National Rural Health Mission

# Third Common Review Mission Report

NOVEMBER 2009






NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

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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,
New Delhi-110 011



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गुलाम नबी आज़ाद
GHULAM NABI AZAD

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110108

Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110108

# MESSAGE

I am pleased to see the third Common Review Mission Report of the National Rural Health Mission (NRHM). The NRHM is the flagship programme of our UPA Government and it is our hope that quality health services reach the remotest households in rural areas. The Common Review Mission provides us a useful insight on the journey covered and the journey to be completed. I am happy to find that most States and UTs have made good use of NRHM resources to improve the quality of care and services for rural peroples. There are miles to go as health care in India had been neglected over the years. While a lot has been achieved, a lot more needs to be done.

The success of NRHM will depend on our policy of reaching the last household in rural areas. There are still many difficult, most difficult and inaccessible areas where more effort has to be made to reach quality services to the people. I commend the members of the Common Review Mission for the hard work that they have put in over the two weeks to visit health facilities and to give us their honest feedback on what has been accomplished so far. All their suggestions shall be kept in view during finalization of the Programme Implementation Plans (PIP) in coming years. NRHM is a societal Mission and I am happy that civil society members, Public Health Experts and others have joined the Common Review Mission in large numbers.

**(Ghulam Nabi Azad)**

New Delhi
13.1.2010

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The National Rural Health Mission was launched to strengthen public health systems to provide universal and equitable access to quality health care services and to improve the health status of our people.

The Common Review Mission, an annual process undertaken by the Ministry, is a collaborative effort of a multidisciplinary team of Government functionaries, public health experts, civil society members and development partners to reflect and examine the changes achieved under the Mission. The Third Common Review was undertaken in 14 States and 3 Union Territories during the first and second weeks of November, 2009 to review the progress made on 22 key areas of the National Rural Health Mission. The Third CRM report provides an overview of progress made and examines the areas lagging behind in implementation and the reasons thereof and provides a set of recommendations for further implementation.

While the report highlights several areas of progress in the areas of infrastructure, human resources, institutional strengthening, programme management systems and community processes, there are also many areas which clearly require urgent attention. In order to leverage the outputs envisaged under the goals of reducing the maternal mortality and infant mortality rates for the country, clear targets will have to be drawn with measurable outputs. These will need to be linked to performance for making the system more accountable. The scope for decentralized planning provided under NRHM needs to utilise optimally micro planning approaches including service provider mapping and vulnerability analysis for ensuring that the health needs of the poorest population groups are addressed. Greater efforts are also required for integrating the Disease Control Programmes under the Mission. Appropriate strategies for addressing the gaps should be clearly reflected in the forthcoming State Programme Implementation Plans for 2010-11.

I thank all the officers of the Ministry and the participants from various sections of the society/ public health community who participated in the third CRM and provided their inputs and suggestions. These recommendations would go a long way in leveraging the impact of the Mission.

**(K SUJATHA RAO)**

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# MESSAGE

The National Rural Health Mission is the flagship, programme of the Government of India aimed at providing accessible, affordable and quality health care to the most vulnerable and marginalised population. The Mission, in its 4th year of implementation is well on its way towards strengthening the public health service delivery system.

The Common Review Mission, an annual system of concurrent appraisal is steered by the Ministry of Health and Family Welfare and has active participation of a diverse group comprising of Government functionaries, public health practitioners, development partners and members of the civil society. The CRM seeks to examine the extent of progress on the key NRHM strategies and policies, identify specific areas with limited progress for mid course correction and layout the course of action for accelerating the achievement of the goals under the Mission. The third CRM report documents the findings of 22 review parameters, analyses the observations and learnings from the States on five key areas, reflects on achievement made on processes and service guarantees and highlights areas for further improvement.

The report indicates that considerable progress has been made in strengthening of health infrastructure and human resources and in strengthening management structures. However, there are greater challenges to be addressed in provision of equitable services to the vulnerable communities located in some of the most difficult areas of the country, ensuring quality of service delivery across the board, rationalising of skilled human resources, building enabling partnerships and inter sectoral convergence and strengthening of decentralised planning processes.

I would like to thank all our partners in this journey towards meeting the health needs of the people. I appreciate the effort and time put in by public health experts, civil society members and development partners who have joined us in the endeavour of strengthening the NRHM. I specially thank Secretary, Health and Family Welfare, for the continued support in taking the Mission forward. I am also thankful to the entire NRHM team and NHSRC for coordinating the CRM. Under the dynamic leadership of the Honourable Minister for Health and Family Welfare, we are confident of moving forward towards greater success.

**(P.K. PRADHAN)**

# Contents

# ABBREVIATIONS

| | |
|---|---|
| AGCA | Advisory Group on Community Action |
| AMG | Annual Maintenance Grant/ASHA Mentoring Group |
| ANC | Ante-Natal Care |
| ANM | Auxiliary Nurse Midwife |
| ANMTC | Auxiliary Nurse Midwife Training Centre |
| APHC | Additional Primary Health Centre |
| API | Annual Parasite Index |
| ARI | Acute Respiratory Infection |
| ASHA | Accredited Social Health Activist |
| AWC | Anganwadi Centre |
| AWW | Anganwadi Worker |
| AYUSH | Ayurveda, Yoga, Unani, Siddha, Homeopathy |
| BCC | Behaviour Change Communication |
| BDO | Block Development Officer |
| BEmONC | Basic Emergency Obstetric & Neonatal Care |
| BMO | Block Medical Officer |
| BMWM | Bio Medical Waste Management |
| BPHC | Block PHC |
| BPM | Block Programme Manager |
| BPMU | Block Programme Management Unit |
| BP | Blood Pressure |
| BPL | Below Poverty Line |
| CBOs | Community Based Organizations |
| CEmONC | Comprehensive Emergency Obstetric Neonatal Care |
| CDPO | Child Development Project Officer |
| CHC | Community Health Centre |
| CME | Continuous Medical Education |
| CMHO | Chief Medical and Health Officer |
| CMO | Chief Medical Officer |
| CMOH | Chief Medical Officer Health |
| CPR | Cardio-pulmonary Resuscitation |
| CRM | Common Review Mission |
| CT Scan | Computed Tomography Scan |
| DC | District Collector |
| 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 |
| DPMU | District Programme Manager Unit |
| DT | Diphtheria and Tetanus |
| DWCD | Department Women & Child Development |
| ECG | Electro-cardiogram |
| EDL | Essential Drug List |
| EmOC | Emergency Obstetric Care |
| EMRI | Emergency Medicine and Research Institute |
| ENT | Ear, Nose & Throat specialist |
| FHW | Female Health Worker |
| FM | Financial Management |
| FMG | Financial Management Group |
| FP | Family Planning |
| FRU | First Referral Unit |
| GH | General Hospital |
| GF & AR | General Financial & Administrative Rules |
| GOI | Government of India |
| GNM | Graduate in Nurse and Midwife |
| Hb | Haemoglobin |
| HMIS | Health Management Information System |
| HR | Human Resource |
| HRD | Human Resource Development |
| HSC | Health Sub-centre |
| ICDS | Integrated Child Development Scheme |
| ICTC | Integrated Counselling and Testing Centre |
| IDSP | Integrated Disease Surveillance Project |
| IEC | Information Education Communication |
| IMA | Indian Medical Association |
| IMEP | Infection Management and Environment Protection |
| IMNCI | Integrated Management of Neonatal and Childhood Illnesses |
| IMR | Infant Mortality Rate |
| IPD | In Patient Department |
| IPHS | Indian Public Health Standards |
| IRS | Indoor Residual Spray |
| ISO | International Organization for Standardization |
| IUCD | Intra-uterine Contraceptive Device |
| J & K | Jammu & Kashmir |
| JDS | Jeevan Deep Samiti (RKS) |
| JE | Japanese Encephalitis |
| JSY | Janani Suraksha Yojana |
| KBK | Kalahandi-Bolangir-Koraput (districts of Orissa) |
| LHT | Local Health Tradition |
| LHV | Lady Health Visitor |
| LLIN | Long Lasting Insecticide Treated Nets |
| LR | Labour Room |
| LSAS | Life Saving Anaesthetic Skills |
| LT | Laboratory Technician |
| LWE | Left Wing Extremism |
| MB | Multi-bacillary cases |
| MCHN | Maternal and Child Health, and Nutrition |
| MDR | Multi-drug Resistant (TB) |
| MIS | Management Information System |
| MHW | Male Health Worker |
| MMR | Maternal Mortality Ratio |
| MMU | Mobile Medical Unit |
| MNGO | Mother NGO |
| MO | Medical Officer |
| MOHFW | Ministry of Health & Family Welfare |
| MOIC | Medical Officer In-charge |
| MOU | Memorandum of Understanding |
| MPW | Multi-purpose Worker |
| MRI | Magnetic Resonance Imaging |
| MS | Medical Superintendent |
| MSG | Mission Steering Group |
| MTC | Malnutrition Treatment Centre |
| MTP | Medical Termination of Pregnancy |
| NABH | National Accreditation Board for Hospitals and Healthcare Providers |
| NDCP | National Disease Control Programmes |
| NE | North East |
| NFHS | National Family Health Survey |
| NGO | Non-Government Organisation |
| NHSRC | National Health Systems Resource Centre |
| NICU | Neo-natal Intensive Care Unit |
| NIHFW | National Institute of Health & Family Welfare |
| NIPI | Norway-India Partnership Initiative |
| NPCB | National Programme for Control of Blindness |
| NLEP | NLEP National Leprosy Eradication Programme |
| NRC | Nutritional Rehabilitation Centre |
| NRHM | National Rural Health Mission |
| NSV | Non-scalpel Vasectomy |
| NVBDCP | National Vector Borne Disease Control Programme |
| OPD | Out Patient Department |
| ORS | Oral Rehydration Solution |
| OT | Operation Theatre |
| PB | Pauci-bacilliary (Leprosy) |
| PCTS | Pregnancy and Child Tracking System |
| PHC | Primary Health Centre |
| PHN | Public Health Nurse |
| PIP | Programme Implementation Plan |
| PMU | Programme Management Unit |
| PNC | Postnatal Care |
| POL | Petrol, Oil & Lubricants |
| PPP | Public Private Partnership |
| PPTCT | Prevention of Parent to Child Transmission |
| PRI | Panchayati Raj Institution |
| PTG | Primitive Tribe Group |
| PWD | Public Works Department |
| RCH | Reproductive and Child Health |
| RDK | Rapid Diagnostic Kit |
| RHSDP | Rajasthan Health Systems Development Corporation |
| RKS | Rogi Kalyan Samiti |
| RMA | Rural Medical Assistant |
| RMRS | Rajasthan Medicare Relief Society |
| RNTCP | Revised National Tuberculosis Control Programme |
| RSBY | Rashtriya Swasthya Bima Yojana |
| SACS | State AIDS Control Society |
| SBA | Skilled Birth Attendant |
| SC | Scheduled Castes |
| SDH | Sub Divisional Hospital |
| SHC | Sub Health Centre |
| SHG | Self Help Group |
| SHP | School Health Programme |
| SHS | State Health Society |
| SHRC | State Health Resource Centre |
| SHSRC | State Health Systems Resource Centre |
| SIHFW | State Institute of Health and Family Welfare |
| SNCU | Sick Newborn Care Unit |
| SOE | Statement of Expenditure |
| SPIP | State Programme Implementation Plan |
| SPMU | State Programme Management Unit |
| ST | Scheduled Tribe |
| STG | Standard Treatment Guideline |
| TNMSC | Tamil Nadu Medical Services Corporation Limited |
| TOR | Terms of Reference |
| TOT | Training of Trainer |
| TT | Tetanus Toxoid |
| UC | Utilisation Certificate |
| UNOPS | United Nations Office for Project Services |
| USG | Ultra-sonography |
| UT | Union Territory |
| VHND | Village Health and Nutrition Day |
| VHSC | Village Health and Sanitation Committee |
| WHO | World Health Organization |

Section - I

# Executive Summary

# Summary of the Findings and Recommendations


The mandate of the annual Common Review Mission (CRM) of the National Rural Health Mission (NRHM) is to review changes in the health system since the launch of the NRHM; to examine and document progress on key process parameters of the NRHM strategies; to identify key constraints limiting the pace of architectural correction in the health system envisaged under the NRHM; and to recommend policy and implementation level adaptations that could accelerate achievement of the goals of the NRHM. The third CRM was organized in the first and second weeks of November 2009. This is 55 months after the formal launch of the NRHM and 39 months after its Framework for Implementation received cabinet approval- the date from which its implementation began. This CRM was undertaken in 14 states and 3 union territories— Bihar, Chhattisgarh, Madhya Pradesh, Orissa, Rajasthan, Uttarakhand, Uttar Pradesh, Meghalaya, Sikkim, Jammu & Kashmir from the high focus states, and Andhra Pradesh, Gujarat, Haryana and West Bengal; Andaman and Nicobar Islands, Dadra and Nagar Haveli, Daman and Diu from the non-high focus states and UTs.

The Mission consisted of 16 teams, each composed of four to six persons. A total of 89 persons constituted the Mission, with 32 officials of the central and state governments, 28 public health experts from academic and technical institutions, 8 public health activists and 21 international development partners. Each team reviewed one State, except for the team which visited two neighbouring UTs of Daman & Diu and Dadar & Nagar Haveli. In each state, the team visited a minimum of two districts and at least ten facilities representing all levels of care. The team members received a presentation by the State NRHM, made field visits, examined records and made on-site observations, interacted extensively with the health officials, service providers, elected representatives, ASHAs, VHSCs and community members. Thereafter the teams analyzed the situation in the state, held discussions with the State officials for feedback and submitted the state reports. These reports have been consolidated in this national report along with an analysis of the general trends across states.

The Terms of Reference of the Third CRM contained 22 parameters for review. The findings against these parameters have been summarized in this report under five major headings. The first indicates the main output of the NRHM in terms of achievement of service guarantees. The others present the inputs and processes: human resources for health, efforts at decentralisation and community processes, programme performance, and management issues.

# SUMMARY OF THE FINDINGS

1. The overall impression across all states is of continuing improvement in strengthening of the public health service system, in increasing utilization of the services and in increasing access to health care. In the States which had initiated activities early on, there is a sense of the State NRHM having matured to a point where it is able to consolidate the gains of the first three years and initiate creative approaches with confidence. Making use of the platform NRHM offers, they have progressed through incremental strengthening of the health infrastructure and human resources at facilities, strengthening of the ASHA programme, initiation and strengthening of other community processes, and in management structures and processes.

2. The first CRM report had shown the increase to be only in outpatients and institutional deliveries and speculated on the extent of non-JSY increase. The second CRM report had shown the increase to be across the board, but rather more at the secondary level with a mixed picture in the primary level. However, this year the shift in load from secondary levels to the primary is evident in several states and facilities.

3. The increase in utilisation of public services is still seen to be maximally in delivery cases, but in most states there is also an increase for other health care needs. Utilisation of co-located AYUSH services was reported to be satisfactory in the few states that have reported on this component.

4. While there is sustained increase in institutional deliveries against estimated deliveries in the state, in some districts there is a decrease in the number of deliveries at the District hospital, thus relieving them of the overcrowding and load that had built up in the last two years (though remaining much higher than when JSY was initiated). The increase in utilisation of services at PHCs has been widely observed, and the increase in deliveries at Sub-centres is seen in states where sub-centres with adequate infrastructure have been accredited for institutional delivery.

5. Among the increased number of deliveries at district hospitals and CHCs, there is variability in the proportion of complicated cases as against normal deliveries. In some there is no change, indicating an unnecessary burden on the system, institution and users. But where there is an increase in proportion of caesarean sections of total deliveries, this is likely to demonstrate the success of the strategy of promoting institutional deliveries in dealing with complications and preventing maternal mortality. This, coupled with the shift of normal deliveries to the peripheral primary level institutions, is a welcome movement indicating rationalization of the site of institutional deliveries.

6. In some districts and facilities visited, notably in Gujarat and Bhilwara in Rajasthan, the decline in delivery load and even inpatients is due to a shift to the private sector hospitals and such shift has been actively encouraged by specific PPP tie ups. In most other places no decline in total in-patients handled by the system was seen, though there could be also the displacement of other inpatient care by the increasing load of maternity care. A more thorough examination is required to ascertain whether there is indeed such a trend and if so the causes and remedies for this.

7. Teams have observed remarkable upgradation of many existing facilities, with a large number of new buildings and renovations, addition of human resource, equipment and enhanced efforts at maintaining cleanliness and hygiene. However, the extent and quality of upgradation is highly varied across and within states. The selection of facilities and choice of items for upgradation were often found not to correlate to need, indicating the necessity of rationalizing selection processes during planning.

8. The shortage of residential quarters for health staff persist despite construction in several facilities, adding to the challenge of getting human resources into the system.

9. The facilities have been strengthened in all states in terms of drugs and supplies, furniture, equipment and diagnostic services. However, shortfalls continue and it is difficult to quantify the changes or shortfalls and make comparisons with previous years. We know from many comments that the task is far from over. Some of the lack of preparedness is due to overcrowding, especially in states with shortfall of facilities as per population norms.

10. Most states seem to be sensitive to the issue of availability of drugs, especially for the BPL patients. Almost all States reported improved availability of drugs. While the move to generics is being tried by some, negotiating cheaper prices for sale at shops in the facility premises has been attempted by others. Free drugs to the BPL alone, are one measure tried in states, where drugs are not given free to all. Insufficiency of drugs and thereby the imperative of prescribing medicines from outside continues widely. This could also be linked to insufficiency of understanding of the essential drug concept. Irrational prescribing of higher order medicines instead of basic generics has been reported, emphasizing the need for combining free provisioning with promotion of rational drug use. This would lower costs to the system and the households.

11. While diagnostic laboratories and equipment do seem to have improved all rounds, there is often a lag in improved services due to mismatch between equipment procured and the skills available.

12. Safety measures such as safe medical waste disposal was seen to be practiced increasingly, but a serious lapse continues in the form of radiological services under unsafe conditions posing hazards to the health staff and the community living in the vicinity.

13. Efforts for quality improvement through setting up systems for sustained quality were noted in some states through standards certification, whether ISO certification in district hospitals of the eight high focus states, or the NABH in Gujarat. However, there is an issue of sustained inputs to maintain the improvement and of putting a policy environment and strategy in place to replicate this on a wider scale.

14. User friendly aspects of services were commented upon, showing a mixed picture. Clean toilets with lighting, curtains in examination rooms of OPDs and in labour rooms giving privacy to patients were observed with appreciation, even while noting their absence in a large number of facilities. Signages, citizen's charters being displayed on the wall are all welcome additions. However, the lack of respect shown to patients by the service providers in their interactions is still a pervasive phenomenon that discourages use of public facilities. Lack of dignity in the conduct of sterilization camps has also been reported.

15. Emergency and referral transport services have been instituted in several states, whether through the EMRI contract or through their own ambulance system. Several variations exist of these services, and what people use continues to be more plural. There is a need to bring together these learning experiences to craft together a scheme more appropriate and sustainable for the poor performing states.

16. The basis of the categorization into difficult areas is not very clear nor standardized distances, health indicators, health facility/health human resources density or service output indicators do not always match. For the vulnerable groups identified, some states seem to have built a strong approach while others are providing only token benefits. While initiatives for additional nutrition to them, provision of impregnated bed nets, mobile vans etc. abound and are a welcome input in very vulnerable circumstances, their effectiveness and adequacy as per need remains to be verified.

17. Outreach activities of the sub-centre refer to the services provided by the ANM, and are largely conducted through the monthly immunization session. The male worker and the services provided by him are not noticeable, and the ANM has in practice no house visit function, these having shifted to the ASHA. VHNDs in most states are becoming the points for immunization and ANC, but it often does

not translate into 'an event' in the village or have any community level impact. The supervisory system is poorly functional.

18. The role the second ANM is playing is not clear and states which need them most, such as Bihar, Jharkhand and Chhattisgarh have been unable to recruit them. Ideally the two ANMs should have identical work, with the number of households shared between them. This work could be organised in such a manner that the sub-center is always open with one of the two ANMs for providing delivery services, outpatient care and counselling services. Many states have chosen to divide up different work components between them and hand them some of the work expected of the male worker. There is a need to study what is happening in the field and to strengthen the system to get better health outputs.

19. While the increase in number of new facilities has not been a part of NRHM strategies, the density of facilities seems to be a concern to flag at this stage. In most states the decision had been to address the challenge of making existing facilities functional before asking for more facilities. However as facilities go into overcrowding in some of the states and some geographical areas remain under-served, there is a need to pick up this issue again.

20. Every State visited has reported sharp increases in human resources deployed in the public health sector. Close to one lakh health service providers and managers have been contracted into the system across the country. Decisively therefore the tremendous 15 year stagnation on this front is broken; a factor which, more than any other single factor, led to a crisis of the public health system. Much of the increases seen in performance – in outpatient, in-patient and delivery services have been enabled by and directly related to this incredible increase. However, especially in the poor performing states, with the high deficit and lack of system development as a legacy, vacancy situations are still impermissibly high.

21. All new posts are contractual, making for a perception of this as ad hoc arrangements under the NRHM rather than as basic ingredients of the system that must be sustained and expanded. State governments have been filling up old vacancies after a 15 year gap, but seldom creating new posts as such. 'Across the board' increases in post sanctions leads to considerable degree of inefficiency in deployment of human resources. Though NRHM is about a commitment to comprehensive health care, increases in many states are still focused too narrowly on obstetric care aspects of IPHS, or merely responsive to immediate pressures without a longer term direction and vision. The issue of rationalisation of postings – the most obvious of measures still defies solutions.

22. Many states have come up with innovations for attracting and retaining professionals into public service in rural and remote areas. Most states have focused on financial incentives for working in difficult areas. Others like Chhattisgarh and Rajasthan have gone for the creation of a special cadre with an interesting mix of financial and non financial incentives. Regulatory mechanisms of rural service bonds for medical students and pre-PG mandatory qualification have helped in a major way. Locale based selection and special short term expansion of nursing school capacity under PPPs have led to a strategy of clearing 10,000 ANM vacancies within four years in West Bengal. Haryana has eliminated its vacancies by a mix of incentives and simplification of recruitment processes. Chhattisgarh has used the three year doctor - now called the rural medical assistant - to almost completely eliminate its very high medical officer vacancies. Sikkim has looked at measures that address professional and social isolation by building a positive workforce environment- CME programmes and making PHCs into social hubs. All in all, for the first time, the problem of vacancy of professionals in rural India has been addressed. The frontline now is in carefully studying how much they contribute to retention and workforce performance and to adapt and replicate these innovations in other contexts.

23. Another change since the last CRM is that many more training institutions have become functional. The weakness remains inadequacy in numbers of training institutions, lack of faculty and problems of infrastructure and therefore varied quality of training and poor ability to scale up the training

to meet requirements. Hands-on skill building remains inadequate and neglected in most trainings.

24. At the time of the third CRM, almost all districts and states had decided to make their own plans, without external consultancy support and feels much more confident of their capacity to do so. The third CRM reports show that though there are state advances in this, there are also continuing weaknesses that the district planning teams have still to overcome. These include "inadequate analysis of district level issues leading to generic plans without any local specificities." States with two or three cycles of planning, having institutional memory of the process, and having capacity building programmes in place, show considerable improvement in the process. The use of HMIS data and epidemiological information for planning, the ability to articulate community needs in the plan, are all frontiers of decentralised planning which the more experienced states are entering into. If fund flows to districts are more rigorously based on the final realigned and approved district plans that would also help to give more seriousness and ownership to this process.

25. VHSCs are now beginning to take off in many states. West Bengal is an exception, in that VHSCs have not been established state wide, in Uttarakhand they have started up recently and are yet to become functional. Quality of functionality is now the central challenge in most states.

26. All states have established the RKS and its character has changed to some extent, as it became the vehicle for untied funds. The composition and functioning of *Rogi Kalyan Samiti* in a number of states leaves much to be desired. In many states where the RKS established before NRHM, the mindset is of the RKS as a government vehicle for cost recovery and not primarily as an organ for public participation in management. Untied grants are getting used through the RKS, some states showing a high utilisaton and great appreciation of the benefits the funds are able to provide, but others are still lagging.

27. The ASHA programme is sustained; the ASHAs remain active and enthusiastic despite a huge number of problems faced. CRM teams have noted that that they feel empowered and command respect and confidence from the community and they are available for further improvements in the programme. However quality of training and support varies and needs strengthening. This requires support structures that remain weak in most states. Examples of planned efforts at improving ASHA performance are found in reports from Rajasthan and Andhra Pradesh, Orissa and Chhattisgarh.

28. Partnerships with the non-governmental agencies are of two types. One relates to arrangements with NGOs, and another with the commercial private sector including large corporate groups. Of the former type, the main form of involvement is in the ASHA programme and in community monitoring programmes and to a lesser extent the VHSC programme. Non-governmental participation is still peripheral to the core strategies of NRHM- even to community processes. The ASHA programme and the VHSC programme and even the RKS programme would do much better if energy of NGOs is systematically harnessed, and where it is, the quality of engagement needs to be enhanced and periodically assessed.

29. Examples of private commercial sector participation, on a large scale, are of the EMRI, and the *Chiranjeevi*. The CRM reports on the latter, highlighting the need for monitoring scheme performance parameters of partnerships and relating financing to performance. Sound contract management, basic cost and quality monitoring, are still far from achieved as principles though they have been recognized for a long time. Huge mega projects of private sector partnership should have a systematic and periodic external evaluation mechanism built in and a government financed contract management cell in the state NRHM that ensures adherence to the contract parameters are recommended.

30. Reporting on the disease control programmes shows that they are functional as per their

design, with issues of supplies being irregular. In malaria, the use of Rapid Diagnostic Kits (RDK) is facing problems in introduction, especially that of quick expiry and lack of enough kits to meet the needs. Meanwhile, with the programme shift to RDK, blood slide microscopy may be getting withdrawn or cut back too hastily. The IDSP is functional in most states, but data input and use is sub-optimal. Leprosy cases were increasing in Orissa and in all states proportion of MB cases were increasing, though total number of cases decreased.

31. Reproductive and child health programme reporting shows similar patterns across states, whether high or low performing such as: sustained increases in institutional deliveries, improved referral transport to institutions for delivery, effective use of Village Health and Nutrition Days and improved outreach for enhanced immunization coverage. ANC and PNC coverage remains low and of poor quality. Family planning programmes focus primarily on female sterilization, newborn care continues to remain an area of low priority, and child health and nutrition (apart from immunization) do not appear to get the attention needed. Mothers continue to be in institutions after delivery for less than half a day in most cases, and quality of care needs to improve in large proportion of facilities.

32. A positive outcome of the thrust of NRHM over the past three years on infrastructure strengthening, facility improvement, and enabling adequate numbers of human resources is that the increase in institutional deliveries appears to have occurred predominantly in public sector facilities. This is the case in most states other than in Gujarat. Where the quality of care in the private sector is not necessarily much better than that reported for the public facilities, but because of the push of the system case loads seems to have migrated from the public system to the private sector. In West Bengal and Madhya Pradesh, there are a number of private institutions accredited for delivery under this scheme, but the bulk of cases handled and the increase of cases are largely in the public sector.

33. In almost all states, the reports voice concern regarding the lack of strategy and focus in the family planning programme. It appears that there is an almost singular focus on female sterilization as the method of choice, and even here, quality of care is poor and unmet needs are high. Enhanced contraceptive acceptance rates indicate that facility up gradation has enabled meeting women's need for limiting family size. Most states appear to offer this through a camp or fixed day approach. Promotion of spacing methods remains low, and this is due to issues with both demand and supply.

34. Apart from IMNCI which has been operationalized in a few states, there is little in the reports to indicate that the states are addressing child health issues other than immunization. Every report on IMNCI also reports the roll out to be far slower than planned for. Some states report attention being paid to management of ARI and diarrheoal disease principally through administration of ORS. However supply side constraints remain. Nutrition is being addressed in some states through programmes such as the *Bal Shakti Yojana* in Madhya Pradesh, the Nutrition Rehabilitation Center in selected districts of Bihar, and these show promise. However several of the state reports indicate that nutrition is an area not being addressed adequately.

35. The major opportunity and form of health sector involvement in nutrition seems to be the platform provided by the Village health and nutrition day, which is organised in the Anganwadi Centres (AWC). Unfortunately, in most states there is a lack of focus on the nutrition theme within the health staff- who is fully absorbed with the services they have to provide, and the AWC are occupied with the logistics of supplementary feeding. The health department's role is in providing iron and folic acid, Vitamin A supplements, and in treating severely malnourished sick children. Despite taking weights of children regularly, there is no identification of malnourished children, with gross under-reporting as against the available independent surveys. Besides the ICDS convergence, other areas barely find mention in the CRM team reports, whether on provision of

safe potable water or of waste water drainage, while the total sanitation campaign finds a marginal space.

36. The Programme Management Units at the district level are generally well established and better integrated than at state level. There is now a welcome trend to strengthen this further with more staff for more programmes and also put in place block level programme management units.

37. State level coordination between mission directorates and the NRHM state programme management unit and state health society continues to be sub-optimal. With frequent changes of Mission directors and secretaries, the lack of SHSRCs and support institutions at the state level, continuity on initiatives and institutional memory suffers.

38. Logistics continues to be a weak link though there has been some attention given in some of the states. In some states, opening of pharmacy shops selling generic drugs, or giving drugs free for BPL are seen as a step forward whereas other states have made all drugs in the public hospital free of charge.

39. Integration of financial information system is ongoing. With assistance from the Financial Management Group (FMG) at the central level; the states are adopting customised accounting software (Tally) across all levels where NRHM funds are handled. Some states like Rajasthan had installed this software down to the block level, although the Accountants contracted at the block level are still to be trained.

40. The capacity of states to absorb funds was found to vary considerably across states, from a high of 84% for Rajasthan to Haryana and Bihar which could achieve only around 20% of the approved PIP for 2009-10 by September 2009. Bihar spent only Rs.35 crores per month in the period from April to September 2009, whereas it needed to spend at the rate of Rs.100 crores per month in the same period. Other than issues of governance and health human resources, spending capacity also seems to be directly correlated with the availability of specialist staff for financial management across various levels, the amount of capacity building invested and the use of appropriate software.

41. Data flow on the HMIS has regularized with districts having the software, the hardware and the human resource needed for this in place and most of them regularly uploading data. Data validity and reliability needs to improve, but there is considerable quality even in available data. The main frontier as noted by almost all teams is the lack of use of information, for planning and for other decision making. Going by current trends, this should change in the coming months.

# RECOMMENDATIONS

## 1. Rationalising upgradation of facilities

a. Increasing patient load and overcrowding in District and Sub-divisional Hospitals across States makes it difficult to provide quality services. Planned efforts must be made to rationalize patient load, especially of deliveries, by upgrading the primary level services at PHCs and Sub-centres. If, for example, more normal deliveries are being conducted at the primary level in these states, and an increasing proportion of those reaching the FRUs are cases with complications requiring more specialized care, then the rationalization is being effective.

b. This approach will require attention to the quality of care at all levels, secondary and primary, selection of the facilities to be upgraded prioritizing them based on mapping present and potential patient loads and improved referral transport.

c. Referral audits would be useful for correcting inappropriate referral and overuse of higher level facilities when lower levels are appropriate.

## 2. Density, Location and Distribution of Facilities

a. Infrastructural expansion should be considered by the States now that some level of facility strengthening is underway. This should be decided taking into consideration the existing coverage as against the population norms at present population estimates, and special needs of blocks or districts due to local geographical or other context. This is feasible where the human resource bottle-necks have been addressed in the past 2-3 years and initiatives for producing more of the needed cadre as well as ways of attracting and retaining them in the public services have been devised and institutionalized.

b. Prioritization for infrastructural upgradation should also take into consideration, the capacities of the facilities in the private not-for-profit sector as against the gaps in the public facilities, and enlist them for provision of services and trainings, as done with mission hospitals by some states.

c. Contracting out of service provisioning to the for-profit, commercial health care providers, may also become necessary to fill the service gaps in some areas, but as the experience of such partnerships (e.g. the *Chiranjeevi* scheme) shows, these need to be entered into only under carefully chosen conditions and with a number of cautions in place. Where the private sector is non-existent or weak, strengthening of the public sector facilities is the approach to be adopted. Where both the sectors are in parallel, the public sector must be strengthened to fulfill the objectives of public health and ensure equity in access to quality services. Where the public sector is weak (especially on HR) and the private sector is more active, contracting in of services may be the option, while concomitant efforts to strengthen HR in the public sector should also be pursued actively. Such partnerships should expand net access to services, not merely shift public clientele into private sector, leading to weakening the public sector without significantly adding to total coverage. Robust contract management systems are needed for monitoring and ensuring quality in private sector delivery and this could be even more problematic than monitoring it in the public sector.

## 3. Facility Upgradation: Infrastructure and HR

a. Facility wise master plan needs to be implemented in a phased manner for optimal use of the available land to ensure

services availabilities. The upgradation must be planned so as to ensure backward and forward linkages, such as approach roads to the facility or to new buildings, provision of staff accommodation, skill-building of personnel for use of new equipment that is purchased.

b. Facility wise manpower mapping for ensuring optimal distribution needs to be done both at the State and at District level with some delegation to the district authority for relocating critical manpower within the jurisdiction. Similar block level exercises may be done for the sub-centre level, to be incorporated in the district. Optimal distribution would need to balance considerations of equity of access and patient load.

c. Laboratory Technicians from different sources, e.g. Govt. system, RNTCP, SACS, malaria, etc. are in some places underutilized. Optimal distribution of these Lab. Technicians may increase the laboratory services network in the State.

d. Models may be developed for:

- Strengthening of the PHC (additional or new PHCs) with trained AYUSH doctors, Staff Nurses, Pharmacists, three year rural medical assistants etc providing most of the care needed. PHCs functional only with Nursing Practitioners may be explored,
- Multi-skilling of medical staff especially for on a wider set of specialist skills may be promoted, and of paramedical and nursing staff on a wider set of supportive and service provision skills may be mainstreamed and accelerated.
- Pooled block-level CHC with full complement of MBBS and specialist skills needed for comprehensive secondary level curative care and public health functions.
- Well-equipped SDH and District Hospital as a training cum teaching centre.

## 4. Improving Quality of Functioning

a. Quality improvement systems need to be put in place/strengthened:

- Strengthen quality assurance function at state and district level
- Introduce a team based internal quality improvement process at the facility level linked to the most cost effective and replicable external assessment and certification system
- Incentivise facilities for quality achievements and maintenance as externally assessed and certified and builds a policy framework that mandates this

b. As the utilization of the public health facilities by the care seekers is showing increasing trend over the years, availability of essential drugs in the facilities need to be ensured. The Essential Drug List supported by a logistics system that ensures that facilities receive all the essential drugs and supplies that are required there should be put in place.

c. Annual public health expenditure on drugs and supplies should be linked to total patient loads handled and expected to be handled by the system and adjusted for inflation. The center could incentivize this by picking up a percentage of this expenditure in those states where adequate systems for essential drug list and a TNMSC benchmarked logistics system is in place.

d. Standard Treatment Guidelines (STGs) created in consultation with the senior Medical officers and adopted by the state, must be used as basis for patient management by doctors at facilities. Regular prescription audits should be institutionalized to ensure this and to be sensitive to the need for upgrading the STGs.

e. Integrated laboratory services should be made available. Routine services, such as blood for basic cell counts and anemia testing and smear examination, urine for

sugar and albumin, stools testing, malaria and TB testing, should be made available in all facilities up to the PHC.

f. Privacy of services in OPDs, labour rooms and wards needs to be ensured. Security in the hospitals needs to be strengthened.

g. Hospitals should be certified to be baby friendly and women friendly. Hot cooked nutritious meals to women who are admitted for delivery or any other reason, clean sheets, clean toilets which are cleaned as often as is necessary and users sensitized to keep it clean, facilities for bathing, adequate lighting, 24 hour water and electricity supply – should not be seen as luxuries but minimum standards of any hospital ward where patients have to stay overnight. The hesitation to spend on these areas, even where there is a patient load should be taken as a serious failure of the administration. Inspections should not only check cleanliness during when they visit, but also whether systems to keep in clean and hospitable are in place. (Staff, supervision, consumables, organization of work processes etc.)

## 5. For Strengthening Outreach Activities

a. Identifying areas as inaccessible, most difficult and difficult should lead to evolving creative solutions for the specific problems of the area, the resources it has within the health services and the additional resources that can be generated for it.

b. Outreach activities should have adequate human resources and detailed work description of the functionaries in place. Where there are three health workers in the facility the entire charter of the sub-center functions can be achieved. But if there are only two or only one, what would be prioritized and what would be left out should be spelt out.

c. Bringing about greater coordination between the ANM, ASHA and AWW would be essential to achieve much of the tasks needed at the community and sub-center level.

## 6. For Human Resource Optimisation

**I.** The rationale for IPHS HR norms needs to be appreciated more widely – but actual expansion should be synergized with patient loads and facility needs and not undertaken mechanically.

**II.** Increasing capacity for production of doctors, specialists and nurses. District hospitals may be strengthened as teaching institutions in terms of training facilities, diagnostic and clinical upgradation.

**III.** Attraction, recruitment and retention of skilled professionals in rural and remote areas.

a. Build on incentives for difficult areas. Link financial to non financial incentives. Ensure that quantum of incentives are adequate to achieve objectives.

b. Build on regulatory approaches- rural service bonds after graduation/post graduation and pre-PG mandatory rural service.

c. Learn from the rural medical service corps of Chhattisgarh, Rajasthan etc to build up a package of incentives- financial and non financial.

d. Simplify recruitment process and go for filling up permanent vacancies as priority- learning from the Haryana example.

e. Allow locale specific selection of candidates for nursing and paramedical and three year medical courses so as to generate skilled service providers willing to work in that area (learning from the West Bengal second ANM approach).

f. Create skill sets through special education programmes of persons whose employment possibility is mainly or only in the public sector, that too in India-like the ANM course, the MPW programme, or the three year rural medical practitioner of Assam and Chhattisgarh.

g. Improve workforce management techniques that reduce professional and

social isolation of the doctors. (the early efforts in Sikkim are an example)

**IV.** Rationalising Responsibilities and Skills

- Outline job descriptions for all staff - demarcate responsibilities between regular and new contractual staff
- Link training processes with HR planning

**V.** Trainings

- Strengthen SIHFW to monitor and supervise quality of training, trainer's performance as well as post training follow up.
- Build up/revitalise district and regional training centers catering to cluster of districts and adequately staff and equip them to be handling the training load needed.
- Post-training follow up tracking of the SBA and IMNCI trained personnel (Nurses, ANMs, AYUSH doctors, etc) needs to be done to ensure practicing of the skill learnt.
- SBA trainings need to have a greater hands on skill building components, given the finding of low level of skills for even basic tasks such as measuring BP, of even the SBA trained ANMs. However, in the case of training institutions much insufficient patient load, this will not be possible. Some fast track training in the basic skills and knowledge for ANC and PNC appears necessary in such situations, which could be done locally at the PHC/CHC/DH by the MO and health supervisors, with specific individual attention to each one.
- Integrate training by making district plans spell out what skills would be imparted to each cadre, facility wise, rather than the number who would be trained on each skill.

**VI.** In-service and in-situ skill upgradation/ orientation

Professional development may be explored by initiatives such as the following:

- Sponsoring in-service doctors for distance courses in Family Medicine, District Health Management integrated with short term skill development programmes/ assignments.
- Regular discussion forum of all doctors on clinical and public health issues, at CHC or District Hospital. Could be combined with the monthly meeting at the Block or District
- Monthly teaching rounds by faculty from medical college and nursing schools at CHC / DH
- Use of skill halls/mobile trainers etc to enhance on the job training.

**VII.** Strengthening Health Systems Planning and Management

a. The meeting of State/District Rural Health Missions and State /District Health Societies may be streamlined so that these meetings are held at prescribed regular intervals.

b. Decentralized planning needs to be reinforced with more capacity development programmes, more use of local data from HMIS and IDSP and more community involvement. There needs to be plan based fund allocation and monitoring.

c. The district planning process requires more involvement of the Programme officers and CMHO) in identifying the needs for improving performance of services, and evolving context specific mechanisms to fulfilling them, which the DPMs are not equipped to do.

d. Build capacity of district and facility managers in use of data (HMIS, FM and surveys) for decision making

e. Supportive supervision is very weak and needs urgent attention at all levels. Regular and meaningful visits from district to block level and to facilities below, supported by checklists and output measures should be institutionalized.

f. Introduction of Hospital Management Systems for GHs.

g. Beneficiary tracking systems at the SC level

h. Logistics and procurement system benchmarked to the TNMSC for output and process parameters should be put in place in all states.

**VIII.** Financial Management

a. In states where Tally is being used already, it needs to be customised and all reporting centres linked for real time funds position information. Other states need to undertake Tally based accounting.

b. At a given point of time, almost 20-25% of funds lie as outstanding (advances), of which 33% is actually spent and awaiting UC/SOE. This implies that of the 25% of funds that shows as outstanding, 8% is actually consumed and not outstanding, but because of the procedural delays UC/SOE is cannot be produced and this deficit continues for all subsequent releases.

c. Decision to spend money the VHSC Untied Funds/facility funds should be seen as a right of village community/ facility and not be taken at state/district level, which is being done by some states.

d. NRHM accountants and managers need more orientation on GF&AR, and on the other hand, public accounts officials and auditors need to be oriented on NRHM spirit and guidelines/orders.

**IX.** Non- Governmental Partnerships:

a. ASHA and RKS, VHSC and community monitoring programmes should have strong mentoring support outside the government system. NGOs should be involved maximally in these areas- and everyone wanting to contribute and having the capacity to contribute should find the space. Some sincere NGOs may require capacity building support which should be provided.

b. Improved contract management systems necessary for PPPs with commercial entitites: Such contract management should include:

- Costing and reimbursements to private parties needs to be realistic
- Periodic review and renewal of contracts and professional adequacy of contracts. Contracts to be reviewed for technical adequacy by a capable state or national body.
- Performance parameters of partnerships needs to be monitored and financing may be related to performance with cost and quality factored in. PPPs should supplement, not substitute for public health care.

c. MMUs operating under PPP need to reduce coverage area to ensure more frequent visits and follow up.

**X.** Mainstreaming of AYUSH and Revitalisation of LHT

a. Clarity in role of the AYUSH practitioners needs to percolate to the MOs and NRHM staff at all levels.

b. The large number of AYUSH practitioners and paramedics who have been recruited for co-locating at the facilities must get adequate infrastructure and supplies of their own systems for the patient load and morbidity profile coming to them.

c. Good examples of 'Revitalising Local Health Traditions' (by some states and by NGOs) need to be adopted under NRHM.

**XI.** Disease Control Programmes:

a. Further efforts to integrate disease control programmes into health systems planning at state, district and sub-district levels. Effective integrated district health planning, which identifies and addresses local priorities and specificities of disease prevalence as well as links it to the situation in the health system would be the starting point of such integration.

b. Use of IDSP data and district data from disease control programmes in district health planning. To relate high prevalence of diseases and mortality to social determinants and build in ways to address them.

c. To be on alert and notify if there are higher than expected incidence of leprosy observed.

**XII.** Reproductive and Child Health Programme

a. To plan for facility development and human resource development including training and in service delivery for RCH in an integrated fashion- for maternal health, for child health, for other areas of reproductive and adolescent health care, for population stabilization etc. Integration within the RCH components itself has to be addressed and then of RCH plans with systems development plans.

b. To examine the strategies in use and the strategies needed to improve achievement in RCH training, like the development of district training centers or deployment of full time training staff – which are needed for achieving RCH outcomes. To ensure that these are reflected in the state and district plans.

c. To build programme linkages between RCH and community processes especially ASHA programme, VHSC, and community monitoring etc to improve RCH programmes. Even VHSC and VHNDs do not travel together in the planning and implementation stage.

**XIII.** Inter-sectoral Convergence

a. Intra-sectoral coordination needed at all levels to ensure that staff and resources are not duplicated.

b. SHS and DHS should evolve concrete forms of inter-sectoral coordination through sharing of data, planning common activities between the health, water, sanitation, education, labour and rural development departments especially for the identified difficult areas.

c. Sensitisation to nutrition issues at all levels of the health system. Special measures to sick and severely malnourished children and adults with food and medicines and hospitalization where needed. Village based feeding centres could be considered for strengthening the supplementary feeding by the AWC, especially for the vulnerable groups and in areas not having AWCs and for follow up of patients who were found to be having or were treated for malnutrition in the facilities. Health referral support to *anganwadis*.

d. Monitoring to focus on the upward movement in nutrition scale, and family-specific assessment for difficult cases. Malaria and malnutrition to be tackled in tandem on a war footing with full community mobilization and commitment and multi-sectoral coordination, if impacts to be felt.

**XIV.** Community Participation

Community participation needs to be strengthened, some recommended initiatives being the following:

a. Better dissemination of the DHAP and block plans so that community is more aware. Attempt to involve community participation in planning process at all levels.

b. Persist with village plans and build VHSC capacities to write them and implement them.

c. More extensive involvement of VHSCs in community monitoring and expand NGO support to the community monitoring programme.

d. Wide dissemination of improvements occurring at all levels of government institutions to the people is urgently required to facilitate utilisation

e. Benefits under JSY to be disbursed as

per stipulation without bureaucratic delays and insistence on documentation

f. The character of RKS as a vehicle of public participation and decentralized management leading to equity and quality of care, needs to be emphasized and its role as a vehicle of cost recovery needs to be got out of.

g. Build up an adequate training and support structure for the ASHA programme with NGO support.

h. Clear focus and long term planning for the ASHA and VHSC programmes with the creation of special institutions that could provide guidance and support- the ASHA or community processes resource centers at the state level.

i. IEC/BCC programmes to be improved- more material, better planning, monitoring of outcomes and training.

**XV.** Strengthening institutional structures for technical support in managing change

a. States need to build upon the planning and management capacities they have developed over the past four years. To optimize these requires an active responsiveness to the various reviews and evaluations being conducted under the NRHM.

b. The SHRCs that have been set up in some states should be facilitated to develop as institutions for identifying context specific issues, providing creative solutions for them, and supporting their implementation. In other states, the process of setting up the SHRCs needs to be fast tracked. The structure of the SHRC would itself be in response to the existing technical support in the state and the identified needs.

Section - II

# Mandate and Methodology of Common Review Mission

# Mandate and Methodology of 3rd Common Review Mission

The Common Review Mission (CRM) is an important component of the overall monitoring and evaluation framework envisaged in the Framework for Implementation of NRHM. The report of the Common Review Mission is one of the most important sources of information that the Mission Steering Group of the National Rural Health Mission has mandated.

The National Rural Health Mission is designed as a central scheme to support a comprehensive strengthening of state public health systems. Unlike the past, the central role is not limited to financing a few disease specific health programmes. The CRM seeks to undertake a rapid appraisal of the strategies and policies being adopted by states and promoted by the centre to strengthen the public health system, with an aim to identify mid course corrections which may be needed. It is an opportunity to undertake detailed analysis of how successful / implementable are the strategies of the mission. It is also an occasion for collating and documenting the evidence in support of (or against as the case might be) the policies and the efforts of the state in implementing them. It encourages sharing of experiences across states and cross learning of the key persons involved in planning and implementation of its activities.

The Common Review Mission is an annual event and comprises of a team of experts chosen from all important stakeholder groups and shades of opinion visiting a number of selected states. The first CRM, undertaken in November 2007, assessed the progress of NRHM in thirteen states. It was able to provide considerable clarity on the main areas of progress and the key constraints that the NRHM was facing. The second CRM which took place in November-December 2008 also visited thirteen states. Its report was subsequently published and widely disseminated and has proved to be a useful source of information and assessment of the National Rural Health Mission. The third CRM seeks to further the process set in place by the previous CRMs. The third CRM has the following mandate:

1. To review the changes in health system since the launch of NRHM through field visits and spot examination of relevant records.
2. To examine and document progress on key process parameters of NRHM including decentralization, flexible financing, infrastructure and Human resource augmentation, strengthening community processes, improved programme management and to co-relate this to achievement of outcomes in terms of service guarantees and health status.
3. To identify the key constraints limiting the pace of architectural correction and in the health system envisaged under NRHM.
4. Recommend policy and implementation level adaptations which may accelerate achievement of the goals of NRHM.

The third CRM seeks to undertake the above mandate with assistance of a diverse range of stakeholders and support of the states concerned.

## Members

The Common Review Mission appraisal is undertaken through field visits to states by teams of public health scholars and practitioners, members of the civil society, development partners, senior academics and government officials. The teams for the third CRM were composed of 4-6 members of the following:

1. Two Government Officials (Any two out of the following)
   a. Officials of the Ministry of Health and Family Welfare, Government of India.
   b. Representatives of State Governments (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. Representative of NHSRC
3. One representative of development partners
4. Two Representatives of Civil Society (Any two members from the following)
   a. Representative of Civil Society organizations
   b. Representatives of Advisory Group on Community Action
   c. Representatives of ASHA Mentoring Group

Each team identified a team leader and rapporteur. While the team leader provided overall guidance, the rapporteur was the point of contact for the team and coordinated the authoring of the report of the team.

## State Coverage and Timeline

The duration of the third CRM was 3rd November to 13th November 2009 with a wrap up and dissemination meeting on the 22nd December, 09

A total of 17 states and Union Territories UTs were reviewed (10 high focus states including two NE states, four Non High Focus states and three Union Territories). This is the first time that three Union Territories have been visited under CRM. Six of the states reviewed this year were also covered during 2nd CRM.

The states and UTs visited were:

**High Focus States:** Bihar, Chhattisgarh, Madhya Pradesh, Orissa, Rajasthan, Uttarakhand and Uttar Pradesh; NE states: Meghalaya and Sikkim; Other High Focus states: Jammu & Kashmir

**Non High Focus States:** Andhra Pradesh, Gujarat, Haryana and West Bengal. Union Territories: Andaman and Nicobar Islands, Dadra and Nagar Haveli, Daman and Diu.

The 3rd CRM process began with a daylong briefing at the Nirman Bhawan, the premises of the Ministry of the Health and Family Welfare. Following the inauguration by the Secretary, Health and Family Welfare, the Mission Director, NRHM gave an introduction to the CRM. The TORs and the formats of the CRM were shared by the Joint Secretary (AS). The composition of the team was announced. After the sharing of the TORs, the respective programme division in the MoHFW briefed the teams on the components of NRHM. The National Health Systems Resource Centre (NHSRC) provided an overview of the NRHM progress made in the 17 states and UTs to be reviewed during this CRM. The Principal Administrative Officer of NHSRC also briefed the CRM teams on the logistic arrangements made the state and district level. During this briefing, documents and state specific material were shared with the teams. The day ended with an open interaction of the teams with their respective team members and finalisation of their travel plans.

The CRM Teams reached their respective State Headquarters on the second day where a detailed briefing by the state on the progress in the various components of NRHM in the State. State specific documents and progress Reports were be made available to the visiting team.

On the third day, the CRM teams further subdivided into smaller sub groups for undertaking district specific visits. A district was selected by each sub group through discussion with the State government for a detailed assessment of progress of NRHM. During the district visits, the sub groups covered sample facilities of every level, district hospitals, sub district hospitals, CHCs/Block PHCs, PHCs and some sub-centres as envisaged by the terms of reference of the 3rd CRM. In several States, the teams interacted with ASHAs and village communities.

Having completed the district level visits by the eight day of the Review Mission, the respective sub groups assembled at the State Headquarters. At the State headquarters, the consolidated team debriefed the key NRHM /State Directorate officials on the observations and key findings of the Mission. The teams also prepared brief CRM reports which were shared with the States.

The CRM teams completed their state visits by 10th November. Each team finalised their respective

State CRM reports. The reports were shared within the respective team members and also the respective state concerned electronically. The State wise reports were collated into a consolidated document by NHSRC. This consolidated report is to be shared with the various participants of the CRM, the State and the Civil Society members in a wrap-up workshop to be held in Mid December, 2009 at MoHFW, New Delhi where all CRM teams shall present their state reports and the states which were reviewed in the course of this CRM shall respond. The final recommendations of the CRM would also be discussed and finalised.

## Areas of Review for 3rd CRM

The 3rd CRM appraisal of the state and the districts focussed on two key areas:

- Change in key aspects of health delivery system including quality of services and outreach
- Progress against the approved PIP for 2009-10.

The 22 parameters of the NRHM on which the CRM teams were required to report are listed below.

1. Infrastructure up gradation
2. Human resources planning
3. Assessment of the case load being handled by the Public System
4. Preparedness of facilities for patient care services
5. Outreach activities of Sub-centre
6. Thrust on difficult areas and vulnerable social groups
7. Quality of services provided
8. Availability and utilization of diagnostic services
9. Logistics & Supply chain management
10. Decentralized Planning
11. Decentralised Local health action
12. Community Processes under NRHM
13. Progress on ASHA
14. National Disease Control Programmes
15. Performance of Reproductive and Child Health Programme
16. Preventive and promotive health aspects with special reference to inter-sectoral convergence and convergence with social determinants of health
17. Nutrition related interventions.
18. Non-Governmental partnerships for public health goals
19. Programme management structure at the state and district levels.
20. Systems of Financial management
21. Data Management and its effectiveness
22. Status of the progress of state against specific objectives, expected outcomes and at community level under NRHM.

## National Report of the 3rd Common Review Mission

The national report of the CRM consolidating all the 17 state reports is being presented in three sections.

Section I is the executive summary, presenting in brief the major findings and the recommendations of the CRM. Section II is about the mandate and methodology of the 3rd Common Review Mission.

Section III presents the main report, with structure and methodology of the CRM followed by findings identifying patterns of change across the states and reflecting on the lessons that these provide.

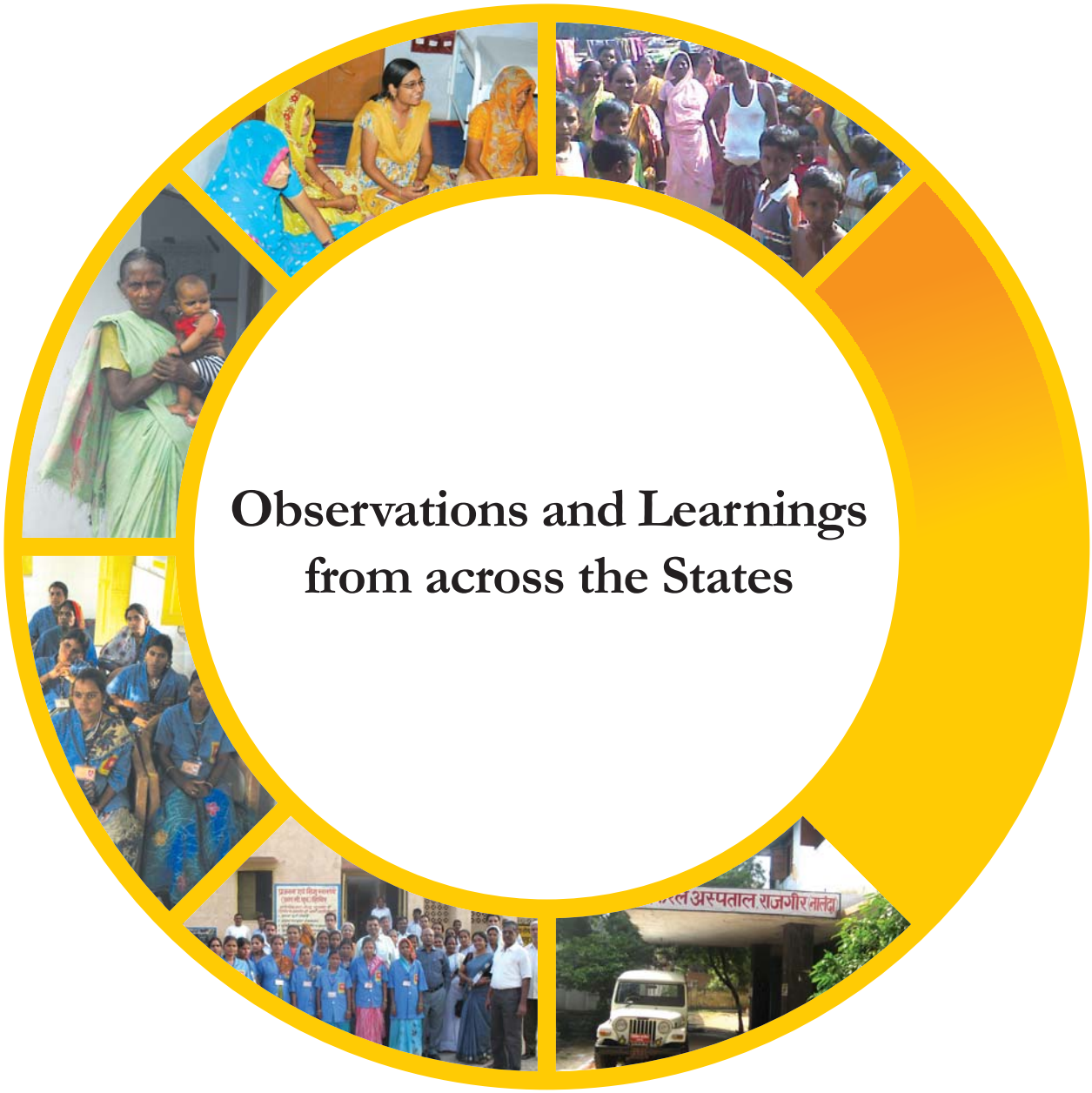
Section IV summarizes each of the 22 parameters across the states, and a quick one page summary of key features of change in each state.

Flowing from these are the draft recommendations that were placed for discussion at the national meet held on December 22nd, 2009 at Vigyan Bhawan in Delhi, with all the members of the CRM and State NRHM officials.

After finalisation, they have been presented here along with the executive summary.

The complete state reports with details of the findings are, as in the last year, being made available as an enclosed CD and on the websites of the MoHFW together with this consolidated report.

Section - III



# Observations and Learnings from across the States

# Observations and Learnings from across the States

## A. Towards Achieving Service Guarantees

### 1. Assessment of case load being handled by the Public System

The trends in revival of the public health system, noted by the first two CRMs continue. Across the states, there is a continuing increase in utilisation of public services, primarily for deliveries but also for other health care. This is well illustrated by this report from the Madhya Pradesh CRM team – "Since the start of NRHM in 2005 there is an increasing trend in the annual number of patients treated (out-patients from 2.1 lac to over 3.4 lac and inpatient from 21 to 47 thousand), institutional deliveries (3.5 to 9.1 thousand normal deliveries and 674 to 1022 Caesarean sections) and other services like surgeries from 1798 to 2441 and threefold increase in diagnostics/pathology and two fold increase in blood transfusions in the Chhindwara district hospital". From Orissa, the team reported that, in Balasore district, "the OPD and IPD load have more than doubled over the years from 6749 monthly inpatient load in 2006 – 07 to 14411 during 2008–09. Full ANC is around 88.6% (2008 – 09) of the total number of cases registered against 79.6% in 2006 – 07. Facility utilization by the pregnant women is also increasing for deliveries over the last three years."

The first CRM report had shown the increase to be only in outpatients and institutional deliveries and wondered how much non JSY increases was there. The second CRM report had shown the increase to be across the board, but rather more at the secondary level with a mixed picture in the primary level. However, this year the shift in load from secondary levels to the primary is evident in several states and facilities. While there is sustained increase in institutional deliveries against estimated deliveries in the state, in many districts there is a decrease in the number of deliveries at the district hospital, thus relieving them of the overcrowding and load that had built up in the last two years, for instance as described for Bhilwara district in Rajasthan and Guna in Madhya Pradesh. In some districts and facilities, there is an additional increase in OPD and indoor admissions beyond the delivery cases; however in others, if the delivery load is excluded there is would be a decline in indoor admissions, which is more marked this year. This could be due to a shift of patients to private providers, as in Bhilwara, and in Gujarat, where such a movement was facilitated by PPP mechanisms. There could also be the displacement of other inpatient care by the increasing load of maternity care. A more thorough examination is required as to the reasons for this phenomenon.

The increase in utilisation of services at PHCs has been widely observed, and the increase in deliveries at Sub-centres is seen in Andhra Pradesh and Haryana (having increased almost 5 times over 2006-7 to 2008-09) as well as in states such as Uttarakhand and Rajasthan where sub-centres with adequate infrastructure have been accredited for institutional delivery.

Among the increased number of deliveries at district hospitals and CHCs, there is variability in the proportion of complicated cases as against normal deliveries. In some there is no change, as in district hospital Panchkula, but where there is an increase in proportion of caesarean sections of total deliveries, for instance in CHC Kalka, this is likely to demonstrate the success of increase in institutional deliveries in dealing with complications and preventing maternal mortality. This, coupled with the shift of normal deliveries to the peripheral primary level institutions, is a welcome movement indicating rationalization of the site of institutional deliveries. Otherwise, increase in normal deliveries at the district hospital is an unnecessary burden on the system, institution and users.

Some states have consciously planned such a strategy. For example Guna district is strengthening health sub-centes and PHCs to conduct normal deliveries and to manage newborns, with efficient

referral transport systems, to transport deserving cases to higher levels. This is well designed and implemented, with good supervision, documentation and analysis. The approach is being adopted by other blocks and districts.

In contrast to the patterns observed above, the CRM team reports from Gujarat that, in facilities such as the CHC Lanava and General Hospital at Palanpur, though there had been a marked increase in OPD and indoor admissions since 2007, but only very few deliveries were being conducted (in all only 21 in 2008-09 at the CHC and 16-18 per month at the hospital), despite the availability of qualified staff and the requisite equipment, space and furniture.

According to the CRM team, "The reason for the low turnout of women for delivery in these facilities is due to the competing presence of *Chiranjeevi* providers (private facilities) either in the same town or in the vicinity. Although the quality of services provided by the *Chiranjeevi* providers is not necessarily better (as described later), they are supported by a demand generation mechanism involving government workers at the village level (ASHAs and ANMs) and by a mindset that deems private sector provision better than government provision..... In places where there are no *Chiranjeevi* providers, government facilities show increases in the numbers of institutional deliveries. For example, the total number of deliveries conducted in the CHCs of Patan district doubled from 461 (during 2007-08) to 991 (during 2008-09); while in Banaskatha district they increased from 1242 in (2007-08) to 2192 (in 2008-09)."

In Chhattisgarh, however, there is a scenario of low utilisation of many peripheral facilities with a low rate of institutional deliveries (under 40%). However, those who do deliver at an institution were found by the team to mostly stay for 48 hours in the facilities, even though most facilities do not provide free food for in-patients. There are many exceptions to this pattern. Besides the teaching hospital in Bastar and district hospital in Raigarh, there was an exceptional overload of patients at the CHC in Lailunga (although this was not functioning as an FRU because there was no anaesthetist and no functioning blood storage unit). "Here, the doctor was committed and had organized his team to ensure that common emergencies were being handled and bed occupancy was over 200%, with beds spilling into the corridors. The team observed that where doctors had such commitment, services were being provided as supplies were also available. Although equipment was in short supply or not in working order in some cases (as noted elsewhere), the doctors were making do with their basic skills and supplies……" And if services are being provided, patients are flocking in.

In Jammu & Kashmir, the presence of doctors (even higher than the norm in many facilities) including specialists and reasonably good infrastructure had led to an increase in both OPD attendance and indoor admissions. "OPD services functional included eye and ENT which were available in district hospitals, CHCs / SDHs while Dental chairs were available and services were being provided at the level of PHCs." However, the team also observed that, "At most facilities, OPD load is not commensurate to the number of doctors or specialists positioned. The OPD does not have appropriate tools of trade (BP instruments are often shared across the labour room, wards, and the OPD). The general ambience of the OPD is dark, cold and stark, not really reflecting the rich cultural tradition of the region."

**Utilisation of Co-located AYUSH Services:** The use of co-located of AYUSH services in the PHCs and CHCs was also observed in several states and UTs. The patient load has been reported for Vizianagram district, Andhra Pradesh — an OPD of 40 patients per day at the CHC (out of 250) and 30-40 at the PHC (out of 120 per day)—showing a good utilisation. In J&K, the team concluded that, "The presence of a service provider (allopathic or AYUSH), some paramedics etc appears to have sustained the interest of the citizens." The AYUSH doctors are conducting deliveries at PHCs in Orissa, for which they have been given SBA training as well. Setting up of Gram Panchayat level AYUSH dispensary by engaging part time MOs is an innovation in West Bengal. The Rajasthan CRM team reports that "A large number of AYUSH practitioners and paramedics have been recruited for co-locating at the facilities. The construction of space for the AYUSH services was found to be lagging, even in Bhilwara where other construction activities at PHC and CHC had been completed. In no state is there an adequate effort to optimize the contributions possible from 'Revitalising Local Health Traditions.' Most CRM reports have not addressed this theme.

All these variations in the utilisation of public services reflect outcomes of policies adopted by States

and their programme designs as well as levels of strengthening of facilities, rather than to user choice alone. Strengthening of public services or equity in access to quality service needs to be focussed on as consciously pursued goals which are facilitated by the programme design and institutional culture.

## 2. Infrastructure Upgradation

The third CRM teams have observed remarkable upgradation of many existing facilities, with a large number of new buildings and renovations, addition of human resource, equipment and enhanced efforts at maintaining cleanliness and hygiene.

In Bihar, where setting up new facilities and new construction has been undertaken, "APHCs are created and being made functional with initiating the OPD and making the medicines available. Every PHC visited had regular and contractual doctors, who are largely present at least during duty hours with at least one or two being available in the nights – along with one or two ANMs or nurses."

However, the proportion of facilities upgraded varies across states. In Haryana, all district and sub-district hospitals are functioning as FRUs, and 43% CHCs, 37% PHCs and 1% SHCs provide services 24x7. In Jammu & Kashmir, large part of the health infrastructure is stated to be located in rented buildings or have insufficient accommodation. The state has reported 64 PHCs without electricity, 85 without a phone and 82 without an all weather motorable approach road. "The Raghunathpur sub-district hospital in West Bengal, with 100 sanctioned beds, has the occupancy of 150-300 everyday. Wherever possible the extra beds have been put up. The proposal is for upgrading it to 150 beds which will still be insufficient." In Bihar, it was observed that "The upgradation of Block PHCs to 24x7 facilities has continued and offers increasing number of Mothers and Children access to services. Case Load of general OPD also continues to increase. General medicines and antibiotics are adequately stocked in all the facilities."

Clearly, while upgrading facilities the need generated by patient load must be taken into account and the infrastructure upgraded accordingly. The teams observed that the order in which facilities are selected for upgradation or renovation is not always as per need. For example, "the CHC at Lanava, Patan district, was recently upgraded despite its relatively poor patient load. The building is impressive now but there were only a handful of patients during our visit. On the other hand, the CHC at Dhanera, Banaskantha district, is a well-utilised facility that has not yet been upgraded due to delays, even though the new construction was approved last year (as per communication from state officials). Consequently, there is only one ward which is occupied by both male and female in-patients and an overcrowded OPD."

Also, there sometimes remain critical gaps in infrastructure development, hindering full utilization due to inadequate planning and inappropriate prioritization in upgradation. As remarked, "If the toilet has been attached to the hospital, it is essential to make arrangements for running water to ensure its use." If the toilet is built outside the main building, the path leading to it must not be slushy and must be well lighted at night is to be used.

The team observed in J&K that "Several facilities are being upgraded or new sections being added to the main wing. In some facilities it was observed that construction work is incomplete and not ongoing. While in certain facilities, new buildings are not operational. There is shortage of residential quarters for staff in most cases or where available is inappropriately located or occupied by clerical staff as in SDH Sarwal." The problem of inadequate residential quarters is a common one across most states, but construction works have been undertaken in most states to provide this as one of the inputs to attract more doctors to the rural services.

In the UTs, infrastructure is generally good. As noted by the Dadar & Nagar Haveli team, "Quality of infrastructure works appears to be good at the places visited by the team. The civil hospital at Sylvassa is very well maintained and infrastructure expansion is being done based on the requirements for service provision."

## 3. Preparedness of facilities for patient care services

The facilities have been strengthened in all states in terms of drugs and supplies, furniture, equipment and diagnostic services. However, shortfalls continue and it is difficult to quantify the changes or shortfalls and make comparisons with previous years. We know from many comments that the task is far from over. Some of the lack of preparedness is due to

overcrowding. The West Bengal CRM team reports: "while overcrowding puts tremendous demand on the facilities, there is need for repair and renovation of buildings. Wards and beds are insufficient for the patient load, and all corridors are full with extra beds to accommodate it. While drugs are adequate in quantity, all basic lab investigations are being conducted and there was a functional emergency unit at the sub-district hospital, the contract for scavenging and security services is inadequate." Some of it seems to be part of a failed focus on some of the service guarantees. For example "The facilities also fell short of essential equipment in some places. For example, baby warmers and resuscitation kits, which are essential for newborn care, were not available in all PHCs of both districts in Gujarat and in the CHCs at Harij, Lanava, Dhanera and Danta, even where deliveries were being conducted."

*Rational Drug Use:* Though almost all states report improved availability of drugs and supplies, this CRM has many reports of irrational use and non-availability of essential medicines. "The full complement of essential drugs was not available at many places (for instance, at Chowgal PHC, injection Magnesium Suphate, Nifedipine tablets were not available, at Tangdar CHC, injection Magnesium Suphate, Lignocaine Hydrochloride inj., Nifedipine tablets were not available, at Drugmulla PHC inj. Oxytocin was not available. Magnesium Sulphate injection was not available in Handwara DH, Sopore SDH (Mother & Child Hospital). No supply of IFA tablets in most facilities visited. Few facilities had recently received supply of IFA tablets."

Another report "in higher facilities, doctors were found prescribing higher order prescription medicines instead of basic generic preparation leading to high out-of-pocket expenditures for the patients. In several facilities, "co-operative" pharmacy shops were seen within the hospital premises selling drugs. Chhattisgarh report also highlights excessive" outside prescriptions, where doctors fail to provide drugs available in the hospital pharmacy and instead give prescriptions for much costlier drugs outside. Some of it is also due to non availability of essential drugs but most if it is driven by irrational prescription or lack of awareness of the essential drug concept. In Madhya Pradesh the team encountered a patient, holding a prescription issued by the BMO, with the following printed on the bottom of the prescription: "above prescribed medicines are available in the medical store situated just outside the hospital." The prescription pad was a sponsored gift by the medical store. Obviously these practices have got legitimised in popular perception and curbing them would be quite a challenged.

A number of states are introducing or have in place commercial pharmacy shops within the public hospital. Introduction of generic prescription in them is sometime projected as an achievement. While no doubt any move to generics is available, this also reflects how universal is the practice of outside prescriptions in the poor performing states and how low is the availability of free drugs in the hospital. Recently states like Haryana and Bihar have started introducing this.

**Diagnostics**: Diagnostic services have improved since the initiation of NRHM. The report from a state like J&K shows that the diagnostic facilities of X-ray, ultrasound, ECG, laboratories are available in all DHs, SDHs / CHCs and even at the level of 24x7 PHCs.

In some states, such as Andhra Pradesh, much more sophisticated diagnostic technologies are also becoming available (eg. CT Scans are provided in all district hospitals), but the proper provision of training to the doctors is not provided. Many labs are restricted to routine investigations like Hb, urine, etc. Newer diagnostic services like HBSAg, serum creatinine and Urea are added to the diagnostic profile but without providing proper training to the Lab technicians. Cross sharing of work by LTs in the lab services is partial and variable.

**Safety measures:** Medical waste management systems are in evidence in most states, which is different observation since the last CRM. However, the degree of use is difficult to gauge in these short visits and there are still many states reporting poor compliance-like Bihar, Chhattisgarh etc.

Safety measures are still at a premium, with violations such as "the X-ray room in Tangdar CHC has wooden walls and provides little protection against radiation leakage posing a hazard."

### 4. User Friendly Quality Services

There has been a greater emphasis on quality this year. In Uttar Pradesh the Allahabad hospital which had been ISO certified was quoted as an example of efforts to improve quality of care. The report called for special support to institutions that had achieved such standards

so as to maintain their excellence, and to use it to promote a general movement to better quality in all public hospitals. Quality improvement of public health facilities in Gujarat is a good initiative and Gandhinagar hospital has been certified by NABH already. In second phase of initiative, Palanpur and Patan district General Hospital are being included. However, quality based accreditation of PPP hospital under *Chiranjeevi* or even quality certification of these private nursing homes is an urgent need in the state to improve quality of services provided.

These facility level quality efforts are however as yet, more of an exception that the rule.

Though cleanliness had improved and was satisfactory in more states visited including states like Uttar Pradesh and Rajasthan, it was still far from adequate in many states visited- Bihar, West Bengal and Chhattisgarh attracting some of the most critical comments. Needless to say the lack of clean toilets affects women much more. Several observations have been made about the lack of cleanliness and hygiene – "The basic utilities (toilet and running water) in the observed facilities were very poor and are not conducive for the women to stay for long after delivery. Even the condition of wards especially in Khagaria, was not hygienic" it was similarly a mixed situation in Chhatisgarh. With regard to gender aspects, it was noted above that women's toilets leave much to be desired. While screens were available to provide privacy in examination rooms, and labour rooms were generally secluded, window screens were less in evidence and the crowding of waiting areas and women's wards in some facilities (including large numbers of patients' attendants) denied women privacy in other circumstances."

Women friendly services are being seen in health facilities in CHCs (except Dhanera) and district hospitals. Privacy of wards, labour room, clinics were adequate in the CHCs and district hospitals. Gender perspective care were missing in Dhanera CHC where male and female patients were kept in one ward and labour room was located in front of the toilet for wards.

Quality in care for women comes for sterilization also needs urgent attention. One team observed that "Women coming to deliver in the facilities or coming for sterilization operations deserve respect which did not seem very evident."

Other aspects of user friendliness are also slowly picking up. In J & K, Citizens charter, signage with services available and user charges were seen outside most facilities visited by team. However, grievance redressal was not seen in almost all facilities visited. Also, there was absence of sufficient seating arrangements, sufficient lighting, direction sign boards etc. in the facilities.

### 5. Emergency and Referral Transport

This is in place and improving in many states. Amongst the states visited, Gujarat, Andhra Pradesh, Uttarakhand, Megahalya and to some extent Madhya Pradesh make use of the EMRI services. But even in Bihar, West Bengal, Madhya Pradesh there are other systems of referral transport in place. The EMRI systems are effective in urban and peri-urban areas and also reach to rural areas- though with less efficiency in Uttarakhand and Meghalaya. The Bihar system is effective but iniquitous, for the poor pay for these services. There is a need to bring together these learning experiences to craft together a scheme more appropriate and sustainable for the poor performing states.

### 6. Thrust on difficult areas and vulnerable social groups

All States have identified the difficult and inaccessible districts and blocks, as also the facilities lying in these areas. However, the basis of the categorization is not very clear, as neither distances, nor health indicators, health facility/health human resources density or service output indicators always match. What is being done in each of the identified areas is also not spelt out in the CRM reports. For instance, in Balasore district of Orissa, categorisation of the health facilities as located in difficult, most difficult or in inaccessible areas needs to be revisited. At present, all the health facilities in Nilgiri block and in Ishwarpur block under Balasore district are categorized to be in difficult areas, which may not be justified, where as Paschimbad area, which does not have all weather road connectivity, remains cut off for at least four months in a year during the rainy season, is not included. However, blocks have been categorized by the State as Left Wing Extremists affected blocks, KBK blocks, tribal blocks in non-KBK districts, etc. and special measures are being worked out for providing services to them. According to the CRM team, "more

thrust is needed in identifying pockets of PTGs (Primitive Tribal Groups) and LWE districts. **Project Arogya** for LWE steps in at positive direction. The state has begun to develop an **equity strategy** which would work with community leaders and traditional workers."

For the vulnerable groups identified, some states seem to have built a strong approach while others are providing only token benefits. In Bihar, a Population of about 1.5 lakhs has been identified as *'mahadalit'* under vulnerable groups but no specific activity is started yet.

In West Bengal, under Tribal RCH, innovative programmes have been taken up in Jalpaiguri and Bankura through NGO and Purulia and Paschim Midnapore by the DoH&FW. Some special programmes such as additional nutrition programme, community impregnation of bed nets with deltamethrin, improvement of signage system for information of patient and patient parties about facilities available in the hospitals, opening of Rogi Sahayata Kendra at DHs/ SDHs, development of dynamic website for DH&FW, Standard Treatment Guidelines for primary health care and *Jibon Jyoti Sahayata Prakalpa* for rendering medical care to Lodha and Sabar population are being implemented.

Rajasthan's Mukhya Mantri Jeevan Raksha Kosh (MMJRK) was established to provide free treatment and medicines to BPL patients, and online data (by patients, treatment, facility, prescription, and cost) is available through NIC. The state is also providing 5kg Ghee is to all BPL women after their first delivery.

Gujarat has instituted incentives for SC, ST and BPL populations for services such as delivery care (through JSY, *Chiranjeevi Yojana*), and enables access to both public and private providers through health insurance via the RSBY. It is also working with NGOs to improve the uptake of services in its remote areas. Records of BPL utilizing *Chiranjeevi* and RSBY were seen in the districts that were visited. Increase of *Chiranjeevi* Scheme deliveries in the state indicates utilization of institutional care by BPL families. However, as the DLHS-III shows, this translates into just over a 4% increase in total percentage of institutional deliveries over DLHS-II (52.2% by DLHS II, 2002-04; 56.5% by DLHS III 2007-08). If this is true than much of the *Chiranjeevi* increases are more in the nature of a shift of provider, rather than an absolute increase in numbers accessing care.

## 7. Outreach activities of Sub-centre

Outreach activities of the sub-centre refer to the services provided by the ANM, (with no MPW-male) and that too conducted through the VHND. The male worker and the services provided by him are not noticeable, and the ANM has in practice no house visit function- this having shifted to the ASHA.

The CRM team to Orissa notes: "the records on activities conducted at the farther villages from the centre are less compared to proximal ones. IEC activities like Village Kantha (Wall Writing with Health Messages) were evident, though recent in many places. VHNDs are planned in coordination with ICDS. But the coordination is limited to holding the event and not yet gelled into a system that takes care of the needy mother and children in festive mood for a gala event, nor does it reach out to the community other than those catered to by the *Anganwadi*. Thus, its impact on the community at large (men, adolescents, mothers not covered by the *anganwadi*) is limited, if any." This is a description that could reflect a wider phenomenon across most states.

The report form Gujarat expressed the extent of health services that is currently expected from the ANMs. "Functioning of sub-centres in both the districts visited was found satisfactory. All SCs had ANMs (FHWs) in position, and several of them stayed in the quarters provided. However, concept of second ANMs was not seen in the state and only few SCs had MPW (Male) functioning in SCs. The physical spaces and equipment in the SCs were adequate for providing ANC, Immunization, and conducting deliveries. Power and water supply to each SC were ensured. However, the ANMs, especially those who were young, preferred to refer women to *Chiranjeevi* providers even when they had the facilities and training to conduct (normal) deliveries themselves.

The ANMs reportedly conducted VHNDs regularly through the active involvement of ASHAs (and at times, the VHSCs) and the output of sessions was good. The ASHAs tracked pregnant women and helped the ANM develop micro birth plans that were then shared with the 108 service to reduce potential delays in transport to institutions during labour.

Records were maintained and these could be seen during each visit to a SC. The ANMs also provided

services linked to NVBDCP. Blood slides were being collected and treatment provided."

Another graphic observation comes from West Bengal, the Department of Community Medicine of B S Medical College, contracted by the DM to monitor the skill levels and performance of village health workers (AMNs, AWWs and ASHAs) in regards to IMNCI between August 2008 and January 2009 in nine (of 20 blocks and 18 of 290) sub-centers. Results revealed that "With the exception of assessment of immunization status, the findings suggest that ANMs are ineffective in conducting their other duties. In some cases, their skill levels are insufficient and in others like conducting home visits, they simply are not on the job. Record keeping is seriously deficient."

— "Most case they are not consulting or following chart booklets. As a result systematic approach is lacking."

— "Counseling seems to be the most neglected part. Discussion with mothers does not seem to be friendly in many cases."

— "Record registers are either not available or maintained properly."

Even more disconcerting, the monitoring team found that no systematic supervisory system existed and therefore village health workers received no feedback on their reports for completeness, timeliness or completeness.

At the heart of the sub-center question is that other than for the immunisation function- how much time the ANMs have with her and what could this be best deployed on. If an ANM has to attend to seven or eight habitations, and spend an extra day on getting or returning vaccines in effect almost 16 days or all her time is used up. In such a circumstance making the most of the immunisation day by converting it into a platform for delivery of all her services is the only way available. But if she has to spend only four days a month on immunisation than, and only then, would she have time for midwifery functions, and home visits, and outpatient care and support to ASHAs– and that too if each of her habitation can be reached within an hour. The distribution of work between the first ANM, and the second ANM and the male worker is the latter two also needs to be thought through based on this principle. Given the soft nature of all the functions except that of immunisation and midwifery, a very good quality of supportive supervision is needed to make all the rest happen.

## 8. Density of Facilities and Access to care

While the increase in number of new facilities has not been a part of NRHM strategies, the density of facilities seems to be a concern to flag at this stage. In most States, the decision had been to address the challenge of making existing facilities functional before asking for more facilities. However as facilities go into overcrowding in some of the states, and some geographical areas remain under-served there is a need to pick up this issue again.

In West Bengal the CRM notes that "the number of facilities in West Bengal is based on 1991 census population. Hence there is a serious inadequacy of facilities in the State. For instance, around 12,000 Sub Centres would be required to match 2001 census population" (of which only about one-third exist). Even in PHCs there is a serious short fall. Thus one could have over crowded facilities and a department feeling that it is performing well growing side by side with people's dissatisfaction with access and quality of care, unless the density of facilities is factored in.

In Rajasthan there is a 4% shortfall in SHCs, 9% in PHCs, and 23% in CHCs (as against the population-norm based need using 2001 census); in Haryana there is a 17%, 13% and 26% shortfall respectively; in Andhra Pradesh the shortfall, is of 19% PHCs and 65% CHCs. With the increases in population since 2001, the shortfall in density of infrastructure will actually be even higher.

The need for attending to distribution of facilities has also been pointed out as this is uneven and iniquitous. For instance, the mapping of health institutions in Orissa clearly showed a dense concentration of health facilities in the eastern coastal districts, with sparse dispersal in the scheduled areas (forested with high proportion of tribal population).

In states like Bihar and Uttar Pradesh too, the number of facilities existing is seriously sub-critical- and this begins to tell when basic services like immunisation fail to reach. However much more redesign and effort to make the existing additional PHCs functional would be needed before a case can be made out for expanding on the numbers.

## B. Human Resources for Health

### 1. Numerical Adequacy:

Every state visited has reported sharp increases in human resources deployed in the public health sector. On the whole, adding across the states, and counting the human power directly paid for by NRHM and not counting the 700,000 ASHAs and their support structures, the health systems have added on close to 100000 health workers and managers into the system. Decisively therefore the tremendous 15 year stagnation on this front, which more than any other single factor, led to a crisis of the public health system is broken. Much of the increases seen in performance – in outpatient, in patient and delivery services have been enabled by and directly related to this incredible increase.

However, especially in the poor performing states, such is the accumulated deficit and poor systems development of the past, which vacancy situations are still impermissibly high. Thus the Madhya Pradesh report from Chindwara states, that even after a contractual staff recruitment drive, and the introduction of a one year mandatory rural posting for graduate and postgraduates from government medical doctors, and the appointment of AYUSH doctors there is a 48.8% vacancy in the 172 doctors posts and 46.5% vacancy in the 243 nurse posts in the district. Shortfalls reported from districts of Uttar Pradesh and Bihar are even higher.

The most important enabling device for such an increase in the public health workforce has undoubtedly been HR norms stated in the IPHS. However as we enter the fourth year of implementation a number of problems seem to be showing up. We discuss four such key problems that the CRM teams draw our attention to.

### 2. Issues in Increasing Human Resources:

First and most important set of issues related to the creations of new posts is that all new posts are contractual. State governments have been filling up old vacancies, after a 15 year gap, but seldom creating new posts as such.

Second the strategy of 'across the board' increases in staff leads to considerable degree of inefficiency in deployment of resources. Flexible appointment of staff within a district and block so as to have the right number of persons in the right place is a priority.

Thirdly, there is little balance and long term HR planning evident in the increase. Though NRHM is about a commitment to comprehensive health care, increases in many states are still focussed too narrowly on obstetric care aspect of IPHS, or merely responsive to immediate pressures without a longer term direction and vision.

Fourth the issue of rationalisation of postings – the most obvious of measures still defies solutions.

To give an example of the contractual versus regular problem, Haryana for example has 2465 functional HSCs but only 1272 sanctioned posts of ANMs- the rest being contractual. Similarly it has filled up its requirements of medical officers- but again about half the posts are contractual. Regular post creation in the state budgets remains far behind. Except for the ease with which contractual appointments are made, all the other stated advantages of contractuality- that they would be more accountable, or perform better etc. need further evidencing. Last CRM, the concern being expressed was- what would happen after 2012. This year around the concern being expressed is of the way only contractual appointments constrains career paths and cadre development policy and makes for poor workforce morale. One CRM team team reports .. "in Alwar district of Rajasthan 34% of such staff is under NRHM. There is no career progression plans/ long-term HR plan regarding contractual staff. Contractual staff was dissatisfied, especially regarding salary and promotion/regularization prospects."

The J & K report, also illustrates this pattern. The number of regular posts have increased marginally, but the vacancy situation in them has declined considerably from 28% to 5%. But contractual posts created under NRHM have increased considerably. Even in the filling up of regular posts, contractual employment has been the major route.

| Cadre | Regular posts as of | | Regular persons Available as of | | Additional Contractual persons recruited under NRHM as of March 2009 |
|---|---|---|---|---|---|
| | *March'05* | *March'09* | *March'05* | *March'09* | |
| Specialists | 604 | 609 | 197 | 274 | 08 |
| Doctors | 2320 | 2340 | 1128 | 1661 | 533 (includes 357 AYUSH ) |
| Staff Nurses | 888 | 927 | 662 | 793 | 231 |
| Female MPWs | 1137 | 1180 | 917 | 1059 | 297 |
| Pharmacists | 2376 | 2427 | 2327 | 2363 | — |
| X-ray Technicians | 270 | 286 | 193 | 241 | 103 |
| Total | 7595 | 7769 | 5424 | 6381 | 1172 |

The whole issue of minimum critical human resource density needs to get recognised as fundamental to health systems. The NRHM additions to human resource cannot be seen as an ad-hoc arrangement and these increases must be sustained and increased further.

Another problem is that if posts are sanctioned, it has to be done across the board to all institutions of a type like all PHCs would have three nurses or all CHCs would have 9 nurses etc. Such across the board post creation does not take into account the varied performance and requirements of different facilities. In West Bengal the team found that in a set of three PHCs visited-all had the same number of staff-2 MOs and one additional MO and two staff nurses. Yet one PHC had an annual OPD load six times the first PHC and double the second PHC. It had 722 in patients and 203 deliveries in the year against none in the other two and for this increased load it had four staff nurses as compared to two in the other two. The rigidity with which posts are sanctioned and then almost cast in stone and the inability of the system to reallocate them according to need is a crippling limitation. It makes for poor quality of work where services are being provided and the poorly productive being incentivised. Thus some physicians are seeing over 75 patients per day spending a few minutes per patient, whereas others may be seeing only 10 patients and that too in the same few minutes per patient.

The pattern of creating posts and filling up vacancies also varies. Whereas posts are created for medicine, surgery in all 367 CHCs of Rajasthan, only half of many gynaecologist positions and one fourth as many paediatrician and anaesthetist positions are created. In Andhra Pradesh, there are only 111 posts created as against 167 CHCs and of these only 30 have been filled up except for gynaecologists where 267 have been recruited. In Bihar ANMs have been shifted to staff many block PHCs which are facing increasing load. APHCs have inadequate staff too- and the staff nurses appointed there are also pooled into block PHCs. In Haryana one notes some SCs with two ANMs and some with none.

In Jammu and Kashmir, the report notes that the advantage available to the state due to relatively better availability of doctors is negated by the acute shortage of staff nurses. In fact 67 PHCs are reported to be working without a staff nurse/nurse midwife while only 2 are reported to be without a doctor.

Finally, we still find irrationalities like "No anaesthetist available in district male and mahila hospital, Almora but an MO trained in anaesthesia is posted in Tarikhet PHC. Tamnar PHC has an orthopaedic surgeon who has not performed surgery for the past 18 months. Is there a way to address this? Why is such irrationality persistent? Issues related to governance certainly, but one needs to find a way out.

The problem is that issues like poor performance and irrationalities of posting both become reasons for denying the further infusion of human resources that these states so urgently need.

## The second ANM:

Many states which need it most have not been able to take advantage of the second ANM provision-for example Jharkhand, Chhattisgarh- due to lack of ANMs available for recruitment. But states like West Bengal and Orissa have had larger pools of available ANMs and been able to introduce the second ANM. Meghalaya has been able to introduce the second ANM in about half of its sub-centers. That is possible for every state to do so, is best shown by the innovative way in which West Bengal has addressed this challenge.

In Andhra Pradesh 10,370 second ANM posts were filled of which 2024 ANMs have been deputed to the 104 service-or the mobile vans being run by a partnership. There is no evidence of the health outcomes garnered by this strategy and the visiting CRM team points out that we do not know whether the resulting weakening of sub-center function, which has been documented by the visiting CRM team has been balanced by the better quality of services presumably provided by the 104 mobile medical unit.

In states which have deployed the second ANM there is a need to fine tune the distribution of work between the two ANMs. Ideally the two ANMs should have identical work, with the number of households shared between them. This work could be organised in such a manner that the sub-center is always open with one of the two ANMs for providing delivery services and outpatient care and counselling services. Many states have chosen to divide up different work components between them and hand them some of the work expected of the male worker. There is a need to study what is happening on the field and to tweak the system to get better health outputs.

## 3. Expanding the pool of recruitable skilled personnel:

Almost all states report efforts at expansion of nursing and medical education-much more so in ANM and nursing schools. In almost all states except Bihar, the ANMTCs are fully revived. Some states have also made efforts at improving the quality of education. Madhya Pradesh has made a partnership with Pondicherry University for improving nursing education in its 6 nursing colleges. Orissa CRM report also documents considerable efforts at expanding nursing education. This was not a focus of the CRM and hence there is little data available in this area from the CRM reports.

## 4. Attracting and Retaining skilled service providers in rural and remote areas:

One of the interesting findings of this CRM is the spate of innovations that have cropped up in every state to attract and retain professionals in rural areas.

West Bengal has focussed on innovative increase of ANM education. This state needed 10,000 more ANMs to close existing gaps and put a second ANM in place. In the last year 2761 new ANMs passed out from 41 ANM schools, about 23 of which are new and the rest were old schools which were revived. Most of the new schools were started up by PPPs. In addition to this, locality based selection of candidates West Bengal by local *panchayats* through a transparent protocol and appointment back to the very same *panchayat* has ensured that these ANMS would be resident in their areas of work. Last year 2761 ANMs completed training and joined duty. Another 969 would be added this year and the entire gap would close with the passing out of 3100 in 2010 and 1285 in 2011. To generate more faculty for the nursing schools, In the last two years MSc nursing seats increased from 25 to 40, and BSc nursing seats have increased from 50 to 255 with the opening of 4 new nursing colleges.

In Haryana, the success story has been with the recruitment of medical officers and specialists. Of 437 PHCs only 10, have a vacancy- and even these are transient. Haryana has solved its medical officer and specialist vacancy problem by having monthly advertisements and district level walk-in interviews. It has changed the role of the state public service commission from a recruiting agency for medical officers to one that only exercises oversight and regulates the departments own selection process. Last year alone 634 specialists and 666 MBBS doctors were recruited. The problem is that there should have been 880 medical officer posts, but there are only 228 regular posts and therefore about that many regular medical officers- the rest are contractual. This is the same situation in specialists also- existing posts have been filled up, but the required numbers of posts have not been sanctioned.

Unfortunately these examples, well known for some time, have not been picked up by the states with high deficiencies. In Rajasthan ANM admissions are still happening every 18 months for 18 months course.

The admissions can be done every year or every six months so that two or three batches are studying at a given time and trained ANMs are available every six month or every year. Currently one batch is ready after every one and a half year and there is little urgency and weak expansion. In Alwar ANMTC, only 3 out of 7 recommended faculties were in position in the centre visited. There is need to fill up vacant positions. In Chhattisgarh and Jharkhand new ANM schools have started functioning, but there is still some distance to go before they start producing the increased numbers needed. Bihar and UP have yet to revitalize its ANM schools.

Uttaranchal has introduced incentives for hard to reach areas, but the CRM team reports that they are not attractive enough. Division of areas into *Durgam, Ati Durgam* is according to the team "not based on the ground situation." It is likely that the state would have a different view. The caution is that incentives may be necessary but not sufficient for attraction or retention of professionals. Of the sanctioned 200 regular posts 67 including specialists are have been filled and 137 are lying vacant. Out of 137, 36 have been filled by contractual appointments (11 allopathic & 25 *ayurvedic* doctors who are paid @ Rs.24000/- per month. The State Public Service Commission takes about 2-3 year to fill vacancies and a Haryana style simplification of recruitment process has not been replicated here. Incentives have been introduced in many states, and mostly they have been welcomed, but it is not clear what impact they have had on vacancies. It is still far too early to know for sure.

Chhattisgarh and Rajasthan have initiated a rural medical service corps which is a bundling of financial and non financial incentives with an optional entry into the system. There is a popular response to this and this may make a substantial difference to the vacancy situation in these hard pressed states.

Sikkim has focussed on providing support to families of those posted in remote areas plus an effort for "improving the learned social network and good facilities as incentive to work in fairly remote areas.: It sees planned efforts to decrease professional isolation through CME programmes and social isolation through making the PHC the focus of many community activities as important. It also sees work performance review as a strategy of reward and recognition that would motivate people to work in remote areas. Positive workforce environment creation as a strategy of retention of professional skills is an under-used strategy in the Indian context and one needs to follow this up. The report also notes that the majority of health care provision in Sikkim is by the public health system- unlike the all India pattern and Sikkim now has remarkable health statistics- comparable to Tamil nadu and Kerala.

In Meghalaya, a combination of rural service bonds for sponsored candidates and contractual appointments have reduced its vacancy situation in PHCs to zero. Given the difficult nature of the terrain, this is a significant achievement. Specialists however continue to be a problem.

Another innovation of this period is the filling up of medical officer vacancies through the three year RMA programme in Chhattisgarh. This has also happened in Assam, which however was not part of the visits. Almost all PHCs, even in remote areas have found and posted one doctor there. Though there is some immediate turnover in about 15% of these appointments, the system is likely to stabilise and the vacancy in MOs likely to decrease from over 40% to less than 5%. One could learn from the strengths and errors of this programme, to craft a strategy of replication across the country.

The Madhya Pradesh CRM report concludes its assessment of the dismal vacancy situation with a resigned – "there is no immediate solution to the HR challenge." If these innovations start showing results, there may be no room for such despondency. The problem of rural vacancies is a remediable problem requiring administrative imagination and some long term evidence based planning.

### 5. Workforce Management Areas:

Another area for improvement across states is workforce management in relationship to performance. There is poor supervision and there are no payments for extra performance, and there are no norms for individual performance that is being set or monitored. Every team notes wide variability in the functioning of the staff across centers. There would be facilities where doctors are seeing 75 patients per day and doing considerable in patient and other therapeutic care plus taking care of public health responsibilities. In other places work would be limited to less than 5 to 10 outpatients per day. And the system would make no difference between the two. This

problem is well recognised. What is not so well recognised is that – like the problem of attracting and retaining doctors in rural areas- this too admits of solutions. The problems are not inherent in public systems, but it requires some degree of administrative imagination and a longer term commitment, to be able to begin addressing them.

### 6. Training institutions:

The big change since the last CRM is that many more training institutions have become functional. The weakness remains inadequacy in numbers of training institutions, lack of faculty and problems if infrastructure and therefore varied quality of training and poor ability to scale up the training to meet requirements.

A typical CRM observation from one of the states goes as follows: "Clinical training was been found very weak. All PHC doctors and all ANMs need to be upgraded on clinical skills. The team recommends that training should be adequately monitored for quality and monitoring may be outsourced. There is need to provide skill based training rather than class room training. GNMs were not trained on IUCD insertion and so were not providing any family planning messages or services. Their involvement is essential for stronger family planning program especially in facilities where ANMs are unavailable. It was observed that the 1977 curriculum is used for ANM training. Though the tutor mentioned about a new curricula being adopted, it was unavailable at the ANMTC."

Another CRM team observes – "ANM did not know how to use the BP instrument in Teetwal MAC and no deliveries were being conducted (as there was no delivery kit in place) however a register had been prepared where weight of newborns had been recorded as "10 kg, 8kg etc"; while at Gurah Talab SC no BP equipment / slides or reagents were found; a register had been prepared indicating slides made."

In most states the achievements in training are well below 50% of the targets them set themselves, and the targets themselves are too low. For example the Madhya Pradesh district report states: "the pace of SBA training is slow. Training was given to only 55 out of 384 staff nurses and 198 ANMs and LHVs out of 576 targetted." The Meghalaya report states "the State has trained only 28 SBAs till date against a target of 124 for 2009-10. The training is done in district hospitals in view of the requirement of adequate case load at training sites." The single major factor seems to be the inadequacy of training institutions. There are too few institutions in relationship to the needs and those that are there are inadequately staffed and with poor leadership. More often than not, the institutions are by passed and training implemented through various ad hoc arrangements, which after the first round get increasingly difficult to sustain.

The CRM teams also note improvements- but at far too slow a pace and incompletely. Take for example this quote from the Meghalaya report: "State has 2 ANMTCs, one at Shillong and one at Tura, the district headquarter of West Garo district. Both of these were visited. Together these have an intake of 20 & 30 ANMs per batch. Both of these are located in good buildings and are adequately staffed and equipped. The training is 18 months. They have not yet initiated the new curriculum which includes training of students at SBAs also. It is an important issue needing immediate attention as additional manikins have been supplied to them from GOI. ANM training is skill based training. The students at Tura have to be transported to civil hospital for which POL should be provided by the state. Scarcity of hostel accommodation at both places. In Shillong, the students complained of non provision of stipend to them for over 2 years."

The recurring recommendation from all the states is that "efforts are to be made to improve quality of training in the training centres, training methodology and faculty. New curriculum has to be adopted immediately."

## C. Decentralisation and the Strengthening of Community Processes

### 1. Decentralized Planning

By the time of the second CRM, the process of district action plan had been well established, At the time of the third CRM, almost every district and state has decided to make its own plans, and feel much more confident of their capacity to do so.

The CRM-III reports show that though there are advances in this, there are also continuing weaknesses that the district planning teams have still to overcome. Some of the observations made were "There was inadequate analysis of district level

issues leading to a generic plan without any local specificities."(Bihar) or "District Action Plan of Almora did not accurately reflect the key health issues and problems of the district. Medical officers at the PHC including block PHC did not recall participating in the district planning process" (Uttarakhand).

The Orissa report provides a good example of decentralised planning "During discussion it was learnt that, while formulating PIP of 09-10 FY inclusive process of planning had been adapted. The DPMU/BPMU and other programme officers had participated in the process of planning. PIP preparation guideline dissemination to all stakeholders and extensive consultation were carried out for PIP preparation of 09-10. The Programme Implementation Plan for 2009-10 had been developed based on a series of consultative workshops held at different levels - block, district and state levels. It, therefore, incorporated recommendations and innovations made at the local level in all 30 districts. .....Using the bottom up approach to planning, village and block plans were consolidated to develop the district project implementation plans that further culminated into the State plan for NRHM. Evidenced based studies and group discussions are being undertaken while formulating some of the Block Health Action Plans (BHAP), but a systematic use of these tools are still awaited. BHAPs are not the consolidation of the Village Health Action Plans…..Facility wise health plans were observed in most facilities in Balasore, and were providing useful prioritization of available untied funds. However, periodic follow up to the plans was in need of strengthening."

The reasons for these differences are not hard to find. In states which are for the first time doing the planning without outsourcing the entire task, struggle to just get the data into place and get the minimum consultations going and ensure a minimum structure in the write up. With two or three cycles of planning, provided there is institutional memory of the process, there is a considerable improvement in the process. Also the degree of capacity building support received tends to be critical. The use of HMIS data for planning, the use of epidemiological information for planning, the ability to articulate community needs in the plan are all frontiers of decentralised planning the more experienced states are entering into. If fund flows to districts are more rigorously based on the final realigned and approved district plans that would also help to give more seriousness and ownership to this process.

## 2. Village Health and Sanitation Committees

Three years after it began, VHSCs are beginning to take off in many states. West Bengal is an exception, in that VHSCs have not been established state wide. Uttarakhand has also started up recently and has some distance to go. Quality of functionality is now the central challenge in most states. We know that they are functional, but they still need much strengthening before they can make an impact.

The most positive reports were from Rajasthan and Andhra Pradesh and Chhattisgarh.

In Rajasthan the VHSCs visited were functional and had regular meetings with well maintained minutes and record of decision taking. But even here identification of local priorities and an informed approach to health outcomes was weak.

In Bihar, the VHSC which had not started up during the last two CRMs is finally showing signs of starting up. Currently, the VHSC is Co-opted by *'Lok Swasthya, Pariwar Kalyan Avm Gramin Swachhta Samiti"* of PRI where the ANM is the Secretary of committee and Selected member of *Panchayat* is the President and this is at the revenue village level. As of now the funds are being released to revenue village level with *'Nigrani* Committees' being established at the village level. Guidelines relating to this have been sent in July.

Strategically, the cooption has the potential of involving PRIs in the improvement of health facilities but the revenue village is distant from the village and does not make the villagers feel part of the ownership process which this VHSC is supposed to do. There were members that were met in the villages when told about the community ownership through village level committees who showed a lot of enthusiasm for more information and action. Uttaranchal too has lagged behind in formation of VHSC. Government order has come out only 3 months back. It has been planned to constitute VHSCs in 2247 villages. *Gram Vikas Adhikari* and *Gram Pradhan* have been authorized to operate account of VHSC.

Village health planning has remained very weak, across the country, probably because of poor capacities and even basic clarity on what it could achieve. Expenditure of the untied funds has picked up in states

where it was established earlier. But in states like Bihar it is as low as 16%!! Perhaps it takes a full three years, to start up, stabilise and then to perform. Also like the ASHA it is closely related to the supervisory and support structure put in place. As the support structure increases for ASHA programme, the VHSC also benefits. Without evaluation, with resource material generation, without guidebooks, without establishing best practices, without capacity building- the VHSCs will continue at a potential far below what can be expected of them.

### 3. Village Health and Nutrition Days

Village Health and Nutrition days are another key community process of the NRHM. In practice it is synonymous with a fixed day of the month, when the ANM visits the *anganwadi* center of a village, and all those needing her routine services or some of the *anganwadi* servces come to the *anganwadi* center. Immunisation is the major activity that occurs and then antenatal care. Take home rations for women with 0 to 3 children are given and in some states child weighing are also done. Thus in most states it has the potential to become a platform for the integrated/convergent delivery of all ICDS and sub-center services on a pre-announced date. In very few places does it have the energy and social mobilisation that is associated with a public event.

One such place is Uttaranchal whose visiting CRM team has this to say about the VHND there- "Session micro-planning for Fixed Monthly Village Health Days is working effectively and has also been well publicized and made known to the community eg in Valta, Pilkha where this is scheduled on the first Saturday of the month. Villages have been classified into 3 types – *sugam, durgam, ati durgam* and intensive efforts are made to reach durgam and ati durgam areas. It was heartening to note that in Valta, while the AWC was accessible, being located in the school premises on the road side- at the request of the *panchayat*, the VHND was organized closer to the community, in the unserved habitation in the valley, where mothers and infants had been mobilized jointly by AWWs, ASHAs. VHND activities included ANC, breastfeeding counseling, immunization, post natal advice, child health check ups and referrals. In the community perception, management of ARI requires more attention. Disruption in Kit A supplies over last two years had adversely affected IFA and VA supplementation through VHNDs/ bi annual sessions. However the range of VHND activities can be expanded to include nutrition counselling, including growth monitoring of children. Availability of weighing scales, growth cards, and charts would need to be ensured. Available IEC material is being used- but this is not comprehensive. It would also be useful to strengthen the monitoring of VHNDs. There was good teamwork between ASHAs AWWs and ANMs, as reflected in their planning for VHNDs. (Second ANMs are located in 22 main sub-centres only). The use of ASHAs mobile phones to inform pregnant mothers regarding VHND timing- so as to reduce waiting time and unnecessary walking/climbing was another local response which the community appreciated in *durgam* areas. Support from *panchayats* was also evident – especially women *pancahayat* members who are contributing *panchayat* resources in some cases."

Nutrition is not a focus in most VHNDs reported. To some extent this is because the nutrition is a daily or weekly function whereas the VHND is a monthly once event. However it is a good opportunity for nutrition education and counselling- but except for a few states, most have not taken this advantage of it.

Paradoxically, VHSC involvement in VHND is weak in many states and hence seldom is it a village event.

In West Bengal, VHNDs are in the responsibility of the WCD ministry and the VHSC is the responsibility of the *panchayat* and rural development and ministry and despite this or because of it, linkages with health department are weak. A good plan of 19 points to be covered per VHND does not occur on the field in this state.

### 4. Rogi Kalyan Samitis

RKS is functional down to block PHC level in all states. It extends even to the PHC level in the states of Andhra Pradesh, Rajasthan (as RMRS) and Chhattisgarh. In Daman and Diu, it has been started even at the sub-center level.

The functioning of Rogi Kalyan Samiti in a number of states leaves much to be desired. In Bihar the RKS team states that the RKS meets irregularly and did not have specific activities outlined for themselves. There is a feeling that it is a redundant

body even before it is up and running. A case in point is a cheque for the society drawn on September 28th has not been deposited till the 5th November, the day of the CRM member's visit! Overall, it is not surprising that only 61.66 lakhs have been spent out of the total of 853 lakhs allotted for the RKS or less than 10%!

In many states where the RKS established before NRHM the mindset is of the RKS as a government vehicle for cost recovery and not primarily for public participation in management. This is seen starkly in Uttarakhand where the CRM team notes that a user charge of Rs.2 is charged for registration in OPD and there are user charges for all the services being provided. 50% of the user charges are deposited in treasury (which is clearly violation of the guidelines) and 50% are given to the facility for use." It adds "The participants of these committees are overwhelmingly government functionaries. Members of the RKS at Belparao included CMO, Dy.CMO, BDO, CDPO, Junior Engineer of the Jal Nigam, AYUSH doctor of the PHC, ICC/Computer, Private practitioner, and 1 BDC member one *Gram Pradhan*. This clearly shows that the RKS will not be able to reflect community interests." Even in Sikkim, the CRM reports that user fees are being deposited to the state instead of being utilised by the RKS at the facility level.

The team found that access to health facilities is still a significant problem in the remote areas of Raigarh and Bastar districts of Chhattisgarh. Further, in all facilities, the JDS (RKS) have levied user fees. "User charges are well advertised at facilities and user fee records in Raigarh showed that up to 90-95% of patients may be charged for diagnostic tests, medicines, supplies (e.g., saline and glucose drips), deliveries, etc. They were also charging for patients' food (although cooking facilities at the centres are inadequate) and, in some cases, have started levying high charges. Those charged most likely include BPL patients as 46% of the state's population is below the poverty line. Indeed, the team observed that most of the patients at the facilities were poor."

In Rajasthan, another established hospital development society; government funding was constrained in key areas - diet, office expenditure and POL, and leaving it to the RKS to finance these aspects.

## 5. Utilisation of untied fund

The untied grants are getting used through the RKS, some states showing a high utilisaton and great appreciation of the benefits the funds are able to provide, but others still lagging.

In Orissa, utilization of Untied Funds, Annual Maintenance Grant & RKS funds has led to visible improvement of the public health facilities. The role of RKS however has been limited by the perception of RKS as an alternative financing structure than an institution for patient welfare. However, it is also

seen that, "People are conscious and aware of their needs in better districts; RKS & VH&SCs members are also pro-active. Proper and prioritized planning for utilization of RKS and VH&SC Untied Fund is leading to higher utilization and increased absorption of the fund in the current year."

In Bihar, the team has remarked that, "utilization of untied grant need to be enhanced as a lot of balance is available at every facility visited. This needs to be monitored not only by submission of SOE but by timely utilization of funds for the activities and available balance. This system is not seen as at state and district level, the release was the major concern. In Gogri PHC, funds released in September have not been deposited in Bank which was brought out by the CRM members and labelled as serious lapse."

"These funds, at least at the level of the HSC level, seem to have been tied! In the blocks visited the authority has taken the decision to buy some furniture and fixtures for all the SHC with the ANMs untied fund for ease of accounting, procuring and based on what was perceived by the MOIC to be needed in the SHC. ANM was clear how she would

want to spend the untied funds money for improving the quality of her services."

## 6. Community Monitoring

Community Monitoring was not evident on the ground in any states visited. This is possibly because the current community monitoring programme under the AGCA is limited to a few states and within this reaches only a limited number of villages. It is also because without the steer of an NGO working on a rights perspective, community monitoring does not take off. No government has been able to successfully take it up, much less deliver it, even through the VHSCs. If the VHSCs get a more organised institutional support and capacity building inputs, there is still potential for this to take place.

## 7. ASHA

This is one of the key forms of community participation. It could also be seen as a major intervention to increase human resources in health care.

ASHA selection is complete in almost all states and UTs visited. It has crossed the fifth round of training in Uttarakhand, Orissa, Andhra Pradesh, Dadra and Nagar Haveli. In Chhattisgarh, it is now crossed ten rounds of training. The fifth round of training is ongoing in all the states of the north east.

It has reached the 4th round of training in Rajasthan, Madhya Pradesh, Uttar Pradesh, and West Bengal.

In J&K it has completed the second level and in Bihar, it remains stagnant at the first round of training.

The good news in the ASHA programme is that the programme is sustained; the ASHAs remain active and enthusiastic despite a huge number of problems faced and that they are available for further improvements in the programme. There is also an increased awareness of their link worker/facilitation function and almost all state visits report a "high level of empowerment in the way they interact and speak out with self-confidence. As per feedback from the community members and *Jan mangal* couples met by the CRM team, they (ASHAs) command respect and confidence from the community in both districts." In some states, the teams calculated the attrition rate in the district, and placed it at about 5% (35 out of 721).

The worrying dimension is that despite, it being pointed out in successive CRM reports both support functions and clear process and output monitoring of the programme remains very weak. So the programme remains well below its full potential. Orissa and Uttarakhand, other than Chhattisgarh are two states visited where ASHA is doing well and in Rajasthan also the programme has noticeably turned around an picking up very well. The common denominator is more investment in management and support structures. In Uttarakhand, NGOs have been used as district resource teams with very good effect. In these states, payments are more regular and complaints are far less, drug kits are refilled more promptly and training achievements are far higher. No other factor has such a strong co-relation as the adequacy of deploying an adequate full time paid mid level management and supervision and training structure.

There are examples where programme weaknesses have been corrected by planned action. One example is the report of the CRM team visiting Bhilwara. The team felt that the learnings from this district must be considered for scaling up across the state. When the Bhilwara intervention began, the district had the lowest achievement of institutional delivery cases accompanied by ASHA-Sahyoginis (9.66%). Between July to Nov 2009, it increased remarkably to 37% of institutional deliveries accompanied by ASHAs, despite an increase in the denominator (total no. of institutional deliveries).

What seems to have resulted in the improved performance of ASHAs in the Bhilwara pilot, as felt by the CRM team, are the following:

- Greater powers given to MOIC – payment of honorarium after performance review/ verification by MO; weeding out & termination powers; selection of new ASHAs; allocation of tasks to ASHAs. Only to inform ICDS.
- Regular and early payment through e-transfers.
- Rs. 1000/- as advance for transporting women in labour.
- The transport allowance of 300/- given to the woman if she comes without the ASHA was stopped, so that it did not remain a factor in discouraging them from coming with the ASHA.
- Increase in SC deliveries has also contributed to this.

Too often weaknesses in the ASHA programme are attributed to structural and design issues, which though may be true, fails to notice a lot of improvement that could occur with improved implementation strategies.

From Andhra Pradesh, the CRM learning is how training programmes could be strengthened provided the government is willing to make the investment in this dimension. Andhra Pradesh has 70,700 ASHAs – 54,000 in tribal areas, 10,000 in rural areas and 5300 in urban areas. They started with a 21 day intensive and residential training programme to conduct which 400 trainers – all with ANM qualifications were hired at Rs 10,000 per month and deployed for an 18 month period. One training team of such trained ANMs managed by a team of three full time programme managers, and given a good training venue was put in place in each district to train the ASHAs in so many sequential batches. After this they have received a one week refresher in the PHC level. About 51,201 ASHAs have been provided drug kits. There is a regular fortnightly meeting with ANMs and a PHC level meeting monthly. They get Rs 400 remuneration monthly and even in this there is a back log of payments. It is not linked to performance in some districts – especially as that many pregnant women cannot be expected every month.

In West Bengal, the ASHA gets a fixed honorarium for carrying out predefined activities. The role where they exist is limited to institutional deliveries, completion of immunisation and reporting epidemics. The programme has not been expanded state wide and in many places visited the ASHAs are not even appointed.

In Bihar, ASHAs have been very articulate; their grasp of the basic child care has been satisfactory. Ironically, training for most of them has not proceeded beyond the first module still. The continuous engagement with the facilities where they bring the women for delivery and the sector meetings seem to have given them a working knowledge of maternal and child health care. This has to be now reinforced immediately through the training on the rest of the 4 modules. Bihar has also not supplied drug kits, nor put a support structure in place. On one hand we can see the tremendous potential of the programme in Bihar and on the other we can see the very poor manner in which this has been managed.

From Orissa, the ASHA *gruha* –a rest house cum help desk for ASHAs and the patients they bring is an innovation that has been noticed as worth wider replication.

## 8. Non-Government Partnerships

Broadly these partnerships are of two types- one relates to arrangements with NGOs, and another with the commercial private sector and larger corporate groups. Of the former type, the main form of involvement is in the ASHA programme and in community monitoring programmes and to a lesser extent the VHSC programme.

Managing MMUs have been undertaken by NGOs in a few states, but these could be exceptions rather than the rule. But many of these are also with the corporate groups the 104 service of Andhra Pradesh or Jain Studios in Uttarakhand etc.

In private commercial sector partnerships we have mainly the *Chiranjeevi* programme that has been re-visited by CRM after a 2 year gap. We also have the 108 and 104 partnerships. *Arogyasri* and RSBY are other private sector partnerships that we see.

There are a few incidences of contracting out facilities- urban RCH centers in Rajasthan for example (Urban-RCH centre functioning optimally (covering 50,000 population @ Rs.13 lacs pa) – but they would largely be exceptions. Voucher schemes are reported from Uttarakhand. In Meghalaya, the proposal to contract out 29 difficult CHCs/PHSs to NGOs under the PPP mode is facing resistance from the local community after the first 20 have been handed over to seven NGOs .

In terms of turnover, Andhra Pradesh probably leads. The 108 and 104 services represent one major PPP initiative and *Arogyasri* is the third. Reports of these programmes are very good, but formal evaluation has not been completed. EMRI is operational in Andhra Pradesh, Gujarat, Uttarakhand and Meghalaya amongst the states visited. In all states the service is popular and serves a felt need – but questions of cost and effectiveness in outreach remain- especially for remote areas. In Meghalaya, 30 ambulances are functional now. Because of the distances & terrain more need to be added. Maintenance of the service however is quite high costing about 1.6 lakhs each ambulance per month and on an average an ambulance is transporting about two emergencies per day.

West Bengal has a different pattern. 5 NGOs have been engaged for implementing several focused programmes. They are – (i) Kasba Shed Foundation for IEC programme on immunization, breast feeding, nutrition of mother & child, institutional safe delivery, etc. and introduction & distribution of Paushi in Murshidabad (12 Blocks), Uttar Dinajpur (9 blocks) South 24 Parganas (7 Blocks); Thalesemia Society of Medinipur for project on thalesemia awareness in Paschim Medinipur; Jukti badi Sanskritik Sansthya of Canning for sensitization programme on snake, snake bite & it's remedies in South 24 Parganas (8 Blocks); Central for studies in social sciences/Eastern Regional Centre, ICSSR for gender hygiene programme for the village women of the State and Liver Foundation for intervention strategy for improvement in rural health care delivery system in 6 blocks of Birbhum district. The way the programmes are micro size and fragmented, it reads more like 'involvement of NGOs' has been treated as an end in itself without using it to strengthen health care delivery systems as such or even areas level services in underserviced areas. In contrast to these is the involvement of CINI, which is also the RRC for the MNGO programme, as the main trainer and support mechanism for the ASHA programme. This is provided a valuable support to strengthening the process- but here the programme's expansion also seems limited by the NGOs capacity.

In Gujarat the *Chiranjeevi* scheme has been examined and commented upon by the team. The team calls for a closer look at the scheme pointing out to some serious cautions and lacunae in the programme design. For one quality of care is a big issue and all the problems we report from other states in public facilities seem applicable here also. Even basic care for newborn is missing. Government oversight is reported to be restricted to ensuring providers receive payments and handling patient complaints. Demand generation by public functionaries seems to have been skewed to the private sector and often at the cost of the government hospital. BPL women in Dahod are reported to be making payments albeit at lower rates as compared to non beneficiaries- and this is attributed to lack of information of the details of the scheme.

In conclusion, we could state two generalizations:

- Non-governmental participation is still peripheral to the core strategies of NRHM- even to community processes. The ASHA programme and the VHSC programme and even the RKS programme would do much better if their energy is systematically harnessed. In Uttarakhand and West Bengal this has happened to some extent, but it needs to happen systematically in all states, and even in these states, the quality of engagement needs to be enhanced.

- In private sector participation performance parameters of partnerships needs to be monitored and financing may be related to performance. Sound contract management, basic cost and quality monitoring, are still far from achieved though as principles they have been recognized for a long time. Huge mega projects of private sector partnership should have a systematic and periodic external evaluation mechanism built in and a government financed contract management cell in the NRHM that ensures adherence to the contract parameters.

## D. Health Programmes and Convergent Action:

### 1. Disease Control Programmes

Anti-malarial activities have been commented on by the CRM teams visiting the states of Orissa, Megalaya, Chhattisgarh, Madhya Pradesh, and Rajasthan. Mostly they identify gaps in one or other component of the control operations. IRS sprays are generally reported to be of poor quality where it is happening and LLIN always appeared as something waiting to happen and standard protocols for treatment and use of RDK etc were often not followed. RDK kits are facing problems in introduction especially the problem of quick expirty and the lack of enough kits to meet the needs. But microscopy may be getting withdrawn or cut back too hastily, if the programme is not careful. In *kala-azar* control also spraying was identified as poor quality, and poor use of standard treatment protocols, and poor lab tech capacities were identified as major problems.

In RNTCP, record keeping was the main

deficiency identified in Orissa. Case detection has been weak in Madhya Pradesh. In Andhra the visiting team was upset because they were told that the internal evaluation report done for the district could not be shared with the CRM team, as it was to be shared only with the World Bank!! The reason for this lack of transparency and in built information asymmetry is to be ascertained.

In blindness control, both public sector and NGOs were providing cataract surgery and payment to NGOs was a problem. But generally most states report an effective programme, except for Chhattisgarh which shows a decline.

There is a disconcerting increase in cases of leprosy being reported from Orissa and in the proportion of MB cases and disabilities in new cases. In Andhra the cases are coming down but proportions of MB and child cases and deformities are still high and there are still 5326 new cases last year. In Madhya Pradesh, 7 blocks have a prevalance rate of over 2 per 10,000 and 51 blocks require close monitoring.

In most states, IDSP was functional but use of this data generated was sub-optimal or absent. P-form reporting was good, but was underreporting as compared to recording registers in Orissa.

## 2. RCH component of NRHM

The performance of the states in regard to RCH varies substantially, but there are intriguing similarities in trends across the states visited, regardless of their being high or low performing. These include: sustained increases in institutional deliveries, improved referral transport to institutions for delivery, and effective use of Village Health and Nutrition Days and improved outreach for enhanced immunization coverage. ANC and PNC coverage remains low and of poor quality. Family planning programmes focus primarily on female sterilization, newborn care continues to remain an area of low priority, and child health and nutrition, apart from immunization do not appear to get the attention needed.

In point of fact many of these findings are similar to those highlighted in past CRM reports, and necessitate a strategic reconsideration of some of the key approaches to improve RCH.

Notwithstanding the gamut of interventions proposed for improved reproductive health of women[1], the state reports of the CRM reflect that almost all states appear to have a predominant focus on increasing institutional deliveries through *Janani Suraksha Yojana* (JSY) as a critical measure of improving maternal health and reducing maternal mortality.

All states visited in the third Common Review Mission continue to report increases in institutional deliveries and in utilization of JSY funds. Chhattisgarh appears to be an exception with the reported proportion of deliveries occurring in institutions is about 22%. Chhattisgarh also charges user fees for 95% of its public health facility users and does not yet exclude pregnant women from these fees- which on an average would be above Rs 200 per delivery – a complete anachronism on which they remain rather stubbornly unaware. JSY payments on the other hand would have the usual delays.

A positive outcome of the thrust of NRHM over the past three years on infrastructure strengthening, facility improvement, and enabling adequate numbers of human resources is that the increase in institutional deliveries appears to have occurred predominantly in public sector facilities. This is the case in most states other than in Gujarat and to a much lesser extent in West Bengal. West Bengal reports an increase in the number of private institutions accredited for delivery, and although there is a rise in the number of cases, they are still substantially less than the number of cases in the public sector institutions. Madhya Pradesh's *Janani Sahayogi Yojana*, is based on the Chiranjeevi Scheme, but service uptake appears to be low.

The positive outcome of JSY in making public health facilities the choice of institutions for mothers is welcome, but the next big challenge is that of improved quality. Almost all states report that quality of care for deliveries and other services in health facilities is poor. This is not just the case in public sector facilities.

[1] Key interventions in the NRHM for improving Reproductive and Child Health (RCH) include : Improving maternal health, strengthening family planning for population stabilization, improving newborn and child health (thought a package of interventions for newborn care, immunization, ARI, CDD), pilot interventions for adolescent health through adolescent friendly health services. Other areas are appropriate management of Reproductive Tract Infections/Sexually Transmitted Infections (RTI/STI) and expansion of services for Medical Termination of Pregnancy.

The Gujarat report, commenting on a private sector hospital accredited under the Chiranjeevi Yojana has this to say, "Moreover the facilities visited in Patan District were unhygienic, cramped, ill equipped, and housed in makeshift premises in market areas, that compromise both quality and safety". Facility preparedness is an issue even in a state like Andhra Pradesh. There are no protocols for management of obstetric emergencies at any level, and no usage of partograph reported from states of the visited except Madhya Pradesh. Pregnancy kits are available in most facilities such as Rajasthan, Orissa and Andhra Pradesh, but the contribution of these kits to early pregnancy registration, or choice of family planning method is limited.

Backlogs in JSY payments to ASHA and mothers are evident in most states, but some states perform better than others.

The second area of concern is that despite the high overload, bed occupancy is low, indicating that mothers appear to leave the institutions within a few hours after delivery. This has serious implications for both newborn and maternal health, given the high reported neonatal mortality in the first three days of life and the contribution of early post partum haemorrhage to maternal mortality. Despite the regulation of 48 hour mandatory stay has been issued, in practice no state appears to be following this. Although it has been reported in the state presentation to the CRM team, in the Andhra Pradesh report, there are no substantiating figures.

There are differences across states regarding the place of delivery, which has a direct correlation to the level of facility upgradation, and recruiting and training human resources. Several states report across the board increases in district hospitals, community health centers and Primary health centers. In Rajasthan the number of deliveries in district hospitals has declined, with a larger number of cases being conducted in the CHCs and PHCs, signifying that more obstetric complications are referred to the district hospital.

In some states, there is a move towards enabling sub centers to serve as "institutions" for delivery to meet the needs of remote populations and to reduce overcrowding at PHC/CHC. Haryana and Rajasthan have reported increases in sub center deliveries. In Madhya Pradesh, there is a move to strengthen sub centers in remote areas to serve as facilities for institutional delivery. How effective sub-centers would be would depend on the quality of skilled birth assistance and referral support made available in the sub-center.

Despite the high institutional delivery rates, home deliveries continue to take place. While high home deliveries are reported in areas like Chhattisgarh, they are also the norm for mothers in remote geographic areas and among vulnerable and marginalized groups in other states. These are not being conducted by "skilled birth attendants" or even the ANM. None of the CRM reports mention TBAs as a provider that is linked to the system, even though it is likely that these home deliveries are being conducted by TBAs. While antenatal "contacts" with mothers is likely given the reach to the system, there are limitations in the quality and coverage of antenatal check up in all states visited in this CRM. This is more pronounced with post natal care. The potential of ASHA and community providers such as TBAs in improving ANC and PNC is yet to be tapped.

Many CRM teams have reported poor progress on the safe abortion objective. While providers in some states have been trained to provide services for Medical Termination of Pregnancy there is very little reporting from public sector facilities that MTP is actually being provided.

Referral transport is another area of focus, albeit to a far lesser extent than JSY. There are varying examples of transport provision for enabling women to reach institutions such as the 108 (in states such as Andhra Pradesh, Rajasthan), The *Janani* Express in Madhya Pradesh and Orissa and West Bengal's ambulance scheme. While the West Bengal scheme works through a voucher scheme, and the MP and Orissa models operate in partnership with the private sector, and the EMRI 108 is completely managed privately. Issues with the West Bengal and Madhya Pradesh models appear to be low caseloads and limited community awareness of the availability of such a service.

Family Planning: In almost all states, the reports voice concern regarding the lack of strategy and focus in the family planning programme. It appears that there is an almost singular focus on female sterilization as the method of choice, and even here, quality of care is poor. Of the CRM states, Bihar reports that there is an increased trend in institutional deliveries and female sterilization, denoting that the facility up gradation has enabled meeting women's need for limiting family size. Most states appear to offer this through a camp or fixed day

approach. Promotion of spacing methods remains low, and this is due to issues with both demand and supply. Some state reports indicate that providers do not appear to be trained adequately in the use of spacing methods and are not familiar even with common methods in use. Chhattisgarh reports major problems in the quality of sterilisation front which need urgent attention. The lack of use of JSY as an opportunity for leveraging better post partum family planning counselling and services have been mentioned in a number of CRM state reports.

VHNDs offer a significant opportunity for several promotive and preventive interventions for RCH. VHNDs have become institutionalized in the states. Yet, there is a wide variance in functioning of VHNDs at the state level, with states like Orissa using VHND to provide a range of RCH services. Immunization appears to be a key function that is addressed, and VHNDs and improved outreach have contributed to the reported increases in immunization coverage for mothers and infants.

New-born Health: Almost all states report infrastructural provisions for improving new born care such as establishment of Sick Newborn Care Units (SNCUs), New Born friendly hospitals, and Newborn corners, but almost all reports indicate that these are inadequately deployed and where available are underutilized. Adequate measures are needed to address home based care in addition to facility based newborn care, for IMR reduction to be accelerated. In Orissa and Rajasthan the CRM reports indicate the positive contribution made by *Yashodas* in providing counseling for newborns and to a lesser extent for post partum care to the mother.

Child Health: Apart from IMNCI which has been operationalized in a few states, there is little in the reports to indicate that the states are addressing child health issues other than immunization. Every report on IMNCI also reports the roll out to be far slower than planned for. Some states report attention being paid to management of ARI and Diarrheoal disease principally through administration of ORS. However supply side constraints remain. Nutrition is being addressed in some states through programmes such as the *Bal Shakti Yojana* in Madhya Pradesh, the Nutrition Rehabilitation center in selected districts of Bihar, and these show promise. However several of the state reports indicate that nutrition is an area not being addressed adequately.

Improved tracking systems for immunization and pregnant mothers to enable micro planning are also beginning to be seen in some states. Maternal and Infant death audits reported from West Bengal, Andhra Pradesh and a few other states. Mobile RCH services, such as 104 in Andhra Pradesh appear to be providing services to the unreached in remote areas. This could be a problem if it affects the functioning of viable sub centers, since there is either duplication or non performance. The Andhra Pradesh report: "While 104 is doing a good job for interior and tribal areas, but also making the health sub center non functional," The experience of MMUs from other states is often reported positively, but there is no evaluation in terms of health outcomes and impact on the rest of the sector.

Increased mobility of ANM in Rajasthan has the potential to improve services.

Some of the reports highlights the fact that other services for women such as screening and management of RTI /STI and adolescent reproductive health services are largely missing.

### 3. Preventive and promotive health aspects with special reference to inter-sectoral convergence and convergence with social determinants of health

- The main forms of convergent action on social determinants of health relates to the village health and nutrition day and the village health and sanitation committee. The RKS and even the district health society have not been reported to be strongly active on the convergence front. Nutrition is one area where there are efforts at convergence from a number of states, and this is detailed below. The *Sakshar Mahila Samoohs* - women's health groups- of Haryana have made a conscious effort at convergence and action on social determinants- and this too could be seen as a variant of the VHSC and VHND approaches.
- IEC/BCC remains weak. In Rajasthan the teams found IEC / BCC materials were not available in sufficient quantity in all centres visited by the CRM team. IEC coordinators were poorly informed. The IEC coordinator (contractual staff appointed under NRHM)

at the district level in Alwar was not aware of the national programmes and the concept of behaviour change communication. The consultant was not involved in planning, preparing, training, etc on IEC / BCC. Most CRM teams have not been able to address this theme.

### 4. Nutrition

The major opportunity and form of health sector involvement in nutrition seems to be the platform provided by the Village health and nutrition day, which is organised in the Anganwadi Centres (AWC). Unfortunately in most states there is a lack of focus on the nutrition theme within the health staff- who is fully absorbed with the services they have to provide. In Alwar, no undernourished (Grade III/IV classification) children were reported. The observation and impressions of the CRM team in this regard as follows: As a rule Identification of malnourished children is inadequate. In Bhilwara, not more than 2 children per AWC were reported in grades III & IV, while surveys show this figure is expected to be around at around 33-40% of the children. Referral of sick-malnourished to MTC/ NRC needs to increase.

In many states, no special effort in this direction was seen. The main exception in this scenario is from Andhra, where a 600 villages programme comprehensively and effectively tackles the nutrition issue – for all vulnerable sections. It is not clear to what extent this is replicable-but there are certainly lessons that one can learn from this for everyone. This is an effort to ensure that all pregnant and lactating woman and all children below 5, get two hot cooked and nutritious meals per day plus a nutritious breakfast- at about Rs 35 per day. This is provided free to the poorest, but as a rule, Rs 7 is subsidized by the government and the rest paid for by the beneficiary. The beneficiary need only pay a part of the amount immediately-the rest being provided as advance with the arrangement for paying back the loan over three years and with livelihood support, so that she is assured a job through which she can earn that much money. There are health linkages into the programme, but it is not clear whether as health approaches they are effective. What is worth noting is that this is the one programme that manages delivery of food most effectively and efficiently. For outcome analysis shows a dramatic improvement in adult and child malnutrition levels, and what is most interesting, in low birth weights also- perhaps the first time that this has been demonstrated in field situations. Replicable or not, there are lessons here, which are applicable to the whole health system.

### 5. Convergence in other areas

CRM reports and activities on the ground on convergence in other areas is minimal. In a State such as West Bengal, with the *Panchayati Raj* institutions being stronger than other states, and the PR department having a health cell under it, the team remarked that "inter-sectoral convergence at the planning & execution level is not up to the mark. … steps may be taken to strengthen the inter-sectoral convergence through capacity building of PRIs." Convergence on provision of safe potable water has barely been mentioned, while the total sanitation campaign finds a marginal space.

## E. Programme Management

### 1. The District Programme Management Unit

The positive report about the work of program managers, accountants and data analysts under NRHM, continues. They are assisting the department in better physical and financial monitoring. The need for such non clinical skills – assisting the regular department's medical leadership at the district level is well recognized. In West Bengal, the district PMU has been defined as having four programme officers plus three consultants plus two data entry operators. District level facilitators have now been introduced for a much wider variety of functions than was seen last year. In Rajasthan, for ASHA, AYUSH, IEC and in Bihar, the 3 plus 2 contractual staff is in place at the district level but the coordination with programme officers is weak. Programme managers at the block level have been put in place in Rajasthan. In West Bengal it is accounts managers and data managers.

At the district level we can safely say that the problems of coordination between programme officers of the department and the new contractual staff are diminishing and there is increasing synergy with their skills. They would not be the harbingers of basic changes in efficiency or professionalization of management as they have limited decision making powers. But they have, even as full time professional management assistance to the district health officers made a visible difference. The main challenge in this area is to address the lack of

a clear HR policy or HR management arrangement for this large number of contractual staff that have been brought in.

## 2. State level Coordination

A number of CRM teams have commented on the problems of lack of coordination that characterize relationships between directorate and state mission. These were reported in earlier CRMs also. Often where the mission director is the secretary or the commissioner the problems of coordination are less – but then the problem is that the mission director is frequently transferred, and there is no continuity of initiatives or even domain specific learning. Health systems improvements require long term thinking, but in a context of frequent changes, the trend is to prioritise only what can be shown within six month periods. Most CRM teams have not examined this issue in any detail and this was also not one of the main parameters for assessment.

## 3. Logistics and Supply Chain Management

The increase in utilization of public health facilities across all levels in the recent past (after NRHM), has lead to an increased demand of drugs and supplies and also for functional equipment. To address this increased demand, NRHM had made additional provision for procurement of drugs, supplies and equipment. Most of the supplies for drugs and consumables under NRHM are in the form of kits, which include the maternal health, child health and ARSH kits for FRU/ PHC/sub-centre (under RCH-II Flexipool), kits for AYUSH and ASHA (under Mission Flexipool), etc. Provision for procurement of equipment for various level of health facilities are on an item basis, and vary between states. It may also be noted that although there is separate provision for procurement of drugs and equipment, in the form of separate budget & activity heads under NRHM, the health societies at state and district level, RKS, the sub centre committees and also the VHSCs are fully empowered to procure items needed by them and they are actually doing it in almost all states.

Exploiting the flexibility provided by NRHM framework, many states have designed various innovations for improving logistics and supply chain management in the state, aimed at improving access to drugs by the general population. Rajasthan has started *Jan Aushadhalaya* stores, where generic drugs procured from public sector firms are made available at lower than market rates. Such stores are being made functional in each government hospital, running on a 24x7 basis, functioning under the RKS of the respective hospitals. Rajasthan is also providing free medicines to BPL patients under the *Mukhya Mantri* (BPL) *Jeevan Raksha Kosh* (MMJRK) scheme, whereby drugs dispensed to BPL patients over and above the state supplies (procured from the market) are reimbursed by the state to the hospital society. Through a software developed in-house by the state, Rajasthan is also tracking in real time the type, number and value of such drugs prescribed and dispensed to BPL patients, by each facility. On the other hand, to bring in greater autonomy, transparency and efficiency in procurements, states like Andhra Pradesh had functionalized APHIMIDC (AP Health & Infrastructure Management Development Corporation) for procurement and supply chain management in the state, based on a policy of RUD (Rational Use of Drugs). The CRM team in AP found adequate supplies in all the hospitals and peripheral health facilities visited. The CRM teams also observed that states are moving towards EDL (Essential Drug List) based procurement and supply, although various states are at various stages of achieving this. Also, the number of items listed in the EDL varies between states, ranging from 272 in Madhya Pradesh, to 582 in Haryana. The states are also creating/renovating regional and district level warehouses, although the storage and retrieval systems need a lot more improvement.

Even though the CRM teams observed an increase in availability of drugs and supplies across various levels of health facilities, there is still gap in terms of stock-outs/over-supply, lack of tracking of inventory, delay in supplies and procurement, and lack of a robust quality control system. Stock-outs were observed for more than 50% of items of stock in Rajasthan across all facilities and stock-outs lasted for more than six months, as observed in Rajasthan and Orissa. Almost all the states experienced both over-supply and under-supply for different items, especially for peripheral level health institutions. It seems that supplies are mostly top-down, based on availability and whatever had been procured, instead of demand-based (as per indents received from institutions time-to-time). Some states have started online monitoring of stocks to address the demand-supply mismatch. Gujarat has implemented its own tracking system, whereas states like Madhya Pradesh and Orissa had started implementing the ProMIS, which is an MIS for drugs procurement and inventory management. There is an acute need of training the

store-keepers and pharmacists in inventory management and the facility in-charges in making evidence-based demand estimations for drugs and supplies. Some CRM teams have observed the need for elimination of 'outside prescription' except when absolutely unavoidable, and the need to popularise and ensure use of essential drugs lists in procurement and prescription, as well capacity building for better stores management and district level logistics.

The CRM teams observed increasing availability of equipment across all levels of health facilities, from district hospital to PHC and sub-centre levels. It was also generally observed that facility level societies/ committees also procure a number of equipment, although most of these are low-end equipment, leaving high-end equipment to be procured at the state level. The sub centres were spending proportionately more on equipment purchase (almost 50% of the untied funds/annual maintenance grants) as against the PHCs and hospitals. Although this is a good sign as PHC-MOs and ANMs are no longer handicapped for service delivery because of lack of equipment like BP apparatus, weighing machine, haemoglobinometer, etc., the lack of maintenance facilities below the district headquarter is a serious constraint in ensuring maintainability of such equipment. There seems to be a need to put in place a system of bio-medical equipment repair workshops, especially for the low-end equipment, at the peripheral level.

## 4. Financial management

The NRHM had adopted the society mode of financing across all levels, and had created institutions like health societies, RKS and sub-centre/Village committees for receiving funds under NRHM and incurring expenditure out of that. Considering a typical district in India consisting of 10 blocks and approximately 1000 villages (@ 100 revenue villages per block), along with an average rural population of around 12 lakhs per district, it would mean 240 Sub Centres, 40 PHCs and 10 CHCs (based on population norms). Assuming additionally one district hospital and two sub divisional hospitals per district; it would mean a typical district would have to reconcile 304 different accounts (including bank statement and cash book for each account) to produce Utilisation Certificate and Statement of Expenditure quarterly/ annually. For a state with, say 20 districts, it would mean reconciling over 1200 accounts every quarter/ year to produce the UC/SOE. This definitely calls for a concerted effort in integrating the financial information system in the states and also adding technical capacity at each level of health society/RKS/committee for financial management through hiring specialised persons and training of existing staff.

Keeping in view, the above described challenge, NRHM had recommended adoption of e-banking for NRHM funds. But this is constrained by the availability of such (e-enabled) banks and their reach in the periphery. Also, because of the constraint in having a single bank with branches in all the interior villages/ *taluks*, most of the states end up in having a multitude of banks across districts and *taluks* where NRHM accounts are opened, complicating funds transfers and reconciliation. Regarding integration of financial information system, with assistance from the Financial Management Group (FMG) at the central level, the states are adopting customised accounting software (Tally) across all levels where NRHM funds are handled. Rajasthan had installed this software down to the block level, although the accountants contracted at the block level are still to be trained on this software and the financial databases are still to be integrated.

The capacity of states to absorb funds was found to vary considerably across states. On one hand we have Rajasthan which had already booked 84% of its approved PIP for 2009-10 by September 2009. On the other hand, there are states like Haryana and Bihar which could achieve only around 20% of the approved PIP for 2009-10 by September 2009. Bihar also had a huge capacity issue evident from an average spending of Rs.35 crores per month in the period from April to September 2009, whereas it needed to be spend at the rate of Rs.100 crores per month in the same period. The CRM teams also observed huge advances lying outstanding in the states, for example, Madhya Pradesh reported Rs. 200 crores lying as advances, whereas in Rajasthan, almost 30% of PIP lies as cash balances and advances at any given point of time. It is felt that e-transfers and electronic bank reconciliation can reduce this significantly. The spending capacity also seems to be directly correlated with the availability of specialist staff for financial management across various levels. In Bihar, there is only one consultant for managing the entire state's RCH-II Flexipool (of Rs.416 crores). In Chhattisgarh also, there are vacancies against the accountants needed at DPMU and block levels.

Another area that needs strengthening under NRHM finances is the standardisation of expenditure heads and communication of unambiguous guidelines

across all levels regarding booking such expenditure heads. Presently, any item of expenditure can be booked under more than one head. For example, salary paid to contractual doctors in a hospital can be booked under Maternal Health, Child Health, Strengthening of FRU, Contractual payments to NRHM staff, etc. Similarly, expenditure incurred on ambulance/referral services contracted under PPP at district level can be booked under referral transportation, innovations, maternal health (for delivery transportation), etc. The CRM teams observed that there are no standard guidelines addressing the ambiguity regarding booking of expenditures at various levels, mostly below the district, in Andhra Pradesh and Haryana. Orientation has not happened for NRHM contractual staff as well as for the regular government officials and clerks/ accountants, on financial management systems and principles under NRHM, as observed by CRM teams in almost all the states.

Some discrepancies were also observed by the CRM teams in financial management practices followed in the states visited. For example, although the central guidelines clearly state that Untied Grants (UG) across all levels have to released on a priority basis, irrespective of the utilisation of previous fund; states like Rajasthan and Sikkim are yet to release the funds meant for all facilities and VHSCs across the state. It was also observed in Rajasthan that the decision to spend money from VHSC Untied Funds had been taken at state/ district level, which is against the principle of decentralization of financial autonomy for local action. In Madhya Pradesh, it was observed that funds for Untied and Annual Maintenance Grants (AMG) are kept in a separate account at the hospital level and not credited to the RKS account. This makes the UG/AMG the responsibility of one person (hospital in-charge through single signature) and out of the purview of the society. Also, in Madhya Pradesh, which had been the pioneer in introducing concurrent audits, the practice had stopped after April 2009, as the process was centralized at the state level, and auditors are being appointed from the state. Haryana is following the practice of making ASHA and JSY payments in cash and not through bearer cheque, against the guidelines issued by the FMG from the central government.

It emerges from the above that streamlining the financial management procedures and systems throughout the country is of utmost importance not only to absorb increasingly greater magnitude of funds at district and health facility level, but also to ensure transparency and accountability. There has to be a greater push for adoption of customized accounting software with interlinking of the financial databases at each level of society/committee which is handling NRHM funds. This will also necessitate clearly identifying and codifying expenditure heads across the spectrum of NRHM activities and schemes. Along with this a staggered training and orientation programme has to be initiated for NRHM and regular government staff dealing with NRHM funds to empower local level financial decision making and booking expenditures.

## 5. Data Management

a. Every state is putting up the data on the web-portal and the flow of information is regular. In every state data entry operators and data managers are in place. Most states have computers upto block level and some have gone to the PHC level. Daman and Diu is an exception and is still not able to directly upload on to the web-portal.

b. Data quality is an issue. Validation and triangulation mechanisms are also poor and integration is only beginning. Registers have not been rationalized in many states. Even the old formats in use had not changed at the field level. These contribute to poor data quality.

c. However the main problem and frontier is in the use of information. The use of data for planning or for facility assessment has been minimal. There is no feedback happening at any level, and most programme managers would be unaware of what their data said. This is despite ccomputers and operators being available at block and facility level.

Section - IV

# Progress on Review Parameters

## *Key parameters of health delivery system*

I. Infrastructure Up gradation

II. Human Resources Planning

III. Assessment of the case load being handled by the Public System

IV. Preparedness of facilities for patient care services

V. Outreach activities of Sub-centre

VI. Utilisation of untied fund

VII. Thrust on difficult areas and vulnerable social groups

VIII. Quality of services provided

IX. Diagnostics

X. Logistics & Supply chain management

XI. Decentralized Planning

XII. Decentralised Local health action

XIII. Community Processes under NRHM

XIV. ASHA

XV. National Disease Control Programmes

XVI. RCH II (Maternal Health, Child Health and Family Planning Activities)

XVII. Preventive and promotive health aspects with special reference to inter-sectoral convergence and convergence with social determinants of health

XVIII. Nutrition

XIX. Non-governmental partnerships

XX. Overall Programme management

XXI. Financial management

XXII. Data management

# I. Infrastructure up gradation

| | State | Key Findings |
|---|---|---|
| 1 | **Andaman and Nicobar Island** | NRHM funds have been appropriately used for the up gradation/new construction and maintenance of health facilities at different levels in the UT. One new building for AYUSH hospital has been constructed (from UT funds), which has facilities for Yoga (*Panchkarma*), OPD, free medicine supply and 30 indoor beds. Charitable organizations such as *Bharatiya Jain Sanghatan* and other international NGOs have made significant contributions to infrastructure construction as well as up gradation. Residential accommodations for providers are available and in some district hospitals, dormitories for attendants are being constructed. Reasonably good maintenance of infrastructure of the facilities is apparent. |
| 2 | **Andhra Pradesh** | 630 out of 800 PHCs designated as 24x7 health facility are providing services. Though 156 FRUs are functional as CEmONC centers, only 88 meet the criteria of availability services of obstetrician, anesthetist and blood storage/ bank facility. 27 FRUs are located in tribal areas. 10 blood banks and 74 blood storage centers are available in the state. 38 birth waiting homes are proposed of which 32 are functional at distant and interior tribal PHCs to facilitate institutional deliveries. 752 108 ambulances for emergency transport and 475 mobile health units are positioned in the state. |
| 3 | **Bihar** | Most of the facilities visited had poor infrastructure, security and cleanliness though power back up was available even at the PHC level. The pace of construction work for the PHCs and APHCs has also slowed down in some places. The portable structure for establishing generic medical stores at block PHC has been set up by State Health Society Bihar as part of their efforts to upgrade the infrastructure of health facilities. |
| 4 | **Chhattisgarh** | Though overall physical infrastructure in the districts visited was adequate in terms of the space needed for the provision of services, the FRUs were not fully operational. Referral services were also not in place. Maintenance of physical infrastructure of the facility and residential quarters, cleanliness and Biomedical waste management was found to be inadequate. |
| 5 | **Dadar & Nagar Haveli** | Labour room construction in 22 sub centers are being undertaken. One CHC/FRU at Khanvel, which caters to significant proportion of poor population, has been upgraded to IPHS. Additionally, three dispensaries are being upgraded 24x7 facilities. Quality of infrastructure works appears to be good at the places visited by the team. |
| 6 | **Daman and Diu** | Physical infrastructure at the UT of Daman and Diu is adequate and well maintained. Daman's district hospital and CHC are adequately resourced in terms of number of beds and there is adequate capacity considering the case loads. Medical equipments, drinking water, sanitation, waste management process, mobile medical unit (only in Diu), 102-ambulance, telemedicine center etc. are available. Utilization of a few of these services like telemedicine center, MMU, 102-ambulance services are not appropriate. There is no NICU in any of the facility in Daman. Mobile Medical Unit is operational in Diu but not commissioned in Daman. |

| State | Key Findings |
|---|---|
| 7 **Gujarat** | Many facilities in state are either newly constructed or renovated under NRHM. The facilities which have been selected for up gradation or renovation do not appear need based. The facilities also fell short of essential equipment in some places like baby warmers and resuscitation kits that are essential for newborn care are not available at PHCs. |
| 8 **Haryana** | Since the launch of NRHM in 2005, only 32 SCs, 29 PHCs, 12 CHCs are added to the rural health services of Haryana. Only 2465 SC are operational against the required number of 3005 sub-centers. Gap of required and existing PHC and CHC is 66 (437/501) and 32 (93/125) respectively. Some facilities may be overburdened. 1502 sub-centres are having their own governmental building; 963 sub-centre are having building from Villages Panchayat, NGO (without paying rents); 285 sub-center building are under construction with support from NRHM funds. 678 sub-centers, it without governmental building will be building in coming years of NRHM. Availability of the untied funds through NRHM flexi-pool has strengthened the SC with equipments and chairs etc. 306 of the total 437 PHCs are operational in government buildings. 87 new buildings are under construction; 87 of the 93 CHCs are operational in their government buildings and 6 are under construction with support from NRHM funds. |
| 9 **Jammu & Kashmir** | There are 14 DHs, 85 CHCs, 375 PHCs, 238 Ads, 1907 SCs, and 346 MACs in the state. The state had 11 trauma centres, 8 ANM training centres run by Family Welfare (with batch strength of 30 for FMPHWs and 50 for Paramedics). In 2005 there were 3 places in the state where CT scan facilities were available in public system (GMC Jammu/GMC Soura/SKIMS). At three locations in the state PET scan facilities are available in the public system (GMC Jammu/GMC Soura/SKIMS). A comprehensive mapping of the health facilities in the state is not available even in the PIP of the state. The two Government Medical Colleges at Srinagar and Jammu are being upgraded to level of AIIMS under PMSSY. Large part of the health infrastructure is stated to be located in rented buildings or have insufficient accommodation. The state has reported 64 PHCs without electricity, 85 without a phone and 82 without an all weather motor able approach road. |
| 10 **Madhya Pradesh** | Only 66% of Health Sub Centers of MP are functioning in government buildings and only 25.4% are having ANM quarters constructed. Out of 1155 PHCs in the state, only 385(33%) have prescribed 4-6 bed wards, 607(52.5%) with labour rooms. Civil hospitals and CHCs including all CEmONC centers are taken up for facility survey and up gradation for civil works to meet IPHS norms. There are dedicated engineers for construction, but not a separate entity like Infrastructure Development Wing. |
| 11 **Meghalaya** | There are 401 Sub-centers, 104 PHCs, 28 CHCs, 1 Sub-divisional hospital, 6 District hospital, 1 Urban family welfare center and 13 dispensaries. 14 PHCs are functioning 24x7 against target of 26. Against the target for setting up 9 FRUs by 2009-10, 4 FRUs (in Shillong, Jowai, Tura & Nongpoh) are located at district hospitals. 2 more FRUs are to be made functional soon. The state has an excellent EMRI catering to 3 functions, ambulance service, police and fire. 30 ambulances are functional now. Because of the distances & terrain more |

| State | Key Findings |
|---|---|
| | need to be added. Maintenance of the service however is quite high costing about 1.6 lacks each ambulance per month. Equipment was not available at about 50% of health facility visited, but at other time it was found that equipments have not been used. |
| **12 Orissa** | Infrastructure in some facilities are adequate, in some, it is grossly deficient. The health infrastructure in the State has been upgraded, building renovation, adding facilities and procuring to make up critical gaps was evident. Some of these processes have not been completed and facilities are unable to provide full service. The existence of critical gaps in up-gradation is hindering full utilization as also regards issues of prioritization. |
| **13 Rajasthan** | Substantial strengthening of building infrastructure, with functional in-house civil wing (absorbed from the civil wing created under RHSDP). Renovation works undertaken for block and district level facilities under RHSDP, Construction at CHC and PHC levels planned for in 2006-09 has been almost entirely completed and handed over in Bhilwara district. Model sub-centres (with ANM quarter and Labour Room, as per IPHS approved design) being constructed and accredited for JSY. Major renovations and up gradations are required for ANMTC/GNMTC and drug warehouses. |
| **14 Sikkim** | All the sanctioned facilities are functional in Sikkim (147 PHSCs, 24 PHCs and 4 DHs). Of the 24 PHCs, 9 are augmented to IPHS during the year 2009-10. 3 district hospitals have already been upgraded to First Referral Units (FRU) out of which 1 was developed according to IPHS. 2 PHSCs are being upgraded to PHCs and 2 PHCs to CHC and 59 PHSCs with 2 ANMs & additional 28 by 2009-10. In addition to this the STNM Hospital at Gangtok is being augmented by supplementation of sophisticated equipments. |
| **15 Uttar Pradesh** | Since the inception of programme in 2005 only 5823 SCs, 700 PHCs, 582 CHCs are added to rural health services of Uttar Pradesh. The infrastructure is substantially short of IPHS standards. Some up gradation of district hospitals, and CHCs, construction of district warehouses, supply of electricity and construction of replacement for HSC operating in rented buildings has been undertaken. |
| **16 Uttarakhand** | Overall infrastructure was found to be good though infrastructure development plan was inadequate. Up gradation of facilities was not necessarily need based resulting in co-location (e.g. PHC/SC and CHC/SC) and some clustering. Residential accommodation for providers by and large available at CHCs and PHCs but were sometimes not occupied. Nomenclature of facilities is not harmonised with GOI and IPHS in the state. |
| **17 West Bengal** | There are nine (9) Medical Colleges and Hospitals, 15 DH, 4 AYUSH Hospital, 295 Ayurvedic Dispensary, 1 Unani Hospital, 3 Unani Dispensary, 12 Homeopathic Hospitals and 1220 Homeopathic Dispensary, 349 CHCs, 924 PHCs and 10356 SCs in the State. There is a shortfall of 149 CHCs, 1069 PHCs and 1745 SCs.Equipments have been upgraded in PHCs and BPHCs through various programmes and the deficits would need to be augmented from NRHM. Residential quarters for staff exist but are not in good condition due to poor maintenance. |

# II. Human Resources Planning

| | State | Key Findings |
|---|---|---|
| 1 | **Andaman and Nicobar Islands** | NRHM funds have been effectively used for hiring various categories of human resources and filling vacancies at various levels. e.g. Doctors, Specialists, Nurses, ANMs, paramedics, etc. NRHM funds have also been utilized for hiring of support staff like ambulance drivers, ward staff, cleaning staff etc. There is an urgent need for the health department to hire NRHM consultants at both headquarters as well as the districts to strengthen the smooth management and functioning of the health system. The provision for incentives of doctors and para- medical staff recruited under NRHM and working in difficult areas has helped in retaining the staff. Capacity of ANM and MPW training schools need to be improved. Pre-service and in-service training needs to be focused. |
| 2 | **Andhra Pradesh** | A total of 96,279 health human resources were added since 2005, inception of NRHM. 1424 Staff Nurses, 381 doctors of whom 165 are Specialists and 786 AYUSH doctors were recruited. 10,370 2nd ANMs/MPHA (F) posts are filled of whom 2,024 2nd ANMs deputed to FDHS (104 Mobile). 70,700 ASHAs are trained and positioned of whom 55,400 are in rural area, 5,300 in urban area and 10,000 in tribal area. Others are other staff under different programs, DPMU, 108, 104 services etc. Multi-purpose workers (Male) have huge gap with 7300 available against the need for 10,568. |
| 3 | **Bihar** | The human resource at sub-centres, PHCs and district hospitals has increased substantially by contractual appointments and pooling or deputing doctors and ANMs from additional PHCs to higher level. However only 30 to 40% sub centres have 2nd ANM in place. |
| 4 | **Chhattisgarh** | The state has a shortage of personnel in virtually all cadres and those available are not being used effectively because of irrational deployment policies and high level of absenteeism among doctors posted in remote areas. In-service trainings for SBA, LSAS, EmOC and IMNCI were found to be irregular and poorly designed. Male workers (MPWs) were encountered in several SHCs. While the 'older' cadre appeared to be working well, formal training needs to be provided to new recruits. |
| 5 | **Dadar & Nagar Haveli** | Resources available under NRHM have been used for recruiting significant number of contractual staff in position and deployed for service delivery to make facilities functional. Vacancy is specialist positions is a major barrier in making FRU functional. There is need for commensurate increase in remuneration as per prevailing market rates to attract specialists. |
| 6 | **Daman and Diu** | Human resource availability and adequacy is varied for different levels. ANM's and health workers are present in all sub-centers. Second ANM recruitment is in progress. There are no ASHA's as Daman & Diu is a high performing unit. There are no Link workers at the community level. ANM's have know-how to conduct their duties. Paramedics and laboratory technicians are adequately present and well trained at the facilities. Contractual staff has also been recruited at is present at PHC's, sub-centers and evening clinic. However, there is shortage of specialists (e.g. OBS & Gynecologist, |

| State | Key Findings |
|---|---|
| | Pediatrician etc.) in the UT. Training across levels is weak and there is no training facility in the UT. |
| 7 **Gujarat** | All PHCs, CHCs, and District Hospitals that were visited in both districts had a shortage of doctors. There is no recruitment plan of full time staff at any level except that of medical superintendent. The state has started a new nursing school to meet the shortages. |
| 8 **Haryana** | Required post of medical officer at PHCs are 880 against the total number of PHC (437) but only 228 posts are sanctioned and 299 (Regular) medical officers are in place. Only 30 post of lady medical officer are sanctioned and 68 Lady medical officers are in position. Medical Officers are more than sanctioned posts, which indicate that the state, have some policy to recruit Medical Officer beyond the sanctioned posts. Similarly shortage of LHV (139/ 437), Lab Technicians (119/437) Staff Nurses (618/1748) is affecting service delivery at the PHCs. Only 24 gynecologists, 27 pediatricians and 19 anesthetics are in place in all 93 CHC or FRU. Shortage of GDMO in CHC is also a concern, only 114 GDMO against required 372 are in place. Every CHC and a majority of PHCs are having dental surgeons. Availability of dental surgeons universally in all health services are unique feature of Haryana and now state have planned to utilize these dental doctor in public health programs. Need and utility of dental surgeons in Rural PHCs may require urgent attention. Basic services guaranteed at the SC under NRHM are provided by ANM but 64 SC are functioning without ANM and 58 of them do not have MPW. There is a marked gap in MPW as only 1290 position are sanctioned against 2465 sub Centre, and of this only 1093 MPW are in position. The 2465 functional SC have only 1272 sanctioned posts. Presently 1563 contractual ANM are recruited and only 1334 regular ANM are in place against the sanctioned 1272. |
| 9 **Jammu & Kashmir** | The state has reported 28 PHCs functional with 4 or more doctors, 85 PHCs with 3 doctors and 182 PHCs with 2 doctors each. A per the generic guidelines, PHCs are expected to be manned by only one MO and higher strength of MOs indicates a relatively better health HR situation in the state with relatively higher possibility of performing on 24x 7 basis and eventual upgrading of services to IPHS standards. At CHC level, state has reported availability of 35 physicians, 35 gynecologists, 40 surgeons and 28 pediatricians. Out of total 85 CHCs, the state has 81 CHCs with functional labour rooms and 65 with a functional OT. The advantage available to the state due to relatively better availability of doctors is negated by the acute shortage of staff nurses. In fact 67 PHCs are reported to be working without a staff nurse/nurse midwife while only 2 are reported to be without a doctor. Some of the steps taken by the state to improve the service of doctors serving in difficult areas are: Two years rural service has been made mandatory for the PG entrance examination and 10% seats in the PG courses are reserved for those who have served in rural areas for 5 years. |
| 10 **Madhya Pradesh** | There are significant gaps in human resources at various levels. 196 out of 1155 PHCs are functioning without any doctors, 153 health sub-centres without both ANM and Male MPW and 1469 HSC out of 8860 in the state |

| State | Key Findings |
|---|---|
| | without a male MPW. SIHMC, Gwalior, where the state level training programs and TOTs are conducted, owing to locational disadvantage is underutilized and understaffed with only three teaching staff. Measures have been initiated at State level to reduce the gaps in availability of doctors, by rural posting of one year for graduate and PG doctors from government medical colleges, as well as appointment of AYUSH doctors to PHCs. The state has also recruited contractual doctors and nurses from the available local market pool to fill the human resource gap. Deficiencies were noted in the competencies of ANMs (health worker female) during the field visits. On the job supervision of practices seems to be missing. Quality of SBA training needs improving as trainees do not appear to have received adequate hands on training in conducting deliveries. There is no post training contact or mentoring by trainers. |
| **11 Meghalaya** | There are 517 doctors (MOs) against requirement of 498 (19 surplus), 525 Staff Nurse against requirement of 546, 753 ANMs against requirement of 967, 141 LT against requirement of 163.There is a huge shortage of specialists in all categories. Proper deployment of specialists/needs assessment for multi-skilling of doctors required for operational sing future FRUs. Staff adequately provided at CHCs and 24x7 PHCs - mostly through contractual appointments. With the facility under NRHM, the State has been able to appoint contractual doctors and nurses, so that there are currently no PHCs without a doctor or ANM. Maintenance arrangement for the health facilities is still with the department. 29 difficult CHCs/ PHSs have been selected for handing over to NGOs under the PPP mode The skills of human resource in place in the health facility visited were found to be poor. There is need for long term HR planning. |
| **12 Orissa** | There is a scarcity of human resources, especially medical and paramedical staff and this is worsened by inequitable distribution. There is especially a serious shortage of nursing staff. Often one GNM managing a 24x7 PHC is compromising the quality of services. The management of the ANMTCs (Principal & respective Chief Medical Officers) needs to be more pro-active in tapping the resources for strengthening of the basic training institutes. As the IPHS standards for HR have not been implemented in the state, the gap has not been ascertained yet. Through NRHM the gap at the newer PHC level is being met through AYUSH Doctors. ANMs trained through the Skilled Birth Attendant training appear knowledgeable, with some of them regularly attending home deliveries. ASHAs are clear about their roles and are quite efficient in reaching the community, accompanying the mothers for delivery but their skill needs strengthening. |
| **13 Rajasthan** | At district level NRHM has strengthened the nursing (Staff Nurse, PHN, ANM) staff (in Alwar 34% of such staff is under NRHM). Trainings, especially under NIPI support for SNCU, have improved skill and confidence levels of doctors & nurses. The Rural Medical Officers cadre has provided doctors to the PHCs. Revision of rate contracts especially for specialists recommended to improve upon their huge shortage. Avenues of career progression and HR issues for contractual staff need attention. All PHC doctors and all ANMs need to be upgraded on clinical skills. 1977 curriculum |

| State | Key Findings |
|---|---|
| | being used for ANM training, new curriculum being planned should be operationalised. |
| **14 Sikkim** | There is a high number of contractual manpower under NRHM but low salaries of contractual manpower are leading to a high turnover of staff. For increasing the availability of specialists, Sikkim has extended its so far state based personnel employment policy to all NE states which may are now eligible to share the HR quota. Although Skill Based Trainings have been initiated, there is a need to expedite the training process all over the States such as SBA and IMNCI Trainings. |
| **15 Uttar Pradesh** | There are shortfalls of manpower at all levels. The percentage of shortfall at PHC level are 79% MO, 82% Ayush doctors, 86% pharmacist, 100% staff nurse, 90% ANM, 96% Lab. technicians, ANM 75% and MHW of 96%. IPHS implies more new post required. |
| **16 Uttarakhand** | There is an overall shortage of skilled human resources due to the difficulty of posting and retaining health personnel in hard to reach areas. Staffing of facilities is not based on GOI norms and there is a mmismatch in deployment of available resources with over skilled medical officers being posted in PHCs. Though state had initiated fresh recruitment of ANMs & LTs there was a delay in the state recruitment process. Remuneration package is not attractive for hard to reach areas and lower than neighbouring states. In-service training is given at limited number of institutions that are overstretched. Special focus should be to provide training opportunities for MOs posted in hard to reach areas for long periods. New / renovated ANMTC, Medical college, and SIHFW are being established; with a tie up with MP for post-basic nursing education. The high availability of pharmacists in the state is a potential resource. |
| **17 West Bengal** | 810 doctors are in position in PHCs against the requirement of 924 doctors. 170 doctors are in position in CHCs against the requirement of 1047 and 186 specialist are in position in CHCs against requirement of 1396 specialists. There are 5214 Staff Nurses against requirement of 3367. There is a huge shortfall in HRH in all categories except for Staff Nurse For upgraded PHCs additional post of one MT Lab has been created. In the sub-centers, second ANM and ASHA has been placed. Districts are contracting the Department of Community Medicine of B S Medical College to monitor the skill levels and performance of village health workers (AMNs, AWWS and ASHAs) in regards to IMNCI. |

# III. Assessment of the case load being handled by the Public System

| | State | Key Findings |
|---|---|---|
| 1 | **Andaman & Nicobar Islands** | The OPD case load in PHCs is around 2500 patients per month and in CHCs it is about 5000 per month. The District Hospital at Mayabunder has a case load of about 3000 patients per month. The rate of institutional deliveries in the PHCs visited was reported to be 4 to 6 per month. The rate in CHC Rangat was reported to be about 20 per month Institutional deliveries are very high in the UT (The UT is reporting around 86 % of institutional deliveries). |
| 2 | **Andhra Pradesh** | Patient case load show an increase at the level of SHCs and PHCs but a slight decline is also evident at level of CHCs and DHs. There has been an increase in institutional deliveries and mothers have also benefited from the JSY scheme. |
| 3 | **Bihar** | There has been a gradual increase in the utilization of service; main reasons identified for this are the improved human resources deployed drugs availability and JSY incentives. |
| 4 | **Chhattisgarh** | Except for the teaching hospital in Bastar, district hospital in Raigarh and one CHC (Lailunga, Raigarh), the other facilities visited were underutilized – the per doctor load was less than 15 OPD per day, and Institutional deliveries were less than one per day at PHCs and above. |
| 5 | **Dadar & Nagar Haveli** | Over all high case load at all facilities. Bed occupancy rates are nearly 110 percent at the CH and CHCs including several instances where patients are kept on floor. In the present year till Sept, nearly 1500 deliveries were reported in the institutions. Sub-centres are also fully functional as many sub centres reporting delivery and regular ANC care. |
| 6 | **Daman and Diu** | Between 2005 and 2008 service utilization has increased marginally for in-patient and OPD consultation, but the numbers of institutional deliveries have increased by 75%. Visits to the facilities also indicated low level of occupancy. The increase in institutional deliveries could be accredited to *Matru Samrudhi Yojana* (MSY) being implemented. Trauma centre has been recently constituted and this is increasing the case load of emergency services. There are no user charges at any of the facilities in Daman and Diu. 102 ambulance services are operational, although there are 3 ambulances but not all are being used due to lack of drivers. At the sub-centre level, the ANM's are well equipped and have the requisite medicine and diagnostic kits. A commendable initiative taken in this regard by the UT is of opening evening clinics twice a week in industrial areas with high male population. |
| 7 | **Gujarat** | The OPD and IPD caseloads in several facilities have increased in a relatively short time, although these increases are not uniform across facilities or even within the same facility. The case load at facilities has been affected due to *Chiranjeevi* providers. In place where there are no *Chiranjeevi* providers, government facilities show increase in the numbers of institutional deliveries. |

| State | Key Findings |
|---|---|
| 8 **Haryana** | Number of delivery at heath facilities were 68 thousand in 2006 but due to JSY and other initiatives under NRHM in year 2009-10 (till September 2009) 1,11, 866 deliveries are reported. In year 2006 1.64 Crore OPD cases are registered but in 2008 a slight reduction in OPD (1.54 Crore). IPD load is increased since 2006. Sub-center deliveries have increased from 4414 (2006-07) to 23773 (2008-09) and in PHC from 9822 (2006-07) to 21375 (2006-07). |
| 9 **Jammu & Kashmir** | The presence of number of people in OPDs and at least a few patients in IPDs suggest increased utilization of services. OPD services functional including ENT and ophthalmology were available in district hospitals, CHCs / SDHs while Dental chairs were available and services were being provided at the level of PHCs. |
| 10 **Madhya Pradesh** | Since the start of NRHM in 2005 there is an increasing trend in the annual number of patients treated, increase in institutional deliveries and increase in diagnostics/ pathology services. In CHC's there is optimal use of maternity wards, availability of specialists for performing Caesareans, blood banks were operational, labour rooms and OTs had been renovated and operational. District Hospitals are over stretched, but management has improved with induction of Hospital Administrator and other supports and funding. But the utilization rates of PHC's needs to improve significantly. |
| 11 **Meghalaya** | OPD cases have increased from 790571 in year 2007-2008 to 1000454 cases in year 2008-2009, and IPD cases has increased from 34238 cases in year 2007-2008 to 49584 cases in year 2008-2009. The number of institutional deliveries remained same at 24,000 while the number of home deliveries increased from 37,921 (2007-08) to 41,981 (2008-09). The reported coverage of fully vaccinated children in the year 2008-09 is 90.57% with the dropout rate of 30.22% between BCG and measles. Sterilization over the period of Family Planning has decreased to 14%, but the number of IUCD insertion has increased by 38%. |
| 12 **Orissa** | Increasing trends are being observed for better utilization of the services provided at the health facilities, with the exception of a declining trend for ANC and a flat trend for family planning. Institutional deliveries are happening in the sub-district facilities, thus the load on the district hospitals is reduced. Majority of the health facilities are having functional laboratories, but unfortunately, routine tests, are not being done. Laboratory services in the public health facilities need immediate strengthening. |
| 13 **Rajasthan** | A pattern of significant rise in institutional delivery and OPDs at all levels and the shift of normal cases to PHCs & CHCs shows improved services, (in Alwar normal deliveries increased by 50% in PHC, more than 100% in CHC and fell by 50% in DH). Fall in delivery related complications at FRUs, but increase in such cases at DH (in Alwar fall at FRU is almost 100%, whereas at DH there is almost 200% increase). The neonatal mortality rate in the hospital is 40/1000 live births. |

| State | Key Findings |
|---|---|
| **14 Sikkim** | Since the implementation of NRHM the number of OPD & IPD patients, ANCs, Institutional Deliveries and PNCs has been on the rise. During 2008-09, the State had 84% of all pregnancies registered for ANC out of which 75% had full ANC and 79% of all deliveries were institutional deliveries. This may also be partly attributed to the improving health seeking behavior because of IEC activities, ASHAs, regular RCH Camps & VHNDs etc. as well as the lack of alternatives in the form of private health facilities. |
| **15 Uttar Pradesh** | OPD attendance has increased from 325007/27083 in 2005 to 534528/76361 in Oct 2009 and bed occupancy has increased from 19% in 2005 to 86.9% in Oct 2009. JSY post delivery stay at facilities has also increased. |
| **16 Uttarakhand** | NRHM, JSY and ASHA have contributed in increasing the case load at OPD, JSY payments have been made regular and easy through the use of mobile phones. Signage display (citizens' charter, drug availability, JSY provisions, other IEC) was also prominent in the districts visited. A higher patient load was observed at PHCs than SDH and DH. |
| **17 West Bengal** | With the introduction of NRHM, patient caseload shows an increase at the level of health facilities. Purulia district has shown an increase in OPD cases by 64%, IPD cases by 28% and institutional delivery by 33% in year 2008 as compare to 2005. The institutional delivery rate seems to be closer to 60% in the state. In Purulia district the institutional deliveries has increased from 55% to 62% from 2008 to 2009. *Janani Suraksha Yojana* - (JSY) uptake has improved during 2008-09. There has been almost 33% rise in numbers of beneficiaries in 2008-09 over that in 2007-08. Referral transport - From 2.03 lakhs beneficiaries in 2007-08, the number of beneficiaries of referral transport has increased to 2.88 lakhs in 2008-09. During 2008-09, no. of deliveries conducted is 6608. This is significantly higher compared to 1225 deliveries in 47 accredited private facilities during 2007-08. |

# IV. Preparedness of Facilities for Patient Care Services

| | State | Key Findings |
|---|---|---|
| 1 | **Andaman & Nicobar Islands** | The UT is making provisions for increasing the number of beds at various levels as well as the availability of appropriate human resources. Facilities are well stocked with medicines, drug and investigations kits. Infrastructure is rapidly growing in several places although delays have taken place. The UT has only one functional First Referral Units (FRUs) and 17 24x7 Primary Health centres out of a total of 19 PHCs. NRHM funds have been used for installing water filters and general improvement of waiting areas, OPDs, wards, toilets. Funds have also been used to create temporary shelters for attendants to stay and cook etc. Referral systems are in place and free transportation is provided to the patient. It is important to note that in such difficult terrain this is a great relief for most patients. Seven ambulances have been procured from NRHM funds and are being deputed to facilities across the UT. Ambulances drivers have also been hired from NRHM funds. |
| 2 | **Andhra Pradesh** | Although state has well established 108 EMRI providing quality emergency referral services, this is not linked to preparedness of the health facility where the patient is expected to arrive. The GOI technical guidelines were not available at health facilities. The medical and paramedical staff also required training in the latest technical protocols. |
| 3 | **Bihar** | The PHCs at the Block are mostly 6 bedded facilities and can only handle normal deliveries but ambulance services are better organized to respond to inter institutional transfer. No FRU was functional in Khagaria with the blood bank facility. The doctors are largely present at least during duty hours with at least one or two being available in the nights – along with one or two ANMs or nurses. ICTC centre were functional at District Hospital and Sub District Hospital. |
| 4 | **Chhattisgarh** | Facilities were inadequately equipped with materials and human resources to provide health care services to the patients. But in some places existing facilities were underutilized. For example in Loing PHC, 9 kms. from the Raigarh district, most of the 22 rooms were under lock and key, and an additional eight rooms were under construction, but the OPD load was less than ten patients per day and there were no in-patients. |
| 5 | **Dadar & Nagar Haveli** | Drugs and other supplies are available in adequate amounts. However, simple supplies for essential new born care are missing at PHCs. Non availability of blood storage unit at FRU, Khanvel is a problem, although this is now being undertaken on a priority basis. Service environment elements such as privacy, drinking water etc, are well attended. Untied funds are utilized for addressing service delivery gaps at SCs/PHCs. |
| 6 | **Daman & Diu** | Trauma centre has been recently constituted and this is increasing the case load of emergency services. Certain equipment (CT Scan) is not functional |

| State | Key Findings |
|---|---|
| | due to non-involvement of private players in running it as a data shows case load between 2005 and 2008 has increased marginally for in-patient and OPD consultation; however, the numbers of institutional deliveries have increased by 75%. Ayurveda and Homeopathy doctors and medicines are available at district hospital, CHC, and the PHC in Daman. An initiative has been taken by UT to open evening clinics twice a week in industrial areas. |
| **7 Gujarat** | Bed occupancy at CHCs and PHCs are below 50-60%. Although state has well established 108 EMRI providing quality emergency referral services but this is linked to *Chiranjeevi* providers as well as health facility. People who accompanied patients, especially in-patients, did not have any designated spaces to stay or cook. NRHM logo was not visible anywhere. |
| **8 Haryana** | In Haryana, 160 PHCs, 40 CHC, 21 districts hospitals and 22 sub district hospitals are operational for 24 × 7 and providing all RCH and other health services under NRHM service guarantee. 24 × 7 PHCs are equipped with three staff nurse or ANM and Medical Officers (and AYUSH Medical Officer) with basic logistics i.e. labour room, wards, drugs, electricity and water etc. In FRU, CHC, DH and sub-districts secondary level facilities are provided like Labour room, wards, operation theatre, ambulances for referral, neonatal care (proposed establishment of neonatal care unit at DH, neonatal stabilization unit in FRU, CHC and sub-district hospital) and specialist are on call is an arrangement for meeting the deficit of specialist in CHC, FRU and sub-district. In sub-centre level neonatal corner are already established in delivery huts across the state. |
| **9 Jammu & Kashmir** | Most health facilities visited, barring a few, had at least a few in patients and the OPD was crowded. Clearly, the public health delivery system in the state is receiving a steady and regular flow of patients both for consultations as well as admissions. At remote, inaccessible locations also, the health facility was seen as a functional entity where citizens were arriving in steady numbers to seek services. The presence of a medical provider (allopathic or AYUSH), and paramedical staff appears to have sustained the interest of the citizens. Over time, substantial installed capacity has been created in the state to provide health services, OPD, IPD, procedures, both minor and major, dental care, lab facilities and so on. However in most cases these services are working at sub optimal level with questionable quality and standards and largely in an unsupervised manner. |
| **10 Madhya Pradesh** | There are 83 CEmONC and 397 BEmONC centres currently operational in the state and 37 MBBS doctors trained in EmOC in addition to specialists posted to take care of women with Obstetric emergencies.40 blood banks and 56 blood storage units are established. |
| **11 Meghalaya** | There are fully functional FRUs with specialists and blood storage is Jowai, Nongpoh, Ganesh Das, and Tura Civil Hospitals, which are district hospitals. The state has four model Mobile Medical Units and 30 Ambulances under EMRI... Two districts have been left out completely |

| State | Key Findings |
|---|---|
| | from the system of EMRI and there is almost no connectivity with mobile telecom in those districts. There are two ANM training center. Training institutions needs to be upgraded. |
| **12 Orissa** | Except in some of the district hospitals, preparedness of the facilities for holistic patient care services is limited. Quality of services is seriously compromised for want of adequate trained manpower, specially the nursing staff and the laboratory technicians. PHCs often only had one nurse limiting their ability to provide round the clock services and diagnostic facilities are ill equipped. Citizen charter detailing the services available at the facility is seen in majority of the facilities visited. |
| **13 Rajasthan** | Following factors have worked in favor of the positive shift patient care and utilization of services: Strengthening of services at CHCs; Posting of doctors & nurses at PHCs; accrediting sub-centres for deliveries, and improving infrastructure such as building a labour room with amenities, equipment for ANC. What is required is completing strengthening of all facilities and increasing number of facilities to decrease coverage area, ensuring timely emergency transport and quality referral services and strengthening SBA training. |
| **14 Sikkim** | The patient load in the Health Facilities has gone up in the last few years. All the 147 PHSCs are functional out of which 59 are managed by 2 MPWs. 16 of the 24 PHCs are 24x7 PHCs and 3 DHs have been upgraded to FRUs (1 of them to IPHS). In general, the health facilities were well maintained and cleanliness evident in the OPDs, wards, labor rooms and toilets etc. However, the user fees generated are deposited to the State treasury and not being utilized at the facility level. |
| **15 Uttar Pradesh** | After ISO certification the facility however has a shortage of staff (paediatrician and anaesthetist) and equipment (ultrasound) and does not receive the financial support required to maintain the ISO standard. |
| **16 Uttarakhand** | Preparedness of facilities especially for emergency obstetric care and other emergencies is inadequate. Blood storage/ bank availability, emergency surgery (including emergency C-section) is not being done in the DH and SDH facilities visited. |
| **17 West Bengal** | The emergency unit was functioning in the sub-district hospital. Drugs are sufficient in quantity. All basic lab investigations are conducted. Untied funds are utilized for contingency, cleaning of facilities etc. Infrastructure needs repairing as well as overhauling as the buildings look too old. Overcrowding of the health facilities places tremendous demand on the facilities. Number of beds are not sufficient compared to the load of in-door patients. All corridors and passages are full of extra beds put up for patients. The increase is not only because of JSY. |

# V. Outreach Activities of Sub-Centre

| | State | Key Findings |
|---|---|---|
| 1 | **Andaman & Nicobar Islands** | Sub-centres are being effectively utilized for outreach activities especially MCH and family planning. ANMs are working in close coordination with AWWs and ASHAs (at present only in Car Nicobar). Village Health and Nutrition Days are effectively planned for immunization coverage.<br>The availability of second ANM in many areas has contributed to the improvement in IEC activities as well as overall good record keeping. Mobile Medical Units are of limited use in the inaccessible areas so the DHS has prioritized the procurement and use of fully equipped Ambulances in the UT. Seven ambulances have been procured from NRHM funds and are currently being deployed to health facilities. New born care ambulances supplied by UNICEF are being used effectively for the transfer of sick new borne to referral units. Limited IEC/BCC activities are in evidence in the sub centers as well as in the VHNDs (in the form of IPC). The larger issue of community mobilization for IEC/BCC remains an area of concern. |
| 2 | **Andhra Pradesh** | Most of the sub centers visited was functioning in rented buildings with inadequate space. The Village Health and Nutrition Days were planned and conducted regularly by ANMs, AWW and ASHA in the villages visited, but limited mainly to the Immunization. One of the reasons identified during the visit was the widespread coverage of 104 mobile clinics which serves interior and tribal areas, but has rendered sub centres non functional. There is a limited convergence of the ICDS and NRHM at the block, district and state levels. |
| 3 | **Bihar** | Sub-centres are functioning with ANMs in place, but their involvement in utilization of untied grant need to be enhanced for grassroots planning and management. Mobile Medical services are likely to be started through a private agency/NGO selected through a state level process. |
| 4 | **Chhattisgarh** | The VHNDs are held regularly at *anganwadi* centers by AWW, ANM and *Mitanins* to provide services like immunization, treatment of minor ailments, ANC, counseling of mothers, growth monitoring, supplementary feeding, vitamin A supplementation, testing of salt for iodine, etc. |
| 5 | **Dadar & Nagar Haveli** | The UT follows the practice of holding two fixed service delivery days in a village each day and this includes monthly immunization day and MAMTA *divas* in villages. The ANMs and ASHAs mobilize women to come to the facilities especially SCs for conduct of ANCs. Dates for service delivery in villages being followed in some areas in place of fixed days for VHNDs. Team was told that this will be changed very soon. There is good liaison with ASHAs for outreach activities. ASHAs have undergone trainings and are working very closely with ANMs. The UT is also planning to start an MMU to cover inaccessible areas. |
| 6 | **Daman & Diu** | UT does not have ASHA's and there are no village health and nutrition days. However, immunization activities are happening weekly at the sub-centers. There are no link workers and outreach activities are limited. By |

| State | Key Findings |
|---|---|
| | means of Inter-sectoral Convergence between Department of Health & Family Welfare and Department of Women and Child Development the nutrition, breast feeding, maternal and child care programme under the ICDS have gained the Momentum. |
| 7 **Gujarat** | Functioning of sub-centres in both the districts visited was found satisfactory. All SCs had ANMs (FHWs) in position, and several of them stayed in the quarters provided. However, concept of second ANMs was not seen in the state and only few SCs had MPW (Male) functioning in SCs. The physical spaces and equipment in the SCs were adequate for providing ANC, immunization, and conducting deliveries. Power and water supply to each SC were ensured. However, the ANMs, especially those who were young, preferred to refer women to *Chiranjeevi* providers even when they had the facilities and training to conduct (normal) deliveries themselves. The ANMs reportedly conducted VHNDs regularly through the active involvement of ASHAs (and at times, the VHSCs) and the output of sessions was good. The ASHAs tracked pregnant women and helped the ANM develop micro birth plans that were then shared with the 108 service to reduce potential delays in transport to institutions during labour. Records were maintained and these could be seen during each visit to a SC. The ANMs also provided services linked to NVBDCP. Blood slides were being collected and treatment provided. |
| 8 **Haryana** | PHC doctor are expected to provide outreach services at all the sub-centres at least once a month. Services include treatment of minor ailments, antenatal care, post-natal care, newborn care, family welfare services, management of RTI/STI cases, diabetes and hypertension screening and treatment, TB and leprosy case detection, nutrition counseling, health education. On an average, a PHC covers between five to six 6 sub-centres. |
| 9 **Jammu & Kashmir** | The quality of outreach in the state needs substantial improvement. The terrain and inherent difficulty in mobilizing the community for health related activities appear to be the reason. The positioning of second contractual ANM appears to have created local disputes since at many places the local residency criteria seems to have been violated by the respective district societies. |
| 10 **Madhya Pradesh** | Efforts are made for strengthening of the sub-centre and the improved performance of all outreach programmes especially the utilization of village health and nutrition days and immunization coverage. Routine immunization control rooms are established at directorate, districts and blocks level to obtain data on the day itself, regarding sessions held, vaccine pickup, social mobilization & supervisors report for immunization. RI Control Room is turning the "monitoring of sessions" into a campaign mode. VHNDs needs better implementation and monitoring. |
| 11 **Meghalaya** | The village health and nutrition days are being held as health education days. Cross linkages with ICDS are in evident for service deliveries IEC/ BCC activities were evident as the only activity being focused on in the VHNDs. Outreach activities through ANMs, ASHAs and AWWs. |

| State | Key Findings |
|---|---|
| **12 Orissa** | Sub-centre outreach activities are limited in villages further away from the center. IEC activities like *Village Kantha* (wall writing with health messages) were evident, though recent in many places. VHNDs are planned in coordination with ICDS. But the coordination is limited and it does not reach out to the community other than those catered to by the *anganwadi* centres. Regular VH&NDs, *Janani* Express are working well, but referrals are still a major bottleneck in under-served pockets. *Janani* Express (exclusive ambulance services for transporting mothers for delivery to FRU/DHH) has been operational from mid-august and since has transported 32% of such cases. |
| **13 Rajasthan** | At least one ANM was reported in almost 97% SCs, 17% with 2 ANMs/ GNM. Infrastructure addition was found to be adequate, increase in number of SC deliveries at observed, as per facility records and feedback of the community, increasing use of two-wheelers by large number of ANMs is positively influencing their mobility. Areas for improvement include: construction of labour rooms for all SCs, strengthening of ANM clinical skills-especially ANC checkups, identifying high risk cases, and SBA trainings. The state may also consider facilitating loans to ANMs for two-wheelers, as a mark of mobility support. |
| **14 Sikkim** | The sub-centers visited were managed by an MPW(M) and MPW(F) and the State is in the process of ensuring the availability of these 2 staff at all the 147 PHSCs. Apart from performing their duties at the Sub Center, these staff are organizing outreach sessions for immunization as well as regular VHNDs along with ASHAs of the respective villages. Already, 418 VHNDs have been held in the 1st quarter of 2009-10. These VHNDs are held at the Angawadi Centers. The MMUs in the State are operational and supplement the outreach activities in the difficult to access areas. |
| **15 Uttar Pradesh** | The scarce availability of ANM limits the possibility of outreach services. VHND conducted as per guidelines but emphasis appears to be on immunization |
| **16 Uttarakhand** | VHNDs are fully operational and well organised even in underserved areas and required regular monitoring. Good cross-sectoral linkage of frontline workers providing immunisation; some ANC and family planning counselling, and breast feeding counselling services. Nutrition services - nutrition counselling and growth monitoring were found to be inadequate Systematically planned operation of 3 MMUs in Tehri Distt to provide specialists and diagnostic facilities (X-ray, USG, etc.) in under-served areas. |
| **17 West Bengal** | Although ANMs, AWW and ASHAs are in place, VNHD are not organized regularly. In 2008, 10,924 mothers benefited by the Voucher Ambulance scheme on in 3 districts. GP Based Mobile Health Camps are being organized regularly at GP HQ Sub Centre where there is no PHC / BPHC / RH. More than 55,600 camps were held during 2008-09 in which more than 44.3 lack patients were treated. Head Quarter Sub-centre at each Gram Panchayat has become the centre for supervision and monitoring of all units in GP area. |

# VI. Utilization of untied fund

| State | Key Findings |
|---|---|
| 1 **Andaman & Nicobar Islands** | Although the UT has made good use of untied fund, maintenance grants and RKS grants and user fees to improve preparedness and functionality of health facilities in some places, there remains considerable scope for full utilization of these resources for improving the quality of service delivery. There have been efforts to improve amenities in all the facilities visited such as lighting, wiring, water supply, flooring, providing curtains patient waiting halls, toilets etc with untied funds. |
| 2 **Andhra Pradesh** | All health facilities receive the untied funds on time and most facilities have utilized their funds and prepared SOEs. However, in some districts fund is stopped for want of spending details and prior approval for untied fund plans which needs to be revisited. |
| 3 **Bihar** | Utilization of untied grant needs to be enhanced as a huge balance was found unspent at all the visited facilities. This needs to be monitored not only by submission of SOE but by timely utilization of funds for the activities and available balance. This system is not seen as at state and district level, the release was the major concern. These funds, at least at the level of the HSC level, seem to have been tied. |
| 4 **Chhattisgarh** | Untied fund and Jeevan Deep Samiti funds remain largely unspent mainly because of irregular meetings of committees, lack of awareness about untied funds and rules and procedures. |
| 5 **Dadar & Nagar Haveli** | Not available. |
| 6 **Daman & Diu** | Untied funds are being used but there is inadequate documentation of approvals from committees. |
| 7 **Gujarat** | In all of the health facilities that were visited, untied fund were used to augment resources required for the upkeep of facilities and records were well maintained. However, untied funds for 2009-10 were released as late as October-November, 2009, and even this was a part-payment for maintenance, and the untied and RKS funds. Most of facilities were using untied funds left over from the previous years. So, many institutions are yet to receive funds for the year due to unspent money with them. No institution-specific plans were evident in any of the facilities, which guided decisions on how the funds (maintenance, untied and RKS) should be used. The MOs in charge of the facilities were utilizing the funds in combination with the user fees that were collected. |
| 8 **Haryana** | The ANM has used the untied funds for repair of the flooring and made a makeshift arrangement for the staying of the relatives who accompanies the pregnant woman. |

| State | Key Findings |
|---|---|
| 9 **Jammu & Kashmir** | Untied funds are being received by the health facilities. Maintenance of separate bank accounts for this Hospital Development Fund and the RKS funds however exhibits a misalignment that needs tweaking. The large balances in these accounts further indicate a need to sensitize the committees at various levels towards the need to use the funds optimally. |
| 10 **Madhya Pradesh** | The AMG and Untied Grant are not credited to RKS account and are being operated separately through a separate bank account and decision to use funds fund are taken by doctors with bank account often operated through a single signatory. State is in the process of bringing in a major reform in the RKS mechanism. |
| 11 **Meghalaya** | Utilization of Untied funds, RKS and maintenance grants is good. Most funds used on minor repairs, purchase of furniture, curtains. Very little is spent on direct patient care like essential drugs. |
| 12 **Orissa** | Utilizing various funds made available under NRHM the services has visibly improved. Gaps however remain. Huge unspent balance in the pass book points to poor utilization of fund in earlier years. |
| 13 **Rajasthan** | Expenditure has increased at SHC and PHC level (in Alwar expenditure at SHC/PHC level was around 110% of funds received during the year; using previous years' unspent balance). Since the start of NRHM (2005-06), expenditure at SHC/PHC have increased 5-6 times (2008-09)…this includes funds handled for JSY, mobility support, ASHA payment, etc. [total funds handled are 3-5 times the amount of untied grants]. Annual Maintenance Grants to hospitals to be made need based (based on no. of beds and bed-occupancy), to must not, be a replacement of hospital funds under treasury budget. |
| 14 **Sikkim** | Untied funds are utilized for improving facilities for patients at the health centers e.g. heaters, water filters, curtains, and cleaning of surroundings etc. Apart from this the facilities also get AMG funds which are used for tiling / cementing of floors, roof paintings, purchase and repair of water taps. The Gram Panchayats have also provided the health facilities (in the areas visited) with refrigerators, water geysers and modular chairs from their own fund. |
| 15 **Uttar Pradesh** | Untied fund at VHSCs used for purchase of bleaching powder, cleaning sewage, construction and covering of drains, referral of pregnant mothers etc. 70% to 80% of RKS funds used for POL for generators and ambulances. Health Mela expenses are likely to deplete RKS kitty. |
| 16 **Uttarakhand** | Utilisation of untied funds at PHCs and sub-centres good and appropriate and can be further improved with timely formation of VHSCs and RKS at PHC level. Contract Medical Officers are not involved in planning for AMG and Untied Fund expenditures. |
| 17 **West Bengal** | Untied fund utilization is very low in Purulia district. For 2008-09, it was 33.5% at PHC level, 51% Sub center, 43% & 37% as annual maintenance grant to PHC & BPHC. RKS funds to BPHC – Bandwan, Manbazar & Hura (RH) were fully utilized. |

# VII. Thrust on difficult areas and vulnerable social groups

| State | Key Findings |
|---|---|
| 1 **Andaman & Nicobar Islands** | Special provisions have been made for rendering health services for tribal, vulnerable and underserved groups and improving access for these groups e.g. reservation of beds especially for minority (aboriginal groups) and free health care delivery for these populations. Health Mela called *Swasthya Jagruti Maah* are being organized in various districts to provide services in all disease control programmes and RCH. |
| 2 **Andhra Pradesh** | Community Health Workers (CHW) working in tribal areas have been trained as ASHAs and they now receive higher remuneration, which includes the salary of Rs 400 as part of being a CHW, and the ASHAs performance based incentives. State has identified the difficult inaccessible remote and hilly areas and designed a policy for an increase in sub centers and PHCs in tribal area as compared to the general areas. However, the remoteness of these locations and has resulted in a greater number of unfilled post in these health facilities. Coverage of tribal areas with 104 is infrequent. |
| 3 **Bihar** | Population of about 1.5 lacks has been identified as *maha-dalit* under vulnerable groups but no specific activity is started yet. |
| 4 **Chhattisgarh** | Where access to health facilities is a problem, ANMs conduct deliveries at home. However there are no clear protocol/instructions or kit. No emergency management system is in place. User charges are well advertised at facilities and user fee records in Raigarh showed that up to 90-95% of patients may be charged for diagnostic tests, medicines, supplies (e.g., saline and glucose drips), deliveries, etc. They were also charging for patients' food and, in some cases, have started levying high charges. |
| 5 **Dadar & Nagar Haveli** | The UT is tribal and many villages are located in hilly terrain and inaccessible areas. Regular services are being organized for these areas. In one area (Dudhni) inaccessible villages are being covered through boats for transport and also organizing regular outreach services. Common User groups for mobile may be useful in reducing time for providing outreach services in difficult areas. |
| 6 **Daman and Diu** | No information. |
| 7 **Gujarat** | The state has instituted incentives for SC, ST and BPL populations for services such as delivery care (through JSY, *Chiranjeevi Yojana*), and enables access to both public and private providers through health insurance via the RSBY. The coverage of services among SCs, STs and minorities are the same as in other areas in both the districts. Facilities located in these areas were adequate to deliver services and quality of services provided in tribal and minority areas of Patan and Banaskatha are satisfactory. Increase of *Chiranjeevi* scheme deliveries in the state indicates utilization of institutional care by BPL families. |
| 8 **Haryana** | Outreach activities are prioritized locally at district level to provide services in remote areas and to complete the backlog of services in such areas. Mobile team and camps are being organized in difficult and unreachable areas. |

| State | Key Findings |
|---|---|
| 9 **Jammu & Kashmir** | The state has classified the difficult areas as two categories of A & B. However, several difficult areas in Kargil are not included in the list. The HR availability is good in difficult areas of Kargil district as ANMs and pharmacists are made available in the remote rural and snow bound areas isolated for over 5 months in a year. The state has proposed availability of contractual MOs at SHCs on weekly basis. The drugs are stocked adequately prior to snowing periods. Mobile Medical Units with surgical facilities have been made available but mostly unutilised. |
| 10 **Madhya Pradesh** | To provide adequate services to difficult areas a compulsory two year government service bond for fresh graduates and post graduates has been introduced. Compulsory rural posting of 255 PG doctors and 317 MBBS Doctors has been enforced. Difficult area allowance is proposed for ensuring availability of doctors and para- medical staff, after categorizing institutions into normal/difficult/most difficult/ inaccessible areas. There are 91 MMU operational under *Dindayal Chalit Aspatal* scheme in tribal blocks. |
| 11 **Meghalaya** | As 85% of the population in the states is STs, there is a focus on the vulnerable and underserved group. However, focus on reaching out of the under educated and economical weak section is missing. |
| 12 **Orissa** | GIS mapping of the health facilities up to the level of sub centers has been done by the State for facilitating planning and implementing different health activities. Project *Arogya* for LWE shows efforts in at positive direction. The state has begun to develop an equity strategy, which would work with community leaders and traditional workers. |
| 13 **Rajasthan** | The state has established 33 urban RCH centres through collaborative NGOs to cater to the health needs of urban slum population. *Mukhya Mantri Jeevan Raksha Kosh* (MMJRK) is another noteworthy scheme to provide free treatment and medicines to BPL patients, with an innovative online data system (segregated by patients, treatment, facility, prescription, and cost, available through NIC infrastructure. But scheme was found to be covering not all BPL families. The state is also providing 5kg Ghee is to all BPL women after their first delivery. |
| 14 **Sikkim** | Patients belonging to the below poverty level and senior citizen categories are exempt from any sort of user charges at all levels of health facilities. |
| 15 **Uttar Pradesh** | Availability of ASHA has improved access for vulnerable groups. No special plan or budget for vulnerable group in PIP. |
| 16 **Uttarakhand** | In Ramnagar hospital that intensive efforts were made by the polio team to mobilize mothers with children from minority communities. Uttarakhand also has a range of gender related practices which are key determinants of women's health and are closely related to RTIs, uterine prolapse and nutritional status of the mother and child. However there was no evidence of including these issues within the planning at the state or district level. |
| 17 **West Bengal** | Under tribal RCH, innovative programmes have been taken up in Jalpaiguri and Bankura through NGOs and Purulia and Paschim Midnapore by the DoH&FW. Some special programmes include additional nutrition programme, opening of *Rogi Sahayata Kendra* and *Jibon Jyoti Sahayata Prakalpa* for rendering medical care to Lodha and Sabar population are being implemented. |

# VIII. Quality of services provided

| | State | Key Findings |
|---|---|---|
| 1 | **Andaman & Nicobar Islands** | Quality of care for institutional delivery and other RCH services are in place: clean toilets with running water in women friendly labor rooms; good sanitation and hygiene (most facilities are clean). Maternal death audits are being conducted and recorded but there is still considerable scope for improvement in the process The health system is trying to ensure 48 hours stay after delivery, however local customs limit such efforts. Most facilities have not displayed information on entitlements for either ASHAs or even JSY beneficiaries. Bio medical waste management still remains areas of neglect. |
| 2 | **Andhra Pradesh** | In most health facilities, qualified doctors and other health staff services are available. However as a rule newborn or delivery protocols are not in place even where qualified specialists are available. |
| 3 | **Bihar** | Patient handling by doctors is good facility management needs improvement viz., crowd management, wards, labour rooms, poor quality of food for patients. |
| 4 | **Chhattisgarh** | Clinical protocols for active management of third stage labour, infection control, labour room management and partographs and infection control protocols are not being followed. |
| 5 | **Dadar & Nagar Haveli** | The CH at Sylvassa is providing good quality services as this institution has access to qualified HR, has a system of tele medicine and is very well equipped. C-Section facilities are routinely available. Medical Officers need MTP trainings to provide services. Team noticed that MTP services are not available at any of sub district facilities. Delivery protocols are not being adhered in absence of SBA trainings, and this is a serious concern. 48 hours stay not happening at facilities. It seems that there is high demand from the clients for early discharge so that they can go home early. Need to focus on Standard Treatment Guidelines especially in National Programmes such as NVBDCP. In many instances irrational transcription are being adhered. This not only increases cost of care, but also impacts the clinical outcomes. |
| 6 | **Daman & Diu** | Reasonably good quality services are being provided at the facilities and appropriate cleanliness maintained at all facilities (Toilets are clean and well maintained. Waste management activities have been outsourced and are working well. ANM's maintain records of immunization in a wooden board containing patient record arranged month by month. This is a good initiative taken by the UT and well maintained by the ANM's at the sub centre level. Institutional delivery is being promoted and there was good infrastructure and hygiene at the labor rooms. There are no quality certification or accreditation programs (NABH, ISO) being undertaken by the UT. Diagnostic equipments are under annual maintenance contracts and are being services regularly. |

| State | Key Findings |
|---|---|
| 7 **Gujarat** | In most health facilities, qualified doctors and other health staff services are available. However, as a rule newborn or delivery protocols are not in place even where qualified specialists are available. Sensitivity to gender issues appears lacking: in Dhanera CHC male and female patients were located in one ward and the labour room is located in front of toilet for wards. |
| 8 **Haryana** | Except in district hospital there is no pantograph or baby corner. Both mother and baby are discharged 6 hrs after delivery in the areas visited. Maternal death audits have been initiated. The delivery huts that have been recently set up in the sub-centres are furnished fairly well in spite of the space constraints. There is display of information about JSY in all the centres that we visited. RTI/STI services were provided through syndromic approach. A surgical package program (SPP) has been developed and rolled out in the last 2-3 months. The package consists of about 100 different surgical procedures that are available at the facility but provides a standard price for the surgery including drugs, supplies, diagnostic tests and charges for use of OT and ward. |
| 9 **Jammu & Kashmir** | Addressed under preparedness of facilities for patient care services. |
| 10 **Madhya Pradesh** | NABH accreditation process is initiated in 5 hospitals to declare quality standards of government hospitals. ISO 2000-9001 Certifications also initiated in one district hospital, one civil hospital, 2 SNCU 5 Regional diagnostic centres. Thrust on infection control and cleanliness, as well as Infection prevention needs to be strengthened. The quality of antenatal and postnatal care requires greater attention and supervision in the field. Provision of supervision and recommendation register would be a very helpful tool for ensuring continuity in supervision. |
| 11 **Meghalaya** | Although, the availability of medical personnel has improved since the launch of NRHM, the status of training is inadequate and affects service quality. By and large the hospital facilities are clean but inpatient control measure including segregation of waste is completely missing. Clean toilets with water are available, but partitions and screens for privacy, and grievance redressal system are missing. |
| 12 **Orissa** | The hospitals and health centers are clean and utilize NRHM funds for up keeping the same. Drugs are available now, though there was evidence of gross irregularity in supply in the recent past. Privacy is not always ensured especially in OPDs, with lack of screens/private areas. In all these 24×7 PHCs, there is acute shortage of manpower, specially the nursing cadre. Quality of services is severely compromised. Laboratory services are also restricted. |
| 13 **Rajasthan** | Improved waste management services, better cleanliness levels and functional ambulance (under EMRI scheme) are noteworthy. Use of colored bins is as per GoI norms, and placenta and other biological waste being managed through CTF (Central Treatment Facility) contract through an external agency at DH and CHCs. Under Emergency Response Services |

| State | Key Findings |
|---|---|
| | (ERS), state is supporting 164 fully equipped ambulances to transfer patients/ women in labour, from difficult areas to health facilities. The service is centrally controlled, and toll free no. # 108 is operational to facilitate early response. Ambulance services are effectively addressing the 2nd delay in the three delays of causes of maternal death. In the last year 45 deliveries were conducted in the ambulance in Alwar. Ambulance driver and nurse are also trained in CPR and other life saving measures. All emergency medicines/ oxygen, etc, are available in the ambulance. But in the districts visited no quality assurance mechanism was established to address quality of health services provided. Current costs of each ambulance at a cost of Rs 1.10 lakh per month need to be reduced significantly. Also, ambulances are running sub-optimally–currently only 2 trips per ambulance per day (optimum is 6 – 8 trips per day). Ambulance nurse should also be trained in management of post-partum hemorrhage (commonest cause of maternal death). |
| **14 Sikkim** | The PHCs and PHSCs visited are providing the assured services to the patients including outreach activities. The labour rooms are well maintained and functional even in the PHSCs. The number of Institutional Deliveries as well as home deliveries attended by SBAs is on the rise. The number of maternal deaths appears to be few; however Maternal Death Audits are not conducted in the State. Skill Building trainings in the State however needs to be expedited so that quality of services rendered can be further enhanced. The implementation of gender aspects throughout the service provision could be observed in terms of availability of clean toilets, partitions and screens for privacy in the labor rooms, display of information on JSY payments etc. IEC materials are on display in the health facilities but not in a structured manner. |
| **15 Uttar Pradesh** | Waste management (segregation and collection) was functioning at district and some CHCs. Use of partograph is missing although training had been given. Stay facility for more than 24 hrs of delivery is only available at District Hospital. Where staff and equipments are available the services appear of good quality. |
| **16 Uttarakhand** | Facilities visited were observed to be clean and equipped to provide privacy in OPD and labour rooms. IMEP / BMWM were found weak and adherence to GoI protocols was lacking. State has developed a tool for facility-based maternal death audit. Some of the PHCs and SDHs displayed the relevant information for JSY though it was not uniform and is yet to be systematically set up. |
| **17 West Bengal** | There were complaints of breakfast not being provided to a delivered mother at the Sub-district Hospital Purulia. There are no orders related to use of partograph in the labour room. It appears that women stay up to 24 hours after delivery. An Illness Assistant Fund to assist BPL families by reimbursing the expenditure incurred on medicines and tests has been initiated, but utilization of Illness Assistant by BPL families are very low. |

# IX. Diagnostics

| | State | Key Findings |
|---|---|---|
| 1 | **Andman & Nicobar Islands** | Adequate stock of diagnostic kits in facilities right down to the sub centre where the ANM is doing haemogram and blood smears for malaria. Routine blood and urine microscopy to X-Ray and ECG are being done in the PHCs. All diagnostics tests are provided free of cost to all segments of the population. |
| 2 | **Andhra Pradesh** | CT Scans are provided in all district hospitals but there is no provision of training to the doctors. Many labs are restricted to routine investigations like Hb, urine, etc. Newer diagnostic services like HBSAg, serum creatinine and Urea are added to the diagnostic profile but without training to the Lab technicians. Cross sharing of work by LTs in the lab services is partial and variable. |
| 3 | **Bihar** | Poor management of the available basic laboratory services was observed. Even the laboratories under PPP seemed likely to close down because of non-payment. |
| 4 | **Chhattisgarh** | Diagnostics and laboratory services are not fully functional and laboratory technicians require training. While VDRL tests are expected to be available at District Hospitals and CHCs, it appeared that VDRL and HIV testing were not being done even at the district hospitals level. |
| 5 | **Dadar & Nagar Haveli** | Very well established system for lab investigations and diagnostic technologies at CH, Silvassa, which includes CT Scans under RKS. Over all labs are very well equipped and routine investigations are taking place. ICTC is functional at CHC Khanvel No wet mount testing undertaken at PHCs for RTIs though LTs are available. It seems that MOs do not routinely write for lab tests for RTIs/STIs. |
| 6 | **Daman & Diu** | Diagnostic equipments are under annual maintenance contracts and are being services regularly. |
| 7 | **Gujrat** | Diagnostic services were available up to PHC level in both the districts and Laboratory Technicians were found in all PHCs, CHCs and district hospitals during visit. X-ray facilities in all CHCs are available and utilized by public. Lab facility for Urine, Blood for Hb, ABO grouping and MP are available in PHCs. Malaria diagnosis is available in all PHCs. Ultrasound facility is available in District hospitals. User charges are levied on lab test, x-ray etc and are used by RKS. It was observed that, safety measures of radiographers of CHCs and district hospitals were not taken care of. |
| 8 | **Haryana** | Diagnostic facilities seem to be affected by the shortage of the Lab technician/human resources in the PHC (119 LT in place against required 437). Investigation like AFB smears, PBF in malaria etc may be sent to other centre where facilities are available but investigation like Hemoglobin estimations, Wet mount and others are not being done in PHC without Lab technicians. Although PHC are provided with lab equipped with required instruments and consumables, state may plan for the multi-skilling of nursing staff and other paramedical staff for lab work. |

| State | Key Findings |
|---|---|
| 9 **Jammu & Kashmir** | Most of the facilities visited by the teams had a rather large number of lab technicians. Most places had essential lab equipment. However the utilization of the labs by the clinicians and the range of services available in the labs were severely restricted by the lack of ownership and supervision by the MO in-charge and BMOs. Most labs provide Hb screening and routine tests. The number of these tests per lab technician is also not very large. The recording of test reports does not follow a standard format. There was no evidence of PPP options being examined for lab services in the state. |
| 10 **Madhya Pradesh** | There is a serious shortage of para-medical staff in the state and less than half of the PHCs in the state have laboratory technicians and pharmacists. Similarly only two third of the CHCs in the state have laboratory, OT and X-ray machines. In many facilities RKS funds were used to procure special investigations like USG, MRI, CT scan, Color Doppler's etc. |
| 11 **Meghalaya** | Availability of diagnostic services as per IPHS is missing. However, basic lab services are being provided at health facilities, with Automated Health Care Facilities available only at district hospitals. |
| 12 **Orissa** | As a whole, the laboratory and diagnostic service is very poor. Routine tests are generally not done at various levels. There is shortage of trained manpower; equipments and maintenance of bio-medical equipments are not satisfactory. |
| 13 **Rajasthan** | New generation diagnostic equipment made available to the health facilities under NRHM/RHSDP/NCU/MTC. RDKs are available at PHC level. Lab technicians are being hired by MRS/RKS of bigger hospitals (with larger funds) and under NRHM. Areas for improvement include: need to train ANMs in RDKs for malaria and distribute the kits to them. Procurement of diagnostic equipment should also include training of the operators at the health facility where they are installed. |
| 14 **Sikkim** | Laboratory Facilities are available at the PHCs and district hospitals visited. Pathologists are posted at the district hospital and all types of pathological and biochemistry tests are being conducted. User charges are levied for laboratory and radiological tests from patients who do not fall in the category of BPL and Senior Citizens. |
| 15 **Uttar Pradesh** | Routine tests (Hb, TLC, DLC, BS, MP and Urine) performed at PHCs level. X-ray facilities are available in few CHCs. User charges well advertised. Investigations free for BPL families. |
| 16 **Uttarakhand** | Diagnostics and laboratory services were inadequate at different levels of facilities and required strengthening. |
| 17 **West Bengal** | In the sub-district and district hospital, the OTs are very well maintained and equipped. X-ray, ultrasonography is available at sub-district hospital. |

# X. Logistics & Supply chain management

| | State | Key Findings |
|---|---|---|
| 1 | **Andaman & Nicobar Islands** | The UT of A&N has a fairly good system of supply chain management for drugs and medicines. Procurement is done through rate contract. Quality control is ensured by stipulating the condition of GMP Certificate and Manufacturer's Test Certificate. More storage space required for medicines. Supply delays occur. |
| 2 | **Andhra Pradesh** | The AP Health & Infrastructure Management Development Corporation APHMIS has been formed in the state. All the visited facilities were adequately equipped but there is a need to ensure appropriate inventory of equipment. The state government has also brought up the policy on rationale drug use. |
| 3 | **Bihar** | The monitoring of procurement, storage, supply, consumption and replenishment is highly in efficient. Lack of coordination between Dy. Suptd., CMO and the store keeper at district hospital was observed. |
| 4 | **Chhattisgarh** | Most facilities had a good stock of medicines and supplies, but inventory and store management were poor. In some places, unnecessary 'high end' equipment such as digital BP monitors and anesthetic agents such as halothane were found where no surgeries/anesthesia done. |
| 5 | **Dadar & Nagar Haveli** | No information. |
| 6 | **Daman & Diu** | Procurement and supply chain of drugs seems to be fairly good with reasonable availability of drugs at all levels. |
| 7 | **Gujarat** | Gujarat Health system has central procurement system with effective inventory control using HIMS from districts. The supply of drugs and logistics is managed through regional warehouses, from where they are supplied to districts. The inventory of drugs is being maintained in the warehouse electronically and registers are maintained. However, drugs were seen dumped on floors without using racks due to shortage of lifters for racks. The quality control of drugs testing is done from warehouses and 6 monthly supplies of drugs are being done to regional warehouses. The Regional Warehouses are online with Gandhinagar DHO office centrally. Supply of drugs to facilities is regular and stock maintenance appears adequate. The system of dispensing of drugs and maintaining daily distribution stocks, with display of names for identification is in place. Crash Cart seen utilized in District Hospital and trauma centre. Kit-A and Kit-B were seen all SCs visited in the districts. |
| 8 | **Haryana** | An integrated procurement division has been set up at state HQ and is under Director NRHM. Agencies identified for procurement are: Director supply and disposable (drugs and equipments), Public Sector Unit (Pharmacy), UNOPS India for medical equipments and HLL life care (Medical equipments). Essential Drug List (EDL) developed at state contains |

| State | Key Findings |
|---|---|
| | 328 essential drugs for DHs, 112 items for CHCs & 84 items for PHCs, but dynamic EDL is being prepared with specialist consultation. WHO-GMP criteria and annual turn-over of 35 Crore has eliminated sub standard companies. Only Indian and British Pharmacopoeia drugs are purchased. Broad based district level procurement committees are constituted and procurement is done on quarterly basis with flexibility to specialist to purchase in consultation with district committee. State level Weekly monitoring of drug consumption and procurement is also in place. Cost analysis is done on periodic basis and cost effective per capita expenditure is reported. Rs. 10 for DH, Rs. 8 for CHC and Rs. 6 for PHCs are observed. Cost of a cesarean section is around Rs. 1000, for casualty it is Rs. 50 and for normal delivery is Rs. 250 only. Medical store procurements at district level out of NRHM funds being done. Procurements are slow. Even from state budget, orders placed for only 10% of budget with additional 10% in pipeline. Certain drugs were in short supply because of delayed fund releases. |
| **9 Jammu & Kashmir** | The procurement of medicines and supplies is by the State Health Directorate based on indents from health facilities. A few facilities send midyear indents also. Adequate medicine is available in the facilities visited. The essential drug list was displayed for benefit of the patients. Pharmacies at most health facilities stock medicines in appropriate, well labeled, catalogued manner. There is a very large complement of pharmacists in the public system and more are being recruited on contract under NRHM. The pharmacists can be multiskilled to undertake other activities in the health facilities. Most health facilities have chemist shops being run by cooperative societies, which have now been taken over by individuals. The state could consider revitalizing these to provide low cost generics. This will off load the logistics and management problem off the state and also make available quality medicines to patients. The state can meanwhile continue to process its proposal of setting up a procurement directorate. Since the indents are annual there are often stock outs which last for the balance part of the financial year. |
| **10 Madhya Pradesh** | Essential Drug list is in place with 272 drugs and Procurement Cell also exists having one Joint Director and two Deputy Director with an additional support of Consultant Logistics, MP-STAT. They have installed Pro MIS, inventory management software for drugs procurement and supply. There are 27 Drug Warehouses out of which 7 are constructed by DANIDA project. |
| **11 Meghalaya** | Drugs and Medicines appeared to be available adequate quantities as they have supplied in response to request sent by the districts. It appears that there is no adequate stock of vaccine at the health facilities. |
| **12 Orissa** | Some streamlining of supply chain management is done in the state and PROMIS software is currently used by the Regional Vaccine Stores in the district for charging supply received from the state depot. Patients incur significant out of pocket expenditure due to purchase from outside. In most pharmacies, there have been persistent shortages (for over 6 months) of some medications from the essential drugs list, apart from the ones that arise out of poor stock management. Essential Drug List also asks for reviewing over the years. |

| State | Key Findings |
|---|---|
| **13 Rajasthan** | Drugs available for BPL patients free of cost under *Mukhya Mantri Jeevan Raksha Kosh* (MMJRK). Emergency medicines and supplies/consumables are being procured from RMRS funds. Waste management supported under RHSDP. *Jan Aushadhalaya* functional with generic drugs from public sector, available at lower than market rates. Drug supply and tracking systems need major improvement, and would require mechanisms to build buffer stocks, to move away from high levels of no stock positions observed (up to 50 % in PHCs / CHCs / DHs for items of medicines & consumables). Instead of completely top-down systems of procurement and supplies, local need based systems also need to be devised. Systems and training in inventory management are required for the storekeepers. |
| **14 Sikkim** | The purchase of items under NRHM has been entrusted to the Central Health Stores Organization under the health care, human services and Family Welfare department and monitored by the Joint Director. A store inspector and store keeper have been given additional charge of projection of requirements, receipt, issue and maintenance of stock registers. The state is also in process of augmenting the district drug stores and also proposed for recruitment of store keepers and short training on material management for the store inspectors / keepers and pharmacists / ANMs posted at various DHs, PHCs and PHSCs. |
| **15 Uttar Pradesh** | State level procurement outsourced to UNOPS, State corporation etc. Medicine generally available as per demand. State may introduce system to monitor the flows and stock outs. |
| **16 Uttarakhand** | Procedures of procurement and distribution of supplies (60 % done locally, 40 % by state) need to be simplified and rationalized. Logistics and Supply needs assessment and planning needs to be improved. Kit A, Kit B supplies from GOI were disrupted over the last two years because of this, Vitamin A and IFA supplementation coverage has been adversely affected. Equipments are largely available, however inadequately utilised. Cold chain maintenance was satisfactory in most facilities – other than Bare china, where there was no generator and no temperature record. |
| **17 West Bengal** | A procurement cell is established & functional at district level in Purulia headed by a Dy CMO Computerized supply chain management system is in place at the cell. On an average proposal for procurement is finalized within 20-45 days after getting sanctioned / budget from state HQ and order is placed within a week time after the proposal is approved by DHS. Order is received within 7 days to 1 month period and within a three month time medicines are further channelized to peripheral institution. 5-10% of the samples taken for quality check fail. Facility level tracking of the consumption of the medicine supplied is weak at district/block level. Four samples tested for quality check failed last year but the medicine were already distributed & consumed before getting testing report by peripheral institutions. |

# XI. Decentralized Planning

| | State | Key Findings |
|---|---|---|
| 1 | **Andaman & Nicobar Islands** | Integrated District Health Action Plans are planned with inputs from sub centres onwards; however community mobilization and involvement in the form of village health action plans are missing. The planning is more top down. District Health Mission and RKS meetings are taking place with participation of key functionaries, such as panchayat functionaries and some civil society groups. |
| 2 | **Andhra Pradesh** | In preparing PIP for the state, DHAPs were not taken into consideration. DHAP preparation was outsourced to Center for Good Governance for 19 districts and IIHFW for 3 districts. Financial allocation and disbursal to districts was made based on their preceding year's expenditure and submission of SOE rather than on the DHAP. |
| 3 | **Bihar** | Though district Plans are made under the supervision of District Collector, the awareness among district level health officials about the process was found to be very low. |
| 4 | **Chhattisgarh** | The process of preparing the district plans for 2009-10 was not based on need (data) or on visits to facilities. No district prepared full plans, with some districts just submitting the budget heads. |
| 5 | **Dadar & Nagar Haveli** | SHS formulated and is meeting regularly. ZP participates in SHS meetings. PIP is being formulated at the UT level. VHSCs are registered and resources to these committees are yet to be transferred. UT needs to address issues related to capacity building of VHSC members. |
| 6 | **Daman & Diu** | Program management unit needs to be strengthened in terms of planning, monitoring. |
| 7 | **Gujarat** | The district action plan for 2009-10 is available in both districts. PRI participation in the planning process of the integrated plan is low. In Palanpur, the team learnt that it has been difficult for the health department to get the District Health Society to hold regular meetings. Consequently, the responsibility for both planning and implementation of the district plan seems to rest entirely with the health sector without the involvement of the PRI. However, RKS meetings at the health facility-level involving PRI members have been recorded. |
| 8 | **Haryana** | Village Health Action planning has been piloted in district Jhajhar, Rohatak, Gurgoan and Sonepat. Medical officers of PHCs and CHC are trained in TOT and Medical officer (community medicine) has the additional responsibility to support the planning initiatives. Block level training for VHSCs members is planned. Prepared village health action plan is expected to be incorporated in the District Health Action Plan for the year 2009-10. |
| 9 | **Jammu & Kashmir** | The District Health Action Plans were prepared once during 2006-08 periods by EPOS. It is reported that detailed consultations with CMOs took place at that time. The process however has not been repeated and updated DHAP |

| State | Key Findings |
|---|---|
| | for periods after 06-07 are not available. There is no PRI structure in the state and not too many NGOs are available to provide an "out of the system" perspective to the state. This can be compensated with greater technical and managerial supervision of the field. |
| **10 Madhya Pradesh** | District Health Action Plans developed through a systematic process seems to have not happened in the state. CMHOs are not comfortable in taking decisions and resort to safety net of approvals of DCs resulting in almost each and every file going to District Collector for approval. The working of DHS needs to be streamlined and made more focused to ensure effective planning and implementation of plans. |
| **11 Meghalaya** | As per interaction with the State, districts and block programme managers, the district health action plan where amalgamation of the block plan. Display of services available, patient rights of and details of *Rogi Kalyan Samiti* (RKS) are permanently display at all health facilities. All RKS societies are in place. |
| **12 Orissa** | Although district has a district health action plan, the processes of decentralized planning do not seem to have really gone into uniform practice at every level and therefore do not adequately reflect community needs. DHAPs are generally generic plans but facility based plan have mapped difficult areas. |
| **13 Rajasthan** | A shift from the present approach of physical activity targets to inter-sect oral convergence, and local need based approach is needed for decentralized planning especially at village level. Planning for prioritization of services and difficult areas, and focused efforts of convergence at district and block level are required. |
| **14 Sikkim** | DHAPs have been formulated in all the 4 districts but the quality of the plans could be substantially improved. In particular, the linkage between the DHAPs and the SPIP requires attention. These DHAPs need to reflect the block and village level plans. The State needs to attend to the realignment of the DHAPs according to the approved SPIP as well as develop stringent monitoring mechanism to monitor the progress of the approved activities. |
| **15 Uttar Pradesh** | Though District PIPs (DHAP) prepared, fund allocation was normative from the state level. There is limited capacity for planning at decentralized level. |
| **16 Uttarakhand** | DHAPs were made with inadequate analysis of district level issues leading to generic plan without any local specificity. Inadequate involvement of PRIs/ CSOs/ user groups / Block MOIC / ANM's / ASHA à lack of uniform awareness of a DHAP was observed. |
| **17 West Bengal** | Decentralized planning is weak. The focus is on providing the information requested in the template and there is little in terms of analyzing local needs and addressing them in the plan. Bottom-up assessment and prioritizing of equipment needed by hospital staff are rarely conducted. |

# XII. Decentralized Local health action

| | State | Key Findings |
|---|---|---|
| 1 | **Andaman & Nicobar Islands** | Village health & Sanitation committee have been constituted, however it is not clear as to extent of their involvement in health and sanitation. *Rogi Kalyan Samiti* and other untied funds are being utilized for ensuring sanitation and hygiene in the health facilities, provision of water filters, and benches for the waiting area etc. The involvement of *Panchayati Raj* Institutions in the functioning of health system is very limited. |
| 2 | **Andhra Pradesh** | Most of the revenue villages have constituted Village Health and Sanitation Committees (VHSC) with operational joint accounts and the members: ASHA, Aaganwadi worker, and the village Sarpanch have been using the untied fund for local needs. Community monitoring of the process was not in place. |
| 3 | **Bihar** | Community ownership through VHSC is yet to be fully implemented in the state. |
| 4 | **Chhattisgarh** | VHSCs have been formed widely throughout the state, and in some instances were found to be working toward 'clean villages' and assisting with family planning camps and VHNDs (particularly supplementary feeding). |
| 5 | **Dadar & Nagar Haveli** | Untied funds are made available at facilities and team found several instances of untied funds being used to improve service quality. |
| 6 | **Daman & Diu** | 28 Village Health and Sanitation Committee (VHSC) have been formed in August 2008. Provision of Zero balance accounts of the Village Health and Sanitation Committee (VHSC) at the Nationalized bank has been made. *Rogi Kalyan Samitis* are formed at all levels. At the sub-centre level the samitis have started functioning and each sub-centre is allotted Rs 10,000 annually. The record keeping on approvals of funds and expenditure is not up to mark and needs strengthening. |
| 7 | **Gujarat** | VHSCs have been constituted. ANMs, ASHAs and PRI members were involved in the formation. These committees appear to be meeting periodically. Untied funds were also released for their use. Although the VHSCs have received some sensitization, they are not fully oriented to their role. At present, they assist the ANM, who manages them. The separation of the VHSC's funds from that of the SC is at present blurred. With the ANMs convening both Committees, there is a tendency for the VHSC's funds to be used for SC activities and up gradation. Local needs were not addressed adequately in the VHSC's utilization of untied funds. |
| 8 | **Haryana** | *Swasthya Kalya Samiti* (SKS) – The SKS has been constituted with the Civil Surgeon as the Chairperson and the MS of the GH as the co-chairman. Other members include medical officers from various departments, matron, and drug controller, district AYUSH officer, locally elected municipal counselor, representatives from NGOs, IMA and others according to the guidelines. The SKS is meeting regularly and minutes of the meeting are well |

| State | Key Findings |
|---|---|
| | documented, but except for Medical officers and health workers no other members attend the meeting. |
| 9 **Jammu & Kashmir** | Untied funds, AMG and RKS funds have reached most facilities over the various years of NRHM. However, the capacity to utilise such funding is low. The CMO, BMO, MO facility do not really provide the leadership and autonomy required and hence the flexibility provided in these strategies of NRHM has not really rejuvenated the system as it has done in many other states. This is a major constraint. The major policy shift in the state of allowing the respective facility to retain its user charges at its own level for local use is indeed a path breaking improvement. |
| 10 **Madhya Pradesh** | Funds are released to all VHSCs, and utilization is adequate but expenditure is not reported periodically. All district hospitals have an MOU with Sulabh International to ensure cleanliness, hygienic wards and toilets with RKS funds. RKS funds are also used for life saving drugs in emergency ARV, AVS, streptokinase and for critical care like cardiac ICCU, neonatal ICCU, trauma center, special investigation USG, MRI, CT scan, and Colour Doppler. |
| 11 **Meghalaya** | The village health and sanitation committees has been informed along with *Rogi Kalyan Samiti* meeting of these institutes are being held and the funds have been received and utilized, right up to the *Panchayati Raj* levels and are being utilized for the procurement of basic facilities like buckets, turtle repair of roofs. |
| 12 **Orissa** | One district, Kandhamal, envisages reach of services through NGOs to underserved populations. This scheme is known as the *"Arogya Plus"* scheme and is currently implemented in extremist affected blocks of the state. |
| 13 **Rajasthan** | RMRS is functional in all health facilities, down to the PHC level. VHSCs have been formed in all villages and function actively in some areas. Well maintained records of VHSC minutes of the meetings (coinciding with MCHN Days) with key agenda items, decisions taken, seen during CRM visits in some VHCs. VHSCs should be trained and empowered to plan community action for improving their own health. |
| 14 **Sikkim** | RKS have been formed in all the PHCs and the DHs and the meetings are convened regularly. However RKS funds have never been released for the PHCs and DHs. But the same has been approved for the year 2009-10. VHSCs have been formed and are operational with bank accounts. |
| 15 **Uttar Pradesh** | Local health action plans are not visible in state |
| 16 **Uttarakhand** | Inadequate involvement of PRIs and other community based stakeholders leads to poor plan without any local specificities. RKS (*Chikitsa Prabandhan Samitis*) are recently being set-up at PHCs without having participation of community representatives. |
| 17 **West Bengal** | Village Health and Sanitation Committee (VHSC) have been constituted with PRI members, ANM, primary school teacher, AWW and SHG members. VHSCs are involved in activities like cleaning of drains, improving water sources, disinfecting water, bleaching, IEC. Annual untied fund is released for the functioning of VHSC. The responsibility of maintaining and constructing SC / PHC / BPHC is with PRIs. |

# XIII. Community Processes under NRHM

| | State | Key Findings |
|---|---|---|
| 1 | **Andman & Nicobar Islands** | There is no community monitoring initiative in place. Some degree of community involvement is being done by engaging Village captains (heads) in NRHM activities, however community level planning and the process of community ownership has not been strengthened. Overall community mobilization and village level health plans need a lot of strengthening. Citizen charter is present in some health facilities, however social audits of services and entitlements needs strengthening. |
| 2 | **Andhra Pradesh** | The State has registered HDS/RKS at 23 district hospitals, 168 CHCs, 73 Other district hospitals, 1570 PHCs. All primary health centers visited have HDS/RKS comprising of medical personnel and members of the public. Accounts have been opened and funds were being transferred and utilized. The public participation in these committees was good with Tehsildars, Zilla Parishad members, Sarpanches, Rotary members, etc on these committees. |
| 3 | **Bihar** | The *Rogi Kalyan Samiti* has been formed up to the PHCs level in a majority of the places but there appear to be high level of irregularity in meetings and funds transfer. This is partially due to lack of clarity in roles and functions. VHSCs are also not fully functional. Currently, the VHSC is Co-opted by *"Lok Swasthya, Pariwar Kalyan Avm Gramin Swakchta Samiti"* of PRI where the ANM is the Secretary of committee and selected member of *Panchayat* is the President and this is at the revenue village level. As of now, fund releases are to the revenue village, with '*Nigrani* Committees' is being established at the village level. |
| 4 | **Chhattisgarh** | VHSCs (and JDSs) have been set up but they require capacity building to enhance decisions to spend untied funds and participation in village activities. |
| 5 | **Dadar & Nagar Haveli** | RKS are fully functional at CHC and CH level, funds have been transferred and being utilized. RKS meetings at CHC Khanvel are infrequent, last meeting held in Jan 2009. It appears that some capacity building interventions are required for effective utilization of resources available. There are no NGOs in the UT and this limits community monitoring. UT is planning to involve NGOs from Gujarat to provide technical support in community monitoring. |
| 6 | **Daman and Diu** | Community in the UT of Daman and Diu is aware of the healthcare services being provided by the UT. PRIs are involved in the healthcare delivery process and work well with the ANMs, AWW and other healthcare providers. Community monitoring initiatives are largely lacking and there are no specific outreach activities. There is inadequate staff to link community with health centers. There are no mechanisms of jan sunwayee, open hearings etc. |
| 7 | **Gujarat** | ASHAs are in place in many villages but they serve as assistants to the ANM or MO of health facilities. Like the ASHAs, the VHSCs are also not true |

| State | Key Findings |
|---|---|
| | representatives of the community that can take village needs on board and force issues of accountability in service provision and in the disbursal of benefits. The VHSCs and RKSs have teachers, private practitioners, members of self-help groups and local farmers, among their members, who seem to participate in meetings that are regularly organised by the health staff. |
| **8 Haryana** | District Health and Family Welfare Society (DHFWS), Swasthya Kalyan Samiti (SKS), Village Health and Sanitation Committee (VHSC) are well functional in state. All districts have DHFWS and meeting regular and monitoring district heath achievement periodically. All 21-district Hospitals, 22 Sub district Hospitals, 91 CHCs and 337 PHCs are having SKS and meeting regularly. Total 474 SKS are constituted and 463 SKS are registered under society act. Linkage between the organizations is well established and periodic reviews are conducted. SKS are functional and have bank accounts with user fees being deposited in bank accounts for proper maintenance of accounts. Total Number of VHSCs constituted is 6282. VHSCs appear to involve participation of the community (SMS, SHGs etc.) and staff from other sectors, (Teacher, MPWs, Water supply department staff etc). VHSCs are supported and mentored by the district level team leaded by DPM along with BEE. Village Health and Nutrition day is organized with support from VHSC and health department. Against the Target of 75324 VHNDs only 18949 (25%) VHNDs have been held. *Sakshar Mahila Samooh* (SMS) is a community based organization in rural area, where women educated (10$^{th}$ pass and above) are organized into collectives and advocate for community issues. These SMS groups are now included in the VHSC, and are involved in program specific BCC/IEC activities i.e. HIV AIDS, RCH, NVBDCP etc. |
| **9 Jammu & Kashmir** | Since the PRI are not in place in the state, community processes generally proceed at a slower pace than in other states. In the field, the team did not notice any community voice in the functioning of the health system. The RKSs do have community representatives but that is not adding much value to the gap filling capabilities of the RKS. As such there is no one to encourage or mentor the community to take part in management of the health facility. There is little involvement of NGOs in the sector. |
| **10 Madhya Pradesh** | VHSC's have been constituted in 24,520 villages. They are reformed into 'Swasthya Gram Samiti's' with inter-sectoral collaboration between the Mahila Bal Vikas Department and other departments. Need for training and handholding of VHSC members, ASHAs, field staff and NGOs to provide clarity about roles, responsibilities, management of accounts etc.<br>The pilot project on Community Monitoring and Planning (CMP) initiated in four districts has not been expanded. While the term Monitoring is changed to community action for health, there is a need to enhance the budget in the PIP, utilize it and expand the program as has been done by other states. |
| **11 Meghalaya** | VHSCs formed and accounts opened. Since PRI do not exist in the state, the system of having males as heads, excludes women from the process. |

| State | Key Findings |
|---|---|
| | Community needs are not assessed in preparation for planning or implementation. NGOs involved in service delivery. VHNDs being held but not as per any plan. Most district staff needs orientation on VHND guidelines. |
| **12 Orissa** | The *Gaon Kalyan Samities* in the villages have largely been formed but most GKS members are not clear about their roles and planning initiatives. |
| **13 Rajasthan** | MCHN days being organized well with participation from AWW, ANM and ASHA. However, the present focus of MCHN days is only on immunization. Nutrition needs to be given greater focus, and community action under active role and leadership of VHSC should be the key strategy. |
| **14 Sikkim** | It was observed that community participation is well developed with 637 Village Health and Sanitation Committees operational with bank accounts and RKS constituted in all the PHCs and DHs. PRI representatives are members of these committees. Even though the PRI members contribute actively to the decision-making, they require orientation to better equip them to their roles and responsibilities vis a vis funding activities and upgrading facilities. Moreover, a system of community monitoring needs to be developed. Preparations of block plans need to reflect the need of the community. |
| **15 Uttar Pradesh** | Community processes have been initiated through ASHAs. RKS are functional, but involvement of VHSC can be further strengthened. Sensitization of PRIs on NRHM appears to have improved. |
| **16 Uttarakhand** | The formation of RKS needs to be reviewed, as they do not reflect the spirit of community participation. The participants of these committees are overwhelmingly government functionaries such as CMO, DyCMO, BDO, CDPO, Junior Engineer of the Jal Nigam, AYUSH doctor of the PHC, ICC/ Computer, private practitioner, and one BDC member one *Gram Pradhan*, rather than a representative of the community. |
| **17 West Bengal** | VHNDs do not function well in Purulia district. VHNDs are within the purview of Women & Child Deptt and linkages and coordination with health department are limited. . One day orientation training is proposed to sensitize all the health supervisors, ANMs, ICDS supervisors, AWWs and ASHAs of the block before launching the program. On a fixed day of each month a set of issues selected from 19 identified points of women & child care and public health is expected to be discussed with AWW & ASHA. However such meetings are not taking place because of logistics issues and provision of training material for these workshops. |

# XIV. The ASHAs

| State | Key Findings |
|---|---|
| 1 **Andaman Islands** | ASHAs are in place in one district (Car Nicobar). Selection processes through community based facilitation by NGO/civil society representatives has been completed in the other districts and are awaiting placements. The ASHAs in place have been trained in all modules from I to V which was imparted through cascading TOT model and provision of adequate drug kits to ASHAs. There is no ASHA mentoring group established, informal mentoring is taking place by ANM and AWW. There is a backlog of payments to ASHA in Nicobar in Car Nicobar district. |
| 2 **Andhra Pradesh** | 70,700 ASHAs are trained and positioned and 51201 ASHAs have been provided with drug kits. All ASHAs in the state have received an initial residential training of 21 days for 5 modules. 41,576 ASHAs have also completed Refresher training. ASHAs receive an average remuneration of about Rs. 400 per month. There is a cap on the amount of performance incentive ASHAs get at Rs 400 to 600. There is a backlog of ASHA payments. |
| 3 **Bihar** | The critical support structures needed for ASHAs to be effective are not available. The payment of incentive was not seen to be on time anywhere. Training for most of them has not proceeded beyond the first module. VHND days are not operationalized anywhere in the district visited. |
| 4 **Chhattisgarh** | *Mitanins* serve a population of 300 (50-60 households) only in the state, which enables them to serve their community well, and record all significant information. Some 'non-functioning' *Mitanins* were found in Naxal areas and in some other areas where there was a lack of supervision and monitoring. *Mitanins* have a different training and supervision system from those of ASHAs and AWWs. Many have been in position for seven years, during which time they have received several modules of training as well as regular refresher training. |
| 5 **Dadar & Nagar Haveli** | ASHAs are in place and have been selected by PRIs. It is encouraging to note that ASHAs have undergone trainings in all five modules, which were developed. ASHA support system needs to be established. In absence of support system, it will be difficult to sustain interest of ASHAs in the programme. There were many instances of pending payments especially for JSY although very good system of raising monthly bills for ASHAs; exist, ANMs can pay ASHAs. ASHAs are engaged in IEC/BCC activities in community and drug kits are available. |
| 6 **Daman & Diu** | No ASHA in the state. |
| 7 **Gujarat** | ASHA has been selected by the gram panchayat. However, the eligibility criteria specified in the guidelines are not always adhered to: in some places, the ASHAs are not daughters-in-law in the village, but young daughters who lacked experience and confidence. Moreover, in bigger villages, where there are two ASHAs, they did not always belong to different sections of the community. Most the ASHAs reported delays in their payments: they are |

| State | Key Findings |
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| | being paid once every 3-4 months. However, they are not at liberty to speak openly about it in the presence of state officials and the ANM to who they are obliged. This dependence on the ANM and the health department also prevents them from becoming voices for the community in matters pertaining to the non-delivery of services or breaches of trust. These issues do arise and should be resolved if the objective of (public health) system strengthening is to be met. He reported performing a range of tasks, notably mobilising pregnant women and new mothers before the Mamta Divas (VHND), facilitating institutional delivery, popularising the use of contraceptives, and assisting in other national programmes such as RNTCP, Malaria, among other. In this respect, they were valuable assistants to the ANMs, who clearly benefited from their presence. The ANMs were also the ones who supervised the ASHAs. |
| **8 Haryana** | Accredited Social Health Activist initiated in year 2005-06 and total Target for ASHA selection is 14,000 and 95% ASHAs are selected in Haryana. Slow pace of ASHA training needs attention of the district and state officer. Payment to ASHS for JSY is delayed by 3 or more months as it is observed in SC in district Rewari. Coordination with ANM is satisfactory. The state also conducted TOT for the module V. No apparent evidence of a mentoring process for ASHA. In almost all the PHCs and SCs the ANMs felt that the ASHAs were providing support for linking the services to the community. No ASHA in the state has been provided with the drug kits. |
| **9 Jammu & Kashmir** | ASHAs had been recruited and were available. They have been trained in two parts / sessions, and had received drug kits in 2008-09 which has not been replenished this year. Many motivated ASHAs were found working in the system. Some of them even paid for referral services from their own pockets to bring the pregnant women to the hospital for deliveries / ANC check-ups. Few among them are tracking children due for immunization and maintaining registers. |
| **10 Madhya Pradesh** | There has been a significant increase in the number of ASHA's from 44,832 ASHAs to 62,253 but the selection process has not always been following the guidelines. There is no system at state level of knowing who the ASHAs are or tracking them, though payments are being made to them regularly by cheque and many have received IDs at district/block level. There is no functional support to ASHA's due to the absence of ASHA facilitators, and due to lack of field visits by ASHA mentoring group as funds are not released for the activity. |
| **11 Meghalaya** | ASHA has been recruited NRHM in place the vast majority of them have been trained on all the four modules, and training on Module-5 is on progress, and also have received the ASHAs kits. However, they are getting payment only from institutional deliveries. There is weak supportive supervision of ASHAs. |
| **12 Orissa** | ASHAs are co-terminus with *anganwadi* centres (AWCs). Till date, 37510 out of targeted 41102 ASHAs have been selected, 33115 ASHAs (97.2%) have been trained in module I – IV. "ASHA *gruha*" – Help Desk cum rest house are being commissioned in district headquarter hospitals (30), medical colleges (3), Rourkela Govt. Hospital, Capital Hospital, Bhubaneswar, which are being managed by ASHAs on rotation. |

| State | Key Findings |
|---|---|
| **13 Rajasthan** | State fares well on ensuring selection of ASHAs & their training (up to 4 module completed) across state. 42,385 selected and 40,361 ASHA-*Sahayoginis* in place with complete training upto 4th module. The systems of payment to ASHAs also show improvement with regular and timely payments through e-transfers. The present CRM team felt that the ASHA-*Shayoginis* showed a high level of empowerment in the way they interact and speak out with self-confidence. As per feedback from the community membes and *Jan mangal* couples met by the CRM team, they (ASHAs) command respect and confidence from the community in both districts. But there is a need to rationalise the authority structures in implementation of the ASHA programme, since she is answerable to both the ICDS and health system. She has to be given a greater role as 'social activist', and not as a 'health worker'. |
| **14 Sikkim** | In Sikkim, the ASHA training has been completed with the 5th module for the overall 637 ASHAs. These ASHAs who have been provided with drug kits are participating with aspects of health care delivery other than RCH activities e.g. DOT provided under RNTCP. The training schedule stated under the PIP is followed up to 90% and on the job training is also done to selected participants. The ASHA Mentoring Group (AMG) has been constituted in the State. |
| **15 Uttar Pradesh** | ASHAs are highly visible, motivated and effective in community. They have substantially increased the awareness of service availability at community level. Most of them have received two round of training. Payments of incentive are delayed. ASHAs require regular refresher training and also need a career path particularly for well performing ASHAs. |
| **16 Uttrakhand** | ASHAs are in place in most of the communities and have completed all 5 training modules. However, inadequate mentoring supports to ASHAs at local levels- especially in hard to reach areas. Mismatch was found between 731 sanctioned ASHAs and 2200 VHSCs (in Almora) – especially with reduced population norms. Payments of incentives to ASHA are irregular and inconsistent especially in hard to reach areas. |
| **17 West Bengal** | ASHA intervention has not been effectively established in Purulia district as majority of ASHAs are yet to be selected and trained. Role of selected ASHAs is limited in visiting number of households, reporting of possible outbreaks/epidemics and institutional deliveries. The monitoring format of ASHA has limited scope in monitoring her effectiveness in health care. ASHAs could be involved in DOTS provision, radical treatment for malaria, blood slide collection for malaria, adolescent counseling, motivation for adoption of family planning method, hygiene and sanitation issues etc. is lacking. Incentive package of ASHA is based on fixed remuneration for carrying out predefined activities. |

# XV. National Disease Control Programmes

| State | Key Findings |
|---|---|
| 1 **Andaman Islands** | The programme is integrated within the overall NRHM framework and the UT and District level set up for the programme has been integrated into the UT & District Health Society. There are various posts under NDCPs that have not been filled yet at the district level and this is affecting the performance of various programs.<br>NVBDCP : Vector control measures are in place, fogging and spraying activities are being routinely carried out. Impregnated bed nets are used in health facilities. Biological control through *Gambusia* fish are in place in certain areas.<br>RNTCP : There are vacancies of contractual staff like Senior Treatment Supervisors, Senior TB Lab Supervisors since last year. Lab technicians at PHC are conducting quality diagnostic sputum some of the smear microscopy activities at the Designated Microscopy Centres have been hampered because some of the microscopes have not been repaired.<br>NLEP : The UT has achieved the level of elimination: i.e.: PR<1/ 10000 well before target date. The level of elimination has been sustained and as on Dec 2008 is around 0.46.<br>NPCB : There is no independent fully functional eye operation theatres in the UT. Paucity of eye surgeons in the rural areas is hampering cataract and other eye operations. Cataract and other Eye operations are rendered free of cost.<br>NIDDCP : The NIDDCP is running in the state with financial constraints, although the NIDDCP project under SPIP has been approved through ROP the funds have not been released to the State Health Society in 2009-2010. Last year the funds were released through treasury route in spite of repeated request to release the same through the State Health Society.<br>IDSP : is not functioning well in the UT due to reasons like un-availability of trained manpower at different levels of health facilities. Data collection on P, S and L forms has not been put in place. Lab facilities are not in place for validating and confirming L forms. |
| 2 **Andhra Pradesh** | NVBDCP : Supply of ACT is not regular, LLI are not in supply and the program staffs are not using the district drug stores for storage. There Is a need to strengthen the malaria control measures in high endemic areas.<br>RNTCP **:** There is trend of decline of new smear negative cases and slight increase in new smear positive cases, both of which are normally expected to be equal proportions. Internal evaluation report was not made available.<br>NPCB : This program is doing well in the state. Some of the complex surgeries are covered under Arogyasri insurance for BPL families. There needs to be timely utilization of Collected of eyeballs. Ophthalmic services need strengthening at CHC level and sub district Level.<br>IDSP : Use of the epidemiological data was not attempted for triangulation or for use. The epidemiologists positions created under IDSP are still vacant. |

| State | Key Findings |
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| 3 **Bihar** | NVBDCP : Bihar contributes to more than 80% of kala azar burden in the country and 31 out of 38 districts of Bihar report kala azar. The slow progress made by Bihar remains the major issue for National KA elimination goal set for 2010 by GOI. The inconsistency in treatment protocols was observed and Capacity of Lab. Technicians was also found to be inadequate. |
| 4 **Chhattisgarh** | NVBDCP : Link workers under the (earlier) Malaria Control program had been given no training. Laboratories were not adequately equipped. Despite the high incidence of Pf in the state, only 4 deaths were recorded in the first six months of 2009-10 (which includes the high transmission season) indicating decline of malaria surveillance in the state. Management of malaria at the facilities is poor with lack of bed nets even in wards in the crowded health facilities.<br>RNTCP **:** DOTS providers are in place and treatment is being given. However, only cases that are coming to facilities where there is a lab are being detected, as there is no detection through outreach. Leprosy: The integrated Leprosy program in to the Primary health care system has not been effectively implemented.<br>NPCB : Active screening for cataract and surgeries are being performed largely through camps, for which modern ophthalmological equipment is available. Low availability of ophthalmologists at the state level has been responsible for a steady decline in the number of cataract surgeries performed in the state.<br>IDSP : No Surveillance cell was found in the visited districts. |
| 5 **Dadar & Nagar Haveli** | NVBDCP : API is high, falciparum prevalence in some areas; chloroquin resistance has been reported from pockets. There is reported resistance to Malathion, entomological investigations are going on in the area. RDKs and IBNs are not available. Filarial control activities including mass treatment in place. BCC activities were on at the time of visit of team. Very effective system of social mobilization to ensure mass treatment was evident.<br>RNTCP : Very good progress registered in RNTCP implementation on sputum conversion rate i.e. 92.92 percent last year, and cure rates 84 Percent. Microscopic centers at PHCs and DOTs at periphery are fully functional. No vacancies for STS and other functionaries in the programme. Required drug kits are available in adequate quantities.<br>NPCB : More than three times achievement of targets in the programme, for last year. Involvement of private hospitals is one of the important components of the strategy. Large number cases from adjoining districts in Gujarat and Maharastra.<br>NIDDCP/IDSP : Salt testing units established at different levels. Similarly IEC activities for consumption of iodised salt were visible in the field. |
| 6 **Daman & Diu** | All National Disease Control Programmes (NDCPs) are being implemented reasonably well with diagnostic procedures and standard protocols. There have been no deaths in the last few years due to malaria. IDSP is operationalized. ICTC centre is in place and there are trained ICTC counsellor. |

| State | Key Findings |
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| | Non-communicable and lifestyle diseases like diabetes, hypertension, mental health, IDD etc. are well provided and district hospital and CHC. Laboratory facilities are well structured for these diseases. |
| 7 **Gujarat** | At sub-centre level records were maintained and the ANMs also provided services linked to NVBDCP. Blood slides were being collected and treatment provided. |
| 8 **Haryana** | District level officers are implementing the disease control program. Human resource shortages in managerial positions affect the functioning of disease control programmes, except RNTCP.<br><br>NVBDCP : In year 2008 increase cases of Plasmodium falaciparum malaria reported (1397 Pf cases) and Dengue cases (1159 with nine deaths reported) were also higher in the year. In year 2009 up to September 09 number of PF (434) and Dengue (64 with one death reported). In Haryana sporadic cases of JE are also reported due to migratory population reaching to Delhi and adjacent districts of Haryana.In year 2007 32 cases of the JE were reported and 18 deaths were reported. In year 2009 (Up to Oct 09) only one JE case is being reported and also died.<br><br>RNTCP : Dots plus has been launched successfully in seven districts (Bhiwani, Jind, Jhajjar, Karnal, Panipat, Sonepat & Rohtak) since July 2008 and treatment activities started in Dec 2008. At present MDR treatment services have been given to 39 patients till date.<br><br>NPCB : Cataract surgeries are one of major activities of the NPCB and since year 2007 states are achieving more than 100%. Screening for eye problem in school is also one of the important activities of NBCP. In year 2008-09 in 1857 camps 7817171 school children were screened for refractive errors 13047 were found to be having refractive problem and 2994 were provided with free glasses.<br><br>NIDDCP: In year 2009 more than 18865 salt samples were tested and only 12617 were having standard quantity of Iodine (more than 15 PPM). IDD laboratory is established in Karnal. IEC activities are taken up.<br><br>IDSP : In Haryana state, diseases of public health concern are Dengue, Viral Hepatitis, Japanese Encephalitis and meningitis. State and District Surveillance units have been established in states with Laboratory at all the three levels (L1, L2 and L3). 696 Medical officers, 4660 MPWs (male and female) and 160 Lab technicians are trained in IDSP and weekly reporting are in place and regular which include reports about outbreaks and sporadic cases.<br><br>NLEP : Haryana has achieved the status of "Elimination of Leprosy" by WHO (less than one case per 10,000). In Haryana, 21 district have district leprosy treatment centre with 420 leprosy patients. Leprosy cases are showing declining trends. In 2008-09 total cases are 11 and in 2009-10 only 6 cases are reported and under treatment. Drugs stocks are as per needs and records are well maintained. ASHA, SMS and SHGs are involved in the IEC activities. |

| State | Key Findings |
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| **9 Jammu & Kashmir** | RNTCP : Low case detection rate is perpetual problem. However, the sputum conversion rate of 92% and cure rate of 89% in NSP patients are satisfactory. The sputum conversion rate is low in Rajouri and cure rate in Leh and Rajouri districts. The DOTS Plus is to be started.<br>Leprosy : The state is low endemic for leprosy with prevalence rate of less than 1 /10000 population. However, new leprosy cases are detected every year (200 cases on record) indicating active transmission of the disease and need for in-depth situational analysis in districts/blocks reporting large number of new cases and take suitable actions<br>IDSP : The reporting of disease out breaks are to be initiated as several diseases (diarrhoeas, typhoid etc) are showing upward trends in Jammu region during 2008 in comparison with previous year (2007).<br>Blindness Control : The State has relatively high prevalence of blindness with 15.1 (all India 11.2) and the cataract surgeries to be increased. |
| **10 Madhya Pradesh** | The NDCPs are yet to be integrated well within the overall NRHM framework. Programme Management support requested and available to the disease control programme from the PMU is not as much as for MCH or JSY. Mainly guidelines come from National level and the State units implement the activities as per given norm. |
| **11 Meghalaya** | PMU support for NDCPs not available in the State. Vector control measures in place. There are no shortages reported for reagents, or drugs. ataract surgery being done as also screening for visual acuity in schools; However there are delays in providing spectacles and no follow up. Under national blindness control program till date, out of a target of 90,000 children, 73,731 have been screened, 8217 have been detected with refractive errors and 1694 children have been provided with corrective glasses.1234 teachers, 46 MOs, 342 health workers and 1005 ASHAs/AWWs have been trained in the current year(to date). |
| **12 Orissa** | The disease control programmes are active in the district. ANMs, Pharmacists and doctors are conversant with the IDSP, NVBDCP and RNTCP reporting system and some of them regularly generate reports for onward transmission.<br>NVBDCP : Orissa is a high burden state in India with average Pf > 85%. PRIs are involved in community monitoring of IRS. Vector management intervention in Kandhamal district is limited to IRS spray and Gambusia culture in water bodies. Balasore, one of the coastal districts of Orissa, is known to be filarial affected district. There was no mention of anti – filarial activities in the district presentation.<br>RNTCP : NSP Case Detection Rate in the State has followed a seasonal trend whereby the target of 70% has been achieved in the 2nd quarter every year with dips in the 4th quarter. The NSP Treatment Success Rate however has remained consistently around and above 85% since 2004. RNTCP data management and record keeping were found to be sub standard at the G Udaigiri CHC, a key microscopy center of the district.<br>RNTCP : NSP Case Detection Rate in the State has followed a seasonal |

| State | Key Findings |
|---|---|
| | trend whereby the target of 70% has been achieved in the 2nd quarter every year with dips in the 4th quarter. The NSP Treatment Success Rate however has remained consistently around and above 85% since 2004. RNTCP presence in Kandhamal district was visible, but the data management and record keeping were found to be grossly sub standard at the G Udaigiri CHC, a key microscopy center of the district.<br>NPCB : The activities were mainly limited to cataract surgery at the district hospitals and reaching out to the community for transporting the patients for such surgery. In Kandhamal, the district capacity of a 20-bedded hospital with full-time eye surgeon and several paramedics were utilized to conduct 200 surgeries in the last one year, whereas the NGOs operating in the district conducted 600 surgeries during the same period. The payment to the NGOs, organizing the cataract surgery camps in earlier years is still lying unpaid and unadjusted. There is a need to develop a strategy at state level to reach the needy population in Orissa<br>NLEP : The data of newly detected cases reviewed from 2004-5 reveals a disconcerting recent increase in the ratio of MB to PB and the prevalence of disabilities in the newly detected cases.<br>NIDDCP : There is high incidence in some of the districts of the State, yet, there was no presentation /briefing was made either at State level or at Balasore district.<br>IDSP : The sub-centre level S-form & P-form reporting from PHC and CHCs were regular but providing data which do not match records. |
| **13 Rajasthan** | The CRM team observed a lack of coordination between technical program managers and NRHM program managers. It was also felt that the NRHM program managers were not clear about their role in National Disease Control programmes, i.e. they were aware of only Parts A, B and C of NRHM and not aware of the plans and their roles therein for Part D. Under RNTCP all lab technicians met were trained and equipment was available. ASHAs have not been trained, neither are they involved in identification of suspected leprosy cases. |
| **14 Sikkim** | Merger of societies have taken place at the State and District Levels but Vertical disease control programs are yet to be integrated under NRHM in the true sense. |
| **15 Uttar Pradesh** | NDCP still implemented as special programs. |
| **16 Uttrakhand** | Slide examination for malaria was found in adequate – especially in terai area. Integration of NDCP into district level societies has not taken place. |
| **17 West Bengal** | Protocol for maintenance of malaria lab is lacking. standard treatment protocols of malaria and tuberculosis are not followed. Laboratory technicians under RNTCP & NVBDCP are not optimally utilized despite the low volume of lab tests both the technicians are placed at one facility. Presumptive treatment is very much prevalent; RT is not given in all the cases. Second line drug (Artemisin) is available with ASHA which is not in accordance to guidelines. RDK is in short supply and the kits supplied are for detection of PF cases only. |

# XVI. RCH II (Maternal Health, Child Health and Family Planning activities)

| State | Key Findings |
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| 1 **Andaman Islands** | Good quality RCH services are being provided by SC, PHCs, CHCs and District Hospitals. ASHAs (in Car Nicobar) are creating demand for services in the community as well as making timely referral to the facility for MH, CH and FP services This has promoted institutional delivery. Community is aware of range of RCH services offered by the health department and is making good use of it. Labor rooms and residential quarters are being constructed in sub centers with NRHM funds. JSY payments have been timely in most places and this has also increased institutional delivery. Sick New born Care Unit (SNCU) is functioning well in the G.B. Pant referral hospital, however there is the issue of repairing several new born care equipment which currently are lying unutilized in the hospital. The issue of non-functioning specialized equipment especially new born care equipment was also found in facilities in other districts visited. There is one functional First Referral Unit (FRU) in the UT in referral hospital in Port Blair and the health department has not been able to reach its target of operationalization of 4 FRUs through- out the UT as planned in the PIP. The major road block is the recruitment of specialist especially for serving in the isolated and inaccessible islands. The State department has also not rolled out the multi skilling of medical officers in Emergency Obstetric Care (EmoC) to fill in the manpower and skill gap required. The issues of operationalization of FRUs in the other districts should be given high priority as the population living in these districts do not have easy access at all times to the single functional FRU in Port Blair. Nutritional services and counseling with micro-nutrient supplementation (Vitamin A & IFA) are being provided at Sub centers and Anganwadi. |
| 2 **Andhra Pradesh** | Increases in institutional deliveries and JSY uptake have been noted. At some places cold chain for immunization maintenance was improper, ORT and ARI programs also needs strengthening. Even though some centres had Pediatricians, Infant Warmers and Phototherapy units, the team did not see new born corners, SCNUs, NICUs and protocols of ENBC. Resuscitation equipment like bag and mask, mucus suckers were not available. |
| 3 **Bihar** | Institutional deliveries have seen a steady rise over the years and the district hospitals cater to about a quarter of these deliveries. There is a backlog of incentive payments to be made both to the ASHAs and the Mothers. Safe abortion including MVAs/EVAs/DNCs- training has been initiated with the help of a technical agency. Minilap services are made available through a camp approach in the block PHCs. Unmet need continues to be likely because of the lack of any consistent strategy to increase the coverage for spacing. Emergency contraceptive as an option for unwanted pregnancy has not been initiated in the district/ sub district. Muskan has been successful in enabling the ANM, AWW and ASHA to come together for improving the coverage of immunization. The Mamtas were enthusiastic but were not being |

| State | Key Findings |
|---|---|
| | training at all places. The potential of the group is limited as of now because of lack of supervisory support. |
| 4 **Chhattisgarh** | JSY coverage overall is low (under 40%). Only 22% of deliveries in the state take place in public health institutions. The state does not make JSY payments to women below 19 years of age nor to those having a third or higher order birth. This is against the JSY guidelines for the state, which deem all women delivering at public health facilities in Chhattisgarh eligible for payment. Currently only 12 FRUs are reported to be functioning in the state. Equipment for neonatal management such as resuscitators and warmers were mostly out of order or not in use. As VHNDs are taking place and focusing largely on immunization, coverage of mothers and children is good. AWWs are keeping immunization cards, and appear to be following up in time. The state's FP coverage is low (below national average). It is still focusing on laparoscopic tubectomy through the camp approach at CHCs. Spacing methods are hardly being promoted. Safe abortion services were not being provided in any of the facilities visited, although the state reported that services were available in the district hospitals and in private accredited hospitals. The state has no data on safe abortions provided. Nischay kits were available. RTIs/STIs and HIV/AIDS. VDRL or HIV and testing facilities are not available in any of the facility. Department of Women and Child had been running Adolescent Girls' centre and providing some iron supplementation, but these were no longer functional. School health programs (which could also be used for weekly iron supplementation) are also not running. |
| 5 **Dadar & Nagar Haveli** | There is significant progress in MH. There is improvement in ANC coverage as compared to previous years. PTC kits available and given to ASHAs and ASHAs are using these kits regularly. Nearly 50 percent deliveries are taking place in institutions. In many villages home deliveries also attended by ANMs. Investing in SBA trainings could be very useful. As far as JSY implementation is concerned, JSY payments by ANMs to clients are on time and no delays were noticed. However there are issues such as no disclosures of beneficiary names at facilities. Maternal deaths are being reported. Only 3 maternal deaths reported last year to the programme authority. There is a need to focus on provision of MTP services especially MVA and Medical abortion facilities. This will entail developing a training plan and also to ensure availability of equipments and supplies. Though NICU at CHC and VBCH are fully functional, new born care corners are needed at PHCs and SCs. Ambu bag for resuscitation are not available in field. Good progress in immunization coverage has been registered this year. Unmet demand for contraceptive remains high as per DLHS 3. Team did not notice any IUD insertions at SCs, though ANMs appear to be trained. No emphasis on NSV in the programme. ECP not available at periphery and many providers are even not aware about this govt. supplied pills although they remember several commercial brands. The UT is running an impressive School health programme which is reaching to 300 schools and more than 60,000 children. |

| State | Key Findings |
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| 6 **Daman & Diu** | UT has a high rate of institutional deliveries. The incentive scheme of MSY *(Matru Samriddhi Yojana)* and DDS (*Dikri* Development Scheme) are available. The MSY scheme is available in both government and private hospitals and to all sections of society including the rich and privileged leading to unnecessary expenditure. Family planning activities are being promoted and mini-lap is the preferred procedure compared to laparoscopy. Community based sensitization has been done under the VHSCs regarding breast feeding practices and awareness on the advantages of exclusive breast feeding. This activity has been under taken by the AWW and SC staffs for all the pregnant mothers approaching the sub-centres and *anganwadi kendra.* Condoms, oral contraceptive pills, IUDs and emergency contraceptive pills are supplied to all the Sub-Centers. *Nischaya* pregnancy kits are available to all the sub-centers. Adequate human resource, equipments are being made available at all the government hospital to provide complete Ob/Gyn care to all needy patients across all socio-economic strata. |
| 7 **Gujarat** | The number of institutional deliveries has increased in the state in both the private sector and in government run facilities. JSY and the *Chiranjeevi* Yojana have certainly played a role here, though the interplay of the factors that have led to these increases should be examined in detail to eliminate the possibility of misreporting. The ASHAs and ANMs play an active role in referring women needing delivery services to *Chiranjeevi* providers, even if the deliveries can be done at well-equipped sub-centres. JSY payments are made in Gujarat in two instalments: the first instalment of Rs.500 during the last trimester and a second instalment of Rs.200 after delivery, if it takes place in an institution outside the village. All maternal deaths are audited in the state using a verbal autopsy form by Block Health Officer and RCH Officer. |
| 8 **Haryana** | Institutional Delivery in government health facilities has increased from 83133 (16 % of the targets of year 2006-07) to 111,866 (29% of targets up to Sept 2009 only). Delivery in private health facilities has also increased but not very significantly. GOI scheme of JSY, State Sub Plan JSY and *Jaccha Baccha Yojana* and delivery Hut scheme has contributedSignificantly in increasing institutional deliveries in state. *Janani Surkhsa Yojana* (GOI scheme) was launched in state in year 2007-08 and achievement of the years was 17685. In year 2008-09 the achievement has increased up to 57447. However, the state needs to develop referral linkages for deliveries with complications occurring in these delivery huts. Neonatal corners are established in delivery huts and there are plans to establish neonatal care unit in district hospitals. Neonatal stabilizing units are proposed in PHCs and CHCs. IMNCI is scaled up to 8 districts in state and 26 MOs, 670 Nurses and ANM are trained. 4 more districts will be included in IMNCI during next financial year. |
| 9 **Jammu & Kashmir** | The public facilities are witnessing increased patient attendance and institutional deliveries are also rising. There is a need to ensure a commensurate increase in capacities of facilities to deliver high quality maternal and neonatal health services, as well as use this opportunity for |

| State | Key Findings |
|---|---|
| | post partum family planning. The JSY disbursal is sometimes delayed by a month and sometimes longer. ASHAs have started generating demand and are making referrals to facilities chiefly for MH. However a number of cases of institutional deliveries are self admitted. Essential new born care was found lacking; poor post natal care; lack of counseling leading to early discharge and poor newborn care practices: hardly any facility hosted a newborn corner in LR. The concept of neonatal care as a planned intervention is not clear to many of the service providers at 24x7 PHCs, SDH/CHCs and district hospitals. No area had been earmarked and equipped for newborn care in the OT and labour room in FRUs / 24x7 PHCs and most equipment for "essential newborn corner" are not in place within the labour room or OT. Early initiation of breastfeeding was not being practiced. Early breastfeeding practices was not too encouraging Awareness of medical and nursing staff to the concept and need of essential newborn care services in the labour room and OT was generally lacking even at district hospitals and FRUs (CHCs / SDHs). The immunisation performance in the state has improved substantially as per DLHS-3 data. However, the state could further improve performance in this area through more rigorous follow up and tracking of defaulters. Defaulter tracking through use of tickler bags etc is not done at most places and in many cases the counterfoils of the immunisation cards are given away/ or not being filled which should be avoided. Reorientation of health workers needed in storage and use of vaccines. Sterilizations, mostly tubectomies are being conducted at DHs, FRUs and in some PHCs. The vasectomies however are very few and in some facilities male sterilizations are not being done. Any systematic efforts to improve performance of terminal methods (especially post partum sterilization) and spacing methods were nonexistent. Counseling for family planning by ANMs & clinical providers, an important component of FP services, appears to be lacking. IEC material on FP was not seen in adequate quantities at peripheral facilities. The role of ASHAs as motivators was not seen. There is no involvement of male peer groups. The teams did not find evidence of Adolescent Reproductive & Sexual Health (ARSH) services in the facilities visited i.e. District hospitals/ FRUs, 24x7 PHCs or PHCs. Health care waste management and infection prevention practices and knowledge are poor at all facilities with no segregation of waste, poor storage and disposal of sharps and placenta and body parts. There is very limited understanding of the concepts of infection control and management, and waste segregations and disposal at all levels in the state. |
| **10 Madhya Pradesh** | Bal Suraksha Mah is a good strategy implemented biannually to clear the backlog of coverage in immunization, Vitamin-A supplementation, de-worming and promotion of iodized salt and iron supplementation. The achievement of family planning activities is not satisfactory. The state has initiated Janani Sahyogi Yojana with private institutions, for increasing access for Emergency Obstetrics services. The scheme needs to be more aggressively promoted, explaining the basis for arriving at the package and marketing the business case to the doctors of increased client flow. The state has free transportation models in 313 blocks to reach a health facility for maternity services with 10 call centres. |

| State | Key Findings |
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| **11 Meghalaya** | The State has an infant mortality rate of 58, maternal mortality rate of 400 and total fertility rate of 3.8 in the State. Meghalaya's CPR (Contraceptive Prevalence Rate) is 22.9% which is much less than the national average of 54.1%. Unmet need has come down but at 32.7% it is still way above the national average of 21.5%.Sterilizations (both male & female) conducted at public & private facilities have decreased by 14% (108 cases less compared to last year period). On the other hand the numbers of IUCD insertion have increased substantially in both public and private facilities by 38.1%. The performance in JSY has been increasing steadily in the State with more and more women delivering in institutions. There are significant gaps in the provision of newborn care at both health facility and community levels. In both districts visited by the teams newborn care at facilities was not found up to the mark. There has been a fall in use of ORS for treatment of diarrhea from 81.4% to 63.3% from DLHS-2(2002-04) to DLHS-3(2007-08). Health care workers in general seemed to be well aware of ORS treatment for diarrhea; ORT corners existed at CHCs and civil hospital, but were not much in use. While DLHS-3 data shows some improvement in immunization coverage from 13.5 %( DLHS-2) to 31.7%. Another cause of concern is the fall in number of children with diarrhea being taken for treatment (from 81.4% in DLHS-2 to 63.3% in DLHS-3). |
| **12 Orissa** | There is improvement in the field of Maternal and Child Health and Family Planning. During the year 2008–09, 60% of total deliveries occurred in institutions. The quality of care however was not uniform and in some sub-centres was limited. Reach of MCH services to distant villages was poor. |
| **13 Rajasthan** | Almost all facilities visited were providing 24X7 services for delivery. *Nishchay* pregnancy test kits are available. ASHAs are referring clients for institutional deliveries and had knowledge on maternal and child health. Labour rooms lacked suction machines at most facilities visited, though almost all medicines were available. Post-partum care is getting addressed in select areas through *Yashodas* (counselors) and ASHAs. *Yashodas* need to be trained on promoting family planning. Institutional deliveries have increased due to JSY scheme, but quality needs to be addressed. It was reported by the staff as well as the beneficiaries that women are not staying for 48 hours after delivery. JSY payments are given timely (mostly within a week). JSY need to be used as a good opportunity to counsel women in family planning. *Yashodas* can include family planning messages along with counseling on post–delivery care, breast feeding, nutrition, etc. Complete immunization status is not satisfactory in Alwar. Coverage in 2008 – 09: TT (10 yr) – 10.78 %; TT booster – 5.38 %; Measles – 33.87%; DT- 27.78%. Malnutrition Treatment Centres established at the district hospital. Family planning program is lacking focus. The present focus only on sterilization needs to change to bring spacing methods promoted extensively. BCC / IEC materials were not-available in sufficient quantity. In some IEC materials, the state seems to be promoting two child norms for families. Post- delivery family planning programme needs to be strengthened to avoid missed opportunities. |
| **14 Sikkim** | Institutional deliveries are being conducted at the sub-centers which offsets the barriers in accessing PHCs due to difficult terrains. Even though New Born |

| State | Key Findings |
|---|---|
| | Care Corners have been developed in most of the centers, in some centers, the concept of baby corners is not well translated, and baby warmers considered a substitute. Safe Newborn Care Units need to be developed in every PHC along with Sick Neonatal Care Units (SNCU) at the FRUs. Inspection of the fistrict hospital and peripheral facilities showed that the services have been well developed with the help of the additional NRHM funds and are well maintained. |
| **15 Uttar Pradesh** | There is a substantial increase in institutional delivery. The increase in deliveries at HSCs underlines the urgent need for second ANM across the state. 24×7 facilities are functional for normal deliveries but stays at facilities are still an issue. Increase demand of RCH services underlines the need to address the issue of emergency transport, mobile vans and help-line services- for both providers and users of services. |
| **16 Uttrakhand** | Increase in institutional deliveries and immunisation coverage. No public sector facility for EmOC / C-section; patients going to private sector provider (not accredited under JSY) hence women are not getting JSY benefit. Delay of payments of JSY was noticed in some blocks. High unmet need of women for family planning services and sterilization achieved only 9.8 % of the set target. Inadequate attention to neonatal care and public referral services in the state. |
| **17 West Bengal** | Purulia district has conducted several analyses, including an in-depth maternal and infant death audits in 2007 and 2008 and a base line survey of JSY assistance (2008). Each drew on relatively large samples. The JSY survey found that 68% of eligible births received JSY payment (66% of eligible home births and 70% of eligible institutional births). The district has conducted maternal audits every year since 2005 based on a sample that averages 82% of reported deaths. Eclampsia, hemorrhage and malaria represented 57% of deaths in 2008. Over two-thirds were post-natal deaths with 39% being gravida 1. Over half the deliveries occurred in government institutions. At some of the visited facilities trained Dais are involved in the institutional deliveries. Trained *dais* are conducting deliveries at sub-center at Kuchiya sub-center of Bandwan block. In Hutmara PHC area ASHAs are not posted and trained *dais* escort the pregnant women to PHC, assist staff nurse in delivery & also make first post natal visit though there is no incentive for this work to the trained *dai*. ANWESHA clinics for adolescents are functioning at the BPHCs. The number of girls coming for counseling at the clinic of visited facilities is very low. Infant mortality audits were conducted in 2008 and 2009. Prematurity, low birth weight, asphyxia, ARI and feeding problems were the main culprits. About 27% occur in the first 24 hours while another 27% take place during the first 7 days. Home and government facilities were the place of birth for 53 and 42% of infant deaths respectively. During the site visits, local workers reported that purported 48 hour post partum stay policy does not appear to be enforced. Follow-up monitoring of newborns and their mothers by village health workers is very weak. In terms of full immunization of children, the district exceeds the state average. However, the district lags the state in ANC registration, ANC-3 check-ups and institutional births. |

# XVII. Preventive and promotive health aspects with special reference to inter-sectoral convergence and convergence with social determinants of health

| | State | Key Findings |
|---|---|---|
| 1 | **Andaman and Nicobar Islands** | Limited involvement of Panchayats and civil society in health planning. Community mobilization and monitoring through Village Health and Sanitation Committees has not been fully explored. There is very little emphasis on engaging the community in preventive and promotion health care services. There has been negligible emphasis on the use of IEC/ BCC messages in the form of wall paintings/ folk theatre/ hoardings in the community. There is good convergence of health dept with Women and Child Welfare (WCD) department in the efforts at reducing malnutrition. Greater inter sectoral convergence has to be taken up with other departments like PWD, electricity and water and sanitation. |
| 2 | **Andhra Pradesh** | Good convergence with ICDS system as well as coordinated efforts was observed with involvement of professional bodies like Indian Medical Association. HIV cases are handled without any discrimination particularly for HIV positive pregnant women. |
| 3 | **Bihar** | Limited success in achieving inter-sectoral as well as intra-sectoral convergence. |
| 4 | **Chhattisgarh** | Convergence with ICDS at the village level appeared strong with *Mitanins*, AWWs and ANMs were found to be working together at the VHNDs, held at AWCs and were providing good services. Formal coordination at the District and Block levels is weak. |
| 5 | **Dadar & Nagar Haveli** | There is effective convergence with HIV as ICTCs are providing services for PPTCT also. Similarly ICDS infrastructure is being used for services delivery. School system fully on board on the SHP. |
| 6 | **Daman & Diu** | Convergence has taken place with the PWD to improve the health and sanitation measures towards the implementation of Rajeev Gandhi Water and Sanitation programme. Intra-sectoral convergence between PRI and Directorate of Medical and Health services has been effective in creating the hospital and sub centre welfare committees towards improving the quality of care, and in addressing malnutrition and anemia. |
| 7 | **Gujarat** | No information. |
| 8 | **Haryana** | District Health and Family Welfare Society is the forum for convergence at district level for preventive health and promotion of coordinated health initiatives. NGO involvement in health program also provides the opportunity for convergence given that NGOs operate in multiple sectors such |

| State | Key Findings |
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| | as: education, gender, poverty and socially excluded groups. SKS and VHSC serve as the platform to increase participation of related sector for over all community ownership of the health services and community monitoring of health program. In VHSC and SKS, participation of School teacher, Water supply department personnel at villages and Block level, PRI members, CBO members, SHG members is required to ensure effective convergence of all stake holders working in various areas. There is effective convergence with Department of Women and Child Development, with the AWW and ANM working closely together to identify and refer severely malnourished children. |
| **9 Jammu & Kashmir** | Good convergence with ICDS for organising VHNDs for immunisation coverage. |
| **10 Madhya Pradesh** | Linkages with the Rural Development department for safe drinking water and sanitation and Women and Child development department were minimal and there was little evidence of convergent efforts at addressing malnutrition, vector-borne diseases, age of marriage, school health etc above the VHSC level. The IEC strategy for the state has been prepared through a consultative process and 8 key behaviors related to RCH issues have been identified in order to streamline BCC planning. The districts are being guided to develop their communication plans aligned to these 8 key behaviors and at the same time having freedom to respond to the local challenges and issues. The state has also developed a BCC implementation and monitoring MIS software, planned to be piloted in two districts. Establishment of a BCC Cell at the district level, as a single umbrella cell to promote inter-sectoral synergy on BCC activities with the IEC unit of different departments like health, ICDS, rural development, Panchayati Raj etc is supported by UNICEF. |
| **11 Meghalaya** | Process of inter sectoral and intra sectoral convergence is weak at district & block levels-though AWWs and ANMs were seen working closely in some areas. Disease progammes are still maintaining separate budget heads and functioning as vertical rather than as integrated interventions. |
| **12 Orissa** | Intersectoral coordination needs to be enhanced to combine the efforts of the women and child development sector and health sector synchronizing into sustainable community benefit. Similarly coordination with PHE, dept. of rural development, and safe toilet promotion is also needed. |
| **13 Rajasthan** | The IEC / BCC materials were not available in sufficient quantity in all centres visited by the CRM team. The IEC coordinator (contractual staff appointed under NRHM) at the district level in Alwar was not aware of the national programmes and the concept of behaviour change communication. The consultant was not involved in planning, preparing, training, etc on IEC / BCC. A large number of AYUSH practitioners and paramedics have been recruited for co-locating at the facilities, but the plans for construction of space for the AYUSH services were found to be lagging, even in Bhilwara |

| State | Key Findings |
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| | where other construction activities at PHC and CHC had been completed. Good examples of 'Revitalising Local Health Traditions' exist in the state, but are not being adopted under NRHM activities. |
| **14 Sikkim** | There is cooperation between ICDS and the department of HRD to include nutrition in the Kindergarten scheme. And between DWCD and health to support VHND. Collaboration is also proposed with schools to involve them in improving nutrition status. |
| **15 Uttar Pradesh** | The crucial component of health promotion is limited to ASHA's providing advice relating to pregnancy and delivery. While the state has a health promotion strategy, it is not visible in field. IEC material is not available. Health Melas are opportunities for educating people and promoting health- in addition to providing secondary care. |
| **16 Uttarakhand** | Effective intersectoral convergence in the state exists between NRHM and ICDS, with potential for supporting improvements in Nutrition. Co-location of schools and AWCs is opening up new possibilities for converging nutrition support and infrastructure. Convergence with Swajal SWAP, TSC is also encouraging, with ASHAs being incentivised for being sanitation motivators. |
| **17 West Bengal** | Convergence of Health, P & RD, and the Department of WCD is working effectively through the Community Health Care Management Initiative (CHCMI). Construction of sub-centres and primary health centres undertaken by *Gram Panchayats* (lowest tier PRI) and *Panchayat Samities* (middle tier PRI), respectively from no health funding sources. In areas where health facilities are non functional, the PRI hires AYUSH doctors for service provision. |

# XVIII. Nutrition

| | State | Key Findings |
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| 1 | **Andaman and Nicobar Islands** | IPC on early and exclusive breast feeding, proper weaning practices and the introduction of complementary foods. , are taking place in the community through Anganwadi worker as well as ASHAs. IEC material on nutrition and BCC strategies need review. |
| 2 | **Andhra Pradesh** | A nutrition program has been implemented by the Society for Elimination of Rural Poverty (SERP) under IKP through women's self help groups. Programme has links with the NRHM, ICDS and JSY schemes, NREGA and Bank Linkages to SHGs .Vitamin A supplementation is being given every month at the Anganwadi center. However, anemia was not being monitored. This program seems to be functioning well and seems to providing convergence between issues related to health, nutrition and livelihood issues. However, this new platform needs to be integrated with the ICDS program. |
| 3 | **Bihar** | Some districts have nutrition rehabilitation centers, which could be expanded to other districts. |
| 4 | **Chhattisgarh** | AWWs carry out growth monitoring and provide nutritional supplements at AWC while *Mitanins* provide counseling on the feeding of mothers and infants, including early initiation and exclusive breastfeeding. Even though very low Hb levels were frequently reported among pregnant women, anemia is not being adequately addressed among pregnant women or adolescents. |
| 5 | **Dadar & Nagar Haveli** | As this is a tribal district, nutrition needs attention. Though there are some improvements in breast feeding and complementary feeding; however more needs to be done. Malnutrition is being monitored through ICDS. The school health programme also needs to address prevailing nutritional deficiencies. |
| 6 | **Daman and Diu** | School Health Education programme has been launched for students up to class VII. This service is provided in collaboration with the school, sub-centres and *anganwadi*. There is a BCC component on anemia and nutrition which is implemented through various fora. In addition to treatment for deworming, students are screened and treated for anemia and provided with IFA tablets. |
| 7 | **Gujarat** | A major concern for the state is the high prevalence of anaemia among women, as evident in consecutive rounds of the NFHS. In response, the state plans to address the issue by initiating nutrition supplementation and treatment in few selected blocks. |
| 8 | **Haryana** | Despite being a leading food-producing state, Haryana continues to report high prevalence of malnutrition and anemia in children and women. Under the National Nutritional Program Iron, Folic Acid tablets are provided. |
| 9 | **Jammu & Kashmir** | Village Health and Nutrition days (VHNDs) are not being organized as envisaged. The services in these sessions are limited to immunization only. In the Anganwadi centre in Kupwara district, supplementary nutrition activities such as distribution of take-home-rations for pregnant women |

| State | Key Findings |
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| | and in-house feeding for children has not been carried out for the past 2-3 months as there has been no supply of food, while in the Anganwadi Centre Gurah Talab in Jammu, food for supplementary nutrition activities has been available only from second week of October. |
| **10 Madhya Pradesh** | Under NRHM, steps are being undertaken by the state & districts to improve early & exclusive breastfeeding, especially among institutional delivery cases as well as identification of early malnutrition and management of moderate to severe malnutrition with complications. In view of the severe acute malnutrition and under-nutrition among a large proportion of under-five children the State has developed 189 Nutrition Rehabilitation Centres (NRCs) including 50 district hospitals. Apart from therapeutic diets, mothers are well trained in preparing and feeding the child correctly by Nutritionists. Follow up after the child leaves the NRC is weak. |
| **11 Meghalaya** | VHNDs being held but not as per any plan. Most district staff needs orientation on VHND guidelines. |
| **12 Orissa** | While the nutritional support system is well established, it does not have adequate impact as the Grade I and Grade II malnutrition have remained unchanged in spite of provision of the nutritional supplement. Pushtikar Divas programme provides for tracking of children for Grades III and IV malnutrition and funding for supplementary nutrition and treatment. |
| **13 Rajasthan** | Although nutrition is integrated into the MCHN Days, which is organized in the *anganwadi* centres (AWC), there appears to be a lack of focus towards the nutrition component from the health staff. In Alwar no undernourished (Grade III/IV classification) children were reported. Identification of parts of the village which are under-served and where malnutrition is more likely is required, so that ASHA/ANM/AWW can pay focused attention to these families. Referral of sick-malnourished children to MTC/NRC needs to increase. VHSCs may be involved in identification of malnourished children. |
| **14 Sikkim** | ICDS scheme run by the Department for Women and Child Development is merged with a HR from the Kindergarten Scheme to support the monthly Village Health and Nutrition Days. |
| **15 Uttar Pradesh** | Malnutrition including anemia is still a major challenge-especially for delivery. Although potential exists for ASHA to play a much more effective role, currently nutritional interventions are limited to advice on initiation of early breast feeding (within first hour in cases of institutional deliveries), exclusive breast feeding for six month and IFA tablets for pregnant mother. |
| **16 Uttarakhand** | Growth monitoring and promotion component needs support – there is a shortage of functioning weighing scales, growth cards, and charts with new WHO growth standards. Severe malnutrition is not clearly assessed as ICDS; Health functionaries are not familiar with new WHO growth standards for correct nutrition assessment. School Health Check Ups being held twice a year – nutrition education component needs to be enhanced. |
| **17 West Bengal** | No separate programme for malnourished children in place. A nutritional packet of food provided by the AWW to the mother to feed the malnourished (grade-IV) child at home. There is no monitoring of the food being given to the child. |

# XIX. Non-governmental Partnerships

| | State | Key Findings |
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| 1 | **Andaman and Nicobar Islands** | The health department is exploring partnerships with various non – governmental organizations. At present they have entered into a partnership with the NGO Prayas for school health program as well as for orienting VHSC. The health department has appointed consultancy firm HSSC for setting up a medical college through a PPP modality. The UT is keen on exploring further collaborations with various established NGOs in the health care sector for various areas like training, service delivery, security etcetera and has started the process of dialogue with them. |
| 2 | **Andhra Pradesh** | There are many NGOs working in the state in the health sector. Services such as 108 and 104 services and *Arogyasri*, a Health Insurance Scheme for the BPL families, are managed by Public Private Partnerships. |
| 3 | **Bihar** | NGOs do not appear to have been able to create space for themselves or have not been given any specific role except for centrally selected NGOs for taking on the responsibility of Mobile Medical Van. |
| 4 | **Chhattisgarh** | The district hospital at Raigarh had an OPD wing established by a corporate agency and eye camps are conducted by an on behalf of the state in Bastar. |
| 5 | **Dadar & Nagar Haveli** | There are no NGOs in the UT. There is a plan to invite effective NGOs from neighboring Gujarat. |
| 6 | **Daman and Diu** | No information available. |
| 7 | **Gujarat** | The *Chiranjeevi Yojana*, a PPP model is credited for the increase in institutional deliveries in the state. An allied scheme – the Extended *Chiranjeevi Yojana* – is now rolled out in which private obstetricians who are willing to set up practice in remote areas will be provided monetary incentive to do so, in addition to being reimbursed based on the number of deliveries conducted. There are no attempts to make beneficiaries aware of their entitlements in the scheme. For example, the innovative toll-free number service run from Patan district hospital that provided details about the whereabouts of *Chiranjeevi* providers and their contact numbers, did not spell out the services that women could expect to receive for free. This is an important omission, given that research in one of the scheme's pilot district, Dahod showed that BPL women who availed of the *Chiranjeevi* scheme in district did end up making payments, albeit at a lower rate compared to non-beneficiaries. |
| 8 | **Haryana** | NGO are involved in Mother NGO scheme, Janani Suvidha Yojana, Hemophilia, Social marketing of sanitary napkins and VLC and VHSC for village health action plan. Community based Organization are involved in Social Marketing of sanitary napkins in all 21 district, subsidized sanitary napkins are sold to rural women at rate of 10 rupees (cost is 25 rupees and 15 rupees are subsidized by Department).Social mapping of health and sanitation problem in four villages of Panchkula with the support of NGO is being piloted. Rangoli methods are used in village mapping and village planning for health and community development. In some districts, the Lions Club is involved in Anemia reduction and de worming campaign. |

| State | Key Findings |
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| 9 **Jammu & Kashmir** | The availablity of NGOs are very minimal and the state could only had 10 MNGOs for the 22 districts. |
| 10 **Madhya Pradesh** | Partnership with NGOs, facilitated by UNICEF in Guna district, has led to strengthening ASHAs and VHSCs in the project areas. Similarly Mobile Medical Unit of Tamiya block operated by KGN Welfare Society, Betul is a good example of Civil Society partnership. Adequate representation of NGO's needed in RKS of various hospitals. |
| 11 **Meghalaya** | Management of two CHCs, 18 PHCs, one Dispensary and sub centers has been handed over to NGOs, through an MOU, wherein the NGO is responsible for staffing and provision of services. A referral and transport service for medical emergencies, Police and Fire service has been established through a PPP mechanism. |
| 12 **Orissa** | Management of PHC (Paschimbad PHC) by NGO since 24.12.2007. The services provided by the NGO include OPD services, Laboratory services, Ambulance services, IEC activities in outreach areas, emergency health services during disaster situation. Increased OP/IP and institutional deliveries due to this initiative. Urban slum health programme initiated with the help of two NGO's managing urban clinics for slum dwellers. |
| 13 **Rajasthan** | Community monitoring program is undertaken in collaboration with NGOs. 33 NGO run Urban-RCH centres functioning optimally (covering 50,000 populations @ Rs.13 lack pa per center). 108-Ambulances functioning effectively in urban/semi 1 urban areas and Mobile Medical units (MMUs) are functional under PPP. Non-governmental participation is still peripheral (not mainstream) to the core strategies of NRHM. Costing and reimbursements to private parties needs to be realistic. Performance parameters of partnerships need to be monitored and financing may be related to performance (sub-optimal use of 108-ambulance making around 2 trips per day per ambulance, even in the 2nd year of operations) |
| 14 **Sikkim** | Voluntary Health Association of Sikkim is functioning as the mother NGO (MNGO) in three districts to supplement RCH activities. Evaluation of the MNGO Scheme in Sikkim by the RRC for N.E. States, Guwahati is being planned in the coming months. |
| 15 **Uttar Pradesh** | NGO involvement requires increased attention. MNGO scheme need to be reviewed. Under "*Saubhagyawati* scheme" 9 private nursing homes identified for referral of complicated cases for safe delivery. |
| 16 **Uttarakhand** | MNGOs are working as an ASHA resource centre namely Garhwal Community Development and Welfare Society in Tehri and INHERE in Almora. However, inadequate mentoring support to ASHAs at local levels-especially in hard to reach areas. |
| 17 **West Bengal** | 5 NGOs have been engaged for implementing several programs for service delivery in selected districts of the state. They also include specific issues such as Thalassemia awareness, snake bite, and gender and hygiene. Under *Ayushmati scheme* private facilities are being accredited and implemented in 68 private nursing homes across 16 districts. |

# XX. Overall Programme Management

| | State | Key Findings |
|---|---|---|
| 1 | **Andaman & Nicobar Islands** | Program Management Unit is in place; however the staffs are over burdened and this leaves them with little time for critical analysis and reflection for program planning and quality improvement. Programme management teams below district level suffer from lack of appropriate mentoring primarily because of the heavy workload on senior staff. |
| 2 | **Andhra Pradesh** | Decentralized planning was outsourced to a few institutes who were making centralized plans, with inputs from the districts. Supportive supervision is required at all levels. |
| 3 | **Bihar** | Program management units have been established at State Health Society, district and block level with full time contractual appointment of a program manager and an accountant. The coordination between State Health Society and Directorate of Health needs to be enhanced. Capacity building of DPM and BPM unit staff is also required. |
| 4 | **Chhattisgarh** | The state PMU is in place providing management support to the programme. Better coordination and supportive supervision is required between CMOH team and DPMU at district levels. |
| 5 | **Dadar & Nagar Haveli** | PMU is fully functional and well integrated within the system. Overall they are providing necessary support to the programme managers by analyzing data and also ensuring implementation of the work plan. |
| 6 | **Daman and Diu** | The PMU needs to be strengthened in terms of planning, monitoring and control of various initiatives. The availability of human resources is weak is in areas of financial management, MIS & data management, etc. District Accounts Manager/Finance Manager position has just been filled in for Daman and it is vacant in Diu. |
| 7 | **Gujarat** | Programme management at all levels appears to be well functioning. |
| 8 | **Haryana** | Programme Management Units are operational at all levels of the system from state to block levels and appear to be functioning effectively. |
| 9 | **Jammu & Kashmir** | In Kupwara district, 5 out of 10 BPM are in place. There is no DPM in place for last 4 months, no district data assistant (DDA) for last two years. Only district accounts manager (DAM) position is filled. In Baramula district, the attrition rate in DPMU is high. DPMU did not have any DAM from May'08 to August '09 while there was no DPM and DDA from July to October. |
| 10 | **Madhya Pradesh** | The programme management structures recommended by NRHM i.e. SPMU, DPMU and BPMU are in place. Currently, 14 out of 50 DPMs positions are vacant and recruitment seems to be an ongoing process. The effort to integrate the directorate and the existing officers with the new NRHM staff at the State level is a positive development. The coordination between the State and district programme management teams and between district and block programme management teams seems to be lacking at |

| State | Key Findings |
|---|---|
| | places. There is also a great need to build the capacities and enhance training to DPMU and BPMU staff on programme management including finance & accounting needs to be implemented soon. |
| 11 **Meghalaya** | PMU staff appointed at district & block levels. Well functioning PMU at West Garo Hills. PMU (district & Block) at Jantia hills need orientation to NRHM & mentoring. No evidence of Village /PHC health plan seen. No comprehensive plan in districts for upgrading facilities. District plans not adequately reflected in State PIP. District Officers not fully aware of planning process even 4 years after NRHM. |
| 12 **Orissa** | The PMUs both at the State and at district level are in place, but need to increase supervisory skills, which are required to be supported by regular health services managers, both at the State level and at the district level. The gap between the programme managers (State & district) and the SPMSU/ DPMSUs is evident and lack of regular appointees for programme management is affecting implementation of NRHM in general and the vertical national health programmes in particular. The block PMSUs were either absent or has not taken roots yet. |
| 13 **Rajasthan** | Program managers, accountants and data analysts are in place under NRHM, assisting the department in improved physical and financial monitoring. Facilitators for ASHA, AYUSH and IEC placed at district and block levels for increased monitoring and mentoring. Areas that need improvement include: coordination amongst NRHM and departmental (ministerial) staff, Emphasis on monitoring of physical and financial numbers, at the cost of quality of services/activities, orientation of program management staff regarding the concepts, strategies and components of NRHM and the health priorities of the local area, Vacancies at block and facility level. |
| 14 **Sikkim** | SPMU and DPMU are functional and vacancies at the block and district levels have been filled up. Capacity building workshops are conducted at regular intervals for these PMU staff. |
| 15 **Uttar Pradesh** | SPMU, DPMU and Divisional PMUs are in place. Institutionalizing the integration of PMU with Directorate/CMO activities is required. Block level team yet to be constituted. |
| 16 **Uttarakhand** | Programme management staff needs more clarity on their roles and job responsibilities. Attrition among the management staff was observed, possibly due to low remuneration. Induction and refresher training are not being carried out systematically. |
| 17 **West Bengal** | Purulia district has established an adequate PMU consisting of 4 program officers and 3 program managers, 2 data entry operators. 20 block account managers and 40 block data entry operators complement this. A public health group consisting of deputy CMOH and four-person PMU oversees public health programs, complemented by an HIV/AIDS cell, a district leprosy officer and a district TB officer complement them. DPMU is more or less limited to routine work and emphasis on supervision/monitoring are getting back seat. Observation of the field visits is not properly documented. Follow up of poorly performing facilities is weak. |

# XXI. Financial Management

| State | Key Findings |
|---|---|
| 1 **Andaman & Nicobar Islands** | Funds are being transferred by E-transfer. Fund releases up to the level of sub center are by e transfer. Where cooperative banking is available, telegraphic transfers are made. Financial records are being well maintained, and payments to contractual staff are being made on time. There are delays in fund transfers and in finalization of accounts. Audits are also delayed. |
| 2 **Andhra Pradesh** | State has an efficient funds management system that uses technologies like e bank transfer and Tally system for improved accountability. Expenditures are reported on Tally Software. Standard guidelines for financial record maintenance particularly below district hospitals were not available. |
| 3 **Bihar** | Bihar has an overall approved funding of 1254.70 crore for 2009-10 under the Programme Implementation Plan (PIP). This gives an average of 100 crore to be spent on an average per month. However, till end of October 2009, the expenditure is Rs. 250 crore, which averages only about 35 crore per month. The inadequate staff strength at the state level, lack of Supervisory/technical cadre and the slow pace of expenditure has an adverse effect on implementation at the district and block levels. |
| 4 **Chhattisgarh** | Financial management and utilization of budget was found to be poor because of poor availability of human resource to manage finances and accounts. |
| 5 **Dadar & Nagar Haveli** | 84 percent of allocated funds were utilized last year. Regular audit reports are available and FMR are submitted on time. No major non-compliance reported in audit reports. |
| 6 **Daman and Diu** | Financial Management system is relatively weak and needs a lot of strengthening. Financial training has also not been initiated, as there was hardly any staff for finance training. There is no internal audit/concurrent audit being done at the UT level. Statutory audit report for the year 2008-2009 is still pending. NRHM Fund utilization at UT is low. The UT is utilizing only 30%-40% of fund. UT has not contributed 15% of the funds towards NRHM in 2008-09. Funds under RKS are not being utilized as there are no user charges and RKS funds are left untouched. |
| 7 **Gujarat** | Financial authority has been delegated in both districts. District level account keeping and tracking of funds are evident in both districts down to the PHC, SC and VHSC levels. Financial reporting to the district and from the district to the state takes place on a monthly basis through the MIS. At the district level, the disease control audit is merged with NRHM audit. Release of funds to the districts has been delayed in 2009-10 and unspent funds are beginning to be tracked now. In the district also, fund releases to facilities is not against approved activities, but in a lump sum fashion and adjusted against the available balance in accounts of the RKS/Facility accounts. Untied funds for 2009-10 have not yet reached all facilities in Patan district; these releases have not been uniform. |

| State | Key Findings |
|---|---|
| 8 **Haryana** | NRHM funds allocations to the districts are via electronic medium but communication to district official and block official is delayed and often funds are transferred, without adequate communication. Financial management needs a lot of attention, as the systems are not standardized in different districts and within the district itself. Fund flows need to be stream lined. Fund transfer from state to district by e-transferring method and from district to block is done by cheque only. Fund utilization is effective in drug procurements, maternal health, family planning and Village Health and Sanitation Committee heads. Bank accounts are opened for SC untied funds and these funds are being utilized for the health care services. ASHA and JSY payments are done in cash and those also delayed by three months and there are backlogs in these payments. JSY funds not available at all level ANM, PHC-MO and BPHC-MO. |
| 9 **Jammu & Kashmir** | While the expenditure has been increasing, state needs to take urgent steps to increase the absorptive capacity. Reported expenditure during 2008-09 is less than 10% of the allocation. Overall expenditure reported by the state in the 1st quarter is Rs. 3.52 crores (31.6% of the budget Q1 09-10): including Rs. 73.23 lakhs for base flexi pool (21.2% of the total base flexi pool budget), Rs 2.71 crore for JSY (38.7% of the JSY budget), and Rs. 8.28 lakhs for sterilization compensation (12% of the sterilization compensation budget). The state has reported zero expenditure on family planning and reported high variance from the amount planned for child health and Innovations / PPP/ NGO in Q1 09-10. State had planned for Rs. 2.38 lakhs under family planning for Q1 09-10, including female sterilization camps (Rs. 1.50 lakhs) and monitoring progress, quality and utilization of services by Quality Assurance Committees (Rs. 0.88 lakhs). The state has reported no expenditure for the 1st quarter. |
| 10 **Madhya Pradesh** | Fund flow was found efficient at all levels. E-transfers to all Districts are taking place from Bhopal with the help of State Bank of India and sanction letters are e-mailed to Districts so that the Districts can start using the funds received through e-transfers. Financial approvals of DHAP's and delegation of financial powers have been done and communicated to all districts. The post of State Accounts Manager and State Finance Manager are vacant and needs to be filled up immediately. It is found that huge advances amounting to more than Rs.200 Crore are lying in the books of the State Health Society. Utilization of funds both under the Mission Flexible Pool and RCH Flexible Pool was low up to second quarter and stood at 13% and 26.32% respectively. The concurrent audit mechanism pioneered by Madhya Pradesh has led to significant improvement in quality of book keeping at all levels, including at the Sub-Centre level. |
| 11 **Meghalaya** | State level audit completed up to 07-08, 08-09 going on. Financial allocation from the Centre to State is delayed due to lack of UCs. E-banking is proposed through SBI and the process is on. Financial allocation disbursement from State to District does not match the DHAP. Most disease control programmes in process of integration with state society. State contribution of Rs. 23.79 crore has not yet been provided. |

| State | Key Findings |
|---|---|
| **12 Orissa** | Significant increase in total expenditure is reported under maternal health, IEC/ BCC activities under part A and 83% increase in part B during 2008-09.But under part B the state has utilized only 37% of the approved PIP. State needs to improve expenditure in Child health, ARSH, Tribal Health & in Vulnerable group related expenditures, training under Part A. Moreover, the overall utilization rate of the PIP from inception is found to be only 50%, which needs to be expedited. JSY and ASHA payments are made promptly, and monthly clearing of ASHA payments is helping to ensure that these are up to date. |
| **13 Rajasthan** | The state had already booked 84% of the sanctioned PIP for 2009-10 by Sep. 09. Accountants available at district, block and facility level. Updated (latest) QFMR format being used and Tally software system installed up to block level. But Tally needs to be customised and all reporting centres need to be linked for real time funds position information. NRHM accountants and managers need more orientation on GF&AR, and on the other hand, public accounts officials and auditors need to be oriented on NRHM spirit and guidelines/orders. Decision for spending money from VHSC untied funds should be taken at state/district level. |
| **14 Sikkim** | The capacity of the State to utilize the funds made available to it under the various components of NRHM has consistently increased. E-banking facility in the State up to the district level is in place. Delegation of powers has not yet disseminated to the districts and vertical integration not yet taken place amongst the NRHM and the various NDCPs. Delay in completing civil works leading to inability to receive funds from the Centre. Districts and blocks have not received the final approved action plan from the State and it was also found that RKS money is not reaching the district hospital & PHCs. |
| **15 Uttar Pradesh** | There are significant improvements in the field of financial management, with timely reporting for both FMRs and Audit Report, and timely fund transfer from state to districts. There are proper mechanisms for record keeping and payment is made by cheque only. Concurrent audit system is in place. Regular monthly meeting held with all DAMs. Fund flow from district to block and to below need to be streamlined. |
| **16 Uttrakhand** | E-transfer of funds at district, DH, SDH, CHC and PHC in practice therefore timely flow of funds. Audit reports should be shared timely with districts. |
| **17 West Bengal** | Funds are transferred from state to district through e-banking and through Cheque / Draft down below the district level. There is no formal mechanism of reconciliation of accounts though occasionally it is being looked into by the district account manager/account officer during their visit to concerned facility. Observations of such visits are not formally documented and monitored. Tally is not in use for financial accounting at the district level. Income from interest is not monitored. At district level, approximately Rs.80 lakhs is generated from interest income. Activities not supported/planned in PIP are taken up from this income. |

# XXII. Data Management

| State | Key Findings |
|---|---|
| 1 **Andaman & Nicobar Islands** | HMIS data is being collected effectively from sub center onwards. Data is entered at the District level directly. Data validation is thus a major issue. There have no major initiatives at the UT for the convergence of HMIS with IDSP. |
| 2 **Andhra Pradesh** | Though the data is being generated regularly at facility level, compiled at district level and put up on web portal there is no validation or triangulation mechanism in place to assure quality of data. It is not integrated with IDSP. The data analysis not regularly done for monitoring and improving the service delivery. Data managers need to be trained and mentored by the program officers. |
| 3 **Bihar** | Data of various programmes are being maintained by the District Data Manager except for disease control programmes for which the concerned programme officers have to be consulted. There is a need for orientation of data managers along with district programme officers for convergence. |
| 4 **Chhattisgarh** | The state has developed a daily on-line data reporting system. Fifty percent of PHCs (those which have electricity connections) have been provided computers while data is collected manually from other PHCs. The formats for primary data as well as the basic registers have been developed. Data quality needs ongoing monitoring and improvement. |
| 5 **Dadar & Nagar Haveli** | Web based reporting started in January 2009 and UT is posting progress regularly. There is an effective system of data reporting in monthly meeting of SCs using form 6. However there is need to focus on analysis and feedback, through capacity building of concerned staff. |
| 6 **Daman and Diu** | Data management activity is a weak area, as the UT does not have standardized templates and formats for recording outpatient and inpatient data. The entire process of data capture and storage is manual. There is no use of computers in data keeping and manual effort leading to inefficiency and errors. |
| 7 **Gujarat** | There is effective data management at state and district levels. Data entry takes place at the block level, with individual facility reports being entered at that level. Regular reporting through the MIS from all levels enables state officials to effectively monitor the programme. |
| 8 **Haryana** | HMIS has been effectively utilized by the district officers in reviewing program performance. Presently 70-75 % data are uploaded from district and the state reports to GOI on a regular basis. Despite HMIS being established in the state, data information reporting from different sources still exists and about 80 various reporting formats are in use i.e. RIMS reporting, Immunization reports to district administrations and others. |
| 9 **Jammu & Kashmir** | The HMIS data is being uploaded at the district level and there is a need for verification of this data as the data is not correlated with services utilization including deliveries, out-patients and In-patients. While an HMIS is in |

| State | Key Findings |
|---|---|
| | place, systematic analysis and understanding of data and feedback to facilities or its use for planning or effecting corrections was not visible. State needs to ensure quality of data, including capacity building of data entry personnel. |
| **10 Madhya Pradesh** | New HMIS formats are being introduced, with the Hindi translation being complete. State and divisional level training are complete. There is a further capacity building training plan on new formats at district and block level. Programme Managers are initiated to GIS mapping, NRHM web portal and DHIS-2. Apart from routine programme reporting, there is a central monitoring system for financial allocation/utilization. JICA supported GIS maps are used for institutional delivery, JSY beneficiaries, and labour room performance. |
| **11 Meghalaya** | All the facilities located in the district are sending information manually to the district directly or through BPM. There is no analysis of data either at the State or District level. Monitoring and Supervision need to be strengthened. |
| **12 Orissa** | Uploading of data in web portal is more or less regular, but utilization of data needs to be more focused. Analysis and regular feed back to the facilities, generating these data, is not happening. The IDSP unit is fully manned and operational. The District Surveillance Officer is also trained and maintains continuity. |
| **13 Rajasthan** | Pregnancy & Child Tracking System (PCTS) and MMJRK software provide excellent tool for tracking & monitoring. Computers and operators are available at block and facility level. Redundancy exists among myriad registers and formats (ANMs need to spend 2-working days per week for filling up formats). Feedback is not happening down the reporting chain. |
| **14 Sikkim** | HMIS is in place in the State. Reporting formats are being used for transmission of data from the sub-centers to the PHCs and then to the district headquarter where data is uploaded on to the Web Portal. The process of analysis of MIS data and its use for planning, monitoring and mid-course correction if necessary however needs to be strengthened. |
| **15 Uttar Pradesh** | Data uploading on HMIS portal is good. The state needs to institutionalize systems for validating the data. Capacity of staff at all levels to be built for reporting and planning based on data analysis. |
| **16 Uttarakhand** | First level of data entry in HMIS format is at district level. |
| **17 West Bengal** | The HMIS system is still compiled manually due to lack of connectivity in most blocks. Most data is collected and forwarded to the state and is not used locally for decision-making. Record keeping by ANMs and ASHAs is far from optimal. The same probably can be said of some PHCs and BPHCs. In the sub-district hospital, staffs were yet to compile an annual report for 2008 on basic statistics. Facilities do not use data to make decisions or to plan service improvements. |

Section - V

# State Summaries

*PHC Garacharma Andaman & Nicobar Islands*

*AWW Centre - Andaman & Nicobar Islands*


*Newborn Care Mobile Unit - Rangat CHC - Andaman & Nicobar Islands*

# ANDAMAN AND NICOBAR ISLANDS

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- **Sh. Talem Tapok,** MD (NRHM), Arunachal Pradesh

**The Districts/Institutions Visited**

1. **District Nicobar :** DH and 3 SCs
2. **District Middle and North Nicober:** DH, CHC,2 PHC and 3 SCs
3. **District South Andaman :** 2DH, 2 PHCs, 2 CHCs, 1 AWC

## *Progress under NRHM*

- HR: The provision for incentivization of doctors and Para- medical staff working in difficult areas has improved staff retention. The gap between "needed" and "available" has been reduced in most places.
- Sub centres are functional, utilised effectively for outreach activities especially MCH and Family planning. ANMs are working in close coordination with AWWs and ASHAs. VHNDs taking place.
- ASHA are in place, have good knowledge of maternal and child health. ASHAs used for IPC with the community.
- Good performance on DOTS programme: 90% cure rate. Elimination of leprosy has been achieved and is being sustained.

## *Areas for Improvement*

- UT faces difficulty in the recruitment of specialist to serve in "hard to reach areas". HR cell needs to be set up augmentation of health human resources Multiskilling of medical as well as Para-medical staff is lagging behind.
- PMU/ DPMU needs strengthening, filling up existing vacancies, skill building of staff by exposure visits and short term trainings in other states.
- The roll out of comprehensive BCC strategies in nutrition and greater coordination of the health department with WCD for the treatment of severely acute malnourished children needs attention.
- Need to strengthen community mobilisation and monitoring to address local needs; Optimise use of IEC/BCC.
- Quality of services in the facilities could be better: 48 hour stay required for mothers delivering in facilities, signage for entitlement, biomedical waste management practices should be put in place.
- ASHA Mentoring group should be established to strengthen the ASHA programme. Timely payment to ASHAs to be ensured.
- The UT needs to focus on preventive services through adequate community involvement and IEC/BCC activities.
- FRU operationalization in district hospitals and CHCs needs to be taken up on a urgent basis
- Provision of separate Infectious disease ward/ beds in all health facilities is required
- Operationalization of Tele medicine facilities should be expedited
- Validation, analysis and utilization of HMIS data required for effective planning and implementation, community monitoring process to be initiated and strengthened to understand and address local needs.
- IDSP programme implementation needs to be improved. There should be efforts to strengthen and use surveillance information collected through IDSP for effective management of disease control during disasters.

*Baby warmer, CHC, Aganampudi, Andhra Pradesh.*


*IEC Campaign by NGO in Shandy village, Andhra Pradesh*

*ASHAs during VHND in VHO-Jogimpeta, Andhra Pradesh*

# ANDHRA PRADESH

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- **Dr Arun Agarwal,** PGI, Chandigarh
- **Dr Rajiv Tandon,** USAID
- **Dr K.S. Jacob,** CMC, Vellore and MSG, NRHM

**The Districts/Institutions Visited**

1. **District Vizianagram** - District Hospital, MCH/Ghosha Hospital, CHC Bhogapuram, CHC S Kota, CHC Kothavalsa, PHC PM Palem, PHC Kottam, Subcentre,AWC and Village, AWC, Subcentre, out reach session, and community interaction, Visit to 104 Ambulance service delivery area.
2. **District Vishakhapatnam** –District Hospital, Area Hospital, CHC Aganampudi, CHC Arku Valley, Nutrition centre under SERP/Velugu Project, PHC Ananthagiri, PHC Pendurthi, PHC Kasim Kota, PHC Revidi, PHC Anandapuram, PHC Lambasing, Tribal Sub centre, village selected randomly through a patient's TB card, Subcentre and AWC, and community interaction, PHC Lothu Gedda.

## *Progress under NRHM*

- Out of a total of 800 PHCs, designated as 24x7 health facility, 630 PHCs are functional
- About 96,279 human resources for health were added since the inception of NRHM, which includes, inter alia, 10,370 second ANMs.
- 70,700 ASHAs trained and in position, of whom 10,000 in tribal area
- Increased utilization of services at the Sub centre
- Active Public Private Partnerships in place. They include: ambulance services, mobile health service clinics and *Arogyashri*.
- AYUSH services available at most facilities
- Inter sectoral convergence between ASHA, ANM and AWW at village level appears promising
- Birth waiting homes has proved to be helpful in preventing complications of delayed labour.
- Effective community participation seen in VHSC and RKS
- Efficient and transparent funds management system in place
- Increases in number of PHCs and SHCs in difficult areas.
- CT Scan facilities available at all district hospitals
- ASHAs trained as DOTS providers.
- Nutrition project SERP covering 600 villages under the Indira Kranthi Pratham (IKP) programme.
- Logistics and supply chain managed by the AP Health & Infrastructure Management Development Corporation
- HMIS is operational.

## *Areas for Improvement*

- Infrastructure strengthening required in FRUs and sub centres.
- Clarity of roles and functions of 104 mobile clinics, subcentres, ASHA and AWW needed to avoid duplication and overlap of services.
- Quality Assurance mechanisms to be implemented at all levels.
- Health care services for tribal populations to be better focused.
- Large vacancies of human resources in health in remote areas to be addressed
- Need to provide In-service training for the health personnel in the latest technologies eg- CT scan
- Issues of mapping, and grading of difficult areas and introducing adequate incentives for health personnel necessary.
- Appropriate inventory of equipment is required
- Limited Convergence of the ICDS and NRHM at the block, district and state levels needs improvement.
- No village or block level planning undertaken so far.
- Malaria control measures in high endemic areas to be strengthened.
- Role of epidemiologists at district level needs clearer definition.
- Cold chain system for vaccines needs to be strengthened
- Increased utilization and triangulation of HMIS data required.


*Add PHC, Nalanda, Bihar*

*IEC Campaign by NGO in Shandy village, Andhra Pradesh*


*Referral Hospital Rajgir, Bihar*

# BIHAR

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- **Dr. B. Kishore,** Asst. Commissioner, Child Health, MOHFW, New Delhi
- **Dr. Sunil Nandraj,** WHO, New Delhi
- **Dr. K. Pappu,** NIPI
- **Dr. P.K. Srivastava,** Joint Director, NVBDCP, New Delhi

**The Districts/Institutions Visited**

1. **District Nalanda -** District Sadar Hospital, Sub District Hospital, Block PHC & Add PHC - Chandi, Noorsarai,Rajgir (refrral Hospital),Pawapoori, Nalanda; ANM Training School Bihar Sharif –located at District Hospital, Health Sub Centre - Ghosarama, Dashrathpur, Lahuar, Nalanda, Naroona
2. **District Khagariya -** Sadar Hospital , Referral Hospital ;Gogri PHC cum Referral Hospital, Block PHC & Add PHC - Mansi PHC, Beldaur PHC, APHC- Mahesh Khunt, APHC – Pirnagara, Community interactions: Village Pirnagara, Village Sisba

## *Progress under NRHM*

- State Health Society, Bihar has initiated the process of upgradation of health facilities
- APHCs have been created.
- Increased utilization of public health facilities mainly because of improved human resources deployed, drug availability and JSY incentives
- Human resource in health sub-centres, PHCs and district hospitals has increased substantially through contractual appointments, pooling or deputing doctors and ANMs from additional PHCs to higher level.
- Muskaan has been effective in improving immunization coverage.
- ICTC centre functional at District Hospital and Sub District Hospital
- Safe abortion including MVAs / EVAs/DNCs- training has been initiated with the help of a technical agency.

## *Areas for Improvement*

- Only 30 to 40% sub-centres have 2nd ANM in place.
- DPMU needs capacity building for proper management of the health programme at district levels.
- Lack of technical human resource to manage the funds and programme efficiently
- Very few functional FRUs in the state
- Standard quality protocols not being followed at the health facilities
- Management of hospital, diagnostics and logistics is highly inadequate
- Procurement and inventory systems need to be developed
- Decentralized planning not fully achieved
- Community ownership through RKS and VHSC needs to be strengthened
- Irregularity in the training and disbursement of incentives for AHSA
- Inconsistency in treatment protocols for Kala-azar
- Capacity building of Lab. Technicians required
- Huge backlogs in JSY payments to ASHA and mothers.
- Mamata worker needs better support and supervision
- Lack of strategy to address high unmet need for family planning.
- Newborn care services at home and in facilities need action

*Chhattisgarh*

*Waiting area for patients, Chhattisgargh*


*Citizen charter for National Blindness Control Programme, Chhattisgargh*

# CHHATTISGARH

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- **Mr. Sanjay Prasad,** Director (RCH, DC), MOHFW
- **Dr. Meera Chatterjee,** Senior Specialist, The World Bank

**The Districts/Institutions Visited**

1. **District Raigarh-** District Hospital, PHC Loing, CHC Pussore, PHC Badebhandar, SC Kotmara, PHC Saraipali (VHND), Punjipatra(VHND), CHC Tamnar, CHC Gharghoda, SC Amlidihi, CHC Lailunga, PHC Rajpur, PHC Sisringa, Civil Hospital D.Garh, CMHO, Raigarh
2. **District Bastar-** FRU RNT Kondagaon, CHC Bakawand, SHC Kinjoli, PHC Kachnar, CHC Darabha, PHC Pakhnar, Village Kutapara, SHC Tirathgarh, PHC Chindbal, SHC Sohanpal, SHC Keslur, Village Sohanpal, Civil Hospital, DH Narayanpur, PHC Chhotedongarh, Ramakrishna Mission Hospital, SHC Garhbengal, CHC Lohandiguda, PHC Chaperbhanpuri, PHC Chaperbhanpuri, Village Chitrakoot

## *Progress under NRHM*

- Well-established Mitanin Programme for every 400- 500 population.
- Introduction of RMAs to increase the availability of skilled human resources in remote areas holds potential
- Residential quarters for ANMs in sub-centres enabling improved service access
- Good coordination at Panchayat level
- Regular VHNDs conducted at Anganwadi Centers through well coordinated action by AWW, ANM and Mitanins to provide maternal and child health services
- On-line data reporting system in place

## *Areas for Improvement*

- Low JSY coverage (under 40%) as compared to other states.
- Home deliveries in the state continue to be high.
- Lack of clarity about untied funds at all levels
- Service delivery for vulnerable and marginalized groups needs improvement.
- Procurement and inventory management systems to be put in place to avoid wastage of 'high end' equipment such as digital BP monitors and anaesthetic agents.
- Quality and safety protocols are not being followed in the facilities
- Capacity building of the Jeevan Deep Samitis and VHSC required
- Strengthening of Malaria control programme , IDSP and Leprosy Eradication programme needed
- Testing facilities for STI and HIV/AIDS need to be introduced at all appropriate facilities.
- Poor coordination between DPMUs and CMOH teams
- Lack of technical human resource leading to poor financial and data management
- Acute shortage of health personnel at all levels
- Irregular in-service training for health personnel and those trained are not utilized fully because of poorly structured deployment policies.
- Poor utilization of the health facilities in the state evident from low patient load

*School Health Programme, Dadra and Nagar Haveli*

*Immunization Programme, Dadra and Nagar Haveli*

*Tele-medicine in action, Dadra and Nagar Haveli*

# DADRA AND NAGAR HAVELI

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- **Mr. Prateek Goel,** Deloitte Touche Tohmatsu India Pvt.Ltd., Gurgaon
- **Dr.G.S. Meena,** Deptt. of PSM, MAMC, New Delhi
- **Dr A.T. Kannan,** Professor and Head, Deptt. Community Medicine, UCMS, New Delhi

**The Districts/Institutions Visited**

1. **Dadra and Nagar Haveli -** Institutions visited : Government Hospital, Silwasa , Khanvel, CHC, Dudhani PHC, Mandoni PHC, Sub centres in Selti, Kauncha,Sindoni, Silvasa, GNM school, Sindoni, Anganwadi centre

## *Progress under NRHM*

- All 38 functional sub-centres have ANM quarters. All 6 PHCs are functioning as 24x7 facilities.
- Optimal utilization at facilities indicated by increase in caseload in CH, PHs and CHCs (institutional deliveries is above 50%).
- ASHAs trained and in position, with drug kits.
- Community processes are in place: RKS set up, VHSCs registered.
- Web based HMIS data reporting initiated.
- Financial management systems in place
- Home deliveries attended by ANMs.
- Timely payments being made under JSY

## *Areas for Improvement*

- Human resource gaps need to be addressed through HR mapping, redeployment of existing personnel; and incentivization to specialists.
- Early initiation of training for ANM as SBA, in IMNCI and IUD insertion
- MTP services are not being provided at the sub district facilities..
- Need to focus on Standard Treatment Guidelines and delivery protocols.
- Community participation processes need to be strengthened through building capacity RKS and VHSCs.
- HMIS needs to be operationalised.
- Nutrition needs attention in this predominantly tribal UT. Prevailing nutritional deficiencies among children should be followed up through the school health programme

*Trauma Unit & Emergency Medical Services, Govt. Hospital Daman & Diu*


*Rogi Kalyan Samiti fund : Daman & Diu*


*I E C for NIDDCP, Daman & Diu*

# DAMAN & DIU

**The Review Team**

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- **Dr AT Kannan,** Professor and Head, Deptt. Community Medicine, UCMS, New Delhi
- **Dr.G.S. Meena,** Professor, Deptt. Community Medicine, MAMC, New Delhi
- **Mr. Prateek Goel,** Manager - Strategy & Operations, Deloitte Touche Tohmatsu India Pvt. Ltd.
- **Mr. Kal Singh,** Director PNDT, Nirman Bhawan, New Delhi
- **Dr. Dinesh Aggarwal,** UNFPA

**The Districts/Institutions Visited**

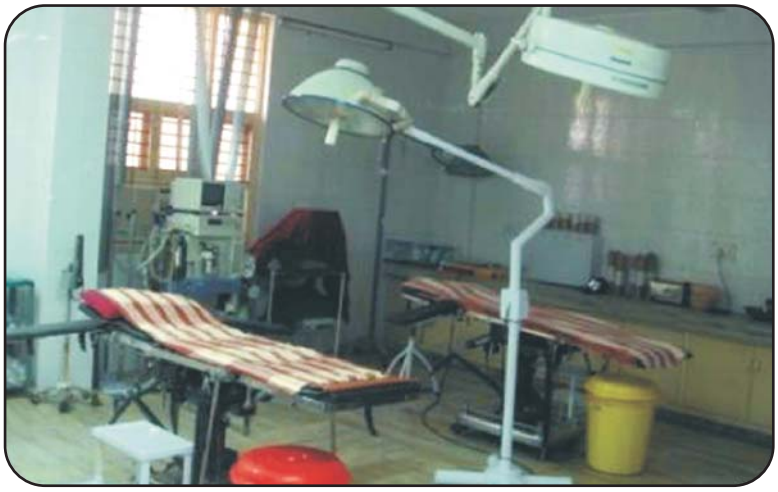
1. **UT - Daman & Diu**

## *Progress under NRHM*

- Adequate level of physical infrastructure and manpower available in all levels of health services
- Substantial increase in institutional deliveries due to Matru Samrudhi Yojana (MSY) being implemented in the UT
- Evening clinic is an innovative initiative by the UT and is done twice a week in industrial areas.
- Procurement and supply chain management is reasonably good in the UT.
- There are no user charges existing at facility level.

## *Areas for Improvement*

- Utilization of services like telemedicine center, MMU, 102 ambulance services is not appropriate and needs reprioritization
- Skill based trainings for medical officers and staff is not in place and trainings for finance and data management staff is also non-existent.
- Because of non –availability of ASHA's and link workers, outreach activities are limited.
- Social audit mechanism and community involvement is not present.
- Financial Management system at the UT of Daman of Diu is relatively weak and financial training has also not been initiated. Further T internal audit/concurrent audit is yet to be implemented.
- Data management activity is weak as they do not have standardized templates and formats for recording outpatient and inpatient data. Entire process of data capture and storage is manual leading to inefficiency and errors.



*Operation theatre (Gujrat)*

*Patient at health facilities in Gujrat*

*VHND in Gujrat*

# GUJARAT

**The Review Team**

- **Dr. Kiran Ambawani,** DC, MoHFW, New Delhi
- **Prof. A.C. Baishya,** Director, Regional Resource centre for Northeastern States
- **Dr. Aditi Iyer,** Research Consultant, IIM, Bangalore
- **Dr. V.K. Raina,** Joint Director, NVBDCP, MoHFW, Govt. of India, New Delhi

**The UT/Districts/Institutions Visited**

1. **District Patan**
2. **District Banaskantha**

## *Progress under NRHM*

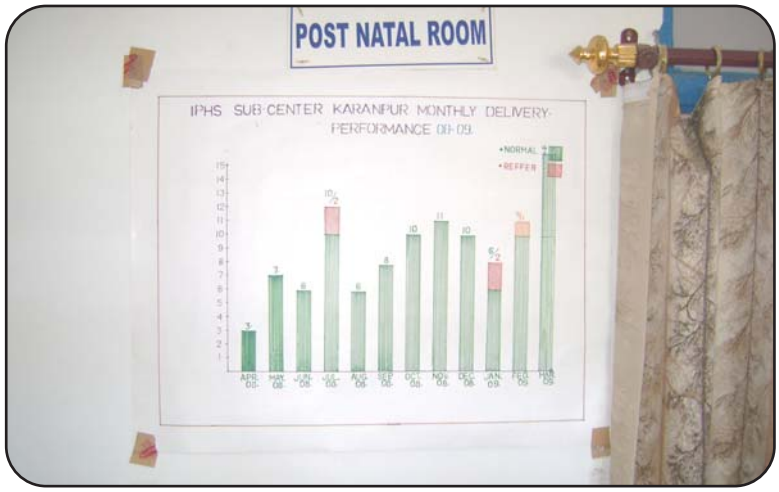
- Most facilities at all levels were well equipped for OPD, and deliveries.
- Lab technicians and Pharmacists were available at all faciltiets and routine investgtiosn were being conducted.
- All SC are well equipped and ANMs are residential
- Both districts had ANM training schools
- 108 EMRI services is being well utilized in all areas.
- VHND conducted regularly with active participation of ASHAs
- ASHA tracked pregnant women and helped the ANM develop micro birth plans that were then shared with the 108 services to reduce potential delays in transport to institutions during labour
- The state has instituted incentives for SC,ST and BPL populations for services such as delivery care through JSY and Chiranjeevi Yojana and enables access to both public and private providers through health insurance via the RSBY
- Programme Management Units at all levels are functional.
- MIS is effectively managed at District and state level

## *Areas for Improvement*

- A clear human resource policy is needed.
- Shortage of Manpower at PHC/CHC (Medical officers/ General Nurse Midwife) and district level as per IPHS and NRHM's guidelines needs to be addressed.
- Training quality needs improvement
- Need to monitor demand generation and referrals for Chiranjeevi scheme by ASHAs & ANMs to ensure that women's health is not compromised by commercial interests
- The 24X7 PHCs need to establish/strengthen newborn care corners
- Training and capacity building of VHSC to be undertaken on a priority basis
- Fund releases need to be streamlined and tracked


*PHC Bakhapur, Rewari, Haryana*

*Displayed ANM check up at Sub-centre, Haryana*




*Displayed ANM check up at Sub-centre, Haryana*

# HARYANA

**The Review Team**

- **Dr. Dinesh Baswal,** Asst. Commissioner, Training Division, MoH & FW, Govt. of India
- **Dr Sunita Abraham,** Christian Medical Association of India
- **Prof. (Dr.) Amitav Datta,** Dept. of Community Medicine, AFMG, Pune
- **Mr Vikram Rajan,** Health Specialist, The World Bank, Delhi
- **Dr Aboli Gore,** Consultant, HRM, JICA, Bhopal (MP)
- **Mr Jagvir Singh ,** DPD, IDSP, New Delhi

**The Districts/Institutions Visited**

1. **District Rewari -** District Hospital, Sub-divisional Hospital Kosli, Community Health Centre, Nahar Primary Health Centre, Bachod, Sub-centres at Rampur, Jadra, Kasola
2. **District Pachkula –** District Hospital, SIHFW, Community Health Centre Raipur Rani & Kalka. Primary Health Centres at Hangola and Nanakpura, Sub-centres at Sameldhi, Ramgarh, Karanpur, Marranwala.

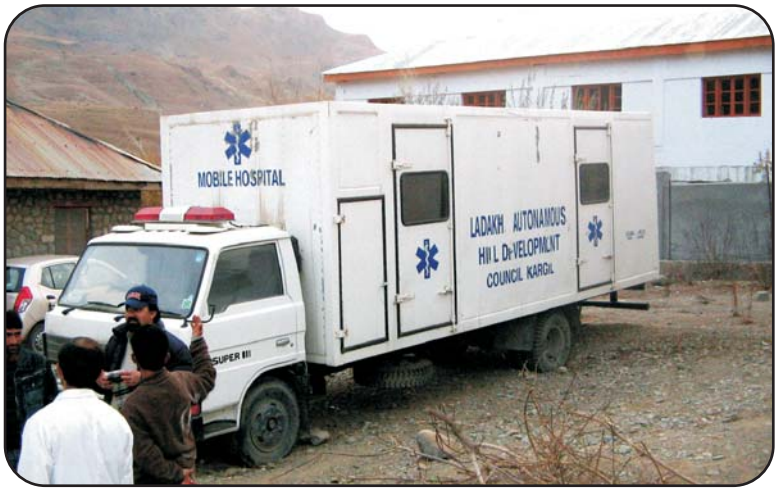
Additional Districts visited – 3. District Karnal, 4. District Mahendragarh

## *Progress under NRHM*

- Sub centres provide range of services: treatment of minor ailments, Antenatal care, Post natal care, New
- born care, Family welfare service, Diabetes & hypertension screening and treatment, TB and Leprosy case detection, Nutrition counselling and Health education
- Institutional deliveries continue to rise.
- A surgical package program has been developed and rolled out in the last 2-3 months
- Swasthya Kalyan Samiti has adequate representation from PRIs.
- All expenditure at CHCs and PHCs level are backed by formal decision of RKS/SKS
- District Health and Family Welfare Society, Swasthya Kalyan Samiti, Village Health and Sanitation Committee are functional.
- Community based organisations are involved in Social marketing of sanitary napkins in all 21 districts
- BCC is taking place through through Sakshar Mahila Samooh
- MNGO involvement in Janani Suvidha Yojana is effective in reaching SC/ST women.

## *Areas for Improvement*

- Human Resources gaps need to be filled at all levels of health facilities.
- Lack of equipment for basic functioning at all level of health facilities hampers service delivery
- Financial management systems need to be standardized.
- Delay in the payment of ASHA incentives need to be corrected.
- Monitoring and supporting mechanism need to be improve in ASHA programme
- NGOs involvement in various programmes needs to be strengthened.
- Waste management require urgent attention
- Specific planning for migrant population is required
- Hospital Management systems for General Hospitals and beneficiary tracking systems at the SC level need to be in place.
- Capacity of district and facility managers in use of data for decision making to be built.
- Community Participation processes need to be improved.




*MMU J & K Drass –40 Degress Tem*


*J&K - ANM, 2nd ANM, Health Worker Male of SHC*


*Maternity Centre : 3 Obst. specialists, Nurse & Pharmacis*

# JAMMU AND KASHMIR

**The Review Team**

- **Dr. Tarun Seem,** Director - NRHM, MoHFW, New Delhi
- **Ms Gayatri Mishra,** DS (H&CR), Nirman Bhawan, New Delhi
- **Dr Thamma Rao,** Advisor - HRH, NHSRC
- **Dr. Sumangala Choudhury,** TMSA, RCH – II, New Delhi
- **Prof. S.C. Gulati,** Institute of Economic Growth, Delhi University
- **Dr. Shyam Ashtekar,** School of Health, Sciences YRU, Nasik

**The Districts/Institutions Visited**

1. **District Phulwama** - SDH Pampore,DH Phulwama
2. **District Kupwara** - DH Handwara (FRU), SDH Kupwara (FRU), CHC Tangdar (FRU), PHC Chowgal (24/7), PHC Drugmulla,MAC Teetwal,Lonewala AWC
3. **District Baramulla** - Baramulla DH (FRU),Sopore SDH /Mother and Child Hospital (FRU), PHC Boniyar (24/7)
4. **District Jammu** - SDH Sarwal, PHCMisriwala, HSC Gurah Talab, AWC Gurah Talab

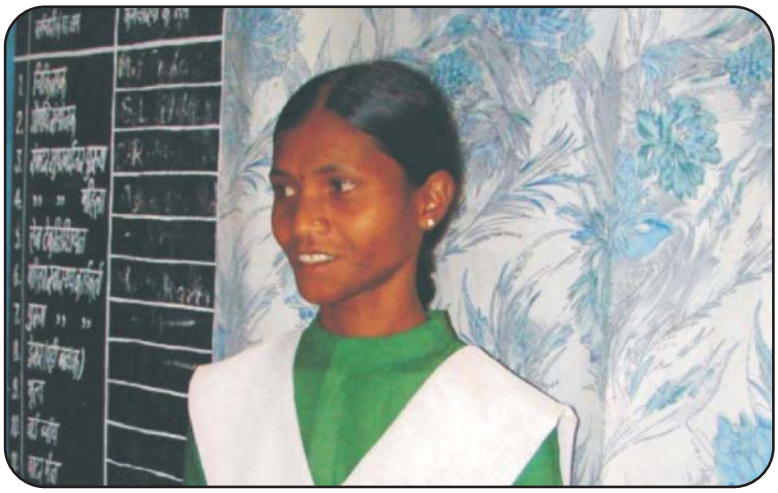
## *Progress under NRHM*

- Substantial improvement in health infrastructure.
- Increasing trends in OPD attendance at facilities compared to the past years and the baseline of NRHM; rise in various service utilization
- RKS, Village Health and Sanitation Committees formed across most facilities and villages ;untied funds disbursed to facilities.
- Considerable progress made in recruitment, training and provision of kits to ASHAs across the districts.
- Increased patient attendance and institutional deliveries in public health facilities.

## *Areas for Improvement*

- Rational mapping and planning for location of infrastructure required, perhaps through an Infrastructure Development Wing at the Directorate level
- HR planning needs to be in tandem with infrastructure plans to ensure adequate utilisation of facilities.
- Several problem areas in HR are evident, including insufficient numbers and irrational postings. There is an urgent need for an HR policy.
- Gaps in service delivery including quality are apparent.
- Blood banks are constructed but not registered or functional.
- Need to establish basic, non-negotiable list of services available in facilities to better inform the public
- Standard operating procedures and standard treatment guidelines not in place.
- Improved utilisation, reporting, supervision, audit and public disclosure of RKS funds and untied funds is required.
- VHSCs need to be pro-active in furthering strong community action.
- Building of perspective and skills are required to operationalize decentralised planning.
- There is an urgent need for an ASHA Support structure, including a mentoring group to strengthen the ASHA programme.
- Limited community representation in the RKS due to apathy of the local health officials for the facility;
- Improvements in post partum care including family planning services are needed. Neonatal care strategies need focus.
- Timely payments under JSY need to be ensured.
- Infection control and waste management systems need to institutionalise in all facilities.
- Tracking of mothers and children for immunization programme needs strengthening..
- VHNDs need to be effectively utilised to promote desired health seeking behaviour.


*PHC, Linga: The proper utilization of RKS funds has changed the look and feel of the hospital and boosted the morale of the staff*



*Ms. Ramahai Dubey, ANM, PHC, Chhindi*

*NRC at Civil Hospital Chandameta, Chhindwara*

# MADHYA PRADESH

**The Review Team**

- **Dr. K.R. Antony,** Director, State Health Resource Centre, Chhattisgarh
- **Dr. Thelma Narayan,** Centre for Public Health and Equity, SOCHARA, Bangalore
- **Mr. Rajesh Kumar,** Dy. Controller General of Accounts, Ministry of Finance, Office of the Controller General of Accounts, Lok Nayak Bhawan, New Delhi.
- **Ms. Moni Sinha Sagar,** USAID, American Embassy, New Delhi
- **Ms. Mona Gupta,** Technical Management Services Agency, New Delhi
- **Mr. Sanjeev Kumar Gupta,** Finance Controller, NRHM, FMG, New Delhi

**The Districts/Institutions Visited**

1. **District Chhindwara**
2. **District Guna**

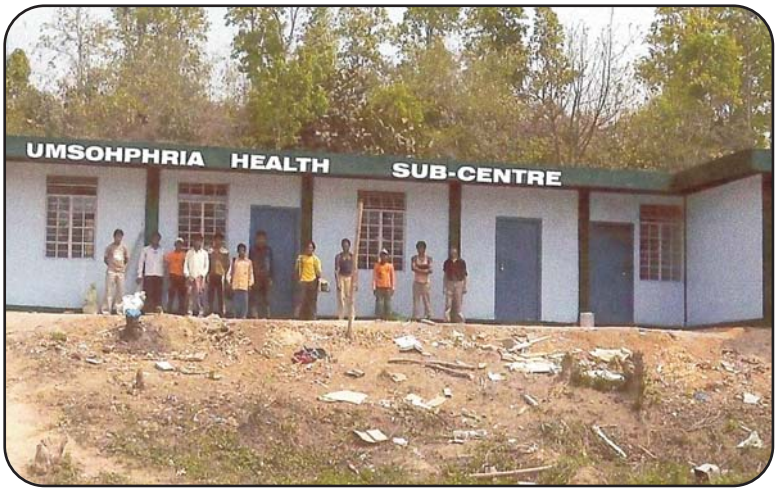
## *Progress under NRHM*

- Strong Political Commitment to Health Weekly Jan Sunwai's at different levels statewide initiated by the political leadership, emails to the CM, and an SMS complaint system by the Guna Collector are examples of a complaint cum grievance redressal system.
- Induction of hospital administrators at the district hospitals has increased the management capacity.
- RKS fund utilization is found to be good and many facilities are using the funds to procure drugs and equipments like x-ray machines, CT- scan etc.
- Free referral transportation models through PPP and call centres functioning well in the state.
- The concurrent audit mechanism pioneered by Madhya Pradesh has led to significant improvement in quality of book keeping at all levels, including at the Sub-Centre level.
- Baal Suraksha Maah, a useful mechanism to clear backlog of immunization and Vitamin A supplementation

## *Areas for Improvement*

- Significant gaps exist in physical infrastructure and manpower across various levels of care. Very high shortage of nurses, pharmacists, laboratory technician need to be addressed.
- Quality of ante-natal and post natal care services, infection control and cleanliness needs to be strengthened.
- Development and implementation of District Action needs improvement. .
- There is a lack of integration of NDCP's which is not in keeping with the NRHM
- Coordination between the State, District and Block programme management teams needs improvement.
- Fund utilization under the Mission Flexible Pool and RCH Flexible Pool is low.
- Posts of State Accounts Manager and State Finance Manager, and many posts of DPMs need to be filled to improve programmatic and financial management.


*State Medical Ware House N.R.H.M., Shillong*




*Sub Centre, Umsohphria*

*District Medical Health Ware House, Baghmara*

# MEGHALAYA

## The Review Team

- **Dr Sangeeta Saxena,** Child Health, MoHFW, New Delhi
- **Mr. Biswajeet Das,** Director (Statistics), MoHFW, New Delhi
- **Ms. K. Kalaivani, Professor,** National Inst. of Health & F. Welfare, New Delhi
- **Dr. Narendra Gupta, Prayas,** Chitorgarh, Rajastahn
- **Dr. V.K.Manchanda,** The World Bank, New Delhi
- **Dr. Pavitra Mohan,** UNICEF, New Delhi

## The Districts/Institutions Visited

1. **District East Khasi Hill (Shillong)** – Shillong- Gopal Das Hospital, Regional Blood Bank, Pasteur Institute, State Warehouse, ANM Training Centre, Central office of EMRI, North East Indira GANDHI Regional Institute of Health & Medical Science, Urban Health Centre:Demisieming CHC, Sohara
2. **District Jantia Hill-** Civil Hospital Jowai, CHCs: Khliehriat, Lasken, Ummulog, PHCs : Nartiang, Shangpung

   **Sub Centres:** Wahiar, Mowtyrsiah, Primary school Myusngat
3. **District West Khasi Hill-** Civil Hospital Tura, Ampati CHC, PHC: Bapadam, Asanag, Garobadha, Betasing, Tikrikalia, Jeldupara , Sub –Centre : Damlagre, Balzek.

## *Progress under NRHM*

- The state has an excellent referral transport system: catering to three functions, ambulance service, police and fire. 30 ambulances are functional now.
- The State has been able to appoint contractual Doctors and Nurses, so that there are currently no PHCs without a Doctor or ANM.
- There have been significant increases in OPD cases
- FRUs are fully functional with specialists and blood storage in Jowai, Nongpoh, Ganesh Das, and Tura Civil Hospitals
- Utilization of Untied funds, RKS and maintenance grants is effective
- ASHA are in place and training on Module-5 is underway, with ASHA having received kits.
- The national blindness control program has reached more than 80% of its targets,
- There is active Involvement of NGOs, in management of CHC and PHC

## *Areas for Improvement*

- Proper deployment of specialists and need assessment for multi-skilling of doctors are required for operationalising future FRUs
- The status of training is inadequate and training institutions need to be upgraded
- Equipment and diagnostic services need to be improved in a substantial proportion of the health facilities.
- Timely payments of ASHA, supervision and monitoring are required.
- Convergence at district & block levels needs improvement.
- Comprehensive planning for upgradation fo district facilities is required.
- District planning is weak and needs redressal.
- E banking is required to improve financial management systems.
- Monitoring & Supervision need to be strengthened


*ASHA GRUHA at Balasore DH*

*Outreach Immunization session in Kandhamal district*

*SORO CHC, Balasore (Orissa)*

# ORISSA

**The Review Team**

- **Ms. Archana Varma,** Director, NRHM-I, MoHFW, Govt. of India, New Delhi
- **Sri P. K. Hota,** Director, NIPI, New Delhi
- **Dr. Ashoke Roy,** Advisor, Public Health, RRC – NE, Guwahati
- **Billy Stewart,** Health Adviser, DFID, British High Commission, New Delhi
- **Dr Vijay Aruldas,** General Secretary, CMAI, New Delhi
- **Dr. Shah Hussain,** IDSP Division, NICD, MoHFW, Govt. of India, New Delhi

**The Districts/Institutions Visited**

1. **District Balasore**
2. **District Kandhmal**

## *Progress under NRHM*

- Overall increased utilization of the public health facilities,
- ASHAs appear to be the key motivators in immunization, ANC and institutional deliveries.
- "ASHA GRAHAs" (Help desk cum rest houses), monthly ASHA Diwas, streamlining of incentive payment and hand holding support keep ASHA interested and motivated
- RKS & VHSCs members appear pro-active, proper and prioritized planning for fund utilization in RKS and VHSC Untied Fund improves fund utilization.
- NGO participation for management of Janani Express is effective.
- Active tracking of children and pregnant women by ASHAs, AWWs and ANMs has improved ANC coverage, institutional deliveries, and immunization status of children.
- GIS mapping for the districts is of high quality.
- Bilateral donors such as NIPI and DFID providing technical assistance in the State
- Regular on line assessments of Programme Management Support Unit staff at state and district levels ensure quality control of staff

## *Areas for Improvement*

- HR planning for manning the peripheral facilities needs to be improved, especially for nursing cadre and Lab. Technicians.
- Infrastructure improvement can be speeded up through effective coordination among multiple agencies.
- Drug expenditure by state government needs to be substantially increased.
- Vacancies for the NVBDCP from District Malaria Officers to Lab. Technicians and MPW (M) need to be filled up. Laboratory services network needs to be expanded.
- Although nutritional support system is well established, there appears little impact on the nutritional status.
- Planning for underserved difficult areas/communities needs to be prioritized and adequate resource flow ensured.
- Regular monitoring and evaluation of NGO interventions is required.
- Scaling up of integrated Mother & Child Health services, FRU operationalisation, and IMNCI needs to be given high priority.
- Linking of TBAs with ANMs to improve services in underserved areas/ marginalized population groups is necessary.
- Nursing training institutes need to be strengthened.
- Co-ordination between the Finance division and Programme Implementation division needs to be strengthened in order improve expenditures in child health, ARSH, tribal health & in vulnerable group related expenditures under Part A.

*Facility Based Neonatal Care (FBNC) Unit, District Hospital, Alwar*

*ASHA Sahyogini in Bhilwara Rajasthan*


*Innovation-SAHKARI DAWA KENDRA, Mandalgarh, Rajasthan*

# RAJASTHAN

## The Review Team

- **Dr. P. Anbarhgian,** Sr. Regional Director, Regional Office of Health & FW, Bangalore
- **Dr. Ritu Priya,** Advisor – Public Health Planning, NHSRC, New Delhi
- **Dr. Sanjay Dixit,** Prof.&Head, Deptt. of Community Medicine, MGM Medical College, Indore
- **Dr. Loveleen Johri,** Senior Reproductive Health Advisor, USAID, New Delhi
- **Mr. Gautam Chakraborty,** Senior Consultant - Financing of Health Care, NHSRC, New Delhi

## The Districts/Institutions Visited

1. **District Alwar :** District Hospital, District level Women's Hospital, PHC : Harsora, Gunta, Neemrana, CHC : Behror, Thanagazi, Sub Centre : Kalsada, Anganwadi centre (MCHN day) : Indpura, Kalsada
2. **District Bhilwara :** District Hospital, ANMTC, Satellite Hospital: Shahpura, CHC: Banera, PHC: Rayala, Gurla, Sub Centre: Chamanpura, Bera, Sangwa, Anganwadi centre: Bhilwara, Anganwadi centre (MCHN day): Khari ka Lamba

## *Progress under NRHM*

- Substantial strengthening of building infrastructure, with functional in-house civil wing.
- Significant rise in institutional delivery and OPDs at all levels & shift of normal cases to PHCs & CHCs
- Trainings done under NRHM have made impact on service delivery
- ANM posted & functional almost in all Sub Centres, (with increased use of two wheelers by ANMs)
- Regular MCHN days functioning well.
- Significantly improved fund utilization under NRHM; five to six fold increases since 2005-06 for CHCs & PHCs.
- Improved waste management services and functional ambulance (EMRI) across state
- Free Drugs for BPL patients under Mukhya Mantri Jeevan Raksha Kosh (MMJRK),
- Generic Drugs made available at inexpensive rates
- ASHAs trained and in position across state
- Financial management improved, Tally systems being used up to block level

## *Areas for Improvement*

- Mapping required to plan additional facilities, more focus on construction of labour rooms and upgradation of FRUs needed
- FRUs need strengthening to deal with complicated cases
- HR issues with specialists and contractual staff are an area of concern.
- Need to ensure that NRHM funds do not replace treasury funds
- MCHN day needs to focus on Nutrition interventions with active involvement of VHCs.
- Cost reduction and better utilization of ambulance services required
- Drug Supply and tracking systems need major improvement, need buffer stocks
- Decentralised planning needs greater focus on local needs and convergence,
- The 'administrative authority' of Health & ICDS dept. over ASHA needs rationalization
- From major focus on sterilization, a shift to spacing methods needed, IEC / BCC interventions need strengthening
- Better coordination needed between NRHM managers and other national programs

*ASHAs in Karamatar (Sikkim)*


*Pelling PHSC_Citizens' Charter*

*VHND, Karamatar (Sikkim)*

# SIKKIM

**The Review Team**

- **Dr Naresh Goel,** Asstt. Commissioner (UIP), MOHFW
- **Dr Vibha,** Professor, Dept. of Community Medicine, LHMC
- **Dr Dilip Singh,** Advisor - Public Health, RRC-NES, Guwahati
- **Dr K. B. Singh,** GTZ India
- **Dr. Ute Schumann,** Programme Manager, Delegation of the European Union to India
- **Mr. Rohit Mehra,** Financial Controller, NRHM, New Delhi.

**The Districts/Institutions Visited**

1. **District West Sikkim**
2. **District South Sikkim**

## *Progress under NRHM*

- Considerable improvements in Infrastructure of the health facilities, with functional Labor Rooms and New Born Care Corners (NBCC) and PHSCs also have functional Labor Rooms and Deliveries are being conducted.
- Manpower including Specialists at the District Hospitals and MOs at the PHCs has been posted.
- The Institutional Mechanism for people's participation is in place and is meeting regularly.
- ASHAs have been selected and trained up to the 5th Module and drug kits have also been provided.
- VHNDs are also being conducted regularly and the contribution of the Village Panchayat is visible in the facilities visited.
- Immunization Sessions are held at the health facilities and outreach sessions are being conducted.
- All activities pertaining to NDCPs are being carried out and SPMU, DPMU and BPMU are in place. The PHC Accountants are also in place.
- The capacity of the State to utilize the funds made available to it under the various components of NRHM has consistently increased-banking facility in the State up to the District level is in place and customized version of Tally software has been procured after receiving the advisory from the centre.

## *Areas for Improvement*

- Planning process needs to be further decentralized and strengthened with the SPIP reflecting all the needs of the districts.
- Health functionaries at different levels need support and supervision in planning, recording and reporting.
- Administrative and fiscal functions need to be devolved to the District level under NRHM decentralization efforts.
- Skill based trainings to be expedited and monitored. Multi-skill trainings for MOs (LSAS / EmOC) to be planned as per need.
- RKS funds to be released to the PHCs and DHs
- State must start the settlement of pending advances at the earliest for the civil works.
- Inter-sectoral cooperation models should be developed beyond the current school and teachers' involvement to accommodate more specific cooperation, i.e. in areas of hygiene and sanitation, including smoke reduction in houses to reduce the high level of respiratory infections and waterborne diseases.
- State needs to identify state specific problems and solutions e.g. home deliveries for low risk women by SBA in difficult areas and severe weather conditions; adequate compensation to ASHAs for travel; identification of health problems common in Sikkim and incorporating these in health care services.

*OPD at Almora District Hospital*


*Mobile Medical Unit in Almora*

*Clean Labour room - PHC Nandgaon - Tehri Dist - UA*

# UTTARAKHAND

**The Review Team**

- **Dr. Manisha Malhotra,** MoHFW, GoI, New Delhi
- **Ms. Shagun Mehrotra,** European Commission, New Delhi
- **Dr. Ravish Behal,** RCH II TMSA, New Delhi
- **Dr. Anil Kumar,** MoHFW, GoI, New Delhi
- **Ms. Deepika Shrivastava,** UNICEF India, New Delhi
- **Dr. Abhijit Das,** Centre for Health & Social Justice, New Delhi

**The Districts/Institutions Visited**

1. **District Tehri Garhwal** - District Hospital, Baurari ,Sub-district/ Combined Hospital, Narendra Nagar, CHC / FRU: Bileshwar, 24x7 Block PHCs: Pilkhi, Nandgaon, Sub-centres: Chopriyal, Jhajal, Duadhar, AWCs: Chopriyal, VHNDs: Thangdhar, Jharipani,MMU run by Jain Video, EMRI: Bhilangana.
2. **District Almora** - District Hospital Almora –Male and Female,Sub-district hospital- Civil Hospital Ramnagar Nainital, CHC: Dwarahaat, Almora, Additional PHCs: Hawalbagh, Barechina, Binta, 24x7 Block PHCs: Takula, Bailparao, State Allopathic Dispensary Takula, Sub-centres: Dinapani, Hawalbagh, Takula, Binta, Bailparao,VHNDs: Tatik, AWCs: Pilkha, Tatik, Matena, Basera, MMU: Bailparao,EMRI: Ramnagar, Takula,Schools: Pilkha, Matena, Basera, ANMTC

## *Progress under NRHM*

- Residential accommodation for providers by and large available at CHCs and PHCs
- Setting up of new Medical colleges, nursing colleges and ANMTC is in process.
- Pool of pharmacists available in the state as potential resource.
- 108 ambulances providing good referral services
- NRHM, JSY and ASHA have contributed in increased utilization of public facilities. Eg - 53% increase at DH OPD, Increase in Institutional Delivery from 24/year in 03-04 to 196 in 08-09 in Dwarahat CHC
- VHNDs are fully operational and well organised even in underserved areas with good cross-sectoral linkage of frontline workers.
- MMUs provide specialists and diagnostic facilities (X-ray, USG, etc.) in under-served areas.
- Good inter-sectoral convergence in the state between NRHM and ICDS,

## *Areas for Improvement*

- Infrastructure planning to be linked to decentralised village micro planning to avoid co location (e.g. PHC/SC and CHC/SC)
- Nomenclature of facilities needs to be standardised as GOI and IPHS norms
- Strengthening of DH/ SDH with blood bank and emergency OT facilities
- Rationalise posting and transfers, improve remuneration for hard to reach area within districts
- Skill-based trainings, especially for MCH, to be fast tracked and linked to facility operationalisation plan
- Procedures of procurement and distribution of supplies (60 % done locally, 40 % by state) need to be simplified and rationalized
- Recruitment Process delays contributing to large no. of vacancies in state.
- IMEP, BMWM and GoI quality protocols need to be put in place.
- Formation of RKS needs to be reviewed so that reflects the spirit of community participation as most of them are overwhelmingly government functionaries.
- Decentralized planning to be strengthened.
- Delays in formation of VHSCs and RKS at PHC level
- Severe malnutrition is not clearly assessed as ICDS, Health functionaries not familiar with new WHO growth standards for correct nutrition assessment

*Out-patient services, Uttar Pradesh*

*ASHAs in action, Uttar Pradesh*

*Waste Disposal system in place, Uttar Pradesh*

# UTTAR PRADESH

### The Review Team

- **Shri Pravin Srivasatava,** Director, MoH & FW, Govt. of India, New Delhi
- **Shri Sushil Pal,** Principal CCA, Central Board of Direct Taxes, New Delhi
- **Dr. T.V. Antony,** IAS (Retd.), Chennai
- **Ms. Birte Sorenson,** The World Bank, New Delhi
- **Dr. P. C. Bhatnagar,** VHAI, New Delhi

### The Districts/Institutions Visited

1. **District Kanpur** - District Hospital, FRUs, CHCs, PHCs
2. **District Allahabad** - District Hospital, CHCs, PHCs

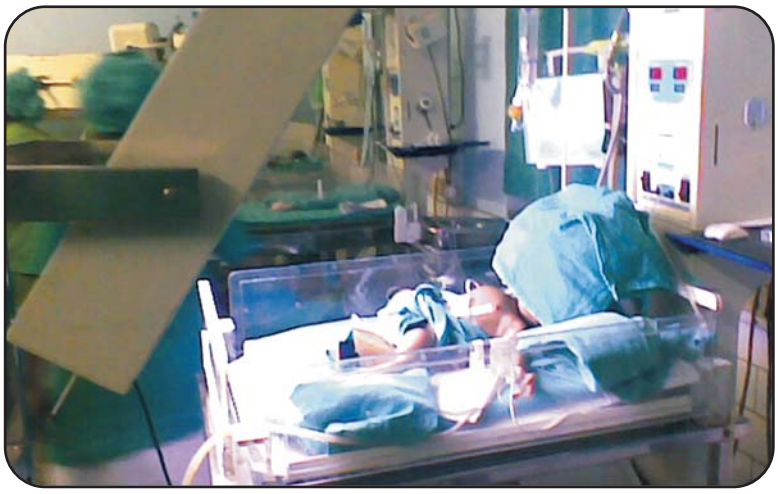
### *Progress under NRHM*

- ASHA are highly visible, motivated and play an important role in raising demand for RH services and in organising VHND
- Staffing of state, divisional and district programme units is in place.
- Medicine shortages were generally not observed by the review team.
- Some improvements in financial management systems such as improved uilzition, cheque payments and timely reporting are in place.
- Periodic video conferencing facilities are held to monitor performance.

### *Areas for Improvement*

- Critical shortage of human resources at all facilities: need a major HR review for all tiers of staff.
- Facility improvement with upgradation of equipment and infrastructure required
- Programme monitoring to assess performance of key service delivery indicators needs to be institutionalized
- VHSC members need a programme of orientation and sensitisation
- Untied funds and RKS funds need to be used for stipulated purposes.
- Delays in fund flow to districts and blocks need to be corrected.
- Malnutrition continues to be a major challenge

*Bed used corridor in Purulia, West Bengal*



*Neo-Natal care Purulia, West Bengal*

*ASHA among Community in West Bengal*

# WEST BENGAL

## The Review Team

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- **Mr. Jerry La Forgia,** The World Bank
- **Dr. Yamagata Yoichi,** Project Manager, JICA, Bhopal

## The Districts/Institutions Visited

1. **District Purulia**
2. **District Cooch Behar**

## *Progress under NRHM*

- There is an increase in utilization of services at all level of health facilities
- Sufficient quantity of drug are available in health facilities
- Voucher Ambulance Scheme (for institutional delivery) benefited 10924 mothers in 3 districts
- More than 44.3 lakh patients were treated through 55,600 mobile health camps (Gram Panchayat based – at GP HQ Sub Centre where there is no PHC/BPHC/RH)
- Nursing Training Schools has been established-– 11 in PPP mode & 3 in Govt. Facilities
- 82 BPHCs upgraded to Rural Hospitals with at least 30 beds with additional 3 posts of specialist MO [1 G&O, 1 Paediatrician, 1 Anaesthesist]
- 224 PG seats are reserved for 'in service' candidates who are working in difficult areas
- SNBCU- Sick newborn care unit in the District hospital has been created.
- Purulia model effective in reducing mortality for LBW newborns
- Referral transport is being provided up-to the PHC level
- At some of the facilities trained Dais are involved in the institutional deliveries. Trained dais are conducting deliveries at sub-center at Kuchiya sub-center of Bandwan Block
- Good convergence with WCD and PR & RD. AYUSH- MOs are hired by gram panchayat for places where no formal health facilities exist.

## *Areas for Improvement*

- Need to strengthening/increase in health infrastructure at CHC/PHC/SC level
- A huge shortfall of health human resource(HRH) in all categories except for Staff Nurse needs to be addressed
- Utilization of untied funds is very low.
- Facility level tracking of drug consumption required at district/block level
- Decentralized planning needs substantial strengthening.
- VHNDs are not properly functioning /happening
- ASHA intervention needs to be effectively established
- Standard treatment protocols of Malaria and Tuberculosis are not followed.
- No separate programme for malnourished children in place
- Supervision/monitoring by DPMU needs strengthening
- Financial management systems need to be strengthened and Tally to be used for accounting.
- HMIS system is still compiled manually due to lack of connectivity in most blocks. Data to be used locally for decision making or planning

This report of the Third Common Review Mission (CRM) is a documentation of the progress of the National Rural Health Mission in a sample of 17 States. It also identifies areas that require strengthening of the 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 Groups, 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 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 the 3rd CRM report along with the State-wise reports. It also contains 1st CRM report - 2007 and 2nd CRM report 2008.*

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