortions coming for referral. |
| 11. | Rajasthan | While maternal health has received attention, child health needs more focused attention, especially neo natal mortality. Need for birthing kit in JSY delivery centres. This year there was a shortage of vaccines. |
| 12. | Tamil Nadu | Excellent MCH services. Pending JSY payments. Increase in family planning services at PHC level. |
| 13. | Uttar Pradesh | Upsurge in institutional deliveries. Thrust on child care programmes. Family Planning services need improvement, especially IUDs and the availability of emergency oral pill. |

# THEME-XIX

## ASSESSMENT OF PROGRAMME MANAGEMENT STRUCTURE AT DISTRICT AND STATE LEVEL

| | State | Key Findings |
|---|---|---|
| 1. | Assam | 149 BPMs, 149 BAMs, 454 PHC Accountants in place. Cleavages between public health system and NRHM. Need for coordination between NRHM and the Directorate of Health. PMUs at all levels playing a significant role in planning and monitoring. Most of them are young and enthusiastic. The regular cadre of health personnel still not fully involved. |
| 2. | Bihar | Programme management units at State, district and Block levels. These units are functioning well. Need to expand supportive supervision. |
| 3. | Chhatisgarh | SPMU/DPMU in place. Need for more coordination with the Directorates in an effective and efficient way. Block level Programme Management teams being put in place. |
| 4. | Jharkhand | SPMU, DPMU and BPMU have helped the programme in developing a system at the field level. Need for closer integration with the mainstream health administration. |
| 5. | Karnataka | SPMU/DPMU is in position. BPM appointments in process. Merger of NRHM and KHSDP enhances efficiency. |
| 6. | Kerala | SPMU and DPMU are functional. Block Coordinators in each Block. More integration of Directorate with NRHM would help. |
| 7. | Madhya Pradesh | State and District Health Societies established and functioning with management skills. |
| 8. | Maharashtra | SPMUs and DPMUs are fully functional. Taluka Health Offices strengthened with additional human resources. Directorate staff fully involved in programme implementation. |
| 9. | Mizoram | SPMU and DPMUs are in place, are a strong support to the district health administration.. State Programme Manager to join shortly. |
| 10. | Orissa | SPMU strong. Good working ethos. DPMUs active, professional and vibrant. Good team work with district and block medical teams exist in the State. The professionalization of health systems management in NRHM in Orissa has been a major factor in enabling the paradigm shift and effective decentralization of health management. District Health Action Plans prepared by the district teams. |
| 11. | Rajasthan | SPMU DPMU structure is well established and provides useful support to the programme. Need for closer integration of the Directorate of Health activities. |
| 12. | Tamil Nadu | Implementation of the programme in the State is exemplary. The District Health Mission meetings are not being held as envisaged under NRHM. There is no DPMU and BPMU as yet. Block PHC has an Office Superintendent. DMHO is from the public health cadre. |
| 13. | Uttar Pradesh | SPMU is active. DPMU and BPMU are being set up. These skills are acutely needed. Divisional PMUs have been set with SIFPSA support. |

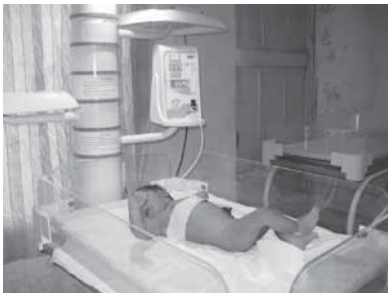
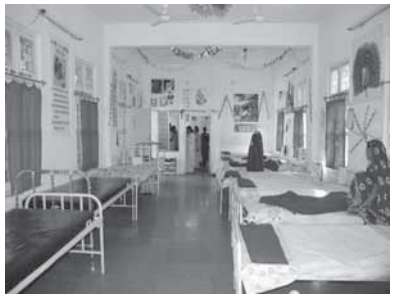
# SUMMARY POINTS FROM EACH STATE REPORT







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Functional Sub Centre in Assam

Operation Theatre with necessary infrastructure

Community interaction with CRM team

# ASSAM

## THE REVIEW TEAM

1. **Dr.Tarun Seem,** Director NRHM, MoHFW, New Delhi
2. **Dr. Anil Kumar,** CMO, Nirman Bhawan, New Delhi
3. **Ms. N. Angami,** MSG, Convenor & Ex-President, Oking Hospital, Kohima, Nagaland
4. **Mr. Gerard La Forgia,** World Bank, New Delhi
5. **Dr. Shyam Ashtekar,** ASHA Mentoring Group, School of Health, Nasik

## THE DISTRICTS/ INSTITUTIONS VISITED

1. Savisagar District
2. Bongaigaon District

| Progress under NRHM | Areas of improvement |
|---|---|
| 1. Increase in general utilization of OPD and indoor services, institutional delivery, and immunization.<br>2. Improved infrastructure, ambulance and logistics: construction of new PHCs, proper Cold Chain maintenance, waste management.<br>3. VHSC, RKS, instituted at village and facility level.<br>4. ASHAs are active, involved in VHND, JSY and immunization activities.<br>5. NGO participation in RKS and Community monitoring.<br>6. Weekly radio programmes are popular.<br>7. Dibrugarh boat clinic is a good initiative for island communities.<br>8. Special efforts being made for services to tea plantation workers.<br>9. Malaria cases and deaths have reduced mainly due to use of rapid diagnostic kits and insecticide treated bed nets. | 1. Strengthening Delivery services: still weak in SC and non existing at night in PHC<br>2. Further strengthening of infrastructure, drug supply, emergency facilities, OT, blood storage facilities, lab services, mental health services.<br>3. Incentive disbursement of JSY, HR policy and rational postings of specialists, performance based payment schemes and referral audits<br>4. Augmentation of AYUSH services.<br>5. Rational utilization of RKS fund for patient care.<br>6. Strengthening of ASHA programme through resource Centre, mentoring group and telephone helpline<br>7. Training in basic financial management to doctors as part of professional development course<br>8. Develop a long-term master plan for capital investments in districts<br>9. Encourage involvement of NGO support |

Increased case load in District hospital

Improved accessibility for women and children in District hospital

Drug availability at facility in Bihar

# BIHAR

## THE REVIEW TEAM

1. **Dr. P.K. Srivastava,** Joint Director, NVBDCP, MoHFW
2. **Dr. Jagvir Singh,** Joint Director, IDSP, NICD, New Delhi
3. **Dr. T. Sundararaman,** Executive Director, NHSRC, New Delhi
4. **Mr. Billy Stewart**, DFID India, British High Commission
5. **Prof. Rajesh Kumar,** Professor & Head, Community. Med. PGI, Chandigarh
6. **Dr. G.N.V. Ramanna**, Lead Public Health Specialist, World Bank, New Delhi

## THE DISTRICTS/ INSTITUTIONS VISITED

1. **District Muzaffarpur** Sadar Hospital, Referral Hospital, Saraiya **PHC:** Bochaha, Saraiya, Paru, Marwan **APHC:** Kuffin, Karza, Dawoodpur **HSC:** Pokharaira. Phulwariya, Kala Azar Medical Research, DHS office and data center, ANM Training School, Nutrition Rehabilitation Centre, ASHA training camp, AWC of Karza village
2. **Vaishali District**: Lalganj Sadar Hospital : **PHC:** Vaishali, MSF run hospital, Central District Drug Ware House
3. **Gaya District**: Lady Elgin Zanana Hospital, District health society office, Pilgrim Hospital, ANMTC Magadh Medical College **PHC:** Belaganj. Khijarsarai. APHC, Kudwan. Bodh Gaya. **HSC:** Mohanpur.

| Progress under NRHM | Areas for improvement |
|---|---|
| • Increased utilization of most services - outpatients, in patients, institutional delivery at block PHCs and district hospitals with over 100% bed occupancy<br>• Efforts to improve amenities & infrastructure; outsourcing arrangements for X ray & cleanliness.<br>• Improved supply of drugs, establishing generic medical stores at Block PHCs.<br>• Increased human resources in SCs, PHCs, DHs; innovative HR policy, additional ANM at SC.<br>• Nutrition rehabilitation programmes, Muskan ek Abhiyan immunization program<br>• Availability of Kala-azar kits<br>• District health society meetings held and well recorded, RKS in place.<br>• Societies of disease control programs have been merged with the health society,<br>• State initiated data centres and NRHM HMIS system both in place | • Addl. PHC strengthening for institutional deliveries; provision of referral transport; Enhancing use of Untied Fund<br>• Filling of regular vacant posts particularly nursing & specialists; HR policy, improvement of service conditions, skill upgradation<br>• Higher allocation for drugs and management structure for procurement; supply chain including contraceptives to be improved.<br>• Rationalization of public and private lab services at BPHCs by workload; quality protocols in Labs<br>• Vector control and programme management; Timely supplies<br>• New treatment protocols for KA should be disseminated<br>• Child health interventions to be prioritised<br>• Supervisory mechanisms from district level for outsourced activities<br>• Enhancing the range of beneficiaries exempted from user fee<br>• Bridge courses to upgrade ASHA to AWW to ANM to Graduate Nurse and to Postgraduate Nurse to be set up<br>• Public Health Cadre to be created<br>• Quick disbursal of incentives to ASHA<br>• NGOs need to be monitored for outputs or quality<br>• Formation of VHSCs<br>• Active involvement of RKS members in funds utilization & facility development; involvement of DHS in planning process<br>• Functional coordination between the State Health Society, Directorate of Health and program divisions |

Condition of Regional F W training centre at Bilaspur

ANM at Sub-centre Keonchi, Bilaspur

Mitanin Help desk, Bilaspur

# CHHATISGARH

## THE REVIEW TEAM

1. **Dr. R.S. Sharma,** Joint Director, NVBDCP, MoHFW, Govt of India.
2. **Dr. Kaushik Ray Barman,** Senior Consultant - Public Health Planning, NHSRC, New Delhi
3. **Dr. Pavitra Mohan,** Health Specialist, UNICEF India Country Office, New Delhi.
4. **Dr. Joe Varghese,** Senior Programme Coordinator, Christian Medical Association of India, New Delhi

## THE DISTRICTS/ INSTITUTIONS VISITED

1. **District Bilaspur:** Sanatorium and Eye hospital (CHC Gourella), District Hospital, bilaspur CHC: Kota, Pendra PHC: Ganiyari, Kenonchi, Amadand, Andhiarpur, Seepat SC: Gobripat, Kenwachi, Dahibahra, Bacharwar, AYUSH Dispensary Pendra Regional FW Training Center-Bilaspur,DPMU, Keonchi, AWC, Jan Swasthya Sahyog Kendra, Ganiyari
2. **District Dhamteri:** Dist Hospital, CHC: Kurud, Nagri PHC: Bhakhara (Kurud),Megha (Magarload), Bade Kareli (Magarload) Dugali (Nagri), SC: Bhakhara, Koliari, ANMTC
3. **District Raipur:** Directorate of H & F W, SIHFW, SPMU Medical college CHC, Abhanpur

| Progress under NRHM | Areas for improvement |
|---|---|
| • Increasing trend of OPD, normal delivery at CHCs and SCs, decline of malaria cases, infrastructural and service improvement at SCs are seen<br>• Exceptional teamwork between ANM, *Mitanin* and AWW<br>• Innovative initiatives: Recruitment of LT through JDS (RKS), Rural Medical Assistants initiative in tribal districts, Centralised drug procurement system, equipment management program, partnership with Red Cross drug stores, Telephone facilities for SC,<br>• Strong workforce of 60,000 *Mitanin* high degree of skills, *Mitanin* help desks,<br>• Sishu sanrakhan mah, VHND, Swasth *Panchayat* Scheme, Block Leprosy Awareness Campaign<br>• 92% VHSC are formed and account opened for most of the VHSC<br>• Bal Hriday Suraksha Yojana started with PPP mode<br>• Representation of other dept in SHS & DHS<br>• Sickle Cell test camps for screening have been launched in the state<br>• Usage of bed nets in indoor of facilities<br>• SPMU, DPMU working enthusiastically in tandem with directorate and district officials | • More focus for PHCs, 24x7 services & SNCU operationalisation; Emergency drugs availability, MMU for outreach activities should be streamlined; SC & PHC level facility survey, infrastructure upgradation; more co-location with AYUSH<br>• Replenishment of supplies for *Mitanin dawa peti*,<br>• Sensitisation of PRI leaders in JDS activities, merger of subaccounts, state budgetary contribution to SHS account, operationalising E banking from district to block should be done on a priority basis<br>• Infrastructure development wing, Procurement policy, Condemnation procedure,<br>• Strengthening training institutes, Developing HR policy, Strengthening public health capacities in all personnel,<br>• Develop cohesion and rational distribution of work among State health mission, SHRC, SIHFW & other training institutions, & directorates<br>• Streamlining of JSY based incentive distribution are to be planned<br>• Timely fund disbursements from state to districts, DHAP based financial disbursement adopting ROP process for districts<br>• Merger of sub accounts under SHS, transfer of state contribution to NRHM pool, decentralization of financial power need to be expedited<br>• Strengthening and sensitization of VHSC & PRI leaders, Village level planning process, social auditing, community monitoring need to be considered<br>• Frequent reshuffling of administrative and technical officials to be reviewed |

Functional Sub-centre in Jharkhand


Functional PHC in Jharkhand

ANMs in Jharkhand

# JHARKHAND

## THE REVIEW TEAM

1. **Shri Amarjeet Sinha,** Joint Secy, MoHFW, GOI New Delhi
2. **Dr. Dinesh Baswal,** Asstt. Commissioner, Training, MoHFW, New Delhi
3. **Dr. G. K. Ingle,** Prof, Maulana Azad Medical College, New Delhi
4. **Dr. Manoj Kar,** Advisor, NHSRC, New Delhi
5. **Dr. J.N. Sahay,** Advisor, NHSRC, New Delhi
6. **Dr. Nupur Basu Das,** Member, National AMG, CINI, Kolkata

## THE DISTRICTS/INSTITUTIONS VISITED

1. **Hazaribagh District:** District Hospital, **PHC:** Chouparan Barakatha Ichak Addl. PHC Basaria **HSC:** Chaikela, Thuthi, Kalabad, Silvar, Mahesra, ANM Training Centre, AYUSH Centre, AWC Chaikela, HFWTC Hazaribagh Mobile Medical Unit, Chanda,Community Monitoring, Sadan *Sahiyyas*
2. **District West Singhbhum, SARAIKELA:** SDH, Chkradharpur, Sadar Hospital (Saraikela), **PHC:** Sonua, Tantnagar, Zikpani **APHC:** Keraikela, Hatgamaria, **SC:** Kokcho, Singhpokharia, Haghari, Narsanda, Lupungutu,
3. **Others:** AYUSH Dispensary Chaibasa, ANMTC, AWC Jodapokhar

| Progress under NRHM | Areas for improvement |
|---|---|
| • Increase in caseload at some Block PHCs and sub-centres<br>• Doctors on contract at PHCs and Addl. PHCs.<br>• Infrastructure up-gradation initiated.<br>• Essential drug list and standard treatment protocols prepared<br>• Sahiyas (ASHAs) are functioning well<br>• Community monitoring with NGOs has been piloted in 15 villages<br>• RNTCP and NVBDCP shows an increase in number of patients where as decrease in number of leprosy cases<br>• Strong NGO support for Sahiyas & Community processes<br>• MMUs serving unreached population. | • Focus on facility strengthening; Non-functional PHCs to be revived<br>• Improvement of drug supply, enhancing OPD services<br>• Hospital quality management needs to be strengthened<br>• JSY guideline still not clear to the health providers<br>• Compensation package for Sahiya needs to be improved; replenishment of drug kit to be improved<br>• Deployment of District Sahiya Facilitators<br>• Emphasis should be given for the preparation of District Health Action Plan involving multiple stakeholder<br>• HR Policy is necessary<br>• Shortage of nurses to be met with by setting up of Nursing and ANM schools<br>• Residential accommodation for staff at facilities<br>• HMIS to be strengthened |

Pay Ward for patient care in Kerala

Citizen Chart in Kerala


ASHA in Kerala

# KERALA

## THE REVIEW TEAM

1. **Mr. Amardeep Singh Bhatia,** Director – NE Division, MoHFW, New Delhi
2. **Dr. Rattan Chand,** Chief Director – Statistics, Nirman Bhawan, New Delhi
3. **Dr. K.S. Jacob,** MSG, HoD, Psychiatry, CMC, Vellore
4. **Dr. Narendra Gupta,** AGCA, Secretary-PRAYAS, Rajasthan
5. **Mr. Sunil Nandraj,** WHO, New Delhi

## THE DISTRICTS/ INSTITUTIONS VISITED

1. **District Thiruvananthapuram:** Women and Children's Hospital, Thycaud, Fort Hospital **CHC:** Vizhinjum, Kesavapuram, Kanyakulangara PHC: Kunnathukal, Kuttichal, Pulluvalla SC: Pazahayakunnume, Aramanoor, Karali, Muttukadu
2. **Others:** Directorate of Health Services, Kerala Medical Services Corporation Limited, Kerala State Institute of Health Training Centre Tribal Health Camps, Pancode

| Progress under NRHM | Areas for improvement |
|---|---|
| • Marked improvement in infrastructure and human resources by the utilization of NRHM funds.<br>• Increased availability and quality of medication and marked reduction in cost of drugs after the setting up of the Kerala Medical Services Corporation Limited.<br>• The Compulsory Rural Service for doctors is a major step forward.<br>• Initiation of the computerized HMIS.<br>• Successful setting up and use of the e banking system.<br>• Good Outreach facilities. (WHND, Newsletter )<br>• A state-wide community based Pain and Palliative Care program for terminal illness in the community<br>• The initiation of comprehensive health insurance scheme in collaboration with Department of Labor.<br>• The selection process for ASHAs has been good. | • There is wide variation in the performance between districts, district/ taluk/ subdivision hospitals, CHCs, PHCs, and Sub-centers. Need to monitor the services from the point of input vs. services and improve poorly performing regions. Increase in the no. of field level functionaries in underserved areas is urgently needed.<br>• There is a need to focus on Non-Communicable Diseases<br>• A state wide emergency ambulance service needs to be established.<br>• A disaggregated analysis of data from health surveys can be used to identify disadvantaged groups (e.g. females, SC, ST, etc) for focused action.<br>• Equipment bought should be audited for their utilization and the value addition to services<br>• The NRHM coordinators seem not integrated into the health system<br>• Maximising the utilization of AYUSH facility owing to its strong presence (the State has more AYUSH facilities than modern medicine). |

Meeting among ANM and ASHA

CRM team with ASHAs in Karnataka

Drugs store in a facility

# KARNATAKA

## THE REVIEW TEAM

1. **Smt. Ganga Murthy**, Economic Adviser, Ministry of Health & F.W.
2. **Dr. V.R. Muralidharan,** Prof. & Head, Deptt. of Humanities & Social Sciences, IIT Chennai
3. **Shri A.K. Shiv Kumar,** UNICEF, New Delhi
4. **Dr. Dinesh Agarwal,** UNFPA, New Delhi
5. **Dr. Aditi Iyer,** Research Consultant, IIM, Bangalore
6. **Dr. Deoki Nandan,** Director, NIH&FW, New Delhi

## THE DISTRICTS/INSTITUTIONS VISITED

1. **Tumkur District:** District Health & F.W. Office, District Hospital,titpur general hospital, **PHC:** Nittur, Chelur, Biligere, Honnavalli, Kodigenahally **Sub-centre**: Somalapura, Thimmalapura, ANM Training Centre, Chikkamalur AWC, Goudi
2. **Raichur District:** Raichur General Hospital, Dist. Health & F.W. Office, Sindhanur General Hospital, Lingasugur, General Hospital, **CHC:** Kavithal, Mudgal, **PHC:** Matamari, Kallur, Kurdi, Hatti, Sirwar, Kalmala, **Sub-centre:** Mallat Meganapur, ANM Training Centre, ASHA Training Centre, Drugs Logistics Centre

| Progress under NRHM | Areas for improvement |
|---|---|
| • OPD, Institutional deliveries increasing in Sub-centers & PHCs<br>• Infrastructure created for facilities is impressive<br>• Significant initiatives for postnatal care, investigation of maternal deaths, spacing methods<br>• Fixed monthly outreach plans at Sub-Centres.<br>• Medical doctors, paramedics and staff nurses availability improved in public services,<br>• Public Health system at district level is under purview of the Panchayat system<br>• District Health Action Plans created in all districts; meetings of DHS take place regularly.<br>• Well designed training program for ASHAs<br>• Concurrent audit in place in 6 districts,<br>• Web based HMIS introduced on pilot basis<br>• Community monitoring through VHSC piloted in 4 districts<br>• PHCs outsourced to NGOs, showing mixed results<br>• Good convergence with NACP III and ICDS in VHND<br>• Suvarna Arogya Chaitnya School Health Program<br>• Holographic maternity card | • District Hospital, FRU to be strengthened<br>• New Born Care and Management of sick new born at peripheral facilities need strengthening<br>• Coverage to be widened for EMOC and LSAS trained MOs<br>• Quality Assurance needs focused attention<br>• Greater guidance and closer monitoring of untied fund utilization<br>• AYUSH doctors role to be clearly defined and oriented about NRHM<br>• Human Resources in health sector to be framed<br>• ANM training centres to be strengthened<br>• Quality of construction to be improved<br>• Conflict between ASHA/AWW/ ANM for incentive to be sorted-out<br>• Accounts for disease control program to be merged<br>• E-transfer of funds to block level<br>• Capacity Building of Samiti members for utilization of funds |

Nutrition Day at Dimba PHC


Kalthan SC in Maharastra

Premises of Dimbha PHC in Maharashtra

# MAHARASHTRA

## THE REVIEW TEAM

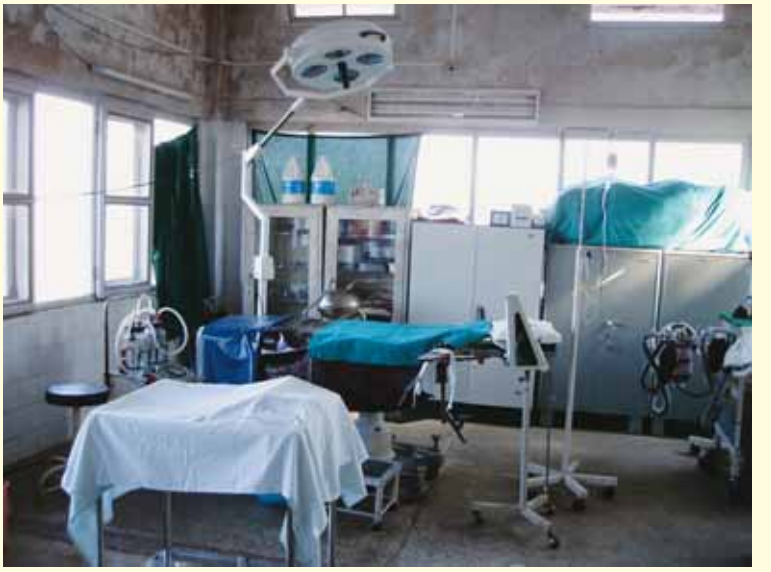
1. **Dr. A.C. Baishya,** Director – Regional Resource Centre for Northeastern States (RRC-NE), Guwahati
2. **Sh. Rajesh Kumar,** FMG Nirman Bhawan, MOHFW, New Delhi
3. **Sh. T.V. Antony,** MSG Former Chief Secretary, GOI
4. **Dr. K.B. Singh,** GTZ India, New Delhi
5. **Ms. Sushma Rath,** PAO, NHSRC, New Delhi

## THE DISTRICTS/INSTITUTIONS VISITED

1. **District Pune, Raigad –** District hospital, Alibaug, Sub-district Hospital, Bhor, CHC: Manchar PHC: Nagothane, Khedshivapur, Ambavade, Dimbe SC: Kikawi, Shinoli Others: Public Health Laboratory, Zila Panchayat Pune, SHRC, State Transport Depot
2. **District Nashik Thane** – District Hospital Nashik, District Hospital Thane, Kalwan SubDist. Hospital CHC: Rural Hospital, Vani PHC: Karanjali, SC: Rasegaon, Ambegarh, Manur Others: ANM/GNM training school, Regional FW Training Centre (Nashik)

| Progress under NRHM | Areas for improvement |
|---|---|
| • Improvement in out-patient load in sub centers, PHCs and CHCs and in institutional deliveries.<br>• JSY redressal Cell at district head quarters are existing<br>• 30% of SCs and PHCs upgraded to IPHS, with additional blood storage facilities in them<br>• All 24x7 PHCs are with basic lab facilities, semi-auto analyzer, ECG, and X-ray<br>• Well stocked with drugs and supplies with proper storage conditions<br>• Free meals for mothers at institutions are executed.<br>• Excellent involvement of PRIs, RKS and VHSCs regularly participate in meetings and take part in PIP preparation<br>• ASHAs well motivated and enjoy the confidence of the community. Support mechanism for ASHA in place. VHSC formed and bank accounts opened.<br>• Untied fund for better health facilities is observed<br>• Two FMGs are created: one for NRHM, NPCB, IDSP and the other for RCH, RNTCP, NLEP, and NVBDCP.<br>• NGO based sickle cell disease control program, MMUs providing services to underserved areas | • Sub district hospitals need to be improved for better support for patients<br>• JSY incentive distribution need to be improved<br>• Newborn care at institute needs to be strengthened.<br>• Initiatives to be taken for more BPMUs to be made functional<br>• Data is not made available on national website under HMIS.<br>• Rational utilization of Civil works funds as per guidelines<br>• Rationalization of posting of anesthetists needed<br>• Maintain a woman friendly atmosphere at institutional level |

Progress of NRHM in Mizoram



Bio-medical waste disposal facility at CHC

# MIZORAM

## THE REVIEW TEAM

1. **Shri Rajesh Bhatia,** M&E Division, MoHFW
2. **Dr. Ashoke Roy,** Regional Resource Centre for Northeastern States (RRC-NE), Guwahati
3. **Dr. Vijay Aruldas,** Christian Medical Association of India (CMAI), New Delhi;
4. **Shri M.K. Talukdar,** NHSRC, New Delhi
5. **Dr. Sharad Iyengar,** Action Research and Training for Health (ARTH), Udaipur, Rajasthan

## THE DISTRICTS/INSTITUTIONS VISITED

1. **District Kolasib:** District Hospital, CHC: Vairengte PHC: Bilkhawthlir, Kanpui, Lungdai SC: Bilkhawthlir, Diakkaun, Thingdawal, Bualpui, Zanlawn
2. **District Serchhip:** District Hospital CHC: Thenzawl PHC: Thingsuliah SC: Chinchhip,Buangpui, Thenzawl

| Progress under NRHM | Areas for improvement |
|---|---|
| • Presence of Regular MO has made positive impact on IPD / OPD at PHCs and institutional deliveries<br>• Significant number of home deliveries being conducted by ANMs<br>• Facility survey has been conducted in all the health institutions<br>• Well maintained facilities with proper cleanliness, disposal pits (using RKS funds) and at District Hospital<br>• Central procurement of medicines, Engineering cell for construction activities set up<br>• Upgradation of DH and CHC are already initiated<br>• ANM, Nurse, MPW (M) in fair numbers<br>• Active involvement of the Village Council Members in RKS<br>• Financial recording at various facilities are in place<br>• VHSC are operational with a high degree of involvement<br>• Pilot project on health insurance with Reliance,<br>• NGO participation in MMU is initiated<br>• Training for DPM staff regarding District Action Plan formulation done | • Cash disbursement of untied fund and annual maintenance grants; deposition of user fees in RKS<br>• District Health Society meetings not regular<br>• New born care corner, Blood storage unit, functional OT at CHC, supply of RD kits & EC pills, emergency drugs to be ensured<br>• Role differentiation among ASHA & ANM not well understood by community hence need to be clarified<br>• Usage of HMIS data for feedback<br>• Coordinated inter sectoral thrust should be developed with NVBDCP<br>• Health workers of SC should be made aware of TB patients as they are not DOTS providers<br>• Ensuring home visits by health workers<br>• Need to invest in improving quality of primary healthcare services beyond the clinical care by doctors<br>• In service training for Staff Nurses,<br>• Timely payment of JSY should be initiated<br>• Training in IMNCI & a maternal component might be considered as a pilot exercise<br>• District mentoring groups, and district and block facilitators for ASHA are suggested<br>• Integrated compensation package for ASHA need to be put in place<br>• Involvement of SPMU & DPMU in JSY monitoring suggested<br>• More involvement of VHSC<br>• Oral health interventions might be considered by the state.<br>• Male health workers should be given an active role in condom promotion and their performance need to be monitored. |

PHC with BEmONC facility at Unn (District Khargon)


Nutritional rehabilitation centre in MP


Family Welfare Camp in a Facility

# MADHYA PRADESH

## THE REVIEW TEAM

1. **Shri Javed Chowdhury,** Former Secy, Health, MoHFW, GOI
2. **Dr. Kiran Ambwani,** Deputy Commissioner – Family Planning, MoHFW, GOI
3. **Dr. L.M. Nath,** Former Director, AIIMS, New Delhi
4. **Dr. Manoj Kar,** Advisor, NHSRC, NIHFW, New Delhi

## THE DISTRICTS/INSTITUTIONS VISITED

1. **District Kahargone:** CMHO Office, Distt. Hospital PHC:Padalia, Karhi, Pipalyabujurg, Bamnala, Segaon, Unn SC: Dodwa, Bablai, Kavadiya, Lalkheda, Thibgaon, DPMU, District ICTC Services Centre, AWC, Village gogariakhedi MMU – Mobile Medical Unit
2. **District Dhar:** CHC CEmOC, Sardarpur, PHC BEmOC PHC Nalchha, Amjhera, ANM Training Centre, MMU at Sardarpur

| Progress under NRHM | Areas for improvement |
|---|---|
| • Significant increase in IPD and institutional delivery at SCs and PHCs<br>• Newborn corners are in place in the labor rooms in most of the FRUs<br>• Swastha Gram Swastha Panchayat- MCH services being provided at CHC, PHC and Sub Health Centers through specialists from Private Sector<br>• Janani Express vehicles for referral, Mobile health unit (DINDAYAL CHALIT ASPATAL) in tribal blocks<br>• NABH Accreditation project in Bhopal & Jabalpur initiated<br>• Sub-Center untied fund utilization has been high but without the consent of Sarpanch<br>• ASHAs have a Identity card with drug kit, AYUSH specific incentives for ASHA are planned<br>• VHSC formation under progress<br>• Outreach activities through Mobile Medical Units<br>• Insurance schemes for BPL families, Nutrition Rehabilitation Centers, Janani Sahyogi Scheme (Accreditation of Private Institutions) & Matra Shakti Yojana through PPP for MCH services initiated<br>• Strong community monitoring pilot<br>• Infrastructure development wing, Constitution of a separate AYUSH cell, developed drug policy, procurement through TNMSC, Warehouses are initiated, Privatisation of waste disposal,<br>• SPMU, DPMU, RKS are functional, Block PMU is proposed, District Community Mobilisers recruitment in Progress.<br>• Monthly audit of district accounts | • Strengthening of PHCs<br>• Quality assurance committee at various health facilities to be formed<br>• Training of PMU staff and District Programme Officers for District Health Action Plan (DHAP)<br>• State funded construction should not be replaced by NRHM funded constructions<br>• HR policy, upgradation of medical practice skills of MO & SN are required, additional incentives may be planned for persons posted in difficult areas<br>• VHSC should be operational with formal orientation<br>• Fund utilisation, PPP need to be streamlined<br>• Timely availability of compensation, replenishment of drug kits are critical and need immediate attention<br>• State budget should flow into the Health Society account<br>• HMIS needs improvement in reporting & analysis<br>• MMUs should be made available on a more frequent and regular basis.<br>• Additional incentives may be planned for personnel posted in difficult areas<br>• Functional merger of Disease control programmes with DHS, Nodal officer for M&E is designated at the BEMOC and CEMOC facilities need to be strengthened<br>• Development of District Health Action Plan involving multiple stakeholders |

Well decorated SC in Orissa

Functional CHC in Orissa

Interaction with ASHAs

# ORISSA

## THE REVIEW TEAM

1. **Dr. K.R. Antony,** Director, SHRC, Chhattisgarh
2. **Dr. Prabha Arora,** Deputy Director, NVBDCP, MoHFW
3. **Dr. Ritu Priya,** Advisor – Public Health Planning, NHSRC, New Delhi
4. **Ms. Deepika Shrivastava,** Specialist (Child Development & Nutrition), UNICEF
5. **Dr. Rajmohan Panda,** Public Health Specialist, Public Health Foundation of India
6. **Dr. H. Sudarshan AGCA,** Hon Secretary, Karuna Trust, Bangalore

## THE DISTRICTS/INSTITUTIONS VISITED

1. **District Dhenkanal:** Dhenkanal District Hospital, Kamakhyanagar SDH, CHC: Anlibereni, Parajang, Sriramchandrapur PHC: Guneibili, Khankira, Deogan, SC: Mahulpal Sarang Parjang, Sriramchandrapur, Sadangi Village Gundrapasi, Badapokharia
2. **District Subarnapur:** Subarnapur DH,CHC: Tarva, Ullunda PHC: Charbhatta, Naikenpal SC: Kamsara, Charbhatta, Kotsamalai, Khaliapali, Kotsamalai AWC

| Progress under NRHM | Areas for improvement |
|---|---|
| • Increased patient load and institutional deliveries in CHCs, Sub-divisional & District Hospitals<br>• Effective use of untied fund at facilities<br>• 'Yashodas' in the hospitals as companions & counseling women during delivery.<br>• PHC (N) and Mobile health units being managed by AYUSH doctors<br>• NGO participation in NRHM activities for management of Janani Express and a few PHC (N)<br>• VHSCs formed; PRIs, women's SHGs and ICDS actively involved with the health system.<br>• VHNDs being conducted as effective forums for increasing community ownership and convergence<br>• Excellent GIS mapping for all districts<br>• NRHM financial guidelines are being followed very effectively by the state<br>• The State and district IDSP operational.<br>• The State PMU has strong leadership and very good working ethos. District PMUs are active, professional and vibrant<br>• Bilateral donors such as NIPI and DFID providing technical assistance in the State | • Strengthen PHC and Sub center services; including staff quarters<br>• All vacancies for the NVBDCP from District Malaria Officers to Lab. Technicians and MPW (M) to be filled up.<br>• Integrated vector control, with engineering works and use of biological control needs to be strengthened; supply of insecticide treated bed nets to be improved in high endemic zones<br>• An integrated Mother & Child Health, FRU operationalisation, IMNCI roll out needs to be given high priority.<br>• Linking of TBAs with ANMs for underserved areas/ population groups.<br>• New born care equipments, Childhood illness care at primary level needs strengthening;<br>• Scaling up of telemedicine facilities for "hard to reach" areas.<br>• Transparency and need based procurement and distribution of drugs, infrastructure development mechanisms<br>• Creation of a public health cadre in the state |

Sub Centre in Rajasthan


CRM team with VHSC Members

Emergency Respose Services

# RAJASTHAN

## THE REVIEW TEAM

1. **Dr. Gian Chand,** Ex-Director Health Services, Government of Himachal Pradesh
2. **Mr. Gautam Chakraborty,** Senior Consultant, Financing of Health Care, NHSRC, New Delhi
3. **Dr. Rajib Dasgupta,** Associate Professor, Centre for Social Medicine & Community Health, Jawaharlal Nehru University (JNU), New Delhi
4. **Mr. Sanjay Saxena,** Senior Advisor, Finance, Operations & Administration, NIPI-UNOPS, New Delhi
5. **Dr. Ute Schumann** - European Commission, Golf Links, New Delhi

## THE DISTRICTS/INSTITUTIONS VISITED

**District- Jaipur, Dungarpur:** SIHFW, Jaipur Medical College, Udaipur EMRI Centre- SIHFW Campus, Jaipur, JK Lone Hospital Static Centre- Adarsh nagar, Janana Hospital **CHC**- Sagwada, Simalwada, Bichhiwada, Govindgarh, Chomu, Bassi, **PHC**- Kaladera, Vatika, Tunga, Kanba, Bhiluda, Dudhiabara Vidyadharnagar Urban RCH Centre **Sub centre-** Mohanpura, Bagrana, Meghtalab, Bedsa, Narniya, Malikheda, Karauli VHSC Meeting- Vijaypura, Bedsa, Ramratanpura, Meghtalab District ANM Training Centre- Dungarpur

| Achievements | Areas of Improvement |
|---|---|
| • Marked increase in case load at all levels.<br>• Human resource shortages minimised.<br>• All PHCs with MBBS doctors.<br>• ANMs under TSP contractual; drawing hardship allowance under NRHM in tribal/desert areas<br>• Approval of district PIP and release of funds using flexi pool mechanism has been initiated from 2008-2009, reducing the no. of transactions and increasing flexibility at the district level.<br>• Pregnancy Tracking System (PTS)--individual record of identified pregnant mother at Block level. Extending PTS to PCTS (Pregnancy and Child Tracking System | • Strengthening Community Health Centre services.<br>• District Health Missions, on the other hand, are non-existent/non-functional.<br>• ANMs and doctors not residing in the facilities located in difficult areas or located outside habitations.<br>• ANMs to be trained; were not confident of application of rapid diagnostic kits for malaria and haemoglobin assessment available with them<br>• Clear guidelines for fixing of salary of DPMs and BPMs<br>• Institutional synergy between the Regional Institutes at Jaipur and Ajmer, the Directorate, the SIHFW, the schools for LHV and ANM training.<br>• Need to streamline social protection schemes that include use of RMRS funds for the BPL, Rajasthan Swasthya Bima Yojana, to BPL card holders& Bhamashah scheme.<br>• Coordination of teamwork between the AWW, ASHA and ANM<br>• Follow up of PNC visits and monitoring by ANM / supervisor to be strengthened<br>• Design pneumonia control programme - with referral for sepsis management.<br>• The register kept at the institution does not record a) weight of the newborn b) condition at the time of discharge – difficult to track pre mature / mal nourished neonate. |

School Health Scheme

MMU clinic

New born care unit Sub div hospital Hosur

# TAMILNADU

## THE REVIEW TEAM

1. **Prof. A.T. Kannan** Prof & Head of Department of Community Medicine, UCMS, New Delhi
2. **Dr S.K. Sikdar** Assistant Commissioner – Family Planning, MoHFW, GOI
3. **Dr. D. Thamma Rao,** Advisor – Public Health (HRD), NHSRC, New Delhi
4. **Mr. Sushil Pal,** Financial Management Group, Nirman Bhawan, New Delhi
5. **Ms. Sheena Chhabra,** Chief, Health Systems Division, USAID, American Embassy, New Delhi

## THE DISTRICTS/INSTITUTIONS VISITED

1. **Villupuram District :**. Kallaikurchi Hospital Kallaikurchi town District Hq. Hospital **PHC:** Saram, Kiliyanur, Iruvelpattu, Elavanasur Kottai, Nainarpalayam, Chinna, Thirunavallu **SHC:** Kandhalavadi, Killapalayam, Sempi
2. **Salem District, Krishnagiri, District, Vellore District**

| Progress under NRHM | Areas for improvement |
|---|---|
| • High per capita financial allocation, low out of pocket expenditure, good Infrastructure, laboratory services, logistics situation are the trend in Tamil Nadu<br>• Facility survey, AYUSH collocation are in progress<br>• Fair number of institutions is providing 24x7, FRU facilities. diet for ANC cases, 2 nd day stay for Post natal care, functional OT at PHC are seen<br>• Maternity picnics, bangle & birth companion programmes for pregnant women, Additional SN in PHC, gestational DM screening & preventive measures are observed<br>• VHSC exists in town *panchayats*<br>• Filling up over 99% of specialist positions at FRUs, rationalisation of posting & transfer policy, promotional avenues, relocation of Specialists from periphery to bigger institutions are good initiatives.<br>• Smooth disbursement of Untied fund, Annual Maintenance Grant, RKS fund in most of the facilities<br>• Functional MMU with contractual staffs<br>• 'Short stay home' for 10 days for the expectant tribal mothers near the health facilities is a good initiatives<br>• Computer and internet connectivity in PHC | • Promotion of nutritional improvement, early diagnosis & treatment of anaemia, and health education for obesity in children, adolescents and women, male participation for Family Planning are required<br>• Strengthening of SC, remuneration for staffs in hilly areas,<br>• Reassess blanket JSY coverage, Streamline district society meeting, provide rural and hard area allowance for all categories of health workers, consider 2nd ANM, implementation of double ledger accounting systems should be strengthened<br>• Reorientation trainings for ANMs to facilitate decentralized preparation of Village and SHC level health action plans<br>• Skill up-gradation of laboratory Technicians and Radiographers<br>• Enhance intra-sectoral coordination (Directorates of Public Health, Rural Health, Medical Education etc) for strengthening of linkages<br>• up-gradation of SDHs as per IPHS<br>• Electronic transfer of funds to sub-district levels<br>• Establishing Infrastructure Development division at State level and units at district level for high quality infrastructure<br>• streamlining of the TNMSC procurement and distribution systems to eliminate short expiry drugs<br>• Capacity building of the six regional training institutes for Continued Medical/ Nursing/ Paramedical Education<br>• Plan definite program for all non communicable diseases<br>• VHND need to be augmented |

Functional Sub Centre in UP


PHC in UP: supporting services

Male Hospital Bahraich

# UTTARPRADESH

## THE REVIEW TEAM

1. **Dr. N.C. Saxena,** Consultant, UNICEF India Country Office, UNICEF House, New Delhi
2. **Dr. Sunil D. Khaparde** Dy. Commissioner (Immu. & ID) MOHFW, New Delhi
3. **Dr. Arun Kumar Sharma,** Professor in Community Medicine, UCMS, New Delhi
4. **Dr. P. Padmanaban,** Advisor – Public Health Administration, NHSRC, New Delhi
5. **Mr. Gopi Gopalakrishnan,** President, World Health Partners, New Delhi

## THE DISTRICTS/INSTITUTIONS VISITED

**District Unnao and Bharaich:** District Hospital for Women & Men- Unnao, **CHC**-Nawabgunj, **Block PHC**-Safipur, Fatehpur Chauras, Achalgunj, Asoha, Kalukhera, Hiloli, **Addl. PHC**- Roop Pur Chandel,, **SHC**-Jamalpur, Kardhaha, Kalukhera **Village**- Dhannapur, Pichauda, Sarai, Katha

| Progress under NRHM | Areas of Improvement |
|---|---|
| • Upsurge in institutional deliveries and increasing OPD attendance<br>• Excellent improvement in infrastructure of facilities, Very spacious HSC buildings.<br>• Those in position work hard to deliver health care<br>• ANMs and ASHAs are well accepted and respected in the community<br>• RKS formed up to Block PHC level<br>• Steps taken to activate VHSCs<br>• Clear Guidelines for the use of funds | • Second ANM and MPW (M) needed at Sub-centres<br>• Active screening for communicable diseases (Malaria) needs more attention<br>• FRU and Mobile medical Units not operationalised<br>• Mapping of human resource and redistribution for rationalization of services at different levels following IPH standards is recommended.<br>• Creation of a public health cadre<br>• Mass media campaigns to inform community about facilities created and their benefits<br>• Transparent policy and procedures for recruitment and transfer of workers, protection of erring workers.<br>• Funds for new PHCs<br>• PRIs not uniformly involved for VHSC<br>• Monitoring and supportive supervision of programs should be ensured<br>• Rapid grievance redress for staff and beneficiaries.<br>• Community participation and social audit to be encouraged<br>• Nutrition supplementation, nutrition rehabilitation and provision of food for mothers after delivery and after tubectomy<br>• HMIS and data utilization for planning and monitoring<br>• Expansion of nursing education and post graduation in specializations where there are inadequate specialists. |

This report of the Second Common Review Mission (CRM) is a documentation of the progress of the National Rural Health Mission in a sample of 13 States. It also identifies areas that require strengthening of health systems to meet NRHM goals.

NRHM (2005-2012) is Government of India's flagship programme for health which aims to provide accessible, affordable and accountable quality health services to the poorest households in remotest rural regions. Launched in 2005, in a mission mode, NRHM is guided by the objective of improving the reach and quality of public health services by decentralized public health planning and greater community participation.

CRM is a part of the Mission Steering Group's mandate of review and concurrent evaluation of NRHM, on an annual basis. CRM undertakes appraisal of the public health system through field visits by a team of public health scholars and practitioners, senior academics and government officials, members of civil society and development partners. It reflects on the implementation of NRHM strategies and policies, to identify mid-course corrections which may be needed. It also encourages sharing of experiences across the States and across the different sections involved in planning and implementation of this programme.

***A mini CD placed in the jacket at the back of this cover contains the electronic version of this as well as state-wise reports.***

NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

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MINISTRY OF HEALTH & FAMILY WELFARE
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