



National Rural Health Mission

FOURTH **COMMON**
REVIEW MISSION
REPORT 2010





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Ministry of Health and Family Welfare
Government of India, Nirman Bhawan
New Delhi-110 011

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Message



I am happy to learn from the Report of the Fourth Common Review Mission (CRM) that the States have been able to successfully move towards increasing access to health care services even in remote places in rural areas. Though the NRHM has led to an increase in patients seen and in the availability of drugs and diagnostics, there is still much more to be done for increasing both access to health care and quality of health care.

I read with interest the large number of innovations that are taking place in making health care services available to weaker sections in the States. The CRM process provides an opportunity to share these best practices across the States, so that the States learn from each other.

I am sure the State Governments will take the recommendations offered by the experts in right spirit and improve the performance of their health system in the areas identified with increasing speed.

As we enter the last year of the 11th Plan, we have a lot to do to catch up with the goals and objectives we set ourselves, and must aim to have even better outcomes in the coming year. We must also learn from the observations and insights offered by the Mission Report when we make our 12th Five Year Plan. My government remains deeply committed to the goals of increasing public health expenditure to 2 to 3% of the GDP. However, to achieve this goal, we need to successfully address the human resource constraints and improve the quality of governance and management of public health system. We hope the release of the Report of the Fourth Common Review Mission would be seen as an occasion to rededicate ourselves to this goal.


(Ghulam Nabi Azad)

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Message



The National Rural Health Mission (NRHM) aims to bring about the architectural correction of the public health system so as to make it "equitable, affordable and effective" with an enhanced capacity to absorb the increasing outlay on health. The hallmark of NRHM has been in establishing and strengthening state institutions in sustaining the continued inputs required in the health sector, improving accountability structures and fostering openness and transparency. These initiatives are monitored and evaluated through several mechanisms on an ongoing basis both through internal and external agencies.

The Common Review Mission (CRM) is one of the important monitoring mechanisms to assess the progress of NRHM and it has been an annual exercise since 2007. The findings of the Review Mission emanate from the discussions with State Government officials, interaction with service providers, NGOs and also field visits to the States and Districts. The key findings are further discussed with the stakeholders in a participative manner and these then form the recommendations of the Review Mission. The Review Mission comprises experts in the health sector from NGOs and Civil Society Organizations, donor partners in addition to the State and Central Government officials. The recommendations of the Review Mission covers several aspects of the health delivery system in terms of infrastructure, increase in OPD, IPD and institutional deliveries, increased utilisation of untied funds, drug and diagnosis availability, emergency transport etc. One special feature of the current CRM has been a representation of Ministry of Women & Child Development and Planning Commission in the Mission teams which facilitated considerable attention on the functioning of Anganwadi Centres in an integrated fashion. These recommendations are also used by States while preparing their Programme Implementation Plans (PIPs) for the following year.

Health is an ever expanding sector requiring partnership with diverse professionals from both the public and private sectors as well as from NGOs, Civil Society Organisation etc. The Common Review Mission has identified some of the key challenges and the reports, progress and other findings are placed in the public domain to promote wider debate and inputs. The Ministry looks forward to receiving inputs and suggestions from the various stakeholders and the public at large for taking steps to further improve the functioning of the health sector and address the evolving and dynamic challenges.

I thank all the members of the CRM for supporting the fourth CRM and offering their useful insights in moving forward to achieve the goals of universal healthcare.

(K. Chandramouli)



National Rural Health Mission



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MESSAGE



The launching of the National Rural Health Mission (NRHM) in 2005 has been acclaimed as one of the most noteworthy government-led initiatives in health care in India. With the Mission completing five years, it is time to make a detailed assessment of the progress made and the constraints faced.

The Annual Common Review Mission (CRM), organized once every year since 2007, is one of the important monitoring mechanisms to assess the progress of NRHM. The CRM organized in December 2010 was the fourth of the series. Each CRM brings together public health experts from leading public health institutions, civil society organizations, development partners and government officials to undertake joint visits to a number of States to interact with officials, professionals and members of the community and to visit a cross section of facilities so as to understand the progress the programme is making and identify the problems faced. One special feature of current CRM has been a representation of the Ministry of Women and Child Development in the Mission.

The Report highlights the gains as well as the limitations. It is heartening to note that the case loads managed by the public health system have continued to increase more and more women are getting institutional care at delivery and that States have made considerable progress in public health facility development. The ASHA programme received a positive comment from almost all State Missions. Many problems of programme management and financial management are now sorted out. However, a lot still remains to be done and there are areas where there is very little forward movement. I am sure that States would find the report and recommendations very useful and ensure that the issues are adequately addressed in this year's State Programme Implementation Plan.

On behalf of the National Rural Health Mission, I convey our gratitude to all those experts and officials who have contributed to the making of this report and who have made this Mission a learning experience for the States and for us. I am sure with these insights and with the cooperation of all, we would be able to strengthen the public health mission and achieve the objectives and goals laid before us.

(P.K. Pradhan)

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ABBREVIATIONS

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



Executive Summary





EXECUTIVE SUMMARY

INTRODUCTION

The Fourth Common Review Mission of the National Rural Health Mission was held from 15th to 23rd December, 2010. A total of 14 states and one union territory was reviewed by 15 teams. These teams were constituted of 125 public health experts and officials. Each team was presented with a report of the progress made at the state capital, by the Mission Director of National Rural Health Mission and his team and the senior officials of the department of health and family welfare. The teams then visited a sample of facilities and villages in two districts and then finalized their report and presented it back to the state teams on the 23rd December and subsequently finalized their recommendations. These state reports were then compiled, analyzed and the national CRM report was formulated and circulated back to team members for comments and was finalized, after incorporating the feedback and suggestions received. A summary of these findings and the recommendations are presented below. The state reports and recommendations are available in the enclosed CD.

SUMMARY FINDINGS OF THE 4TH CRM

Infrastructure: The rate of construction was satisfactory and in accordance with district plans and state goals

in about 8 states, all of which had efficient state level institutional mechanisms in place for executing the contracts. Some of the leading states, notably Punjab, Kerala, Tamil Nadu and Maharashtra, are close to achieving the goals as regards infrastructure gaps. On the other hand, infrastructure development in the states of Chhattisgarh, Jharkhand, Nagaland and Uttar Pradesh is slow and a few states like Arunachal Pradesh and Uttarakhand show a pattern of infrastructure development, where progress is good, but where efforts at improved utilization or choice of facilities has been weak, leading to underutilized facilities. Problems of the design being technically sound and adhering to IPHS recommendations are observed in many states. As part of the Facility development plan related to the MCH centre concept, the need for residential accommodation for 24 hrs facility has been widely recognized and planned for in many states as compared to the last CRM. Adequate numbers of residential accommodation for all staff in the category is however an issue in all states. In a few states, accommodation is available but utilization of existing accommodation is the issue.

Human resource availability: The rise in human resources over the last few years has been sustained and the addition of about 100,000 new service providers in less than five years has perhaps contributed more than any other factor to the turnaround in the public sector. There is however, no major further increase in numbers

this year – though in some states recruitment processes which were ongoing earlier have been completed. The problem remains acute for specialists and defies solution – though the good news is that multi-skilled medical officers are now more often found playing the specialist roles expected of them. The situation is much more optimistic in ANMs and nurses, with availability for recruitment set to increase dramatically as the major expansion of nursing courses in the previous years fructifies and the batches pass out. The change in ANM and nursing availability is truly dramatic with an almost 300% increase in seats – even in high focus states, with the notable exception of Bihar where such a major expansion has not yet begun. If the impact of this change is not yet seen in service delivery, that is the very nature of change in building public health systems and we would caution against uniform impatience. But there is still a bottleneck which is the sanction of nursing posts in public health facilities – which lags woefully behind IPHS norms, especially for district hospitals and CHCs and where urgent attention is needed. In some states the gap is in framing of service rules to facilitate easy recruitment from the available pool of nurses.

Retention in rural areas: States which had gone in for measures to attract and retain doctors in rural areas are able to see some of the benefits of such reform, but despite intensive planning and discussions in states actual conversion to working schemes has been low. States which had in the previous year put retention measures in place are Assam, Chhattisgarh, Orissa, Madhya Pradesh and Maharashtra. A major central initiative in this regard that was a planned responsive to last years' CRM recommendations did not fructify and perhaps in anticipation of this, new state initiatives also were not seen in this period.

Contractual Character of Employment under NRHM is now being associated with an increasing number of problems. Renewal of contracts, poor service conditions and increments, high turnover rate, reluctance to send them for longer skill-based training and unnecessary and retrogressive hierarchy between the contractual and the permanent staff are some of the problems. For example the regular ANM would get approximately Rs. 16,000 per month at the start of the scale and the second contractual ANM would get about Rs. 6000 for the same job description – and thus the second becomes the working assistant to the first. There are no clear benefits in relation to workforce performance. States like Tamil Nadu, Haryana and now Maharashtra have

shown there is no reason for permanent employment recruitment to be time consuming either. There is need to move away from contractual terms as the major NRHM workforce innovation to more robust “strategies of attraction and retention of skilled professionals to rural and remote areas.”

Case Loads continue to increase – for outpatient and for inpatient services and for institutional delivery at primary care and at secondary care level, though the rate of increase may be higher at higher levels. This increase is across all states, with the sole exception of Uttarakhand where there is reason for concern. The range of services also continue to increase, again more so at the district and sub-district hospital level.

Laboratory and Diagnostic Services are available in most hospitals, though the range of services at peripheral levels are too limited and user fees could be a limitation to access.

Assured Referral transport arrangements are picking up in all states except in Uttar Pradesh and Jharkhand, but in all states its reach to more difficult areas and more marginalized populations is going to require far greater planning and inputs. In five states it is the 108 service that pre-dominates, whereas in the rest it is state level alternatives.

Availability of drugs has improved but there is no clear commitment to give all patients all essential drugs free of charge, or at least to give BPL drugs without charges – except in Jharkhand, Assam and Kerala. However in-hospital supply of drugs is interrupted due to lack of demand-responsive logistics in all states except in Tamil Nadu – where it is still a problem for sub-centres, and Kerala. The widespread practice of prescribing drugs in public hospitals that the patient needs to buy in the open market, therefore persists. In Rajasthan the functional Jan Aushadhi Kendras were found to be effective mechanism for supply of cheap generic drugs to reduce out-of-pocket expenditure, and are worth replicating nationally. Equipment situation was good in most facilities visited.

Supportive services: Within the limitations of what can be commented upon by CRM teams, the impression is of good progress made in cleanliness of facilities, the provision of electricity, water and clean linen and bio-waste management. Diet availability in district hospitals is now ensured in 8 of the states visited, but availability beyond the district hospital is still rare. Reports on

Uttarakhand were however not positive on any of these. Bio-waste management was weak in the four states of UP, Chhattisgarh, Jharkhand, and Orissa. Privacy issues, especially related to women, are being addressed in more states, but still much more needs to be done.

User Fees: In most states user fee collections are less and less insisted on, and some – especially Jharkhand and Kerala have stopped its collection. Where collected the fee is retained and used at the facility level. Uttarakhand is the exception, where 50% of user fees are still deposited into the treasury and there has been a fee-hike during this period. Some like, Punjab had a higher level of user fee collection and this continues.

Strengthening Sub-centres: The picture as regards village health and nutrition days and the functioning of sub-centres is about the same as mentioned in earlier CRM reports, with some benefits because of the introduction of the second ANM and the male MPW worker in many states. However in some of the high focus states where the needs are the highest, the lack of available personnel continues to limit recruitment, though as fresh graduates come out, this problem is likely to diminish considerably in all states, except perhaps Uttar Pradesh. Over 1558 MMUs also provide outreach services in remote areas.

Changing nature of sub-centres: The nature of the sub-centres are no longer seen as a site of delivery in official policy in Kerala, Tamil Nadu and Punjab, Chandigarh and perhaps in Nagaland also, and only about 10% of sub-centres are actually providing any midwifery services. Whereas in most states there is still a huge load of immunization and antenatal and post natal care to be provided, even this work has migrated upwards in the first four of these states, making it necessary to re-define the role of the health sub-centre. However there are many areas where the sub-centre needs to retain its role as the most accessible form of safe delivery- and a premature shift out of the sub-centre definition in states with high rates of persisting home delivery and low immunization rates would be a problem.

ASHA's roles: There is no other component/parameter of NRHM progress which so uniformly receives positive reports as the ASHA programme – and in most cases this is despite many key processes like training, payments and supervision being weak. The positive feel is because of the impression that the ASHA herself makes on the visiting team – and programme management has to rise to reach her level of motivation. ASHA's main effectiveness is being

seen in motivating women for institutional deliveries and immunization. ASHAs play an active role in community mobilization, especially for institutional deliveries. They are also active in referral and follow-up in disease control programmes. In Kerala, they are poised to play a major role in palliative care in non-communicable disease management. Breastfeeding practices are reported to have improved. Home-based newborn care is happening in Chhattisgarh and planned in other states. There is some concern that with one per 1000 ASHA for every household, there are states like Uttarakhand which is still not receiving coverage for her services and even more ASHAs would be needed here. There is also concern that show that although she is functional in many areas, she would need better training and better support to make use of her bond with the community for better health practices and community-level care provision.

ASHA Training and support: ASHA programme in most states is now in the stage of introducing module 6 and 7 and the major urgency in this context is to strengthen the full time resource support at state level and the full time training and support and supervision teams within the district. Only five of the 15 states visited had an adequate support structure in place, or were clearly committed to it. Payments reported range from as low as Rs. 350 per month in Kerala and Rs. 500 in Uttarakhand to Rs. 2000 per month in Assam and Jharkhand. There is a wide range of payments even between the ASHAs of a district. Drug kit refills remains a problem – with both the low priority given to this task, and the problems of drug logistics contributing. The good news is that from all states with one exception, there are reports of good coordination between the ANM, AWW and the ASHA.

Emerging trends in ASHA programme: There is a strong element of mobilization in the Chhattisgarh and Jharkhand programme. The importance given to help-desks for those who come to the facilities. Introduction of lodging arrangements for ASHAs in the form of ASHA *Greh* in UP, Jharkhand, Uttarakhand and help-desks in states like Uttarakhand, Orissa and Jharkhand has facilitated the work of the ASHAs and increased public facility utilization. 457 Mitranins are admitted into ANM courses in Chhattisgarh and 31 into nursing schools. Orissa has also taken a similar initiative.

Maternal Health: There is a sustained increase in institutional delivery reflecting the continuing gains of RCH. Efforts to improve the quality of services also seem to be bearing fruit, though progress is more

in facility development areas than in the skills and protocols followed. Access to emergency obstetric care has improved though nowhere near the scales on which it was hoped for and the volume of complications managed effectively within the public system is still sub-optimal. The skewed distribution of this increased load and the failure of supply side support in the form of finances, human resources and supplies to match this case loads – a problem identified by the third CRM remains a major issue. JSY payments are better, but payment on the day of delivery is still difficult to obtain. Maternal death reviews are starting up or are already in position in all states visited and this has much potential to close last mile gaps that lead to maternal deaths.

Child Health: In child health, in contrast progress has been much more limited – and the pattern seen by earlier CRMs is repeated. Peripheral service providers and community level care has on one hand been geared towards a high level of referral, but the sites to receive these referrals i.e. where institutional care of the sick newborn and child are available, have not grown even at the level of growth of emergency obstetric care. Most states have planned measures to improve the quality and content of home-based care as well as to develop more facilities to receive and manage referrals, and these would have to be taken to scale in the coming year.

Family Planning: The good news in the family planning front is that male sterilization is reported to be increasing in many states. Female sterilization continues to be the mainstay of the programme, and even here post-partum sterilization has not picked up much. Progress is reported to be slow in three of the high focus states. There is also much potential for working on increasing utilization of spacing methods with ASHAs promoting services and ANMs delivering them.

Nutrition: Progress has been made in Nutrition Rehabilitation Centres and these are functional now in the state of Assam, Madhya Pradesh, Rajasthan, Jharkhand, Maharashtra, Chhattisgarh and Uttar Pradesh. Chhattisgarh which had none one year back, now reports 18 functional units. In Madhya Pradesh the number has reached 230 this year, and this state has really gone to scale and is making a difference with this programme. In Assam it has started up in three districts. Complete utilization and long-term follow-up is a challenge in many states. Infant and young child feeding promotion is also reported positively from two

states. Take-home rations for the below 3 year old child are a major problem in some of the states – and the old problem of this age group where malnutrition is most likely to strike getting missed out, persists. Availability of weighing scales was a problem reported from Uttar Pradesh. But other dimensions of supplementary feeding and mid day meal programmes are in place.

Disease Control Programmes: In RNTCP performance is sustained, and four states still had low case detection rates and two had low treatment completion rates as well. These main issues were the need for improved sputum testing rates through more microscopy centres and private sector partnerships. ASHAs are contributing to both the RNTCP programme and malaria control in many states. Leprosy shows a sustained decline, but there is some cautions in the report from Orissa. Blindness Control Programme faces specialist and technical staff constraints in some states. As regards IDSP, while most reports note that progress in establishing infrastructure and systems has taken place, the use of information and local response to outbreaks and disease reports and use of information for planning is weak in almost all states.

Institutional Mechanisms: State and District Health Societies are in place in all states and most states report regular meetings and decision-making at least at the district level. Coordination between the directorate and the societies – a problem reported prominently in earlier CRMs was not highlighted in any report. On the other hand states like Maharashtra and Kerala positively observed that they are functioning as a team at the district level. The Programme Management units are generally well integrated with the CHMO office, but there is concern that the role and responsibilities of the DPMU and the BPMU have become less clear, and they may be providing only assistance on a day-to-day basis and not the planning and management support intended.

Institutional Mechanisms-2. As the NRHM rolled out it was felt necessary for all states to have distinct institutional structures for the following functions 1. Infrastructure development, 2. Procurement and logistics, 3. SIHFWs to lead skill-based training programmes of service providers, 4. SHSRCs as technical support units and 5. A community processes resource centre to lead the ASHA programmes and VHSCs. These are in addition to the state programme management unit and the directorates. Each of these could be separate entities or states could try different

combinations based on their contexts. Kerala is the only one which has all five of these in place. Tamil Nadu and Kerala have a quality institution – the TNMSC and the KMSC for procurement and logistics – but all other states have failed to initiate it. Punjab also has a PHSC but focused more on infrastructure than on logistics. SIHFWs are in place in all states visited, except in the smaller states of the North East. SHSRCs are in place in Punjab, Maharashtra, Kerala, Chhattisgarh, Jharkhand and Rajasthan, whereas some other states make use of development partner – funded technical support units for this task. ASHA resource centres are in place in 5 of the 15 states visited. States with these institutional arrangements clearly have better management resources and fare better in programme implementation in that area – but in most states many of these institutions, especially the SIHFWs need considerable strengthening. The failure of states to start up a TNMSC benchmarked system of procurement and logistics is one of the major weaknesses of the NRHM. The Rogi Kalyan Samiti functionality is also reported as improving over the years.

Health Management Information Systems: The HMIS system is in place in all states and regular feeding in of data in the system is taking place. Many states for the first time are reporting good use of information at the local level – notably Orissa and Chhattisgarh and to some extent in Punjab and Chandigarh – but much more needs to be done. The frontier is now further improvements in data quality and feedback of HMIS reports to programme managers.

NGO participation is one area where there has been a decline over the last five years. No state has still set up a grant-in-aid committee, and no state is anywhere near the commitment to spend at least 5% of its resources through NGOs. Community monitoring has been most successful in Maharashtra and to some extent in Madhya Pradesh. It has taken place in three pilot districts of Chhattisgarh and also in Orissa and Tamil Nadu – but there is little priority given to it, and no major efforts at replication on scale. There is need for strengthening and expanding civil society involvement in various areas such as ASHA training, capacity-building of VHSCs, orientation of PRI members, and community-based monitoring and planning.

Financial Management: There have been substantial improvements in the process of accounting – with the addition of staff, with improved leadership arrangements, with the use of a customized software and with the electronic transfer of funds upto district level in almost all states. However, problems with expenditure rates remain much the same as earlier. A few states like Orissa and Arunachal Pradesh and Kerala report improvement, but others like Assam which reported good progress earlier, now report lagging behind only 51% expenditure in Assam. The main reasons identified were – activity-wise transfer of funds from state to district often with many delays for some line items, untied funds blocked in facilities which have poor turnover and utilization, lack of guidelines, weak management structures leading to poor progress of programmes. Accounting per se is not presented anymore as the main problem in delayed expenditure.

Decentralization: At the fifth year of the NRHM, the district planning effort has weakened in many states and district planning often reduced to filling up a budget template form. Exceptions were Kerala, Orissa, Jharkhand, Arunachal Pradesh, Zunheboto district of Nagaland and Punjab. One problem is the increasingly rigid programme component guidelines which now cover all aspects of planning. The other is its lack of use of the district plan for either budget allocation or programme review. There is a need to understand the constraints on quality district planning and work out measures to overcome it.

Innovations: The CRM teams visiting Maharashtra, Assam and Kerala have reported a number of innovations. These have been described in some detail in the main findings. One interesting innovation reported from both Kerala and Assam are boat clinics. This has been already reported, what is new is that it is now scaled-up to wherever it is needed and are reported as successful by the Mission. One interesting observation from the Lakhimpur visit records “Since boat clinic visit takes place only once a month in these difficult riverine island localities, medicines and ampoules are given alongwith prescriptions to the patients and the ASHAs in these villages are trained to provide follow-up care.” The other major innovation reported is palliative care in Kerala.



Recommendations





RECOMMENDATIONS

INFRASTRUCTURE

- ❖ An autonomous body like PHSC (Punjab Health Services Corporation), or a team of engineers located in the department of health as a wing, is a minimum that should be insisted upon in all states where construction work is well behind schedule. There is a clear association between construction as per schedule and having in place a State Level Institutional Arrangement to supervise and expedite constructions. Further, financing for infrastructure in 'slow progress' states should require that as a pre-condition.
- ❖ Infrastructure development units should be provided with a basic training package by a suitable hospital management institution to understand the specific aspects of safety and efficiency in hospital construction. Technical Guidelines on these should be prepared and made widely available.
- ❖ Prioritization of health facilities for infrastructure development needs to be based on mapping of village by village utilization patterns of health facilities such that we ensure universal access in areas which are under-served and simultaneously also respond with support for increased infrastructure and beds in hospitals facing major increase in case loads.

HUMAN RESOURCES

- ❖ There should be a dialogue with each state on the quantum of human resources needed, to add to existing health facilities to enable their reaching IPHS norms. In many states the numbers of sanctioned posts, especially of nurses is well below the IPHS norms. States should commit to the proportion of their contribution and sanction these posts in the coming year. The MoHFW should also increase the number of staff it supports as a long term commitment from the one ANM currently, to at least two ANMs in the sub-centres and three nurses in each of the primary care facilities which are handling a minimum number of case loads.
- ❖ The differential in wages between contractual service providers and regular staff providers for the same job description and case load should be minimized. If anything, there is a case for contractual take home salary being higher than the regular. The Tamil Nadu pattern where after two years of work, if their performance is found satisfactory, the contractual staff are routinely regularized in service, is the best way forward. But for that, states need to create these posts and that is the first priority for the coming year. Every state should decide and announce a mix of regulatory measures and financial

and non-financial incentives by which it attracts and retains skilled professionals in under-served areas. In addition it should specify the workforce practices it would adopt towards reaching this end. The recommendation on incentives has been taken up seriously, and the state should now make conscious efforts to build up a positive, supportive environment to overcome social and professional isolation.

- ❖ The NRHM has spurred a 300% increase in nursing institutions within five years in the country and also a major increase in medical education. In high focus states (Non-NE), 1032 nursing and midwifery institutions are added till 2010-11 against the baseline of 275 institutions in 2005-06. In North-Eastern States 42 institutions are added during NRHM period till 2010-11. But in Bihar there is decrease of 4 GNM schools and overall decrease of 2 nursing and midwifery institutions. However such growth is skewed and public financing is need for ensuring geographically balance development of professional education.
- ❖ Policies of professional/technical education should specifically be re-examined in each state from the lens of attracting skilled persons to work in rural areas. Preferential admission for candidates from under-served areas (Tamil Nadu), new educational institutions opening up in areas where needs are greater (Madhya Pradesh), preferential admission in specialist courses through either awarding extra points or reservation of seats subsidized in private medical colleges, service bonds for rural service for all those who choose to study in highly subsidized seats in government institutions (Tamil Nadu and Kerala) are all measures that would each yield some incremental gain. The three-year course in Assam, which leads to the creation of a dedicated public health service provider cadre meant exclusively for use in the public health system and conditionally licensed to work only in such areas, is a good example to learn from and introduce in many other states with similar situations.
- ❖ Contractual staff at the management and technical levels requires a different approach from the contractual service providers. Since these tasks are largely being retained as contractual posts, states should decide on which posts are required on a long term basis and which are redundant. They should set

up a HR wing to manage all those positions that are essential. The HR policy should specify the nature of contracts, annual increments, performance appraisal, skill upgradation opportunities and ways to seek higher posts, or posts in institutions like SIHFV and SHSRC and develop a career path. These institutions too should develop meaningful career paths and HR policy for their staff.

- ❖ A clear message to the states that these contractual posts of service providers and of technical and management support staff would continue into the next plan period, is essential to promote long term planning and prevent any disruption of services.
- ❖ There should be a nationally coordinated management and technical effort to recruit, develop and support faculty (Nurse/ANM tutors) for all the ANM training centres in all the 6 northern high focus states (Jharkhand, Bihar, Uttar Pradesh, Madhya Pradesh, Uttarakhand and Chhattisgarh), which have not yet been able to fill the second ANM position for over five years due to inability to recruit ANMs. (Rajasthan and Orissa and Assam have largely put the second ANM in place). These states may need help even for ANM recruitment. Other states would not need support for recruitment of ANM or ANM tutors but could form part of a nationally coordinated faculty development programme.

FACILITY DEVELOPMENT

- ❖ The district plans should clearly indicate which facilities are prioritized for strengthening within the coming year, and over the next three years and the level of care and set of services they would be delivering and expected case loads. This has already been done in high focus districts for RCH services. In the coming annual plan, such planning should be extended from high focus districts to all districts and from RCH care alone, to trauma care, and care for communicable and non communicable diseases.
- ❖ Facility development needs to be guided by the IPHS with regard to inputs. The state should also put in place adequate institutional mechanisms for provision of diet, laundry, security, and for other supportive services essential for providing quality care and have systems in place to measure the quality of care that is delivered. It needs to plan to reach a situation where every public health facility

is quality-certified by some external process against standards as are appropriate to that state.

- ❖ User fees need to be phased out as they tend to exclude the poorest- but while doing so care should be taken to provide untied funds with greater flexibility and responsiveness to case loads so that the dependence on user fees in the facility is not affected. As a first step all states may exempt all pregnant women and sick newborn and life-saving emergency cases and trauma care from user fees with immediate effect.
- ❖ Advocacy and policies to promote rational drug prescription and hospital pharmacy-based prescription with free drugs in every public health facility have to be prioritized.
- ❖ Generic drugs covering the entire essential drug list should be procured at the cheapest rates with assured quality and made available in each district and in the next phase, in every block, in a time bound manner.
- ❖ The minimum range of diagnostics available at each facility should match the services being provided there and there should be a commitment to close these gaps at least within a year.

OUTREACH SERVICES: STRENGTHENING SUB- CENTRES

- ❖ States need to define the work allocation of both ANMs where they are in place, so that both have a rational share of the work and responsibility. Until the salary is brought to parity, the regular ANM should have the greater share of the work. There should be a clear allocation for a 7 hour working day, for 5 days a week at least for each of them and where midwifery services are not required of her, due to a better health facility being equally accessible, she should have a greater load of other outreach programmes like school health, adolescent health and addressing non-communicable diseases.
- ❖ Sub- centre handling high case loads of deliveries would require more untied funds to ensure cleanliness and support services.
- ❖ States need to assess MMU services and act to optimize outcomes from these services.

- ❖ Strengthening referral transport services: In areas where there is 108 services or equivalent, the priority should be to extend free services to newborns and complications in the antenatal and post natal period and to ensure that these services are prioritized for rural areas, where there are no alternative transport mechanisms available. In states where there are no assured referral transport services, they should choose from existing available modules to put one in place.

ASHA

- ❖ Attention needs to be paid to developing full-time supportive supervision structures and improving payments and refill of drug kits for ASHAs.
- ❖ Greater emphasis on the training of essential skills that can save lives by the provision of community level care is essential. This would require a well planned and rapid implementation of training on modules 6 and 7 alongwith the supportive supervision it needs
- ❖ Develop permanent training teams at state and district level who would be available at least for the next three years.

REPRODUCTIVE AND CHILD HEALTH

- ❖ In non-high focus where there are still high levels of home deliveries even after accessibility to services has improved, detailed assessment of causes for this including the possibilities of social or financial barriers to care-seeking should be determined and strategies should be assessed. Where there are low levels of persistent home deliveries, the exact areas where this is a problem should be identified from HMIS data and the additional efforts should be focused there at without spreading the effort thinly across the state. This is also true for reaching unimmunized children and all other outreach services.
- ❖ In high focus states, the focus of the programme should shift to more beds and staff where the case load is high, and providing improved quality of care to those who are coming to the facilities. The numbers covered under JSY is on an increasing trajectory, and the focus of government efforts could be on quality of care as measured by greater percentage of complications being managed

within the public health system and lower levels of mortality and morbidity.

- ❖ Delays in JSY payment have much reduced, but even now there is substantial delay which would have to be managed by improved mechanisms. Delivery of the sum for both mother and to ASHA on the day of admission/discharge should be the focus and the system should not consider a one or two week delay as acceptable.
- ❖ Scaling-up of multi-skilling programme for emergency obstetric care needs to be enhanced. A review should assess why in some states progress is slow and take steps to enhance the rate of training and post training follow-up and support in those states where the gaps are largest.
- ❖ Also to be enhanced are the rate of training for SBA, IUD insertions, IMNCI, F-IMNCI etc. State by state assessment of planning gaps and weak institutional training capacity which leads to scale of training being much less than that desired should be identified and corrected with central assistance for deploying more trainers and developing training facilities.
- ❖ In the area of child health, the central problem to be addressed is how to scale up newborn care interventions like newborn stabilisation unit or some equivalent degree of facility-based care for the sick newborn to every institution where significant number of deliveries are taking place. Plans should clearly list how these can be done in a three year framework and if internal management and capacity is not adequate to reach this target, strategies to supplement this with national support should be worked out in consultation with the states.
- ❖ In parallel to the above, all ASHAs in high focus districts should be skilled with home-based care for the sick child and newborn, including interpersonal behaviour change and sensitized to reach the most marginalized within a period of one or two years.
- ❖ For pregnancy and child tracking, careful studies may be done in those states where this is most advanced so as to learn how to optimize the strategy so that it yields benefits in terms of

improved child and maternal survival and better quality and outreach of service delivery. Studies would also help understand the constraints the programme is facing and build a meaningful time-frame for completion of this task.

- ❖ Greater emphasis in implementing maternal and infant death review in every district with focus on building the capacity of districts to use this as a feedback mechanism to help improve district health systems with respect to maternal and child health is required.

NUTRITION

- ❖ Ensure at least one functional NRC in every district and one per block where severe acute malnutrition is high.
- ❖ Build up the nutrition component in ASHAs training, especially to address the first two years of life. This requires training in Module 7, and follow-up by facilitators in the field.
- ❖ Build up capacity of VHSCs and PRIs to act in a convergent manner to ensure access to all nutrition related schemes. Since internal human resource capacity is limited and cannot be prioritized for this, roping in suitable NGOs to undertake this capacity-building is one way out.
- ❖ Coordinate with school education and ICDS to introduce the mid-day meal programmes in schools, also take on the challenge of reducing malnutrition and anemia among school-going children.

DISEASE CONTROL PROGRAMMES

- ❖ The IDSP programme needs to be strengthened by having persons trained in epidemiology skills to interpret the data obtained at the district level. There should be an effort to analyze and use information from all disease control programme and from HMIS.
- ❖ There needs to be clear training and protocols provided for responding to reports of an outbreak of a disease.
- ❖ Case detection should improve in TB control programmes through increasing patients screened

for tuberculosis in public health facilities and by collecting similar information from private sector facilities.

- ❖ In the Malaria and Kala-azar programme, the priority is that all male workers should be in place and their training as well as the ASHA training should be completed. The second priority is to be able to include it in district planning meaningfully and use the previous year's prevalence/incidence patterns with appropriate strategies for those areas where the problems are greater.
- ❖ Strict adherence to case detection needs to be advocated to improve detection levels, particularly in districts with migratory influx, and to enable development of response mechanisms.

PROGRAMME MANAGEMENT

- ❖ At the very least, quarterly meetings of district health societies and state health societies and annual meetings of district and state health missions should be insisted upon. Clear responsibility is to be given to a team at the centre and the states may just monitor this aspect. A copy of the minutes would be helpful to identify and reach out to districts where there has been a slowdown or deficit in governance.
- ❖ Strengthening of SHSRCs is urgently required. (SIHFW strengthening has already been discussed in recommendation 2f). The main functions of the SHSRCs should be to: a) constantly increase the quality of district planning and the use of district plans, b) the analysis and use of HMIS data, c) ensuring quality of services in all public health facilities, d) coordination and organization of evaluations and studies, not necessarily by themselves, e) HR planning especially for retention of workforce and measurement of workforce performance and f) for better contract management and planning of PPPs and health budget monitoring and analysis. There should be also a resource centre for community processes, either within or independent of SHSRC to guide the massive ASHA and VHSC programmes and for capacity-building for PRIs and RKS – aspects which are currently neglected. Without such a technical pool, the quality of technical assistance and retention of technical inputs for health systems strengthening would be limited. Lack of progress in these seven areas of health sector reform would be limited.
- ❖ There is a need to strengthen state and district level institutional arrangements for infrastructure development and maintenance (discussed in recommendation 1 a) and for procurement and logistics. The introduction of ProMIS is one part of it. However, the main focus should be on building district warehouses with inventory management which are responsive without time lags to stock situations at the facility level, and which themselves are kept well stocked by an independent procurement agency at the state level. This is broadly the TNMSC model, and even if there is a political-administrative failure to implement this recommendation over the last five years, administrators should be held accountable at least for progress on these process parameters.
- ❖ Most state and district health programme management units have reached a certain level of functionality. For further strengthening, the focus should be on need-based training programmes for each specific job description and also a better HR policy for contractual staff working here. (the latter is discussed in recommendation 2e).
- ❖ Use of HMIS for district planning, especially facility-based analysis and use of information in such district planning should be seen as the main frontier. The outcome is measured, not by whether data is uploaded into one or other system, but whether it is analyzed and used to inform monitoring and planning and review activities. Even current levels of data flow are adequate to make this possible, and only use of information would improve the quality of the data. Gaps in data collection at the primary register level and systemic faults that lead to duplication and poor quality data should be addressed. Capacity-building should be based on such analysis and not merely repeat well known skills. There should be a structured induction programme for new data managers and data entry operators who join the department. Systematic efforts to bring in data from the private sector which some states are doing well, should be scaled-up to all states, at least for some key indicators. Facility level data of private sector facilities should not be merged with public health facility data – though it would merge at district and block aggregated forms.

FINANCIAL MANAGEMENT

- ❖ States that have not complied with the minimum norms of financial leadership that needs to be in place at state levels (director finance from regular cadre, state accounts manger and state finance manager on contractual basis) and financial support that needs to be in place at district levels (district accounts manager and block accounts managers) and are also facing a problem of poor absorption of funds – should be followed up with this as the first step towards increasing absorption and accountability.
- ❖ Ensure that programmes that are showing low expenditure have clear guidelines in place and that these guidelines are available at the district, block and facility level.
- ❖ Ensure that facilities which are handling higher case loads and providing higher range and quality of services receive funds, so that quality of care could be sustained and more supportive staff and amenities could be put in place. Also ensure that absorption of funds is not hampered by a few non-functional or poorly functional facilities holding down the entire process of submission of Utilization Certificates (UCs) by not releasing further installments to them till their first installment is spent.

DECENTRALIZED PLANNING

- ❖ To improve the quality of the annual district plan and utilization of district plans, it is recommended that states work over the year 2011-12, starting early to develop a five-year plan. This should be called the strategic five-year district plan and show year-wise progress, such that most facility development targets and establishment of service delivery packages are met within a three-year framework – the last two years of the plan going

into only increasing volume and quality of services provided. This plan could be updated annually and only the budgets revised. (We note that most states are only asking districts to make budgets every year and find it too much of an effort to write a full plan document annually). The strategic plan could be printed by the year end and if modifications occur due to the nature of schemes approved in the 12th five year plan, the strategic plan could be so modified. But if we wait for the latter, the first plan year would be lost in this effort).

- ❖ Institutional linkages and technical support for each district to help with this plan effort and with subsequent use of this plan as a live document should be specified.
- ❖ Sanctions of funds from state to districts should be made with reference to the district plans – modified if needed.
- ❖ To improve the quality of village health plans and their use, there should be greater clarity on what is expected of village health plans and unreasonable expectations may be avoided. At the current stage, some identification of health priorities, some identification of marginalized sections where health and all related public services are reaching inadequately, an affirmative action is needed to counter this and a plan to spend the Rs. 10,000 untied funds, would itself be a big step forward. The block health plan should not be seen as an arithmetic sum of the village health plans, but as informing the block health plan on some areas.
- ❖ There is a need for deepening and expanding community monitoring in states where it is already implemented, and to link this with village health planning processes. Community monitoring processes need to be initiated in states where they have not been started yet.



1

Mandate and Methodology of 4th Common Review Mission





1

MANDATE AND METHODOLOGY OF 4TH COMMON REVIEW MISSION

The Common Review Mission (CRM) is one of the institutional arrangements for monitoring the progress of the National Rural Health Mission. This Mission takes place annually since November 2007, and the current Mission is the fourth of a series. Every year the Mission Report is made available to the public through the Ministry website and as a publication that is widely disseminated. It is also placed before the Mission Steering Group.

MANDATE OF THE 4TH CRM

- ❖ To review the changes in the health system since the launch of the National Rural Health Mission (NRHM) through field visits and spot examination of relevant records.
- ❖ To document the evidence in respect of the key paradigms of NRHM including infrastructure, Human Resource augmentation, strengthening of community processes, flexible financing, improved management and decentralization.
- ❖ To identify the key constraints limiting the pace of architectural correction in the health system envisaged under NRHM.
- ❖ To recommend policy and implementation level adaptations, accelerate achievement of NRHM goals.

GEOGRAPHICAL COVERAGE AND TIME-LINE OF 4TH CRM

Under the 4th CRM a total of 15 states and union territories (UTs) were reviewed (10 high focus states including three NE States, four non-high focus states and one Union Territory). The selection was intended to provide a representative picture of the progress made under NRHM. The states covered were Arunachal Pradesh, Nagaland and Assam from the North East, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, and Uttarakhand from the high focus states, and Punjab, Tamil Nadu, Maharashtra and Kerala from non-high focus states and one union territory Chandigarh. Bihar, Tripura and Karnataka were left out because they had been covered in Joint Review Mission (JRM).

The 4th CRM started with a briefing of the members on 15th December at New Delhi, at a day-long workshop held at the National Institute of Health and Family Welfare (NIHFW). This was followed by a state level briefing on 16th December held at each state capital, where the teams were briefed on the progress on NRHM of the various divisions. Written reports and data in formats circulated earlier were also made available to the state teams.

From December 17 to 21, the members of each State Mission were divided into two groups, each of which

visited one district for an on-the-spot assessment of progress in NRHM work in that district. This included at the minimum, a visit to a District Hospital (DH), a visit to two or more Community Health centres (CHCs) or Sub Divisional Hospitals (SDHs), two or more Primary Health centres (PHCs) and two or more sub-centres and some interactions with members of the community and ASHAs. In the facilities, visited, the teams interacted with the staff and with the patients seeking care in these institutions. The district leadership of the programme also made a presentation to the visiting teams on their work and the problems they were facing. The focus was on collecting qualitative information in order to understand the working of key processes and strategies of the Mission and the perceptions regarding quality and range of services delivered.

On December 22nd the teams returned to the state headquarters to finalize their reports and present key findings. The recommendations were discussed with the state officers before they were finalized and sent to the national coordinating team at NHSRC and NRHM division of the MoHFW.

COMPOSITION OF TEAMS FOR 4TH CRM

A total of 130 resource persons constituted the 15 CRM teams that visited the 14 states and one Union Territory. There were 40 government officials, 25 public health experts from academic or technical support units and 20 from civil society, 15 representatives of development partners, and 30 consultants working in

the Ministry. Representatives of the Ministry of Women and Children, in charge of the ICDS programme were also part of the teams.

TOPICS REVIEWED DURING THE 4TH CRM

The Fourth CRM evaluated the existing health delivery system in each of the selected states through 11 parameters which covered various aspects of the system. These included:

1. Infrastructure upgradation.
2. Human Resources Planning.
3. Health Care Service Delivery – Facility-based – Quantity and Quality.
4. Outreach Services.
5. ASHA Programme.
6. RCH II (Maternal Health, Child Health, Immunization and Family Planning Activities).
7. Nutrition.
8. National Disease Control Programmes (NDCP).
9. Institutional Mechanisms and Programme Management.
10. Financial Management.
11. Decentralized Local Health Action.

Further the status of progress against specific objectives and Expected Outcomes as stated in the PIP and as compared to the goals set by the NRHM were also reviewed.



2

Key Findings of the 4th Common Review Mission





2

KEY FINDINGS OF THE 4TH COMMON REVIEW MISSION

INFRASTRUCTURE

Progress in infrastructure development in the states of Assam, Orissa, Madhya Pradesh, Maharashtra, Kerala, Punjab and Tamil Nadu and Chandigarh, is good, with prioritization of facilities which was consistent with the plan that had been made. There is, therefore, substantial development of health infrastructure across these states. Linkage between infrastructure development and human resource development is however still weak. Infrastructure development in the states of Chhattisgarh, Jharkhand, Nagaland and Uttar Pradesh is slow. Infrastructure development in Arunachal Pradesh and Uttarakhand demonstrates good progress. However the planning was not based on use patterns and this has led to underutilized facilities.

The rate of construction is satisfactory and in accordance with district plans in states which had efficient mechanisms in place for executing the contracts. Punjab's Punjab Health System Corporation, (PHSC) is a well staffed and professionally managed autonomous organization, which manages infrastructure development against a clearly laid out plan and pools resources from all sources. Punjab may well be the first state to have the requisite public health infrastructure in place as it has a comprehensive plan to close all gaps by end of 2011, and its progress is well on schedule. Kerala

implements infrastructure development through the Kerala Medical Services Corporation and 50% of the NRHM expenditure is on infrastructure. Kerala too has closed most infrastructure gaps except with regard to sub-district hospitals and residential accommodation for staff. Tamil Nadu's infrastructure development is helped by a functional Public Works Department (PWD). Maharashtra has a well staffed Infrastructure Development wing with five engineers at state level, one in each district and 93 junior engineers at block level. The state has taken up 5293 civil work projects and 83% are complete. Madhya Pradesh has an engineering wing at the state and divisional level. Jharkhand, which is amongst the poor performers is now developing an engineering wing to manage infrastructure. Infrastructure development for Sick New Born Care Units (SNCUs), maternity wards in district hospitals and nutritional rehabilitation centres have been prioritized in Jharkhand. Assam has an NRHM infrastructure cell, but there are delays in construction despite this. A greater problem is that most of the construction work seen, was not according to specifications and there were design flaws. The infrastructure gaps are large and the progress is slow.

All the other States lacked such mechanisms and the lack of an institutional mechanism for infrastructure management correlates with poor progress. In

Chhattisgarh too the infrastructure gap is very high, and of the 367 constructions taken up, only 64% are complete. In 15% the work has not even started. Monitoring of work is also poor. Despite these problems the state remains unconvinced about a dedicated and empowered infrastructure wing in the state health department. Jharkhand has a huge gap too with about 3130 sub-centres and 675 PHCs pending. The infrastructure development wing has started functioning but it handles only NRHM fund-based constructions. In Rajasthan the state has farmed out part of the construction directly to the department or CHMO office in the district and the other part to the PWD. The report notes that whereas PWD completed 90% of the construction, the direct expenditure by the department was only 10%.

In Uttar Pradesh progress in infrastructure development is particularly slow. A total of 129 district hospitals were identified for upgradation to IPHS standards during the last two years and construction is about half complete only in three District Hospitals while the rest are still in progress. There is a huge gap in the building position of CHCs, as 308 more CHCs are required. Out of the 50 CHCs chosen for upgradation (2009-10), only five CHCs have been able to achieve more than 50% completion. The rest are still under construction.

As part of the Facility development plan related to the MCH centre planning process, residential accommodation needed for a 24 hrs designated facility has been widely recognized and planned for in many states as compared to the last CRM. Adequate numbers of residential accommodation for all staff in the category is however an issue. In Kerala and Chandigarh, the team mentions the availability of quarters in fair condition, but which are not utilized. In Chhattisgarh 882 staff quarters have been sanctioned in the current year, from European Union (EU) funds.

The design of the infrastructure is also an issue and there is a need to ensure that there is familiarity with the necessities of medical care in the architecture. For example Operation Theatres and Labour Rooms have no zoning as reported from many states. Compound wall construction is usually deferred in the original design and thus is built much after the building is completed.

Jharkhand has been developing the Sahiyya Shelter and Uttarakhand has planned ASHA Ghars at district levels to enable rooms for ASHAs who accompany the pregnant woman.

HUMAN RESOURCES (HR)

AVAILABILITY

Numerical adequacy is addressed to a considerable extent in human resources, showing a sharp increase in PHC doctors as compared to last year. Short-term and long-term plans with regards to recruitment are in place in most states.

In terms of vacancy situations, the highest percentages of vacancies are noted in the posts of specialists. Considerable efforts have been reported from states like Maharashtra, Punjab, Chandigarh, Kerala, Tamil Nadu and Uttarakhand for retaining specialists. Uttarakhand will soon be launching its new HR Policy, which includes measures to attract skilled persons for hard-to-reach areas. At the CHC level the goal of four specialists or even just one gynecologist for each CHC is too distant a goal, and therefore most states are focused on getting one or two gynecologists for the DH and selecting a small part of the rest of CHCs to upgrade to an IPHS level (used here as synonymous with FRU level/level III facility). Even for this limited objective the vacancy situation is proving difficult to fill. Multi-skilling programmes to close the specialist gaps are slow to pick up in some of the states where the needs are most.

The next highest vacancies are in nursing posts and this is reported even from the non-high focus states visited. For nurses the main problem is the failure to sanction the required number of posts - especially in the larger hospitals, as laid down by IPHS. In the weaker states, the problem is further compounded by the lack of nurses available for recruitment, for the limited number of posts which are already created. States in the latter category are Uttar Pradesh, Madhya Pradesh, Jharkhand, Uttarakhand, and Chhattisgarh. Orissa has the nurses required to close the gaps, but needs more sanctioned posts. Chhattisgarh is unable to find the required number of nurses and ANMs. There is an available pool of about 1000 ANMs but the state is unable to absorb them due to a minor change in service rules that are needed. Chhattisgarh needs 4000 additional ANMs. 25 ANMTCs and 14 GNM schools have been set up, as against the three in place when NRHM was launched. The output is now about 416 nurses and 964 ANMs per year and if the state persists with this strategy, the gap can be closed in about five years. Jharkhand, in contrast made much progress and only 20% vacancies need to be filled, even including the second ANM. Staff nurse vacancies are however high.

For the posts of ANMs the situation is better, except in the above five states. There has been a major expansion of ANM schools and most of these are functional, especially in all the high focus states, but the trained staff are not yet on the ground. Thus in Gumla district of Jharkhand the ANM vacancy is about 35%!! In states like UP, positions of the first ANM post are yet to be filled. Those states that started earlier in reviving and expanding ANM training, such as Orissa, Rajasthan and Punjab have however benefitted greatly and the vacancies, even for the second ANM are fewer.

Though all states have created many technical posts under NRHM and as of now, most of these are full, creation of new posts under the state budget was generally not found in most states. States have used varying, mechanisms such as difficult area allowance, incentives and compulsory rural postings and salary hikes to manage retention of doctors in rural areas.

One fact however must be emphasized. The entire revival of the public health system under NRHM and the huge increases in case loads seen would not have been possible without the deployment of almost 100,000 contractual staff under the NRHM. This includes specialists, doctors, nurses, ANMs, programme management staff and technical support staff. In most states there have been increases in parallel of state government-funded staff and though this increase has not been as much, there are no instances of compensatory decreases in state support. The addition of one lakh skilled professional workers in the public health system, in such a short time and with such large problems of distribution and availability is a huge achievement. Any withdrawal of this workforce, or even weakening of the commitment to support this, and the entire system could stand threatened.

One significant achievement of NRHM is the expansion of professional and technical education in health, especially in nursing.

THE CONTRACTUAL CHARACTER OF EMPLOYMENT

Under NRHM the policy has been to support only contractual recruitments or contracting of specialists. This approach has in the past had advantages – especially to start recruitment at a time when there was still high reluctance to increase direct government employment in any form. There is much better recognition of how short

we are of the norms of the density of health professionals needed for effective service delivery. But now many states report an increasing number of problems. Renewal of contracts is a problem, service conditions and pay increments are poorly managed, there is a high turnover rate, and there is reluctance to send such staff for skill-based training programmes of longer durations, essential for high quality service delivery. There also exists an unnecessary and retrogressive hierarchy between the contractual and the permanent staff. For example the regular ANM gets approximately Rs. 16,000 per month at the start of the scale and the second contractual ANM by contrast gets Rs. 6000 for the same job description, thus reducing the second ANM to the role of working assistant to the first. The work output of two combined may thus become significantly less than twice the work of one. Contractual status has no clear benefits in relation to workforce performance. If contractual recruitment is considered a modern approach to improved workforce performance, then the contractual staff, because she has no benefits of permanent staff, and no security of employment should get paid substantially more than the regular staff.

There is therefore, in the current context no clear advantage to retaining these recruits as contractual as it makes it more likely for them to quit public service. (Even permanent employment in government service does not have the same attraction it has had for skilled professionals before). One argument is that it is easier to recruit contractual staff, but as states like Tamil Nadu and Haryana and now as reported in this Mission, Maharashtra have shown, there is no reason for permanent employment recruitment to be time-consuming either. The attention therefore has now shifted in most states to strategies of attraction and retention of skilled professionals to rural and remote areas.

RETENTION OF SKILLED PROFESSIONALS IN RURAL AREAS

The problem that NRHM began with and which was highlighted in the approach paper to the XI Five year plan was how to attract and retain *doctors* in rural and remote areas. This is also a problem for the other cadre, but the problem is greatest with specialists and doctors. Clearly more and more states are addressing the problem through a mix of measures- and what was considered as an inherent and inevitable problem is being recognized as a matter of administrative competence.

Some of initiatives taken by states for attracting and retaining doctors in rural areas are listed below:

- ❖ Assam: The most important development in this state is the creation of a cadre of rural practitioners in the sub-centres of Assam. These are three-year doctors chosen from within the district, trained with a special syllabus at Jorhat Medical College and deployed back in the sub-centre. The first batch is in place this year and the initial reports are encouraging. Even deliveries which were not happening in SC started happening, encouraged by the presence of the RHP (Rural Health Practitioners). Appointing AYUSH doctors against the posts of MOs is extensively seen in Assam. Work force management innovations are also helping. For example in Assam, MOs are posted preferentially in their home districts.
- ❖ Chhattisgarh: This state has created a special Rural Medical Cadre with a package of financial and non-financial incentives to attract doctors to work in rural areas. In addition, it has deployed three years trained rural medical assistants in over 150 PHCs and an equal number of AYUSH doctors. With this a seemingly intractable problem is closer to solution. Admitting 450 Mitans to ANM courses is also a strategy to making ANMs available in difficult areas. A major expansion of nursing and ANM education from three to about 39 schools also has the potential to facilitate availability, though it would take a couple of years more for the benefits to be visible.
- ❖ In Madhya Pradesh, enhancement of retirement age to 65 years and opening recruitment to skilled professionals from other states, starting up nursing schools in high focus districts, the enforcement of a rural service bond for doctors, employing AYUSH doctors in PHCs, and the provision of a “difficult area” allowance for health providers is the package of innovations through which the problem of skilled professionals is sought to be addressed. Most of these schemes are in their infancy and there is still some distance to go, before results are seen.
- ❖ Maharashtra: The package of measures includes a hardship allowance given to MOs and specialists. More important, the selection of MO has been brought out of the public service commission and given to Regional Deputy Directors, resulting in drastic reduction of vacancies. Seats for Post

Graduation have also been reserved for MOs in service. AYUSH doctors as PHC MOs have been used extensively.

- ❖ Orissa: In Orissa, the focus is on differential remuneration and financial and non-financial incentives to facilities categorized as difficult, most difficult or inaccessible. Already in place in the “KBK” districts, this has now expanded to the whole state. The state too has a high number of AYUSH doctors in MO posts.
- ❖ Kerala, Tamil Nadu, Punjab and Chandigarh do not face problems in retention of doctors in rural areas, since availability is good, HR policies are reasonable, there is dispersed urbanization, and the degree of remoteness is minimal. However, even these states are considering incentives for relatively more difficult areas within their states, though by national standards they would not be considered as difficult. Tamil Nadu has a more efficient recruitment system and a low reliance on contractual appointment. Reservation of seats for rural candidates and compulsory rural service bonds for specialists training in government colleges seems adequate to fill their gaps. Kerala has introduced a one-year internship for B.Sc. nursing students and a two-year rural service bond. Even Kerala has scarcity of some specialists. To overcome this the state envisages to develop a poly-clinic system in which specialists offer services on a shifting basis over the seven days of the week. This allows access of patients to all necessary specialities at a given day and promises a cost effective services availability.

In contrast to these progressive HR policies in some states, those which have no innovation in this area are Jharkhand, Nagaland and Rajasthan, Uttarakhand and Uttar Pradesh where doctors’ service conditions remain poor, remuneration is stagnant, there are delays in recruitment processes, no incentive is in place, and vacancies are high. The available pool for recruitment in such states is also very low. These states are deploying AYUSH doctors in PHCs, but this as a standalone policy is quite inadequate. The training for AYUSH doctors to play the role of medical officer including allopathic drug prescription is not in place. Chandigarh and Kerala do not report problems in filling vacancies.

Though a slew of measures are being tried out by an increasing number of states, there is no clear

evidence as to what is most effective. Good concurrent evaluation would help states to evolve the optimal mix of interventions through which the problem of retention in rural and remote areas could be solved in the immediate future.

WORKFORCE MANAGEMENT

The need for rationalization of work force deployment and a rational transfer policy was mentioned in many states. Most of the states are in dire need of a comprehensive and sustainable HR policy to improve cadre management and morale, including revision in remuneration. Measures to assess performance and build a system of incentives and reduce disincentives has also been recommended in several of the state reports.

Training programmes are generally not on schedule, and this is largely due to weak training capacity- not only in the form of faculty in the training centres, but also of infrastructure in some states. Prioritization of who will receive training, and matching those trained to those providing most service delivery has been a major lacuna. Though all districts report Skilled Birth Attendant (SBA) training, this is well behind targets and those ANMs and staff nurses who are providing a large volume of midwifery services have not been nominated to attend SBA training. Training on facility based care for the sick newborn or institutional sick child care is just not visible.

Multi-skilling of medical officers for various courses like Life Saving Anaesthesia Skills (LSAS), Comprehensive Emergency and Obstetric and Neonatal Care (CEmOC) and Basic Emergency and Obstetric and Neonatal Care (BEmOC) are in process in most of the States as part of the plan. Training AYUSH doctors in Emergency medicines or basic Obstetric Care was expressed as a need in Maharashtra and Uttarakhand owing to the large number of contractual appointments of these personnel.

FACILITY DEVELOPMENT – THE VOLUME, RANGE AND QUALITY OF SERVICES

CASE LOADS

The trends in all the states visited as part of CRM clearly shows a marked increase in institutional delivery and increased inpatient admissions. The use of OPD for services has gone up. Uttar Pradesh reports an increase in the load of OPD in PHCs/CHCs from 3.3 lakhs in 2008-

09 to 4.2 lakhs in 2009-10. The bed occupancy ratio in Chhattisgarh was nearly 40% both in FRUs and 24x7 PHCs, which is a significant gain over previous years.

The overall OPD services in Arunachal, Assam, Punjab, Nagaland (70% increase), Chandigarh and Kerala shows an increasing trend. The increase has been recorded in AYUSH services from Chandigarh. In Jharkhand the decrease in OPD in Gumla district has been attributed to well functioning district hospitals and availability of private practitioners in the vicinity and in Chhattisgarh the team reported underutilization of OPD services in some facilities. In Chhattisgarh the shortage of pediatric formulations and an OPD attendance of less than five was reported.

Orissa, Nagaland, Assam, Jharkhand, Punjab and Uttarakhand, reflect increasing trends of inpatient admissions. The data available from Nagaland does not reflect a major increase. In the state of Uttarakhand general and orthopedic surgeries have actually increased in the district hospital and the LSAS-trained doctor is successfully assisting in both the streams. Trauma care and orthopedic surgery was similarly widely available in the district hospitals and civil hospitals of Punjab.

Inpatient management for infectious diseases such as swine flu or dengue with reduced platelet counts are also being reported from district hospitals in a number of states pointing to both a new responsibility that the public health facility has to bear and the increasing range of services being available.

The majority of increases in institutional deliveries are at district hospitals, sub-district hospitals/FRU level among the states visited and relatively lower in PHCs and not at all in sub- centres. C- section services were available at least one public facility in almost all the 30 districts visited by the team. A more detailed comment is given in the RCH section. Sick Newborn Care units were however available in only four of the 30 districts visited.

LABORATORY AND DIAGNOSTIC SERVICES

Laboratory services are available in district hospitals in Arunachal Pradesh, Uttarakhand, Chandigarh, Jharkhand, Kerala, and Madhya Pradesh, Punjab and Tamil Nadu. However certain essential diagnostics are still lacking in some of them. The x-ray machine was reported non-functional in one District hospital of Arunachal Pradesh.

In Jharkhand pathological investigations have been outsourced but the quality has not been monitored. In Kerala the labs were ill equipped and performing sub-optimally. In Uttarakhand, Chandigarh, Kerala, Madhya Pradesh and Punjab; the quality of services in the laboratory and in diagnostic facilities are variable. In Madhya Pradesh, X-ray machines were not available at FRUs. In Orissa labs and imaging services do not have provision for quality assurance.

User charges are being levied in Chandigarh and the rate list was not found to be adequately displayed.

REFERRAL TRANSPORT

An assured referral transport and emergency response system (the EMRI managed 108 service) is now available in Assam, Tamil Nadu, Uttarakhand, and partly in Chhattisgarh, Madhya Pradesh and Rajasthan. There is concern that in difficult terrain the EMRI is not a universal outreach system and tends to serve areas which are closer to the central areas. This is particularly a problem in Uttarakhand and Chhattisgarh. In Tamil Nadu there is an observation that more than half the pregnant women choose an alternative to 108 as the blaring siren and the appearance of emergency for a normal delivery is not preferred.

In the state of Madhya Pradesh, the main referral transport is the Janani express a more informal system of contracted transport with service providers linked by a call centre.

In Uttarakhand, there is an effort to innovate local mechanisms, like “Palki” scheme to bring patients to the pickup point to overcome this problem of access from remote villages.

In Orissa it is state-managed alternatives, and in Arunachal Pradesh it is the hospital-owned ambulances. In Arunachal, Maharashtra, and Jharkhand hospital ambulances are being used but in Arunachal and Maharashtra it is a paid service. In Uttar Pradesh the availability of emergency transport in rural and remote areas is limited and people in case of emergencies hire vehicles at their own cost to reach facilities like district hospitals.

Overall inter-facility transport is also a huge problem. In both Jharkhand and Uttar Pradesh ambulances were limited in number and were used to travel to VHND

meetings, and for delivery of medicines, instead of being used for referral services. However in Jharkhand Rs. 250/300 are given as transport costs to the patient and inter-institutional transfers are paid for, to a limited set of beneficiaries like pregnant women. The state of Maharashtra is expecting 150 ambulances on the road by March 2011. Until then the districts have developed their own call centres from local resources and arranged a centralized system to inform PHC/RH ambulances to pick up emergency cases particularly for delivery. This is known as the 1056 system.

DRUGS AND EQUIPMENTS

The availability of drugs has improved but there is no clear commitment to give all patients all essential drugs, free of charge, or at least to give the BPL patients drugs without charges. In Punjab some hospitals follow this, but avail of user fees gained from diagnostics to fund the purchase of drugs supplied free. In other hospitals a considerable amount of user fees is collected but it is not used for drug purchase.

One exception is Assam, where free supply of medicine in Lakhimpur has increased the overall service delivery. In Kerala as part of the non-communicable disease programme, drugs like oral hypoglycemics, insulin, several anti-hypertensives, cholesterol-lowering agents, and anti-platelet drugs were given free of charge during the OP services conducted twice a month to all BPL patients.

The practice of prescribing drugs which the patient needs to purchase is widespread. Out-of-pocket expenditure for purchase of drugs in the states of Assam, Chandigarh (antibiotics), Maharashtra (Goregaon hospital patients were asked to purchase injections and drugs for Falciparum as well as Vivaxmalaria), Punjab, Uttarakhand, Uttar Pradesh are high. In Assam patients were asked to purchase drugs from the pharmacy despite free supply of the same. In Chandigarh, patients with BPL cards are entitled to free medicines. However poor patients who do not have BPL cards incur huge out-of-pocket expenditure since there are no norms to identify poor patients and provide free drugs. In Chhattisgarh patients were asked to purchase disposables and catgut for Lower Segment Caesarean Sections (LSCS). Irrational use of drugs was pointed out by some states like Chhattisgarh where oral anti-biotic and injectables for normal deliveries are prescribed. The team observed indiscriminate use of Oxytocin and antibiotics in Health

facilities of Gondia (Maharashtra). Standard treatment guidelines were not being followed in most states. Certain states reported irrational supply of drugs. Chhattisgarh reported Iron Folic Acid in excess of stock, oral Penicillins and Amoxicillins in the quantities which were quite in excess to the OPD load. In Uttarakhand, anesthesia drugs like Halothane and Vancurarium were found stocked in a Block PHC of Uttarkashi. Supply Chain management issues, were reported from Nagaland, Orissa, Uttarakhand and Arunachal Pradesh. In Nagaland it was found that VHSCs were procuring drugs for sub-centre. Many non-essential medicines with short expiry dates were purchased. Certain drug procurement policies implemented in Maharashtra related to stock-out of drugs in higher level facilities. Current financial allocation norms for medicines also appear inadequate and need to be reviewed and significantly increased to reach an acceptable level.

The other big problem is drug logistics. Stock-out-of drugs is frequent. States most affected by this were Jharkhand (major stock-outs in Palamu 80% in DH, 50-60% in APHCs, 10-25% in PHCs lasting from one to four months), Chhattisgarh (Paediatric formulations), Nagaland (irregular supply), Punjab, and Uttarakhand (District Chamoli irregular supply). In Kerala stock-outs are generally not a problem, but could significantly affect supplies of OCPs, and condoms. In Uttar Pradesh the team observed that the OCPs were to expire on Jan 2011 all over the districts. Stock-outs do not appear to be a problem in Tamil Nadu.

Essential drugs for managing obstetric emergencies, and which are critical to the success of the institutional delivery strategy such as Magnesium Sulphate were not found even in many CHCs and DHs. Oxytocin and Misoprostol did not figure on the list in many states.

In Rajasthan the functional Jan Aushadhi Kendras were found to be an effective mechanism for the supply of cheap generic drugs to reduce out-of-pocket expenditure. This is worth replicating as it brings down the cost of drugs – even where prescribed by the private sector.

The equipment situation was good in most facilities visited, and there were no instances reported where lack of equipment was the main reason for lack of services. Boyle's apparatus was found to be rented in Jharkhand district hospital. One exception to this trend was Chamoli in Uttarakhand, where generators and

other essential equipment were not in place. Annual Maintenance Contract (AMC) for equipment was a requirement but was not available in Arunachal Pradesh, Uttarakhand, Madhya Pradesh, Uttar Pradesh and Orissa. In Uttar Pradesh, the team reported that due to a delay in the timely repair of large equipment at district level, some recently purchased critical equipment was rendered non-usable. In two or three hospitals visited, X-ray machines were not working. AMC for cold chain equipment was also absent.

Dosimeters for radiographers were not in use as reported from Chhattisgarh and even from Tamil Nadu (available but not used). Generators and Baby warmers were absent in Chamoli district. Hazardous practices such as placing equipment, pharmacy supplies, the generator and electricity panel with fuel in one small room was reported in Uttarakhand. Mismatch between equipment and human resource was also reported from Uttarakhand.

SUPPORTIVE SERVICES

Diet: Diet for patients was available in the district hospital in Arunachal Pradesh, Chandigarh, Tamil Nadu, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Maharashtra. However, below district level diet was only available in selected facilities of Rajasthan under "Kalevo" scheme, Chandigarh on subsidized rates and Madhya Pradesh free of cost in facilities. It was observed by teams that no diet facilities were available below CHCs in any of the other states. Diet and Laundry services were available but inadequate in Kerala.

General Cleanliness: In Arunachal Pradesh, cleanliness in the District Hospital was satisfactory. Observance of good cleanliness measures were observed in facilities below district level visited by teams in Rajasthan and Kerala.

Laundry: Laundry services are available in an increasing number of states – at least at the more central facilities. Arunachal Pradesh, Chhattisgarh, Madhya Pradesh, Kerala, Tamil Nadu, Orissa, Punjab, Rajasthan and Uttar Pradesh, all had some laundry services – the first five were internal and the last four were outsourced. However, no laundry services were seen in Uttarakhand.

Electricity: In almost all states there is a positive report and at least generators are available to ford power cuts. Uttarakhand again is an exception. Low voltage in

Uttarakhand is a major challenge in district Uttarkashi affecting the functioning of equipment like baby warmers, and room heaters in extremely cold facilities.

Water: In Jharkhand and Uttarakhand water supply for hospitals is an issue. In Uttarakhand in particular, drinking water for patients, and piped water for the facility is a problem in several facilities. This problem was reported much less from most states. Many states reported that considerable work to make piped water available had been completed.

Toilet: The general trend of reports is much more positive than earlier CRMs – though even now poor sanitation is reported from two or three states. In more and more hospitals sanitation arrangements are outsourced, and separate toilets for men and women are also reported from most states.

Security: Is outsourced in most facilities and available at the district hospital level, but seldom available in CHCs and PHCs. There is concern about staff having to stay overnight, especially when the facility is outside the main village.

Infection prevention: Infection Management and Environment Plan (IMEP) was present in Tamil Nadu, however re-training was recommended by the team. IMEP protocols are not in place in Chhattisgarh, Uttarakhand, Jharkhand, Orissa and Uttar Pradesh. In Gondia district of Maharashtra a case of a hypothermic child being admitted in a general paediatric ward where chances of nosocomial infections were high and the temperature was not maintained in the ward, was reported.

States have taken measures for Biomedical waste management, and guidelines are available, but downward dissemination of the guidelines and implementation in terms of effectiveness needs to be monitored.

Gender sensitivity: In Kerala, privacy issues are not being addressed properly; curtains are missing at most places in labour rooms and wards. In Uttar Pradesh the team observed, that although wards were separately earmarked for men and women, they were often seen to be mixed in practice. Privacy of patients was an issue in the wards with no curtains or screens available. Safety of women service providers like nurses seemed to be an issue in many facilities. Very few facilities had separate rooms for women staff with attached toilets.

Use of untied funds: Utilization of Untied Funds is helping in improving service delivery as reported from most states. Uses were varied and included support to non-planned and emergency infrastructure and contractual services. There are reports of such increase in utilization during epidemics by procurement of additional drugs and consumables and managing utility backup services. Major uses of these funds are for maintenance, minor repairs, local purchase of emergency drugs, employing contractual staff, and for hiring local transport/ambulance services. One problem noted is the high level of variation between facilities in the utilization of untied funds.

User Fees: These are still in place in most states but now almost all states retain the fee collected at the facility level. Uttarakhand is the exception, where 50% of user fees are still deposited into the treasury while Uttar Pradesh, which had a similar problem before, has now changed. Uttarakhand has actually raised user fees in this period. This could be contributing to the reported decreases in OPD and IP attendance. However, Jharkhand and Kerala report no user fees. In most other states, pressures to increase fees and maximize collections are less, as for example in Orissa, Chhattisgarh, Rajasthan, Uttar Pradesh and Madhya Pradesh. Almost all states have started providing free care for pregnant women, though this has not been extended to newborns. Punjab still has a high level of user fee collection and in many facilities there is no free supply of drugs. Assam also has an active user fee collection approach especially for diagnostics.

OUTREACH SERVICES

- ❖ Village Health and Nutrition days are known by various names e.g. Mamta Divas in Punjab, Jacha Bacha Divas in Uttar Pradesh, etc. It is meant as a medium of convergence between Health and the ICDS department, with the active participation of the VHSCs and PRIs. However, often it remains as a platform for the ANMs services, and the ICDS component is not built in – except for the Anganwadi centre being a venue. Sometimes even this is not happening. Provision of supplementary nutrition in the form of Take Home Rations (THR) to children under three and for pregnant and lactating women, another important function of the VHNDs was accorded low priority during the VHND. In Uttarakhand, UP, Rajasthan, Madhya Pradesh, Kerala, and Chhattisgarh, the VHND as a

platform of ANM services is functioning well on the ground. Though the frequency of such VHNDs are high; the range of services provided is sub-optimal, being limited to ANC and immunization. Jharkhand, Chhattisgarh and Assam, reported that the VHNDs were useful to reach the under-served/un-served communities and marginalized sections and groups residing in remote blocks. In Kerala and Assam boat clinics are innovations now scaled-up to wherever it is needed and are reported as successful by the Mission. One interesting observation from the Lakhimpur visit records “Since boat clinic visit takes place only once a month in these difficult riverine island localities, medicines and ampoules are given along with prescriptions to the patients and the ASHAs in these villages are trained to provide follow-up care including administering injections where needed”. The second ANM is in place in Punjab, Maharashtra, and Chandigarh where over 60% to 80% of second ANMs have been deployed. In Kerala and Tamil Nadu this post was not considered necessary. In Uttar Pradesh and Arunachal Pradesh there are still vacancies of the first ANM. In Madhya Pradesh, Rajasthan, Chhattisgarh, Jharkhand, Nagaland and Uttarakhand the first ANM list is completed, but only 20% of the second ANM are in place, since recruitment remains low in the fifth year of the NRHM. Part of the reason for this, especially in the state of Uttarakhand, is that the state has been sanctioned only as many second ANMs as they have appointed male MPWs, and since states are unable to do this, the sanctioned number of second ANM also suffers. In Assam and Orissa about 50% of the second ANM are in place. Where the second ANM is in place, the roles and responsibilities and areas of work of each ANM need to be demarcated clearly and there should be some parity in terms of remuneration for the same work. In Arunachal Pradesh the contractual ANM has been deployed at the District Hospital rather than at sub-centres.

- ❖ Male worker availability has improved- but many states still have large gaps. In Nagaland all 132 sanctioned positions under NRHM are filled and all have been trained in malaria. This is in addition to filling and training the regular 347 MPW posts. TN has filled 99% of its 8706 posts. Kerala has 3504 posts and 98% of these posts are filled,. Maharashtra has filled 78% of positions, and MP has filled 76% of 7933 posts. On the other hand, Arunachal has filled

only 26% of its 592 positions and Uttar Pradesh only 24% of its 8857 positions.

- ❖ Sub- centres are no longer seen as a site of delivery by official policy in Kerala, Tamil Nadu, Punjab, Chandigarh and in Nagaland also. In Tamil Nadu and Kerala, a significant proportion of immunization services and antenatal care are being provided in PHCS. This leaves a huge vacuum in workload in the sub- centre, and which these states are hoping to fill through programmatic interventions for adolescents or non-communicable diseases (NCD). Punjab has two ANMs in place which makes this problem even more stark. Kerala has gone some distance in programming for NCD, but the other states are only in the starting phase. In Punjab, where about one third of deliveries are still taking place at home, and in Nagaland where about two-thirds are home deliveries, the withdrawal of midwifery from sub-centres is certainly premature.
- ❖ In one district of Uttarakhand, and in one of Assam there are deliveries taking place in the sub- centres. In the second district that was visited in these states deliveries are not taking place in the facility, but home deliveries are being assisted by Skilled Birth Attendants. In Arunachal Pradesh, ANM vacancy compromises the delivery of all services. In the states of Chhattisgarh, Jharkhand, Maharashtra, Rajasthan, and Madhya Pradesh, sub-centre deliveries are taking place in fewer than 10% of sub- centres and only 5% of total deliveries take place in sub- centres. Only in Uttar Pradesh do we have a report of increasing numbers of deliveries in sub- centres. Even so, it appears that almost everywhere, the sub- centre has become an outreach centre for immunization and antenatal care without any midwifery function.
- ❖ Mobile Medical Units (MMUs) are functional in Assam, Punjab, Chandigarh, Chhattisgarh, Jharkhand, Kerala, Madhya Pradesh, Tamil Nadu and Uttarakhand, and are providing essential outreach services in the tribal areas of Kerala and Tamil Nadu. In Uttarakhand, the Chamoli MMU was seen to be providing a wide range of services, essentially as out-patient clinics, mostly diagnosing and referring for follow-up, with some being treated in the MMU itself. In Nagaland, the MMU is poorly functional, often without much equipment, with the vehicle being run-down and in need of repairs and a poorly-planned schedule of visits. In most

Crude Birth Rate (CBR) of Nagaland based on Sample Registration Survey (SRS) Data is 16.5 which place it as high as Kerala in performance. Total Fertility Rate (TFR)(NFHS 3) is as high as 3.7 which makes its performance as poor as the weakest states in the nation. HMIS shows 70% of births are not reported at all and immunization rates are very low, even for the level of development seen. Recently there has been an interesting and instructive discussion on an internet discussion forum, on how to interpret these anomalies and it is useful to see how even data of uneven quality can be very rich in information for programme management, if one knows to interpret it competently.

states, however, the visiting teams were not able to observe an MMU owing to time constraints.

- ❖ The Village Health and Nutrition Day (VHND) is synonymous with immunization sessions in most states. Madhya Pradesh has moved forward in training of cold chain handlers and health workers on immunization. In other states such as Nagaland, for instance, this was weak, leading to poor maintenance of vaccines in the cold chain. Immunization coverage is lowest in Nagaland- but this has to be seen in the light of the general problem regarding all health data of this state (see box above). Tamil Nadu has discontinued immunization services at the sub-centre and moved it to the PHC and above, as a doctor is considered essential during immunization. Community and VHN perceptions are against this move as it is making access more difficult. There is also concern that the immunization rates (UNICEF coverage evaluation survey) show a decrease in coverage and this pattern is confirmed in both districts visited, though in Thiruchirapalli district there has been some improvement in the last year. In Punjab most immunization sessions take place at the sub-centre head quarters, but whether there is such a general trend is not clear. Sub-centre level tracking arrangements, such as tickler bags and registers with tracking pages were found deficient in many states. Nagaland, Arunachal Pradesh, Uttarakhand, and Jharkhand have either not used alternative vaccine delivery to improve vaccination performance or have recently discontinued it, leading to declines in immunization coverage in many areas. Chandigarh has a problem with poor immunization coverage in slums and has been facing a decline in measles coverage overall, although coverage with complete immunization has increased.

ASHA PROGRAMME

- ❖ ASHAs are effective catalysts of the entire service delivery system. Their main effectiveness is in

motivating women for institutional deliveries and immunization. ASHAs play an active role in community mobilization especially for institutional deliveries. They are also active in referral and follow-up in disease control programmes. In Kerala, they are poised to play a major role in Palliative care. Breastfeeding practices have improved. Home-based newborn care is taking place in Chhattisgarh. Though there is a wide range of activities that the ASHAs are involved in, there is some concern from many states like Uttarakhand that with one per 1000 ASHA, every household is still not receiving coverage for her services.

- ❖ ASHA Training upto the 5th module has reached 100% in Nagaland and Chhattisgarh, 97% in Orissa, 92% of ASHAs in Jharkhand, 81% in Uttarakhand, 80% in Assam, 66% in Arunachal Pradesh and 100% in tribal districts of Maharashtra. It is upto the 4th module in the other states visited – 94% in Uttar Pradesh, 85% in MP, 82% in Punjab, 74% in Rajasthan, 64% in Kerala. In Tamil Nadu where the ASHA training is limited to tribal districts, training has proceeded upto Module 2. In Maharashtra where the programme has been expanded to the whole state in 2009, 79% of ASHA have been trained in Module 2. ASHA training in Module 6 has begun in Uttarakhand and Nagaland. Chhattisgarh and Uttar Pradesh have introduced a training programme for building ASHA skills for improving child survival, which they have named IMNCI plus.
- ❖ Payments to ASHA as reported, range from as low as Rs. 350 per month in Kerala and Rs. 500 in Uttarakhand to Rs. 2000 per month in Assam and Jharkhand. The range of payments reported by a group of 30 ASHA in Orissa ranged from Rs. 350 to Rs. 3500. Timely payment was reported from one of the two districts of Jharkhand. In the other it is delayed for two to three months. JSY incentive payment to ASHA accounts for almost all the payment she receives. Payments from all other programme heads

are irregular or are not given at all. For instance, making malaria slides, is not paid for.

- ◆ There is a strong element of mobilization in the Chhattisgarh and Jharkhand programmes. Introduction of lodging arrangements for ASHAs in the form of ASHA *Gruha* (Rest houses) in Uttar Pradesh, Jharkhand, and Uttarakhand and help desks in states like Uttarakhand, Orissa and Jharkhand has facilitated the work of the ASHAs and increased public facility utilization.
- ◆ 457 Mitanins have been admitted into ANM courses in Chhattisgarh and 31 into nursing schools.
- ◆ Supervisory systems are in place and improving in Chhattisgarh, Nagaland, Assam, Jharkhand and Orissa, but most states also report that the quality of supervision needs to improve and for this more training is required. In Uttarakhand Mother NGOs (MNGOs) play this role of support at the district level. These six states have State level ASHA Resource centres. It is weak or non-existent in all the other 8 states. Chandigarh has no ASHA programme. Lack of effective institutional level support structures at state, district and sub-district levels has hampered scaling-up of the programme in the other states. Even where support systems are in place, the challenge is to train and provide leadership to them. Completion of training in Module 5, and initiation beyond this has not been accomplished in the states and this is due to the limited support.
- ◆ Drug kit replenishment remains a problem. There are still major gaps in the range of drugs provided and in the uninterrupted supply of drugs in almost all states. Even in Chhattisgarh where there is a special state government funded scheme called the Chief Minister's Mitadin Drug Fund, there has been a six-month interruption of supply. The problem seems to be both in logistics and a poor recognition of the importance of ensuring an uninterrupted supply of drug kit contents to the ASHA. In Maharashtra a wider range of drugs is planned, but as of now, not yet in place.
- ◆ Coordination between AWWs, ANMs and ASHAs is very good in most districts visited. Almost every state mission specifically looked at this issue and found it to be satisfactory, and more often very positive and synergistic.

- ◆ There are a large number of interventions to provide support to ASHA through varying forms of social recognition and solidarity building. These include ID cards in almost all states, a quarterly ASHA newsletter in Uttar Pradesh, uniforms in Orissa, Kerala, special ASHA-based radio programmes in Nagaland and Assam, ASHA *Sammelans* in states such as Assam, Orissa and Uttar Pradesh. These have also improved morale and made for a better community response. This has also had a good impact in reducing attrition. Attrition rates are even less than the 5% reported in the third CRM and retention has improved. The highest report was in Muktsar in Punjab where drop outs were upto 15% and 10% in Nagaland over a four year period. In the other district of Jalandhar it is less than 2% and this is similar to the reports from other states (except Madhya Pradesh where it was not reported by the team) where teams made it a point to actively obtain this information.

- ◆ While ASHA Mentoring Groups have been formed in some states and are functional in Nagaland, Assam, Uttar Pradesh, Madhya Pradesh, Rajasthan and Jharkhand. They still have to be enabled to be effective in hand-holding and guiding the ASHA programme.

- ◆ One interesting observation while compiling all state mission reports is that there is no other component/parameter of NRHM progress which so uniformly receives positive reports as the ASHA programme—and in most cases this is despite many key processes like training, payments and supervision being weak. The positive feel is because of the impression that the ASHAs themselves take on the visiting team—and programme management now needs to rise to match her level of motivation.

REPRODUCTIVE AND CHILD HEALTH

MATERNAL HEALTH *Institutional Deliveries*

Almost all states have shown a sustained increase in institutional delivery. Kerala and Tamil Nadu already had high institutional delivery rates at over 95% with a marked shift from the private to public sector. Orissa achieved 58% institutional delivery by November 2010. Dhemaji in Assam reported 71% institutional deliveries. In the states of Uttarakhand and in Lakhimpur in Assam

institutional deliveries are less than 40%. In the state of Jharkhand also, despite substantial increases the net percentage of institutional delivery is still low. In Punjab, one third of deliveries take place in the public hospital, one thirds in the private hospital and another one third at home—though neither connectivity nor availability of services is a problem.

The delivery loads are skewed towards tertiary centres and district hospitals. To give an example – in Ajmer district of Rajasthan, the medical college accounts for 24% of the delivery load, and the district hospital and one more satellite hospital for another 35%. The CHC and PHCs together accounted for 18% of deliveries and all sub- centres taken together for 5% of the total deliveries. In some districts visited this 18% in the second level was higher but the trend was the same. In Tamil Nadu the break up is as follows: 31.9% in private hospitals, 39.8% in district and medical college hospitals, 27.7% of deliveries in PHCs and 0.56 in sub-centres. Between PHCs and CHCs, it is the block PHC or CHC which accounts for the major case loads.

This is clearly a pattern of an overload of normal deliveries at the district hospital and medical college level. But to what extent it is possible and desirable to work for a redistribution of these deliveries downwards in different state categories and contexts is not clear. Where home deliveries persist in large numbers, the need to build confidence in more peripheral facilities must take a priority.

Comments on ANC coverage, where made, are broadly consistent with what we know about these districts from DLHS-III. The concern is regarding the quality of care. In Chhattisgarh, the team could not find any records for high-risk pregnancy, no referral records, no records of fixed day ANC at CHC/HSC, Haemoglobinometer, functional BP apparatus either with the concerned staff and the facility, even though there were sufficient stocks available in the store.

The quality of care in institutional delivery remains a matter of concern. The practices that should follow SBA training – like Partograph, recording of complications identified and managed, use of drugs like Misoprostol and Magnesium Sulfate, and the correct use of Oxytocins are not yet established. Protocols of care are more widely available. The training of SBA seems to have focused on getting those ANMs not currently conducting delivery to begin to do so, rather than

ensuring that those doing delivery have higher skills and quality levels – and this could be one reason for this problem. Home deliveries conducted by SBA were significant and need support in the contexts of Chamoli and the two districts of Arunachal, and in Lakhimpur in Assam. Similar experience with de-skilling of ANMs was reported in Uttarakhand. Duration of the Post-natal stay of mothers at facilities appears to be increasing, but in the poor performing six states of Chhattisgarh, Uttar Pradesh, Bihar, Jharkhand, Uttarakhand and Nagaland, the newly delivered mothers are still leaving soon after delivery.

C-section Services and comprehensive emergency obstetric care

C- section services were available in at least one public facility in 27 of the 30 districts visited by the team. This is an improvement from previous years. There are more positive reports also about multi-skilled medical officers performing C-sections. One district where C-section was not available was Chamoli in Uttarakhand. In the other district of Uttarkashi the short-term 18 weeks trained team of two – (one in emergency obstetrics and the other in anesthesia), were performing C-Sections in the district hospital. The other two districts where no C-section facilities are available were Tawang and Changlang in Arunachal Pradesh.

C-section rates of less than 10% were reported across the states. This indicates that though availability has improved, the volume of services still needs to increase much further. Thus the district hospital alone as the site of C-section is inadequate, and states need to have met the norm of at least one centre providing CEmOC in every 5 lakh population, or within one hour of every basic facility. Referral of complications to the private sector, due to lack of skills or confidence in the public system to manage complications continues to be a problem. Even the functionality of the district hospital as FRU is limited, as seen in Uttar Pradesh. About two to three C-sections per month take place in Sonbadhra DH, only in an extreme emergency, and when the surgeon feels that the intervention does not require a blood transfusion. For elective surgery or for surgeries requiring blood, the nearest centre with a blood bank is at least three hours away. Lakhimpur Kheri on the other hand has the DH and one CHC functional as FRUs.

In contrast, we have a different pattern in Kerala, Tamil Nadu and Punjab. In the Kerala districts visited,

Kottayam and Kozhikode, recorded 65% and 54% C-section rates, respectively and the district hospital of Ernakulam reported 70% of LSCS. As per HMIS data for Ernakulam, the total deliveries that go to private sector are 70% of the estimated pregnancies of which nearly 50% are through C-section; whereas of the 30% that go to the public sector, 65% are delivered by C-section (Kerala has a good reporting on HMIS from the private sector). Therefore one explanation for this phenomenon can be that the C-section are mostly heading towards public sector to reduce out-of-pocket expenditure attributed to surgery. In Tamil Nadu's Virudhunagar district there are over 14 sites where C-section is available (1 DH, five taluk hospitals, and eight PHCs !!!). The C-section rate is a relatively modest 15%. The other district Thiruchirapalli of course is a big city with one medical college hospital with a 34% C-section rate, one DH and six SDH with a 18 to 20% C-section rates, and 2 PHCs also providing C-sections. Jalandhar district has 9 functional FRUs and even the much less developed and smaller Muktsar district has two. The C-section rate is about 20%.

Janani Suraksha Yojana Payments

The JSY programme is almost universally known to pregnant women and their families and the scheme is functional in all states visited. Issues of timely payment have improved over previous reports, but problems persist. Rajasthan, Madhya Pradesh, Kerala, Uttar Pradesh and Uttarakhand reported complete and timely payments. Generally payments are made within a time period ranging from one day to one week after delivery. At peripheral facilities payment is more delayed. Punjab reported delayed payments at PHC level as powers of disbursements are at block level. Leakages in payment are difficult to judge, though teams that visited Chhattisgarh and Assam had grounds for apprehension. The Chhattisgarh team reports payments against entries at sub-centre level when no deliveries were happening. In Assam there was considerable non-payment at all levels, with accounting of these amounts as already paid. But this is not the general trend. In most other states, this was looked for and though a one or two week delay was common, non-payment was the exception rather than the rule.

Blood Bank and Blood Storage

Blood banks at the district hospitals was available in all district hospitals where C-sections were taking place

except in Sonbadhra of UP, Zunebphoto of Nagaland and in one district of Orissa. This reflects significant progress. In Chamoli the blood bank has been established but C-sections are not taking place, and collection of blood has also stopped in the last six months. There is a concern about a slide back in these districts of Uttarakhand even on established gains.

Blood storage facilities are however difficult to establish and most non DH FRUs are getting their blood from the DH on demand which obviously limits their ability to act as a facility of Comprehensive emergency obstetric care. For example even in Jalandhar the 7 C-section capable facilities, are supplied blood promptly from District hospital and one SDH, when the need arises.

Abortion Services

Details on the availability of safe abortion services had not been gathered from all districts. As a general comment, such services are available where comprehensive emergency obstetric care is available, and in only a few of the places where it is not. Safe abortion services were to have been made available in all CHCs, at least in site, per block.

CHILD HEALTH

Newborn care

Home-based newborn care is being introduced in most states. In Chhattisgarh and Uttar Pradesh it is already available to a fair degree through trained ASHAs. In Chamoli the training quality was observed to be good, though the medical officers were concerned about the ability of the NGOs to conduct the training. In the other states ASHA training for this has not begun, though a number of ASHAs are making visits to the newborn and responding to sick children, based on the inputs available in the first few modules. Tamil Nadu where mortality reporting is much better, reports that in 2009-10, 65% of all post neonatal deaths in Virudhunagar and 49% in Thiruchirapalli districts occurred at home, emphasizing the relevance of home-based newborn care even in Tamil Nadu. There were no reports from any state identifying Anganwadi workers as being active in either newborn care or care of the sick child and this does not currently appear to be a priority on their work charter.

Baby warmers in newborn care corners are seen much more often and reported from many states than previously – Arunachal Pradesh, Assam, Uttarakhand,

Uttar Pradesh, Maharashtra, Madhya Pradesh, Orissa, Rajasthan, and Tamil Nadu. However their use is very limited and in facilities in Arunachal and UP it is almost absent. Training of appropriate staff to promote the functionality of these corners was found to be very limited.

Facility-based newborn care is however inching forward at a snail's pace. SNCUs were found to be functional in only five district level facilities visited i.e., in both districts of Madhya Pradesh, in Ajmer in Rajasthan, in one district of Maharashtra and in Virudhunagar in Tamil Nadu. In all other districts visited there were no SNCUs functional, though as in Assam, some beginning is being made. Nevertheless, availability of SNCUs in five out of 30 districts is too limited a progress after five years and the contrast with the increase of availability of C-section services needs to be noted. There are no newborn stabilization units at all. Even in Virudhunagar which holds some sort of record with 14 C-section capable units, only two SNCUs are in place. Tamil Nadu also reports a 11% still birth rate – a reason to suspect persistent perinatal mortality. In the SNCUs visited, 70% of the case load was from within the hospital, with a 64% mortality – indicative of the challenge of newborn care, even in the best of situations. Only 30% of the cases seen in the SNCU had been referred. This is a general problem in functional SNCUs everywhere. They are attending to cases born in the same facility, but much less often as a referral site. Referral transport that is reaching pregnant women is not reaching the sick newborn with the same frequency.

Protocols of care for sick newborns or sick children were almost never seen. The newborn stabilization unit was also not reported from any of the districts and even in-state progress reports, such an intermediate level unit does not seem to be on the agenda. Laboratory support is weak. Training on (Facility based Integrated Management of Newborn and Childhood Illness) F-IMNCI or any form of institutional training for sick newborn care or even for sick child care was not observed by almost any team—especially among those working in these wards. Even the two day Navjat Shishu Suraksha Karyakram (NSSK) reached the service provider, except to a limited extent in Madhya Pradesh and Rajasthan.

The whole of facility-based care newborn implementation is at a very preliminary stage. Obviously in such a preliminary situation, home-based care, including a first level of care of the sick newborn and child through the

ASHA and supported by the ANM, would need to continue as the major input for at least the next five years.

Family Planning services

Sterilization/Permanent method services are still skewed towards a higher level that is available only in district hospitals in Madhya Pradesh, Orissa, Uttarakhand, Punjab, Kerala, and Chandigarh. Female sterilization through tubectomy still the predominant approach in all the above mentioned state including Assam, Nagaland, and Arunachal Pradesh. Post partum tubectomy does not appear to be taking place.

Below the district level most of the states are still taking a camp approach. The good news is that Non Scalpel Vasectomy (NSV) is reported as picking up from a large number of states – Assam, Punjab, and Gondia in Maharashtra

Temporary methods: Uttarakhand reported Intra Uterine Contraceptive Device (IUCDs) being inserted in sub-centre levels in Chamoli. In Kerala CHCs were seen to be the weakest link in the provision of sterilization services.

Pregnancy and Immunization Tracking

Orissa, Rajasthan, Tamil Nadu and Uttarakhand have started the Pregnancy and Immunization tracking, but as reported by all teams there is little or no use of this data and no way of judging this quality. In all other states the tracking has either not started or the process of training or distribution of forms is ongoing. Issues appear to be those related to having too many data fields and collection of information difficult to recall (such as date of birth of the mothers). Increase in paperwork was another major issue reported.

Maternal Death Review (MDR)

MDRs implementation spans a range, with some states such as UP being at the stage of issuing guidelines. Others like Kerala are in the process of training and forming district committees. Still others like Maharashtra, Chandigarh, Rajasthan. Assam and Punjab have actually started doing the reviews – but even here the focus is on sending reports upwards, rather than to use this as a process or as a tool to improve the system. In terms of outcomes the state of Assam reported 28/11152 maternal deaths, with the main causes attributed to

anemia and Post Partum Haemorrhage (PPH). Dhemaaji reported 34 maternal deaths out of 8285 deliveries.

NUTRITION AND INTER-SECTORAL CONVERGENCE

One feature of the CRM this time was that representatives of the Ministry of Women and Child associated with the ICDS programme joined the state mission teams. The Anganwadi centre was therefore reviewed with considerable attention and from a perspective of integration.

The progress and limitations of the VHND have already been discussed in the outreach section.

The Anganwadi centres visited were assessed to see whether they provided health check-ups, immunization, and care in pregnancy, health education, referrals of sick children, and adolescent clinics in addition to their role in supplementary nutrition.

More states are reporting action on infant and young child feeding programmes – notably Uttarakhand and Jharkhand. Take home rations for the below 3 year old child are a major problem in some of the states – and the neglect of this age group where malnutrition is most likely to strike, persists. Availability of weighing scales was a problem reported from Uttar Pradesh. But other dimensions of supplementary feeding and mid-day meal programmes are in place.

Adolescent clinics are reported from both Kerala and Punjab.

Progress has been made in Nutrition Rehabilitation centres and these are functional now in the state of Assam, Madhya Pradesh, Rajasthan, Jharkhand, Maharashtra, Chhattisgarh and Uttar Pradesh. Chhattisgarh which had none one year back, now reports 18 functional units. In Madhya Pradesh the number has reached 230 this year, and this state has really gone to scale and is making a difference with this programme. In Assam it has started up in three districts. Complete utilization however may be an issue in the district of Palamu in Jharkhand. Few states such as Orissa have proposed it in their State Plan but are yet to roll it out. States like Uttarakhand, Arunachal Pradesh and Kerala have to still plan for it. In Orissa nutrition is being successfully provided through the Anganwadi and VHND. Home-based counselling is used to make it more effective. Effective coordination

between departments and self-help groups is reported for this programme from Maharashtra.

In the state of Madhya Pradesh a flagship programme called Bal Shakti Yojana is making efforts to address the issue of malnutrition in children. In Uttar Pradesh, celebration of breast feeding promotion week, Bal Swasthya Poshan Mah – the child nutrition month and the Saloni Swasthya Kishori Yojana – an adolescent health programme are taking place.

School Health Programme

School Health Programmes were reported from most states – but most teams could not assess it. One major effort was reported from Kerala where School Health teams are constituted in the PHCs/CHCs in the Panchayat where the school is situated. The team is led by the Medical officer in charge of the School Health Program. Every child assigned to the Junior Public Health Nurse (JPHN) undergoes a health examination and screening by JPHN and those who require further medical attention are identified. These students are examined by the doctor in charge of the school health programme and students requiring specialist care are registered and referred to further specialist medical camps (as long as the condition does not require immediate care) conducted under the school Health program where, the service of a group of specialists are utilized. Chandigarh also reported a good school health programme, with every child having a health card and dental care being a major part of this programme.

DISEASE CONTROL PROGRAMMES

THE CONTROL OF TUBERCULOSIS: REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP)

Though most states show sustained performance in RNTCP, low case detection rates were reported from Arunachal Pradesh, Punjab, Jharkhand, and Uttar Pradesh. Other states that had previously reported low rates are now showing improvement and achievements of targets – these include Orissa, Madhya Pradesh, Rajasthan and Maharashtra. Treatment completion rates are better in most states, though in UP and Jharkhand even this is a problem. The main issues seem to be the need to establish a minimum critical density of microscopy centres and improve sputum testing rates, in the states lagging behind, as well as to strengthen

private sector partnerships, so as to detect chest TB, in cases that prefer private clinics. The implementation of the MDR-TB program lags behind in most states.

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Introduction of Rapid Diagnostic Kits (RDK) appeared to be a problem reported in the 3rd CRM, however the current findings show ASHAs trained in RDK and Fever Treatment Depots (FTDs) in a few states. Assam and Orissa have completed the training of ASHAs in RDK and in primary medical care (FTDs) for malaria and this has made a favorable impact. Madhya Pradesh has initiated it. The others have yet to get started. Chhattisgarh, Maharashtra and Kerala report shortages of insecticide treated nets and of drugs in comparison to the previous year when most states had reported shortages. Kerala has begun to attract migrants into its service sector. Many come from malaria prone areas, in the absence of proper infection control (no blood smears taken routinely) the state is at risk of developing endemic malaria. Short shelf life and expired drugs are also reported from some field sites. Community-based distribution of insecticide impregnated nets is reported to be a problem from some the districts. Supply of Artemisin past expiry date is also reported.

Increasing recognition of dengue as a public health problem and expanding facility-based care of dengue is also reported from many states – notably Punjab, Chandigarh, Tamil Nadu and Rajasthan. Chikungunya is a problem in Jaipur and Japanese encephalitis was reported from Uttar Pradesh.

NATIONAL LEPROSY ERADICATION PROGRAMME

There appears to be a decline in the prevalence of Leprosy which was on the rise (3rd CRM finding). However, the prevalence rate has been increasing in Orissa. There are still new cases being detected from many blocks. In many of these blocks ASHAs have been trained and are supporting in detecting persons with suggestive skin lesions. Reconstructive surgery is available to most cases that require it. The 3rd CRM had noted that the programme had not been effectively implemented in Chhattisgarh and the current findings showed 182 surgeries and procurement of 881 micro cellular rubber foot which is an improvement from previous findings.

BLINDNESS CONTROL PROGRAMME

This program though is successful in cataract/deformity detection in community and school health programmes. Human Resource constraint is a problem. Poor availability of optometrists and Eye Surgeons hampers the program success in few states. The 3rd CRM highlighted the issue of payments to NGOs for performing cataract surgeries, which was not documented in this CRM. The situation has improved.

INTEGRATED DISEASE SURVEILLANCE PROGRAMME (IDSP)

As compared to the previous years, there progress has been made in IDSP. In most places computers are present and functional. Reports are provided regularly, and being received at the district office and being sent up, even in states like Chhattisgarh where last year there was no reporting at all. There are, however, problems in Arunachal Pradesh due to lack of computers and training.

But everywhere the system has to traverse the most important last mile. Response to epidemics, public health action in response to disease reports and use of data from IDSP, or for that matter from other disease control programs for district planning, is still far short of what it should be. Disease prevalence patterns and outbreaks necessarily are to be analysed from the district or sub-districts levels, the lack of protocols and capacity to respond at this level needs to be addressed. Constraints of entomologists and epidemiologists are widespread and could be one reason. But clearly the IDSP staff still see their main or only role as generating reports and not gathering useful information for local action. As in HMIS the lack of use of information would in turn compromise the quality of data. IDSP is reported to be better integrated with the District Health Society, though on most of the other disease control programmes there are still concerns that the integration is only at the state level, and has not yet percolated to the district level.

INSTITUTIONAL MECHANISMS AND PROGRAMME MANAGEMENT

STATE & DISTRICT HEALTH SOCIETY

District and State Health Missions, as distinct from Societies, have not been viable. Meetings of the State Health Society have become frequent. SHS meeting are getting a larger involvement

of stakeholders. This was reported from Assam, Chandigarh, and Madhya Pradesh.

District Health Society meetings are also frequent with more substantial discussions and decision-making on public health and programme issues, apart from targets and financial matters. The exception is Assam, where no District Health Mission meeting was held during 2009-10, as well as in this current financial year. In Madhya Pradesh also the frequency of meetings has come down.

Coordination between the directorate and the societies – a problem reported prominently in earlier CRMs was not highlighted in any report. On the other hand, states like Maharashtra and Kerala positively observed that they are functioning as a team at the district level. The Programme Management units are generally well integrated with the Chief Health and Medical Officer (CHMO) office, but there is concern that the role and responsibilities of the District Programme Management Unit (DPMU) and the Block Programme Management Unit (BPMU) have become less clear, and they may be providing only assistance on a day-to-day basis and not the planning and management support intended. Madhya Pradesh reports a problem of a high number of vacancies in contractual district level programme management staff.

State Health Systems Resource centres (SHSRCs) are in place in Punjab, Maharashtra, Kerala, Chhattisgarh, Jharkhand, and Rajasthan.

In Uttar Pradesh there is a set-back with considerable fragmentation of command and programmes between two CMHOs appointed per district. One looks after the facilities and another after NRHM programmes and funds, notably the RCH component. Since it is facility staff and activities which constitute NRHM programmes and funds are allocated to facilities, such fragmentation hurts the programmes and this was heard from all districts visited. There are 17 division level programme management units also established, but their role and functioning remains poor. At the block level although selection was completed for block programme managers and accounts assistants, they have not been appointed and hence there is a large gap. At some places the Health Education Officer is designated the block programme manager. This fragmentation at the district level is reflective of similar problems at the state level where there are two ministers, two secretaries and one DG!!

ROGI KALYAN SAMITI (RKS)

The functionality of RKS is also reported as improving over the years. RKS are performing various roles mostly deciding about the procurement issues, rate fixation of the services and renovation plans. Also, RKS has provided water filters, inverters and other useful services to each facility. Free drugs for patients in Chandigarh and Orissa and some facilities of Punjab are also being provided. The hospital management societies and district societies are still dependent on administrative clearances for funds and approval. The RKS of Chhattisgarh has been constituted with much thought, and is named the Jeevan Deep Samiti. Of 716 PHCs, 662 are registered, and of these 248 have held meetings, and of 144 CHCs all have RKS, and 112 have held meetings. District hospital RKS have all held meetings. However the functioning of a number of RKS is below desired levels.

PANCHAYATI RAJ INSTITUTIONS (PRIs) ROLE AND INVOLVEMENT

PRI participation varies from notional (only attends meetings) to considerable (supports upgradation of facility and service delivery). The PRI role in NRHM activities has increased over a period of time but still is far short of expected levels in most of the states. In Chandigarh they are involved in the VHSCs and in the governing board of the state health society. In Kerala, health facilities are managed by the PRIs. members are part of VHSCs and RKS and district health societies. They are referred to for management of untied funds and for infrastructure development. These have considerable powers.

SUPERVISION AND MONITORING

This is still weak, though some states report efforts to improve it. Presently, there is no involvement of local NGOs/civil society organizations in social audit and monitoring in the districts visited. In Arunachal Pradesh supervision was weak due to lack of key staff at district level, and the poor understanding of the staff in place. Chandigarh is among the states where supervision is reported as good with a regular schedule of review meetings. 18 NGOs have been included to supplement the efforts of the department.

PROCUREMENT OF DRUGS AND LOGISTICS

Essential Drug Lists (EDLs) have been made and updated, but they are not disseminated and neither

stores nor users have a copy of the list. Drug supply management was observed to be poor in Arunachal, Chhattisgarh, Orissa and Maharashtra. Drug supply management is reported as good in Chandigarh and Tamil Nadu and Kerala.

USE OF HMIS

The HMIS system is in place in all states and regular feeding of data in the system is taking place. But the utilisation of data at the local level needs to be promoted. In Jharkhand, HMIS is entered manually below the block, and gets compiled as per the HMIS format at block level, which is entered in the web portal of NRHM. In many states computerization is done at the block level. Primary recording registers were a bottleneck in many of the states where this was observed. In Assam and Punjab, the aggregation of data from multiple sources in larger hospitals needs to be worked out.

For the first time, many states, report effective use of information at the local level, notably Orissa and Chhattisgarh and to some extent Punjab and Chandigarh. Here the frontier is further improvements in data quality and triangulation of data. Feedback of HMIS reports down the reporting channel also needs to start up.

The ability to analyse and use the data at the level of the facility and block were found to be a problem in many states – Assam, Chhattisgarh and Maharashtra. Tamil Nadu has systems running which are used to generate data locally at the facility level and many facilities visited were analysing their data and using the information to make changes at the local level. But these systems are not able to connect to the national system and the data has to be re-entered. Options that promote the diversity of applications are not just needed, they are inevitable. Where there are multiple systems running the need is to build in standards of inter-operability into all systems so that they can communicate with each other and data can be exchanged at will. Currently duplication of data entry due to multiple systems is a problem in some of the states, but the way forward is to specify standards of inter-operability.

Integration of inputs from processes like village plans and community monitoring into the health information systems is also a challenge. Reporting from the private sector is weak and in most states the effort has not yet begun. In states where the effort has been made the level of reporting is good.

FINANCIAL MANAGEMENT

Problems with expenditure rates remain much the same as earlier. A few states such as Orissa, Arunachal Pradesh and Kerala report improvement but others, like Assam which reported good progress earlier, now report lagging behind – with only 51% expenditure reported in Assam. The main reasons identified were –

- i. activity-wise transfer of funds from state to district often with many delays for some line items.
- ii. untied funds blocked in facilities which have poor turnover and utilization.
- iii. lack of guidelines.
- iv. weak management structures leading to poor progress of programmes themselves.

Accounting per se is not presented anymore as the main problem in delayed expenditure. Reporting on Tally from district and state has expedited better accounting and timely submission of utilization certificates and statements of expenditure. The use of e-transfers has also made a big difference to both transparency and efficiency. In Nagaland these aspects are not fully in place and in Uttar Pradesh, this work has not begun. Problems in book-keeping were reported from many states mainly due to lack of training or qualifications among those holding or supervising accounting functions at the facility and block level – often even at the district level. Staff shortages also contribute as there is an increased volume of accounting transactions, especially with JSY and untied funds. Some states like Jharkhand report problems in RKS funds utilization and accounting – but most state reports are satisfied with the level of RKS funds utilization or have not examined this issue in any detail.

Two important reforms that were mandated included putting in place the concurrent audit and creating the post of Finance (Director and Accounts). The former has been initiated in Assam, irregular in Chhattisgarh and Madhya Pradesh and not reported on by other states. The post of a regular officer of finance heading the accounting system, has not been created or is vacant in Chhattisgarh, Jharkhand, Nagaland, and Punjab. Most states do not have a separate finance manager and a separate accounts manager at state

level as envisaged. Large states were provided with support for appointing block level accounts managers which states with poor absorption of funds have failed to put in place. Progress on this reform is slow.

Spending with proper orientation towards DAP is weak and leads to high level of variances in the FMR (Kerala). This reflects some lack of coordination between PMU and facilities. One visible effect of this weakness are gaps in orientation of the various staff categories about their responsibilities in reporting, but also their opportunities in requesting for facility development. Overall, weak orientation towards DAP and corresponding budget thus shows as unrecognized training need and lack of service delivery and accountability.

DECENTRALIZATION

At the fifth year of the NRHM, there is both fatigue and cynicism developing on the district planning effort. Observations were the following

1. The district planning effort has weakened in many states and often reduced to filling up a budget template form. Exceptions were Kerala, Orissa, Jharkhand, Arunachal Pradesh, Zunheboto district of Nagaland and Punjab. There is no assessment on quality and feasibility of plans or even adherence to a resource envelope. One problem is the increasingly rigid guidelines which cover all aspects of planning. The other is its limited utility for either budget allocation or programme review.
2. Awareness of the plan and its use as an active guide to programme management remains limited. The main problem in this is that the budget seldom flows according to the district plan and there are no reviews done as per the plan. Disillusionment among district and block officials due to the absence of feedback or having their stated needs reflected in the state Programme Implementation Plan (PIP) is harming the program. A second reason is low expenditure of funds already released to the district.
3. A strong emphasis on using HMIS to formulate plans at block level and subsequent aggregation at higher levels is needed. At present only Orissa and Kerala report this. One major problem is that HMIS state managers see themselves not as providing a service to the state/district, but as reporting

and being accountable to their higher national authority – to which their only duty is to send in the raw data in a form that meets expectations.

4. VHSCs are formed and functional in all villages of Assam, Maharashtra, Kerala and Orissa, 97% of villages in Chhattisgarh, in 50% of villages in Arunachal. They are formed but poorly functional in Assam, Uttarakhand, Uttar Pradesh, Rajasthan and Madhya Pradesh. However, VHSCs seem to have little role in conducting and monitoring VHNDs or advocating expansion of scope of these opportunities. VHSCs are uniformly lacking in clarity about their mandates. This is seen even in Assam where a special orientation was conducted for members. The spirit of representing marginalized and vulnerable sub-sections in the Committee is absent, especially in Punjab and MP.
5. VHSCs, making village health plans is also a concept that has been difficult to recognize. Funds are used for a variety of purposes, like AWC upgradation, vector control and sanitation work, or local mobilization events. Consistently this is one activity which has been able to draw in the panchayats.
6. Chandigarh and Nagaland have legislation mandating community ownership of health delivery pre-dating NRHM and are active in fulfilling their roles of facility development and maintenance and oversight over functionality. Most state RKS report improved functionality and an engagement mainly with hospital maintenance, quality of care and the use of untied funds. Hospital management Committees/Medical Relief Societies lack clarity on their revised roles and entitlements and seldom manage more than merely the untied funds from NRHM and the user fee collection – and sometimes not even that. RKS, where functional, haven't yet become a means of community management of health facilities and are perceived as another funds-generating apparatus except in Kerala.
7. Community monitoring had taken place in three pilot districts of Chhattisgarh and also in Orissa. In Chhattisgarh one official stated that the programme had poor sustainability, but on the basis of labelling NGO capacity it is proposed to be done by field and district coordinators – which is hardly the point as it no longer remains community monitoring. Community monitoring has been suspended

for two years in Assam. It was not evident in the districts visited in Rajasthan. It was never started in Chandigarh and Arunachal Pradesh. The only positive news is from Maharashtra where they hope to increase it from 5 to 13 districts in this year and in Madhya Pradesh where civil society involvement has strengthened the process. The main process is of recording community perceptions of received services on 11 indicators and compiling it into a report card which is presented at Jan Sunwai sessions with specific recommendations. The process emphasizes representation of vulnerable and marginalized sections. In Maharashtra, the benefits of this were reflected by significant measurable increases in service utilization and the trend for improvement of PHC and village health services rating scores.

8. PRI involvement is highly variable in local health action from state to state, and inadequate in Assam.

INNOVATIONS

ASSAM

Evening OPD in Assam are reported to be functioning very well with 50% of the reported attendance in morning OPDs. PPP models for service delivery are working well in the Lakhimpur and Harmoti tea gardens. A computerized drug utilization model has been initiated in Assam.

CHANDIGARH

Project foundation: It is an innovative program of Chandigarh health department under which each program adopts each of the village for six months which helps carrying out survey awareness generation of each of the villages for a particular programme the population is screened, diagnosed and treated thereof in phased manner making it a ideal village as per the parameter of the programme. Follow-up is maintained thereafter.

NCD-Program Chandigarh: Under this program Diet Clinics have been set up at CHCs and DH in Chandigarh where trained dieticians are screening, counselling and referring general and high risk population referred to them from different departments within the health care facilities.

As part of the program, health staff in CHCs and DH has been trained to calculate BMI and desired weight of every patient coming to the OPDs in the CHC. Each OPD patient in the CHCs and DH gets a Diet Clinic Number and their height, weight, BMI and expected weight is recorded on the first page of the OPD card. Risk factor screening is done based on the WHO STEPS guidelines for surveillance of non communicable disease.

MAHARASHTRA

There are reports of a number of innovations which are worth assessing before a decision is taken on scaling-up the best of these. The innovations include:

- ❖ Maher – a birth waiting home model to promote institutional deliveries is working well in tribal areas of Gondia. The waiting room is adequately equipped with bathroom, solar heating with beds and food for each patient and one attendant.
- ❖ Promotion of breast feeding by provision of Hirakani Chamber in Kolhapur is worth assessing for scaling-up.
- ❖ An innovation called Silent Observer to check misuse of ultrasound clinics for sex determination.
- ❖ Felicitation of mothers delivering a female child with a thermal set, baby kits, sarees and birth certificate through the Lakshmi Ali Ghari scheme.
- ❖ Solar panels in PHCs of remote areas.
- ❖ Mobile dental clinics for tribal population at Gadchiroli.
- ❖ A 1056 system for referral transport.
- ❖ A Public Private Partnership (PPP) with a group of specialist doctors for specialist consultations in Chandarpur.
- ❖ Hardship allowance of Rs. 18,000 for specialists and 12,000 for medical officers.

KERALA

- ❖ Palliative Care: The state has conducted a survey of persons who are bed-ridden due to disability or chronic illness. The intent is to provide support

to them at home in order to reduce costs of care and the need for hospitalization. It also envisages support to those who need hospitalization. The doctors and nurses are being given training on Palliative care. Orientation course followed by fellowship training is offered by a non-governmental agency, The Institute of Palliative Medicine (IPM). So far 130 doctors have been trained. The ASHA workers and the medical professionals of local Primary Health centres along with community volunteer are participating in identification, linking up and providing care to the patients, including distribution of waterbeds, and bedsores management to bed-ridden patients. Awareness and capacity building in the general community including public and private sector medical professionals is also undertaken. An Outpatient Pain & Palliative Clinic has been set up in the Medical College campus. Those requiring inpatient care for symptom management are admitted in the inpatient building set up on the land provided by Kerala Government, adjacent to the medical college campus, based on screening in the OPD by the medical professionals in close coordination with the community volunteers. Available in two districts, there are 32 beds arranged in 3 beds per cubicle system where the patient and his/her attendant are able to stay during care. Free food is also being provided to the patient. This has a budget of more than four crores in 2009-10

- ❖ Community mental health program of IMHANS is an attempt to incorporate mental health services in the primary health care. IMHANS could provide mental health services in the PHC/CHC level in the 4 northern districts of Kerala, i.e., Kozhikode, Malappuram, Wynad and Kasargode through the community mental health clinics supported by NRHM and DMHP.

- ❖ Child Development Service in Kozhikode District, Kerala aims at providing comprehensive care to children with developmental disabilities like Mental Retardation, Autism, Cerebral Palsy etc. and also with emotional disorders. Programmes to create awareness, Educational and Research/teaching programs in child psychiatry are also being conducted. The centre started functioning in the year 2007. National Rural Health Mission support to this centre (January 2008) was with Rs. 5 lakhs in 2008 and Rs. 6 lakhs in 2009. This is the only centre of this kind in Northern Kerala, run by the public sector, which provides comprehensive care not only to children but also to adolescents with developmental disabilities and emotional disorders. Services of multi-disciplinary professionals like psychologists, speech therapists, paediatricians, psychiatrists, and developmental therapists are provided through NRHM. Out of a total of about 4200 children (boys 2398, girls 1828) seen in the OPD of this centre, the majority were for the services of child psychiatrist, speech therapist, special educator, clinical psychologist & developmental therapist.

- ❖ Medical Care for Victims of Gender-based Violence/Social Abuse: This is organized in selected institutions of 14 districts of Kerala on the lines of Vishakha Guidelines, funded by State Plan Fund. There is one in each district with a female Coordinator/Counsellor. The main objective of this centre is to provide counselling to the victims of GBV/sexual harassment and strengthen the capacity of health care providers in the hospital and also the district, to respond to survivors of violence against women. This also provides sensitization training to the health staff on prevention and management of GBV. Completed E-banking with an introduced interface between bank records and accounts at PMUs for reconciliation of the budget.

Thematic Summaries of 4th Common Review Mission



3





3

THEMATIC SUMMARIES OF 4TH COMMON REVIEW MISSION

INFRASTRUCTURE UPGRADATION

ARUNACHAL PRADESH

- Sub-centres, PHC and CHCs in position are more in number than the required number.
- Improved and clean infrastructure including toilets with round-the-clock water available up to the sub-centre levels.
- Separate Infrastructure development wing not in place in the state.
- More residential quarters needs to be created.
- Infrastructure gaps are not properly prioritized.

ASSAM

- Infrastructure wing exists at the state level.
- Upgradation of facilities has taken place, 841 sub-centres out of sanctioned 1051, 133 out of sanctioned 157 PHCs, 34 CHCs out of sanctioned 39 are have been constructed.
- Infrastructure construction is in progress at many places.
- Facilities visited were clean, no quarters for doctors.

CHANDIGARH

- There is no Infrastructure Development Wing in the UT of Chandigarh; Engineering Department looks after infrastructure-related matters.
- No new construction has been undertaken under NRHM.
- Panchayat has provided infrastructure support (tables, chairs, cupboards) to the sub-centre.
- A number of upgradations of health facilities is underway.

CHHATTISGARH

- State does not have a dedicated infrastructure and finance wing in place; there is an attempt for systemic planning for infrastructure development.

- Number of institutions and their geographical spread across the state is reasonably good. However, 60% of Health sub-centres, 50% of PHCs do not have their own building. Overall deficit of 308 sub-centres, 65 CHCs and 3 Medical colleges.
- Infrastructure strengthening is being done through various budgets including National Rural Health Mission, State Budget, European Union and Backward Region Grant Funds (BRGF).
- Availability of infrastructure above PHC level (CHC and above facilities) is generally better than that of PHCs & SHCs.
- State reported that formation of CSO (Central Stores Organization) has been done in the state and it is envisaged that this organization would take care of development of infrastructure across the districts. State does not intend to create an infrastructure and development wing within the directorate.
- State informed that 882 staff quarters have been sanctioned in current year.

JHARKHAND

- There is an engineering wing at the state level which takes the decision on the architectural, development and financial aspects of the new constructions under state or NRHM budget.
- Major gaps in infrastructure: Short fall of 3130 sub-centres, 675 PHCs and 44% in the case of HSCs, Need to strengthen coordination between Health Dept. and District implementing agency.
- The financial support and overall architectural planning is being done through state engineering cell under NRHM.

KERALA

- The Public Health infrastructure in the state shows nearly an adequacy in terms of numbers but needs improvement especially for sub-district hospitals.
- A well-structured infrastructure development wing is present and is in process to meet the IPHS, NABH standards and NABL standards for laboratories.
- The middle level health care infrastructure (CHC, PHC) received a major impetus in the process of upgradation and renovation.
- Funds for infrastructure upgradation is drawn from different sources like state plan funds, NRHM and other sources. Construction of health facilities is carried out by different agencies like PWD, HLL, HPL, KHRWS, KSCC etc.
- Limited residential accommodation has been provided in most facilities for the health staff. Wherever the residential accommodations was found in liveable conditions they are not being fully utilized by medical and Para medical staff.
- The construction activities undertaken under NRHM have led to creation of a patient-friendly ambience in the health care units. Patients expressed their comfort especially in the waiting areas, OPDs etc because of infrastructure upgradation under NRHM. Provision of drinking water, television, herbal garden was also observed during the visit.
- At state level it was observed that about 50% of the NRHM payments go into infrastructure through the Kerala Medical Services Corporation.

MADHYA PRADESH

- There is a shortfall of 1533 sub-centres in the state whereas that for PHCs is 515. Likewise the shortfall of CHCs is 84. There is a total of 50 district hospitals and 8 medical colleges.
- The infrastructure Development Wings are established at the state and Divisional levels.
- The construction works are being entrusted to the Public Works Department, Madhya Pradesh Housing Board, Madhya Pradesh Laghu Nigam, Madhya Pradesh Warehousing and Logistic Corporation, Rural Engineering Service Department.
- The non-availability of infrastructure development staff at the district and sub-district levels has been noticed to be a major constraint in planning and supervision of the constructions, for early completion of the proposed works and underutilization of funds.

MAHARASHTRA

- NRHM has made significant contribution to infrastructure improvement in the state.
- State has established Infrastructure Development Wing headed by Superintending Engineer who is a regular government employee on deputation from Public Works Department; At district level one Deputy Engineer is appointed at each district HQ (33) and at block level 93 Junior Engineers are appointed. IDW has taken 5293 works in hand out of which it has completed 4368 (83%) works.
- One of the major issues observed was that District Hospitals that have been converted into Medical Colleges have not been integrated into NRHM.
- It was also observed that there is good availability of amenities such as solar power, running water, computers and internet facilities.
- Residential accommodation for providers is inadequate and is not available at all facilities.

NAGALAND

- The state does not have infrastructure development wing to manage and oversee the health infrastructure development.
- 85/135 SC, 6/19 PHCs, 5/8 CHCs and 11/11 DH are constructed.
- 16/49 Staff quarters for CHCs constructed. Only 2/5 warehouses are constructed. Untied funds were used for essential infrastructure development in most places that enabled and gave confidence to local health care providers.
- Non-availability of residential accommodation in all the health facilities visited, except CJC Mangkolemba in Modokchung district. There is acute shortage of staff quarters.

ORISSA

- There is no established Infrastructure Development Wing to handle upgradation and development of infrastructure in the State.
- The health infrastructure in the districts have been upgraded to a great extent, new buildings constructed, some buildings are renovated to make up critical gaps.
- Untied Funds and RKS funds and maintenance grants being used to strengthen service delivery and quality of care in terms of provisioning of non-planned and emergency infrastructure development of state level hospital infrastructure development cell.

PUNJAB

- Punjab Health Systems Corporation (PHSC) act as a Nodal Agency for health infrastructure upgradation. The state has prepared a comprehensive plan for upgradation of civil infrastructure and equipment.
- Under this Core Plan, 4 District Hospitals, 8 Sub Divisional Hospitals and 30 new Community Health Centres are being upgraded/extended/constructed. 204 Primary Health Centres are being taken up for extension/upgradation. A major maintenance activity of civil infrastructure is being undertaken from NRHM funds.
- Secondary level hospitals generate annually approximately Rs. 25 crore user charges, which are retained by the institutions. Out of the collections, 15% is being spent on building maintenance and 15% on equipment maintenance.
- In total 2950 sub-centres, 252 Health sub-centres and 216 Subsidiary health centres were taken up for any upgradation among them minor work completed in the 51 Sub-centres this year and major work completed in 4 subsidiary health centres in this year. Work is in progress in the 17 sub-centres and 76 subsidiary health centres. Work yet to be started in the 184 health sub-centres and 136 subsidiary health centres. In total 445 PHC work completed this year in the 76 PHCs and work is in progress in the 42 PHCs.
- All facilities had good infrastructure, very clean and well maintained, with proper drainage.
- Untied funds have contributed significantly to achieve this. In CHCs and above, user fees have also been used extensively for maintenance.
- Broadly rate of construction satisfactory and in accordance with district plans.

RAJASTHAN

- Planned expenditure on Infrastructure has been good except at those locations, where responsibility of the construction has been entrusted to either Medical & Health Department or CMHO Office.
- Total no. of facilities upgraded equals to new construction.
- Labour Rooms have been added/renovated at 142 PHCs against the planned target of 189 PHCs. However, construction of JSY wards has not kept pace.
- Only approx. 10.24% of funds earmarked for construction of residential quarters at PHCs in the current FY 2010-11, could be spent by Medical & Health Department, while PWD achieved an expenditure of approx. 90% on construction of the residential quarters.
- The state may consider having a specialised cell, which is manned with facility planners, hospital architecture and biomedical engineer.

TAMIL NADU

- Improved infrastructure in primary and secondary care facilities.
- Infrastructure Development wing – tied up with PWD.
- In District Tiruchirapalli, the infrastructure development of 12/14 Block PHCs to CHCs have been completed. Residential accommodation and their utilization need to be ensured.

UTTAR PRADESH

- The progress of Health Infrastructure Upgradation in the State is slow.
- A total of 129 District Hospitals were identified for upgradation to IPHS standards during the last two years and construction in only 3 District Hospital have achieved more than 50% completion and the rest are still in process. There is a huge gap in the building position of CHCs, as still 308 more CHCs are required. Out of 50 CHCs chosen for upgradation for (2009-10), only 5 CHCs have been able to achieve more than 50% completion and rest are still under construction.
- There are 3692 PHCs in the state, out of which 3187 are in Government building and construction of 505 PHCs are yet to be completed. Out of 942 JSY wards, 133 have been completed and rest 774 are under construction. Out of 26344 sub-centres as per the sanctioned strength, 20621 centres are operational. Out of these functional sub-centres only 13781 are operating in Government buildings. Construction of sub-centres is satisfactory. Out of 4104 constructions taken up 3629 (88.43%) have been completed.
- Out of the total funds utilized, NRHM has contributed to 72.7%, whereas the state has contributed 6.9% of the total expenditure.

UTTARAKHAND

- Infrastructure by and large has been upgraded with the help of NRHM in last few years especially in the CHCs and have been following uniform patterns.
- Number of new constructions equals to upgraded facilities.
- Disability-friendly features observed at many places.
- Residential accommodation is available at all levels, and mostly occupied. PROMIS system has been observed to be beneficial.

HUMAN RESOURCES PLANNING

ARUNACHAL PRADESH

- The existing staff is highly motivated and hardworking but requires proper mentoring and capacity-building. In addition, there is a shortfall of specialists, particularly Obstetricians and Gynaecologists. For instances, there is a requirement of 44 Gynaecologists in CHCs but only 1 post has been filled up till date. Irrespective of human resource crunch, state has placed 30 2nd ANMs.

ASSAM

- The state has taken initiatives to ensure posting of doctors in rural areas. AYUSH doctors are being posted in rural areas and a special post of 'Rural Practitioner' has been created to fill this void. In order to retain the staff, the state has adopted a strategy of rationalization of HR in postings. For example, MOs are posted in their home districts but those who are trained in CEmOC are not placed where C-sections are performed and also not supported by placing an anaesthetist. Although, a technical support agency like SIFHW exists in state, but the state is not able to make the best use of this agency and reap the benefits of their technical expertise.

CHANDIGARH

- The availability of HR is not a major issue. The quality of training is good as it is observed that all the training protocols are being followed by the ANMs. However, there is a need to develop the training infrastructure for the capacity-building of staff in the UT. Moreover, for over a decade the staff of Chandigarh UT cadre has not been appointed and the contractual hiring is the norm of recruitment against the sanctioned posts and that too largely from NRHM funding. There is also a shortage of specialists in the state due to low pay packages which demotivates them from joining the organization.
- The state has not initiated the major trainings like LSAS, CEmOC, BEmOC and IMNCI so it is a major issue in providing the quality maternal and child health service in the UT.

CHHATTISGARH

- Availability of the specialists is one of the issues in the state. Sanctioned posts almost in all cadres particularly for staff nurses at every level are much below than IPHS standard.
- 47% positions of class I & II medical and health officers are lying vacant. The vacancy of the staff ranges from 7.4% for Staff nurses to 65% in the specialists cadre; though some of the positions are being occupied by the Post Graduate Medical Officers providing specialist's services.
- Although it appears that the state has infrastructure for training especially for first line health care providers ANMs and MPWs but on a deeper scrutiny it is under-utilized.
- The state has initiated and implemented successfully a three years course in rural medical assistants (RMA) to provide the primary health care in rural areas. The training calendar is not followed by the state with high commitment.

NAGALAND

- There is an urgent need to fill the staff vacancies in the state. About one third of vacancies are yet to be filled from the sanctioned strength. The need is more in the case of specialist doctors at District Hospital and CHCs. PHCs/CHCs are mainly run by Ayurvedic and Homeopathy doctors. Irrational deployment of HR in health facilities leads to lack of adequate services for the beneficiaries. (In some health facilities 5 doctors checking one patient in a month) The state also lacks the good HR policies to attract and retain the human resource and provide enough opportunity for the career growth.
- Multi-skill trainings are adopted as strategy to meet the absence of a specialist, however the progress in training is too slow, only 2 doctors have been trained in CEmOC, same is the case with other trainings given on priority

under RCH II (like IMNCI, SBA, BMONC, LSAS). Rational distribution of the trained HR is needed for maximum utilization of trained staffs/specialist.

RAJASTHAN

- PMUs are in place under NRHM with some vacancies. There is shortage of medical staff in each category (Out of 500 sanctioned posts for the medical staff 364 is vacant is so the case with paramedical staff. Out of 1308 paramedical staff 640 posts are still vacant. There are about 586 vacancies of nurses against the sanctioned strength of 11280. Although 62 doctors have undergone the EMONC training, but the factors like poor selection process, poor confidence level of doctors, non availability of backup support are contributing to under-utilization of training outputs from the expected level. Non-availability of the protocols and guidelines for practising modern medicine at health facilities is one of the major constraints in utilizing the services of AYUSH doctors.

UTTAR PRADESH

- The ratio of doctors per thousand populations of the state is much below the national figure and although the ratio of beds is almost the same as the all-India figure of 0.7, their geographical distribution is highly skewed in favour of the urban areas, depriving the rural masses. Many of the required health facilities alongwith the required human resources are not in position. The considerable difference between “required” and “in position” facilities is reflected in the present health status of the people in the state.
- Contractual hiring is one of the strategies to reduce the gap between needed and available HR. A total of 3248 health care providers are made available from NRHM fund. Rational use of trained staff is also weak.

JHARKHAND

- There has been a huge number of contractual appointments in various categories e.g 457 MOs, 362 Staff nurses, 332 LT, 244 Pharmacists and as many as 4098 ANMs Most of the recruitments are under NRHM.
- Owing to this large number of contractual appointments there is no shortfall of Medical Officers, but the shortfall in other staff category is substantial. There is 94% shortfall in Specialists, 76% shortfall in Staff Nurses, 45% among Lab Technicians, 34% among Pharmacists/Compounders, and 20% shortfall in ANMs.
- Doctors’ service conditions, stagnant remuneration are the issues not at par with other EAG states. There are also delays in state recruitment processes.
- Fragmented Training resulting in overload on MOs, ANMs, where high vacancies exist.
- Overall Institutional supply capacity low – For MOs –highly inadequate, for ANMs also – 10 ANMTCs (govt.) and 8 ANMTCs (pvt.) not enough.
- There is a shortage of medical graduates passing out from the medical colleges in the state as per the state requirement.
- Doctors and field staff need orientation in upcoming diseases like mental health and Diabetes as observed in a few blocks of the districts visited.

KERALA

- There are 24991 medical and para medical personnel attached to Directorate of Health Services, out of which 3862 are medical officers, 81 dentists, 8646 senior/junior nurses and 12538 para medical staff. Health personnel are appointed into three main categories – regular permanent appointments; contractual appointments under NRHM; and under the Compulsory Rural Posting.
- As a motivational measure a separate cadre for specialists has been set up. Residency System has also started in the state. To ensure availability of practitioners in medical colleges Private Practice in Medical Colleges has been banned by compensating it with enhanced remuneration.
- One year internship of BSc Nursing students undergoing their course in the Govt. Nursing Colleges and bonded services of 2 years for General Nursing and Midwifery has also been enforced to ensure availability of nurses.

- Appointment of new posts (block coordinator, bio-medical engineer, quality assurance manager and innovations like incentives for working in Rural/Difficult Rural Area, incentive for specialists, call allowances for specialists and para medical staff, appointment of doctors in Health Services as DPM, Compulsory Rural Posting for MBBS doctors, appointment of para medical staff, appointment of PROs, engineering wing in Headquarters has shown visible impact on improvement in service delivery.
- Actual training is not commensurate with the stated 2010-11 PIP, therefore stress on training of HR needs to be considered.

MADHYA PRADESH

- There has been a large number of contractual appointments under NRHM in the State especially of MOs, ANMs and Staff nurses.
- Some of the initiatives taken to meet human resource gaps are enhancement of retirement age to 65 for doctors, nurses and other categories, contractual appointment of specialists and Medical Officers, rational deployment of available regular specialist, appointment of staff nurses from private colleges and other state institutions, recruitment of candidates from other states for doctors, nurses, ANMs, lab technicians
- EMOC and LSAS trainings of MOs to bridge the gap for specialists, Enforcement of rural service bond for doctors.
- However the state continues to have acute shortage of several critical categories of human resources including specialists (62%), medical officers, staff nurses (53%), ANMs, male health workers, lab. technicians (25%), X-ray technicians (34%) and pharmacists.
- At the CHCs there is a shortfall of 1087 specialists. There are only 93 obstetrician and gynaecologists in position for CHCs against a requirement of 333 in the state.
- There is a huge shortfall of 5324 health workers (male) to be appointed at sub-centres. 1655 nurses and midwives fall short for posting in PHCs and CHCs. Similarly there are only 331 pharmacists in position. The utilization involves recruitment of 1810 ANMs, 347 staff nurses and 442 doctors against the target of 625 ANMs, 1136 staff nurses, and 635 doctors.
- B. Sc. Nursing schools are being started in two districts and ANM schools in all districts and provision of difficult area allowance for health providers.

MAHARASHTRA

- Maharashtra has taken some good initiatives to address the issue of human resources. For availability of Medical Officers in PHCs the posts of MO are exempted from the purview of the Public Service Commission. The Regional Deputy Directors are also delegated powers to appoint Medical Officers temporarily as per need and vacancy. This has resulted in drastic reduction in vacancy of the MOs. Currently, 7419 posts of Medical Officers are sanctioned out of which 6419 (87%) posts are filled in.
- AYUSH doctors are employed at facilities from DH to PHC levels and most of the posts are filled.
- To improve availability of specialists, Seats for Post Graduation have been reserved for MOs in service.
- The state plan for withdrawing specialists (from the Public Health Department) who have been deputed to Medical Colleges is a positive step. There are around 400 such specialists and the plan may be greatly instrumental in plugging the gaps for specialists for rural areas in the state.
- Hardship allowance is being given to medical officers and specialists.
- While regular posts are being filled in the state, there are a large number of vacant contractual posts: posts of 53% contractual staff nurses and 46% contractual urban ANMs are not filled by the state. A large number of vacancies were also observed at District Hospital-cum-medical college (CPR Kolhapur).
- Irrational deployment of available resources has been observed in many instances in the state.
- The quality of training is not optimal in certain areas. In Gondia district, training on use of partographs was not a part of the SBA training. This is a serious issue. There is lack of translation of skills into practice. Management and treatment protocols were not displayed at all facilities. Trained staff nurses were not aware

of the step by step procedure for neonatal resuscitation as observed in most facilities in Gondia District. Post training supportive supervision is non-existent and there is no follow-up of the trained nurses in most cases.

ORISSA

- There has been a large number of contractual appointments under NRHM in the State under various categories, the majority being for MOs, SNs and ANMs.
- A total of 3499 MBBS doctors, 1269 AYUSH doctors, 4234 SN, and 9087 ANMs are in position in the state.
- Campus recruitment for staff Nurse and other paramedics from private and public schools in KBK and tribal sub plan areas to facilitate better placement were visible.
- Integrating and multi skilling of lab technicians, and execution of bond to serve for five years in Govt paramedical institutions was a positive step noted.
- Still a vacancy of about 70% exists under doctors category. The shortage of doctors in Nuapada District is to the extent of 50%, nurses 30%, paramedics 15%.
- In many hospitals critical and key position are vacant, such as the radiologist, gynaecologist, anesthetist and Ophthalmologist.
- Short-term and long-term plans with regards to recruitments are in place; however skill enhancement through capacity-building and training is in early stages of development. Need assessment and training of staff is continuing in the state, which is visible in the increasing skill sets of the ANMs.
- Differential remuneration according to the working condition (difficult, high focus...) has been put in place. However, special incentives (monetary and non-monetary) to the HR in the difficult/most difficult/inaccessible areas is not attracting suitably skilled staff in the absence of special rotational posting policies or workforce management policies, such as the compulsory service bonds, pre-PG rural service mandates etc. in place.
- Comprehensive training calendar is available and it was evidenced that the training is provided as per the schedule.
- Though no training institutions of the medical, para-medical and other staff at district level were found in the public sector.

PUNJAB

- 2064 doctors are working as regular employees and under NRHM 87 doctors are working as contractual employees 865 specialist doctors are working in the public health system of Punjab, among them 807 are regular employees and 58 are contractual employees under NRHM. Total 3399 staff nurses against a required total of 5768. Among total working staff nurses 2300 staff nurses are regular employees and 1099 (19%) are working under NRHM as contractual employees. Total 4505 ANMs are working, among them 21.17% are working under NRHM.
- Punjab state has a shortage of 363(14.95%) doctors. (Total sanctioned posts for doctors are 2657). Total 1114 specialist doctors are required, There are shortages of 249 (22.35%) specialist doctors in the state. There are shortages of 2369 (41.07%) staff nurses in the state. According to IPHS, total 6555 ANMs are required in the state public health system. There is a shortage of 2050 (31.27%) ANM in the state according to IPHS.
- Two medical officers in all PHCs, one of them AYUSH. All PHCs have at least one medical officer. Dispensaries also have medical officers – one in each – but in Muktsar 30/43 (69.76%) are vacant.
- Human resources adequate in peripheral facilities often above the current case load but major gaps in specialists and nurses and even support medical officers in DH and SDH.
- District hospitals and civil hospitals have severe nursing shortage considerably below both norms and the current case loads.
- Effective and rational policies for career progression at all levels like GDMOs, specialists, nursing, and other cadre.

TAMIL NADU

- There is minimal contractual appointments in the State under NRHM because as a policy, the state refrains from such appointments.
- None of the PHCs are without a doctor in the state. Majority of the PHCs (83.3%) have at least 2 doctors.
- Case to case basis hiring of Anesthetists and Obstetrician from outside is a good initiative owing to 100% shortfall of specialists in the state at designated CHCs, because of which they are not functioning as CHCs in terms of service delivery. Medical Officers are being provided specialised training like LSAS, BEmOC, and CEmOC to fill this gap.
- There are no sub- centres without an ANM/VHN. The shortfall of MPW-males at sub- centres and at the PHCs is 65% and 78% respectively (RHS 2009). Only 5239 (60.2%) of the requirement of MPW-male at the sub- centres are sanctioned posts for the state. Similarly, only 383 (30%) of the requirement of Health Assistants-male at the PHCs are sanctioned posts.
- There is a shortage of Pharmacists and Lab technicians at the PHC and CHC level. None of the posts of the specialists at the CHCs was sanctioned by the State.
- There are six Regional Training Institutes, known as Health Manpower Development Institutes (HMDIs), for continued Medical/Nursing/Paramedical Education for in-service candidates.
- Medical officers along with staff nurses and Institution-based ANMs are trained in F-IMNCI, SBA, AMTSL, Blood Storage, etc.
- The skill level of the staff at the visited facilities was good.
- The recruitment procedures are impressive and requires all the Medical Doctors to first join at the Primary Health Care level under the Directorate of Public Health and Preventive Medicine. After a service of three years, doctors can opt for specialization either in Public Health or in clinical and para-clinical specialties.
- 50% of post-graduate seats are allotted for in-service candidates.

UTTARAKHAND

- There have been a large number of contractual appointments under NRHM in various cadres specially MOs, SNs and ANMs.
- There is over-all shortage of skilled human resource (specialists & Allopathic Medical officers) and thus huge vacancies in all categories e.g 59% for medical officers, 20% staff nurses, 41% paramedical staff and 03% pharmacists was found.
- There is shortage of MPWs in the state resulting in poor presence of (2nd) ANMs in the field as the second ANM is provided to states, only in the presence of MPW.
- The state has inadequate institutions leading to poor supply capacity (MBBS doctors, GNM, ANMs, Health worker male, other paramedical skilled manpower). At the same time it has good capacity to train dental surgeons, AYUSH doctors and pharmacists.
- The state has 3 medical colleges, 6 nursing schools and is planning to develop nursing schools at various district head quarters. The share of AYUSH systems of medicine and its practitioners is reported to be quite significant in the state.
- Efforts for area/facility specific recruitment being made by the state, however there is a poor response. Financial incentives being given in the difficult areas and also for the increase in institutional deliveries (not regularly).
- Plan for augmentation HR is not seen at least at district level. Although AYUSH practitioners being utilized for MCH service delivery in few places needing constant reorientation and training.

HEALTH CARE SERVICE DELIVERY – FACILITY DEVELOPMENT – QUANTITY AND QUALITY

ARUNACHAL PRADESH

- **Case Loads:** OPD services satisfactory, Counsellor at ICTC centre has low case load and hence can be used for other counselling.
- **Lab and Diagnostic services:** Basic and routine laboratory services available at DH. ECG, US available at DH (Tawang) but X-ray machine non functional due to some technical reasons.
- **Emergency Transport:** Only government ambulances functioning as emergency transport but assured referral lacking because of difficult terrain. Innovations like Palki scheme, birth waiting home, incentives etc can be considered by state.
- **Drug and Equipment Adequacy:** Purchase of equipment should be rationalized and installation in a specified period with annual maintenance contract. Standard treatment guidelines and quality protocols needs to be implemented. Essential list of drugs not available at the facilities. Drugs were available but mostly out of RKS funds since state supplies limited and slow.
- **Support Services:** Diet and laundry services is available at DH (Tawang), general cleanness was found satisfactory, waste disposal available.
- **Use of Untied Funds:** Good utilization of RKS in improving service delivery. No standard formats for RKS, AMG, and Untied Fund. Funds released from the district to the concerned institution on time. Utilization of untied funds is less than 10%.

ASSAM

- **Case Loads:** Both IPDs and OPDs have increased in last 3 years. Services and their ranges vary across facilities.
- **Drug and Equipment Adequacy:** Labour rooms equipped with almost all equipments and medicines. Free supply of medicines has increased overall service delivery in Lakhimpur. B Complex tab was in powder form in Dhemaji. Patients asked to purchase drugs from pharmacy despite free supply of the same (needs investigation). Standard operating procedures, standard treatment guidelines and monitoring to be institutionalized. Quality consciousness and client respect training may be given to providers through institutional approach.
- **Emergency Transport:** Palna scheme – Call a cab scheme was found very effective at Dhemaji.

CHANDIGARH

- **Case Loads:** AYUSH OPD: 2008-10 – Increase by 32%. At these centres 60-70 patients are treated every day.
- **Drug and Equipment Adequacy:** All essential drugs are available. Basic drugs are provided free of cost but costly medicines such as antibiotics are purchased by the patients in GH. For poor patients there is provision of free medicines through RKS fund but is grossly under-used due to poor availability of BPL cards.
- **Lab and Diagnostics:** At both the visited CHCs lab facilities are available and they are being used reasonably well. Most of the required diagnostic tests are conducted at these facilities at reasonable charges. The rate list for diagnostic tests was not displayed at these centres. Safety measures for the lab technicians and radiologists are in place.
- **Support Services:** Food is provided to the in-patients in some hospitals at the subsidized cost. Waiting area for the patients is clean and seems adequate, but overcrowded in OPD time. Signages are available. Availability of separate toilets for men and women. Services of cleaning the premises at CHCs have been outsourced. There are arrangements of disposal of biomedical waste and sanitation.
- **Emergency Transport:** Ambulances are available for emergency referral. The people call them at the given numbers. At the general hospital more drivers are required to operate all the ambulances round the clock. In some of the cases their maintenance needs to be further improved.

CHHATTISGARH

- **Case Loads:** Facilities visited were grossly underutilized—IPD and OPD. Total available beds in the state are 6820 for the secondary level care. Average bed occupancy rate is 37%, more than 40% of which is contributed by the institutional deliveries. Bed occupancy rates in FRUs is less than 20 to 30 percent and 24X7 PHCs is less than 10% in both districts, which is below state average. Few under-fives reporting in IPD and OPDs.
- **Drug and Equipment Adequacy:** Drugs and equipment were not used rationally. Drugs like Iron Folic Acid, oral penicillin, Amoxycillin was found in excess stock. No dosimeters available for the Radiographer. Many types of equipment which were available in the hospital were found in the stores for the reasons of fear of getting destroyed, stealing or lack of space. The LSCS patients were being asked to purchase disposables and catgut from the market. Every normal delivery is prescribed injectable and oral antibiotics. There is only fixed day ANC registers available at the PHCs. Record keeping is overall very poor. Gloves are mostly not available and re-use seems to be in practice.
- **Lab and Diagnostic:** Total investigation against total admissions in the district is less than 70% indicating under-utilization of available laboratory services. Adequate asepsis observed in the laboratory.
- **Support Services:** Laundry services in the District Hospital and CHCs were found to be satisfactory. Some of the FRU like Tilda have procured innovative washing machine which decrease cost incurred. Waiting areas were satisfactory in most of the centres visited. Sanitation facilities at FRU and PHCs were poor. Signages were well displayed. Privacy in the LR not maintained, toilets are not available/non-functional/not adjacent to LR and at some places not having running water supply due to somewhat very minor repair issue. There are no diet services in the District Hospital or CHC visited. Grievance redressal system is not displayed universally. Very poor illumination in LR across the facility and also no shadow-less lamp was available in some of the operation theatres.
- **Infection Control:** Infection control and hygiene, sterilisation of equipment and biomedical waste segregation and disposal is a weak area.
- **Emergency Transport:** Either public or private vehicles were available within the reach of the facilities. However safety during transportation is a concern. Adequate and responsive referral transport system (Mahatari Express) is available. Slated quantum jump in quality with introduction of 108 services with essential equipment and support systems. State is planning to operationalize 108 Emergency transports in a phased manner in the entire state.

JHARKHAND

- **Case Loads:** Increase in IPD at District Hospital. Decrease of OPD in Gumla DH – decreased by 0.5% (08-09 to 09-10) and by 18% (09-10 to Nov 10). Stagnation in hard-to-reach areas. Patient load found to be concentrated on district level in Palamu.
- **Drug and Equipment Adequacy:** Large stock-outs of drugs and lasting 1-4 months. At PHCs drug availability is relatively good. Drugs are being procured locally from companies/stockists as per state/district rate contract.
- **Lab and Diagnostics:** In DH outsourcing has been done but, investigations are not being monitored. Boyle's Apparatus in DH is on rent. The diagnostic facilities are very poor at the PHC.
- **Support Services:** In DH toilets for general ward were dirty; there was no light and no water. Ladies toilets maintained by Sulabh were away from the female wards. The diet is outsourced in DH however the same is not available in CHC/PHC. Signages are present.
- **Infection Control:** This was found to be adequate in all facilities.
- **Emergency Transport:** Ambulance services are being mostly used by the MO I/C for meeting and delivery of medicines from Civil Surgeon's office and for bringing surgeons from district HQ for sterilizations. Emergency Referral Transport is not available. Patients who need referral are given Rs. 250/300 for transport and they have to arrange their own vehicle.

KERALA

- **Case Loads:** There is low utilization of primary healthcare centres. Unlike other states the sub-centres in Kerala deliver only basic care. Most PHC, CHCs are not providing delivery and safe abortion services.

- **Drug and Equipment Adequacy:** Sub- centre drugs were not found to be regularly supplied. HSC- Hemoglobin estimations are not done at all centres, although team found glucometers at the HSCs provided by the Panchayats. PHC- Laboratories were found to be ill-equipped or sub-optimal functioning. CHCs, DH, SDH, W&C hospital Laboratories were found to be ill-equipped or functioning sub-optimally.
- **Support Services:** Diet and laundry support services were inadequate. Disposal of bio-medical waste was outsourced. The protocol of waste segregation is not strictly followed. Privacy issues are not being addressed. Clean separate toilets for males and females are observed. Construction has led to patient friendly ambience. Patients expressed comfort in the facilities, provision of drinking water, television, gardens observed here 14 hospital for NABH upgradation of which 4 have been completed. Lab in 1 CHC in Khozikode accredited by NABL.

MADHYA PRADESH

- **Case Loads:** There has been a considerable increase in the number of institutional deliveries. Load on the public health facilities is on a rising trend.
- **Drug and Equipment Adequacy:** Drugs not available, standard treatment protocols not available. Policies for maintenance of equipment in place but the providers are not aware.
- **Lab and Diagnostics:** There is non-availability of X-ray machines in FRUs. Under utilization of In-patient facilities – PHCs and CHCs.
- **Support Services:** Non-availability of essential water supplies and electricity affects adversely the quality of services being delivered. Generators procured but yet to be installed in both the districts visited. Diet – available at DH and other health facilities, laundry-services available at all health facilities modern laundry facility will be initiated at DH within three months Sanitation - out Sourced at all Health Facilities. Compound wall and internal roads not developed. Security and privacy major issue for the staff. Security - out Sourced at DH.
- **Emergency Transport:** 13 Ambulances available, 20 Janani Express Vehicles are available.

MAHARASHTRA

- **Case Loads:** OP, IP, immunization, institutional delivery, Family Planning, reduction in DOTS defaulters are activities showing positive trends. OPD increase between 2007 till 2010 varies from 17% to 43% in PHCs of visited district. IPD 50% to 76%.
- **Drug and Equipment Adequacy:** Supplies appeared relatively adequate, but availability of essential medicines seemed to be quite inadequate in high-utilisation facilities including a Rural hospital (CHC), a Sub-divisional hospital and a District hospital. There have been certain major policy changes related to procurement of medicines for the public health system in Maharashtra, which may have been related with the drug shortages being observed in some facilities In one RH it was observed that there were no vaccines at all though IRL and deep freezer were available.
- **Infection Control:** Biomedical Waste Management existed in principle at all facilities.
- **Emergency Transport:** As per state policy, health facilities provide Assured Referral Transport to the Referral Centres from lower centres. However free referrals are not being provided to all in practice. State is currently at the stage of finalization of tender document for Emergency Medical Response Services in Maharashtra. State is expecting 150 such ambulances on road at the end of March 2011. Till then, districts have developed their own call centres from local resources and they are arranging centralized system to inform the PHC/RH ambulances to pick up emergencies particularly the ANCs.

NAGALAND

- **Case Loads:** The District Hospital of Mokokchung OPD load was only 40 due to festive season. Similar trend was observed in bed occupancy rates, as throughout the year it varies in the range 10-40%. In Zuhneboto DH and CHCs, about 10% beds were found occupied. OPD increased to 70% post NRHM period, 33% rise in IPD, 10 times increase.
- **Referral Transport:** Ambulance with drivers were available but not in all the PHCs and CHCs.

- **Laboratory and Diagnostic Services:** At many places laboratory technicians were more than sufficient but the laboratory services were under-utilized. In all the places reagents were not supplied and it is being procured by the hospital from untied fund.
- **Infection Control:** Biomedical Waste Management is a concern. Training on Biomedical Waste Management is not being imparted. The state has not supplied consumables related to Biomedical Waste Management. All the health institutions burn the waste generated including expired medicines. Mokokchung District Hospital and TB hospital have a locally made incinerator. Infection control was practised in all the facilities.
- **Drugs and Equipment Adequacy:** Drugs were available in the health institutions but the supply is not regular. Sometimes the drug supplies are irrational. Essential drug list not displayed. Oxygen Cylinder and emergency drugs were not observed in the emergency rooms. Printed stock registers were not available. Poor supply chain management. It seems at the district there are more than one drug depot. Mechanism to dispose-off expired medicines and obsolete equipment was not clear to staff. The DDWH does not have a stock of all the medicines received by the district. Village Health Committee are also procuring drugs for SCs, which is a concern because they are not aware of drugs that are required in sub-centres.
- **Supportive services:** All the health facilities were clean including toilets. The Mokokchung District Hospital has outsourced cleaning of the toilets to a local person. It is an initiative worth mentioning and a minimal user fee of Rs. 2/- is being charged from every body including the patient.

ORISSA

- **Case Loads:** There is no provision for adequate number of hospital beds for the admitted patients, and the patients were put on floors. The general Bed Occupancy Rate in the hospitals ranged from 25%-60% across districts, except during disasters and epidemics, during which the hospital is supposed to make alternative and make-shift arrangements to accommodate temporary increase in Bed Occupancy Rate.
- **Drugs and Equipment Adequacy:** There is need to develop a system for clinical care management, standardized printed clinical case sheets and registers. Rational use of drugs is not in practice. There is no structured system for calibration and maintenance of old equipment, new equipment is provided under regular AMC. The vaccine carriers are broken. Lack of maintenance of oxygen cylinders. Medical records were dumped in the ILR rooms. Principles of inventory and stores management not practised.
- **Lab and Diagnostics:** The labs and imaging services do not have provision for quality assurance and compliance to critical regulations. Infection control and asepsis in the laboratories, safety measures for the laboratory technicians absent. Assessment of radiation exposure for the safety of radiographers is not practised. There is a need to operationalise the condemnation policy in a systematic fashion.
- **Supportive services:** Laundry, sanitation, security are outsourced but there is a clear lack of comprehensive specifications and a system to manage the contracts. The resources for the provision of cleanliness in toilets, common areas, canteen services, telecom assistance, signage, areas for attendants are grossly inadequate. A provision for Rs. 20/- per day for dietary supplement of the patients needs to be reconsidered. Lack of convergence amongst the executing agencies. Lack of privacy, signages. Grievance redressal systems are currently scarcely available.
- **Referral Transports:** Janani express is available to provide referral transport assistance for pregnant mothers.
- **Infection Control:** Infection control, sterilization of equipment and biomedical waste disposal is conspicuous by its absence.
- **Untied Fund:** Untied funds and RKS funds and maintenance grants being used to strengthen service delivery and quality of care. Funds are used for cleaning the drains in the villages, making a garbage pit for the general wastes of the village, providing nutritious food to the TB patients, funding the mothers for blood transfusion, referring mothers to higher centres for delivery and maintenance of cycles for ASHAs.

PUNJAB

- **Case Loads:** Increase in case loads at all levels.
- **Drug and Equipment Adequacy:** At DH mainly outside prescription are given, high OOPs and internal supply of medicines is very weak. At SDH mainly on internal supply based on user fee hence bulk of purchases made locally. Therefore there are low OOPs.

- **Lab and Diagnostics:** Equipment seems adequate – no major gaps observed. Laboratory services available at all facilities as planned.
- **Support Services:** Diet not provided in any facility at any level even in DH. Security reported as a major issue at the periphery. Laundry services/clean linen were adequately managed.
- **Emergency Transport:** No effective assured referral transport services in place. Limited use of available vehicles for transport to higher facilities.
- **Infection Control:** Quality Improvement program and Record Maintenance. Biomedical waste management systems in place Training of staff could be improved.

RAJASTHAN

- **Case Loads:** Bali block of Pali district shows increase in OPD between 2007-2009 by 6%. IPD on the other hand shows a 23% increase. Major surgeries have gone up by 8.5%. Utilisation of CT scan in BPL is 135 out of 723.
- **Support Services:** Under Kalevo Scheme, hot nutritious food is given to new mothers by Self Help Group. The reception areas for the OPD and In Patients were clean, manned with separate booths clearly marked for BPL patients and online BPL database available till the PHC level.
- In Ajmer, the District Hospital and the two SDHs have well organized OPDs but the Satellite Hospital stands out for its clean environment, well maintained wards and overall organization. In select Blocks and PHCs the quality assurance system was seen very well established with protocols, systems and procedures in place for providing quality maternal, newborn and child health care. Water, lights and security are largely in place.
- **Referral System:** Assured referral transport for emergency obstetric care and newborn emergencies has still remained a challenge and unfulfilled in most blocks.
- **Drug and Equipment Adequacy:** Drugs, vaccines with functioning ILRs and RH products were in place. Jan Aushadhi Kendra is a novel scheme of promoting generic medicines. However, the uptake has not been very substantial (it pales to insignificance when compared with the average 10-20 Private Pharma shops outside the boundary of the facility) The doctors, patients and pharmacists need more convincing for removing the false notions about inferior quality of generic medicines.

TAMIL NADU

- **Case Loads:** Primary Healthcare Institutions are mainly providing RCH services. Bed Occupancy Rate in visited PHCs varies between 4%-12%, and for CHCs it varies between 10%-40% and all were delivery cases. For emergency cases, first-aid is provided by the staff nurses and referred to higher facilities.
- **Support Services:** Diet services to the in-patients need to be strengthened and streamlined. Laundry services are primarily through outsourcing, but in-plant mechanised laundry is in the process of implementation in Taluka hospitals. Citizen's Charter and Grievance Redressal System need to be displayed prominently.
- **Drug and Equipment Adequacy:** Regular drug supply to sub-centres is an issue. The radiology services are not available at the CHC level. Most of the equipment, were found to be lying unutilised.

UTTAR PRADESH

- **Case load:** Increase in number of patients in OPD, IPD services throughout the state. Load in OPD in PHC/CHCs increased from 3.3 lakhs in 2008-09 to 4.2 lakhs in 2009-10. IPD in PHC/CHC increased from 0.15 lakhs to 0.20 lakhs. Most deliveries are happening in the sub-centres with SCs conducting up to 75 deliveries a month.
- **Drug and Equipment Adequacy:** Drug supply is adequate. Transparent reporting of stock positions. Shelf lives of some of the drugs is an issue. Essential drugs like Magnesium Sulphate was not found in many of the CHCs, PHCs and even in the district hospital. Supportive equipment like X-rays were in short supply. For equipment, a 5 year annual maintenance contract has been built into the purchase policy.
- **Support Services:** Funds from RKS is being used in most facilities to provide support services like sanitation, security; laundry and 24 hour power back up, patient waiting areas and shelter for attendants. Canteen/diet facilities for patients or telecom facilities were not available in the facilities visited. While most facilities had

signboards at their front gates, such signage was lacking in providing directions to reach the facility from the main roads. No display of grievance redressal mechanisms. Cleanliness levels were generally satisfactory. Toilets, safety of women staff and beneficiary found unsatisfactory.

- **Infection Control:** Generally, infection control procedures were not followed in most facilities. Active sterilization of instruments was not seen to be happening. Biomedical waste segregation or disposal systems were not in place in most of the facilities visited.
- **Emergency Transport:** Emergency transport not available. Facility-to-facility transport was ambulances, donated by local MLAs from their development funds. However, very often these were used for travel for VHNDs or mobile camps and were not dedicated for emergency transport. They also lacked emergency equipment and drugs and oxygen.
- **Use of Untied Funds:** Untied funds were mainly seen to be used for minor repairs and maintenance, for buying fuel for generators, local purchase of emergency drugs when in short supply, providing shelters for patients and attendants, employing contractual staff for ambulances are improving quality of care.

UTTARAKHAND

- **Case load:** Decrease in case load in both IPD and OPD of both districts. Normal deliveries taking place in Level 2 facilities.
- **Support services:** Shortage of electricity and low voltage is an issue in many places and has affected the functioning of critical equipment. Lack of backup generator. While personal filters were available for the health staff, lack of potable water supply in the facilities for patients, no hot water in winter in the wards and labour room was observed in the facilities. Absence of attached toilets, toilets without water supply or functional flush systems was also observed affecting the operationalisation of infection prevention systems. No provision of diet for inpatients. Infrastructure development of the facilities should be done as per service type and case load. AMC for all equipment needed. Staying facilities for attendants, ASHAs should be uniformly provided and disaster prevention measures for all new constructions are to be in place.
- **Infection control:** Poor biomedical waste disposal systems in the entire district. Disinfection of laboratory wastes observed at some places. Deep burial pits not available in all facilities.
- **Emergency transport:** EMRI providing a good transport service. However, a lot of patients are not getting these services and transportation incurs lot of OOP (Uttarkashi). There is a need to increase the number of EMRI vans and placed at strategic locations. Support for safe transportation of pregnant women to nearest road-head through the Palki system and payment for the same through VHSCs needs to be considered.
- **Lab and diagnostics:** Diagnostic services available at DH and CHCs but not at PHCs.
- **Drug and Equipment Adequacy:** Equipment and drugs are being procured and supplied by pharmacist at present; discrepancies noticed in supply of drugs. AMC for all medical equipment is not available. Equipment in the facilities were lying unused due to lack of calibration. Irrational drug use and high Out-of-pocket expenditure. Equipment were largely available. PROMIS system needs to be established on a fast-track basis.
- **User Fee:** It has been doubled in last 2 years and a GO order for 10% increase every year is present in state.

OUTREACH SERVICES

ARUNACHAL PRADESH

- 2nd ANMs have been placed in 30/592 sub-centres of the state. Several contractual ANMs were found to be pooled at the DH leaving behind vacancies at the SCs. 156 MPWs (Male) have been placed in the sub-centres. Outreach services are provided through VHNDs and at sub-centres. VHNDs are being held regularly. VHNDs are focussed on providing immunization. Provision of ANC, PNC and nutrition services is weak. Micro planning of VHNDs and linkages with ICDS were weak. Few ANMs are trained in SBA, while none of the ANMs are IMNCI trained. MMUs have been placed in all districts.

ASSAM

- Of the 4592 sub-centres in the state, 3699 are functioning with 2nd ANMs. MPW (M) workers have been placed in 359 sub-centres. VHNDs, also known as Health Days are providing a range of services from immunization, family planning, ANC, counselling of mothers about nutrition and supplementary feeding. Promotion of hygiene and sanitation and dissemination of information on state Maternal Health schemes such as *Mamoni*, *Majoni*, *Morom* and *Mamta* kits is also undertaken during the VHNDs. Boat clinics are functional in 10 districts of the state. In the district visited, these also provide outreach services in the tribal areas. Uptake in service delivery of the boat clinics has not been reflected in corresponding outcomes at the community level. VHSCs include PRI members. Several women members are active in promotion of sanitation (undertaking construction of toilets). MMUs are providing diagnostic and clinical services in remote areas. Equipments in the MMU were found to be in need of maintenance.

CHHATTISGARH

- 157 second ANMs are functional in the state. 2514 MPWs (M) are in place against the sanctioned number of 5653. Availability of outreach services in form of VHND, fixed day etc. is satisfactory. VHNDs are providing ANC services besides immunization. Good presence of ANMs even in the most remote facilities. VHND micro plans could not be traced. VHSC members are aware of health programmes. However, their involvement in VHNDs is yet to be seen. *Mitanins* are active in generating awareness regarding various health services among the community. Online system for providing feedback on field monitoring is a good initiative. Fixed Day Services for maternal care at PHC level with LMO providing services is a positive strategy.

CHANDIGARH

- Second ANMs available in some sub-centres. Rationalisation of ANMs is an issue. Outreach services are provided through sub-centres, MMUs and by ANMs in their areas. VHNDs are conducted on the last Friday of every month. There are 16 sub-centres in Chandigarh some of which have been merged with Civil Dispensaries. Deliveries are not conducted at the sub-centre and cases are referred either to the CHC or General Medical Hospital, and some of the cases are sent to PGI. ANMs conduct outreach camps in slums and villages at every month to provide immunization services, and identify pregnant women for ANC checkups. Outreach camps are organized at Anganwadi centres in coordination with the AWWs. Two NGO run MMUs operate for 5 days in a week and provide OPD services in the rural peripheral areas and slum clusters.

JHARKHAND

- State is focusing on organizing VHNDs in remote, unserved habitations. VHNDs are organised regularly as per schedule and taking up activities related to ANC, immunization and IFA distribution. Fixed day approach known to community. New sub-centre buildings are constructed (10% of all HSCs), but still many (56% of all HSCs) are running in rented buildings. Deliveries are being conducted in some sub-centres. There are 66 MMUs operational in the state with an operational expenditure of around Rs. 2 lakhs per MMU. The workload distribution between the two ANMs was also not clear.

KERALA

- Kerala has filled 58% of the 4575 MPW (M) posts. Male workers are conducting surveillance activities and reports on completion of S-form under IDSP. No second ANMs/JPHNs are present at any sub-centres but male health workers as Health inspectors are attached with every sub-centre and play a major role in surveillance and house hold visits for source reduction of vector of malaria. VHNDs are held with coordination of JPHN, ASHA, AWW s. Immunisation, ANC and awareness generation on different health issues are the major components of VHNDs. Good integration of Ward health and Sanitation Committees with ICDS. Floating Dispensary is an innovative step in providing outreach services to the people of the island of Ernakulam and Alapuzha districts. The floating dispensary 'Bodhana Nauka' (information boat) creates awareness on various aspects of health. Radio Health, the FM production under Arogyakeralam are useful programmes for health awareness. MMUs in 7 districts are providing services in difficult areas.

MAHARASHTRA

- State has filled 67% of the 10580 positions of second ANMs. Good progress in filling MPW (M) positions with 78% MPWs in place against the sanctioned position of 12575. VHNDs are being used mainly as a platform for immunisation. However, good session planning for VHND and evidence of cross-sectoral linkages between frontline workers was clearly visible. No ANCs were conducted at the VHND since the sub-centre was nearby and the ANM conducted ANCs on a separate day at the sub-centre. VHSC funds are being spent on AWC upgradation and supplies for malnourished children and referral transport.

MADHYA PRADESH

- 78% of MPW (M) positions have been filled in the state. 1810 contractual ANMs have been placed in the sub-centres. Village Health and Nutrition Days have been very effective in ANC and Immunization, but their scope needs to be expanded. 37080 VHSCs constituted till 2010-11. The immunization sessions/VHND are held mostly in the Anganwadi centres and the Anganwadi worker, the ANM/MPW and the ASHA work as a team for the same. Trainings like IYCF and IMNCI are also held involving the functionaries of both the departments. Special sessions like "Baal Suraksha Mah" are conducted jointly by both the departments. Several sub-centres are conducting deliveries. Community monitoring is weak and so in the VHSC participation. ASHA Mentoring Group is not in place. Availability of drug kits and replenishment is weak. Community monitoring is weak. The MMUs (Deendayal Chalit Aspatal) are functional in 21 districts and the MMUs have been increased from 11 (2006-07) to 91 in 2010-11. They are primarily used in the tribal blocks for disseminating health messages.

NAGALAND

- State has filled all 132 sanctioned MPW (M) positions under NRHM and has also trained them in Malaria. This is in addition to filling and training the regular 347 MPWs. VHNDs are being conducted regularly – every month in each village but not in Anganwadi Centres. The team could visit only one VHND wherein it was observed that the village health committee was actively participating during VHND. However, it was seen that AWWs were not involved in VHNDs. ICDS was not at all associated with VHND planning.
- In terms of service delivery it is limited to immunization and health education.

ORISSA

- The ANMs are undertaking outreach activities, such as immunization, home based new born care, advice on diarrhoea and ARI, maternal and child nutrition and Vitamin A prophylaxis and participates in VHNDs. They monitor their progress through micro-planning of VHNDs, however, BCC activities have not yielded the desired results in terms of handling ARIs. Most sub- centres have second ANMs and MPWs and their support to the outreach activities. Seven units of Mobile Medical Units (2 in pipeline) – Arogya are functioning Staffed with one MO, pharmacist, ANM and attendant and provide service in remote locations. VHNDs are being conducted regularly on Tuesday or Friday as per the micro-plan and the laid down guidelines. Routine Immunization is

conducted once a month on a Wednesday. The VHNDs are organized along with the day for carrying take home rations for the families to ensure greater attendance.

PUNJAB

- 970 sub-centres are functioning with second ANMs. Some of these ANMs are trained in NCD. Both ANMs are involved in immunization. There was no clear demarcation of geographical or thematic work between the two ANMs. No deliveries are being done in sub-centres by order of the state. Immunization is done one day per week – sometimes two days goes to immunization session – both ANMs go for it. However, number of session points not increased. VHNDs also known as Mamta days are providing nutritional counselling and Health Education. 78% of planned outreach sessions have been held in which 15312 pregnant women registered and provided with nutrition counselling. Malnourished children identified during VHND and provided prophylactic treatment. Family Health Camps have been organized to increase the access to health services in under-served/ uncovered areas and to provide an array of good quality health services in a safe, client-friendly and infection-free environment with the involvement of community through outreach camps. One camp per month per district per block by rotation are being organized. School health campaigns have started in the state.
- Every AWCs visited have been provided with the Medicine kit along with a small printed book/write-up on use of medicine. Referral service is not functioning. No AWCs visited had the referral slip to refer children and women with health problem to health facilities. There are MMUs – 4 units in Muktsar, one supported by NRHM and three by Ranbaxy.

RAJASTHAN

- 1321 second ANMs in place. 43, 336 VHSCs have been constituted. However, progress on VHSC achieving its full potential has been slow.
- There is increasing participation of both Health and ICDS departments as well as at times from Village Health and Sanitation Committee (VHSCs)/Sarpanch on Village Health and Nutrition Days (VHNDs). This could be due to the “Swasthya Chetna Yatras” organised by the state in recent months which has led to increased awareness, mobilization of the community and uptake of services on such days. However, complementary strategies of hygiene, safe water and sanitation for improving nutritional levels are not being promoted. Good integration of AWWs and ASHAs observed. Active VHSCs reported and village headmen actively participate in VHNDs. 32 MMUs are operational in the state and 9564 outreach camps organised so far in difficult areas.

TAMIL NADU

- State has filled 35% of its 8706 MPW (M) posts. State has not sanctioned second ANMs so far. Under outreach services, immunization sessions have been discontinued in the sub-centres and there has been a decline in the immunization in recent years. During VHNDs, nutrition counselling is provided to pregnant and lactating women. MMUs are in place in 385 blocks of the state. They are covering remote areas and providing fixed day services.

UTTAR PRADESH

- 1911 new ANMs have been selected for training and posted as additional ANMs. Uttar Pradesh has filled 24% of its 8857 MPW positions. Sub-centres are active in conducting deliveries; however infrastructure facility is not at par given the huge load.
- Selection of Male Worker at the SC level has been delayed. 51,943 VHSCs have been constituted with operational bank accounts. Good coordination between AWWs, ANMs, ASHAs has helped in implementation of the VHNDs (Jaccha Bacha Surakchha Abhiyan). Micro plans are prepared for VHNDs. Quality of services in VHNDs was below expected levels. Saas Bahu Sanmelans provided scope for better involvement of women members in health care.

UTTARAKHAND

- There is shortage of MPWs which has affected the placement of 2nd ANMs in the field as the second ANM is provided to state only in the presence of MPWs.
- Vaccine delivery for VHND was found to be cumbersome due to the time consumed and this affects the cold chain. Immunization is the sole focus of VHNDs and other components. Nutrition supplementation (THR) of AWC was not provided to children under 3, pregnant and lactating women. Involvement of ASHA facilitators, male workers, LHV's poor in outreach. Monitoring of services weak. MMUs are functional and providing good services. ASHA and AWW working together for supporting outreach activities



ANM training centre at Beawar, Rajasthan

ASHA PROGRAMME

ARUNACHAL PRADESH

- 94% of the ASHAs are in place of which most have been trained till Module 5. Module 6 training is underway. ASHAs are functional with good knowledge of their roles and responsibilities. Good quality of training was observed. There is need to look at providing home-based newborn care for home deliveries since institutional deliveries are difficult due to the terrain of the state. Support structures however need strengthening.

ASSAM

- 28798 ASHAs selected; 23271 trained up to 5th Module and 26225 are provided with Drug Kits. Very pro-active and knowledgeable ASHAs who are functional even in tribal areas. Average monthly earnings range from Rs. 600 to Rs. 2000. Provision of ASHA badge and coding system are good initiatives. ASHA radio program is an example of an innovative practice for ASHA updates, improving their knowledge and functioning. ASHA Facilitators are in place, but need to be equipped with skills for supervision and mentoring of the ASHAs.

CHHATTISGARH

- 60092 Mitanins/ASHAs (100%) in place, trained for 36 days, 13th round of training completed, TOT ongoing for 14th round of training on disease control programmes. Mitanins fully functional on promoting immunization, child health services (including referral for malnutrition), depot holder for FP and leading village level initiatives under Panchayat Health Planning and VHNDs and participation. Payments received for immunization (Rs. 150) and JSY (Rs. 350) is satisfactory; SHSRC functioning as Resource Centre along with an informal group for mentoring of ASHAs. Career development Mitanins is a good initiative and needs to be strengthened further. Community monitoring was found to be weak in approach. Payment of incentives to Mitanin was found to be irregular. Replenishment of drug kits is weak.

CHANDIGARH

- AWWs to be used as the Link workers for the NRHM program. There is a plan to train the AWWs of the UT as per the prescribed ASHA modules. 1st round of training using the first 3 modules of the ASHA training is underway. Kits to be purchased after completion of training.

JHARKHAND

- Around 92% Sahiyas trained in 5 modules and empowered with the new skills. Sahiya help desks are established in most DH/CHCs. Supportive supervision structure for Sahiyas initiated. Coordination of Sahiyas, Anganwadi Workers, and ANMs is satisfactory. Sahiya's Shelter is an innovative idea. Average income of Sahiyas is around Rs. 2500 per month, mainly from JSY and transportation payment, but payment received in 2-3 months. Lack of interest among Sahiyas on non-incentivized activities like home visit, counselling, disease control programmes was observed.

KERALA

- ASHAs are very motivated and educated (above 8th standard). All ASHAs are trained in 2nd to 4th training modules. ASHAs spend average of 2-4 hrs a day in their work and average earning is Rs. 350 per month. ASHA payments is done in cash except in Trivandrum district. ASHAs are involved in promotion of promoting breast feeding and counselling on nutrition during ANC and PNC visits, source reduction, immunization, ANC mobilization, household visit, and promotion of palliative care. Proper ID cards are available. ASHA diary is being revised with all the formats needed for case-based and component-wise tracking. ASHAs are playing a vital role in promoting breast feeding and counselling on nutrition during ANC and PNC visits. Registration of institutional deliveries and/or related counseling services were not properly recorded, ASHAs seemed to lack orientation and relevant training inputs.

MAHARASHTRA

- ASHA's have completed 5 training modules in tribal districts and 2 modules in non-tribal districts. Good NGO involvement in the development of supplementary ASHA modules. ASHA's role and support is well acknowledged by ANMs, ICDS, AWWs, mothers and communities. It was observed that in Gondia district, ASHAs were not placed at sub-Centre villages due to a communication gap between state and district authorities and district authorities were instructed on the spot to send in the request for more ASHAs as per norms with an assurance by the state that they would be immediately sanctioned.

MADHYA PRADESH

- 50113 ASHAs in place in the state against requirement of 52177. Training of ASHAs in Module 4 completed for over 85% of ASHAs and modules 5, 6 & 7 are to be started. Timely replenishment of drug kits done for 45971 ASHAs. ASHA receive incentive for JDY, Immunization, Malaria, RDK and treatment in positive cases, for DOTS and Leprosy. The ASHA supervisory structures such as area/block/district coordinators and mentoring are to be established. The ToT of district trainer is in process and 78 trainers have trained in 5th module. There is no tracking of ASHAs drop out. ASHAs appear to be more interested in activities that are incentivized in comparison to activities like awareness generation. ASHAs in 9 World Bank supported districts for malaria have been trained in malarial slide preparation. The needy pockets in several districts which are non-high focus are inadequately attended.

NAGALAND

- 1700 ASHAs currently working in the state and all trained till module 5. Training of District/Block Trainers on 6th and 7th modules completed. Development of ASHA diary completed and distributed to all ASHAs. ASHA Coordinators appointed in 48 blocks for providing hand-holding support to ASHAs. Regular monthly thematic meeting initiated in most of the blocks by ASHA Coordinators. Radio sets provided to all the ASHAs. Translation of ASHA Reading Materials into 3 major local dialects. ASHA Drug Kit provided to all ASHAs. The average continuation duration of ASHA is 4 years and only 10% drop-out rate has been noted in the state. Most of the ASHA vacancies have been filled but their training is yet to be completed. ASHA support system and ASHA Resource Centre are yet to be set up. Diaries have been provided to the ASHAs but are not being used due to difficulty in comprehending the technical terms. ASHAs are playing an active role in VHNDs.

ORISSA

- 755 ASHAs are in position in the district till October, 2010 and trained up to the Module 5. ASHAs are providing most of the envisaged services for maternal and child care including IPC, supporting Anganwadi workers and ANMs for ensuring the ANC, Immunization services. They play key roles in the successful observation of the VHND and Pustikar Diwas for availability and utilization of better health and nutrition services. 102 ASHAs have dropped out due to selection in the AWW position, or as a ward. Excellent branding of ASHA was observed due to uniform, apron, ASHA drug kit, caps, identity card etc. This has also helped to boost the morale of the ASHAs. Drug kits were available with all the ASHAs. ASHA Gruha managed by ASHAs (for their night stay and as a rest room) at two FRUs (i.e. at DHH & CHC Chandragiri) are functional.

PUNJAB

- 17229 ASHAs selected, 14026 ASHAs trained up to 4th module and 14500 provided with drug kits. ASHAs are available in all villages/facilities visited. ASHA meetings are held regularly which is useful for the ASHAs. However, shortfall in ASHAs needs to be filled for ensuring adequate coverage. Payments received: Rs. 200 for promotion of JSY and Rs. 350 for accompanying pregnant women, but number of cases are not substantial. ASHAs are functional on promotion of institutional delivery and immunization and have adequate knowledge related to this. However, they were not addressing the areas of nutrition or childhood illness management. ASHAs could be missing home deliveries – since there is no incentive available for the same – even recognition of marginalization is an issue. State is planning IYCF but without understanding of 6th and 7th modules. ASHA

support system is yet to be established. Attrition in the districts ranges from 2%-15%. Re training plan is weak.

RAJASTHAN

- 43,288 ASHAs Sahayoginis in place and trained up to module 4. ASHA payment was found to be irregular and inconsistent. ASHA paying a lead role in holding VHSC meetings. ASHA Sahayoginis are being trained in early detection in case of outbreak under IDSP. Good coordination of ASHAs and AWWs observed during the field visits. High turnover and poor retention of ASHA Sahayoginis. ASHAs receiving payments in piece-meal manner, in small amounts, through bearer cheques.

TAMIL NADU

- State has ASHAs only in tribal areas.

UTTAR PRADESH

- 1,36,192 ASHAs are in position against the sanctioned 1,36,248 positions. Over 80% ASHAs are trained up to 4th Module. ASHA Mentoring Group has been formed. NGOs are providing hand-holding support to the ASHAs. ASHA Sammelan is a positive forum for the motivation of the ASHAs.

UTTARAKHAND

- 660 ASHAs in the district. ASHA Resource Centre managed by an NGO in Chamoli district. The average monthly income of ASHAs is reported between Rs. 500-600. Good quality of TOT for ASHA. ASHAs have been trained in ARSH, Homeopathy. MNGOs are involved in ASHA training. ASHAs have good knowledge of IYCF. ASHA Ghar provided in DHs, but yet to be set up in the other facilities. Inadequate funds for transport of ASHAs to attend meetings, resulting in high out-of-pocket expenditure. There is inadequate facility for stay of ASHAs at health institutions. Delayed payments reported at some places. Expenses for stay and time not covered when patients referred to higher facility which happens frequently. ASHA in small hamlets earn less compared to Sudoor Swasthya Sahayak who receives Rs. 500.



RCH II (MATERNAL HEALTH, CHILD HEALTH AND FAMILY PLANNING ACTIVITIES)

ARUNACHAL PRADESH

- **Maternal Health:** 84% women for ANC registered. Special efforts needed to increase institutional delivery, ANC, PNC coverage and follow-up. Technical Protocol, RTI, STI, safe abortion, immunization, family planning services, needs improvement. Janani Suraksha Yojana payments are updated by cash. No blood bank in District Tawang. Blood bank is not functional due to Licence issue at Changlang. MCH Centres for 3 high focus districts have been planned. Need to create more level I centres. Maternal Death Audit not yet implemented.
- **Family Planning:** State has reported 528 sterilisations, which is 50% of the Estimated Level of Achievement (1048).
- **Child Health:** Children breast-fed within one hour of birth is 38.2%, in district Tawang and Changlang it is 54% and 35.9% respectively. New born corners were present in facilities but equipment not being utilized due to lack of training. No SNCUs/NICUs available in both the districts.
- **Name-Based Tracking:** Only formats received. Registers are not maintained properly. Training of MOs and other para-medical staff required. Software for tracking needs implementation on priority basis.
- **School Health:** Limited to eye check-up by trained teachers in Tawang.

ASSAM

- **Maternal Health:** Lakhimpur: 28 maternal deaths of 33% institutional deliveries and 64% unreported deliveries in the current year. Dhemaji: 34 maternal deaths 71% institutional deliveries in the current year. SCs at Lakhimpur are conducting deliveries and some have RHPs posted there that has added value to the services. Deliveries not happening at SCs in Dhemaji – despite ANMs being trained as SBAs. DH in Dhemaji has LSCS capability.
- **Child Health:** New born corners in place at all facilities. Stillbirths reported for lack of timely LSCS in Dhemaji SNCU nonfunctional. Deworming programme alongwith Vit-A is working in both districts.
- **Family Planning:** Overall going well but through camp approach. IUCD training completed in Dhemaji but not a popular method of FP. More preference is given to OCPs. NSV has picked up – regular services need to be provided. At DH/Dhimaji, three gynaecologists posted but laparoscopic tubectomy not happening. Post-partum family planning/tubectomy not happening.
- **Janani Suraksha Yojana – Payments:** Formats for JSY payments not followed which makes tracking the JSY payments difficult. (Lakhimpur). At CHC Dhalpur JSY payment records were all fake. Beneficiaries haven't received the money yet for the JSY, but in the records they were shown as paid. Beneficiaries who came for their delivery had not received the money for Mamoni (1st ANC & 3rd ANC).
- **Maternal Death Audit:** Forms filled, but not reviewed.
- **Name Based Tracking:** Routine immunization needs are being picked up and monitored by the tracking system in Dhemaji and Lakhimpur.

CHANDIGARH

- **Maternal Health:** From the year 2008 to 2010 Institutional Deliveries show 3.6% increase, stillbirth – 38.8% increase. Home deliveries – 24% decrease. RTI/STI treatment services are not provided. On account of not having BPL cards the benefits of JSY are not reaching the needy.
- **Child Health:** At CHC 22 neonatal units are dysfunctional. Lack of availability of generator further limits the use of emergency, neonatal and other services. Services at General Hospital and CHCs are below the accreditation norms.
- **Janani Suraksha Yojana – Payments:** Only 0.96% in 2009-10 and 0.91% deliveries conducted in public hospitals were given JSY cash transfers. For 9 out of the only 20 deliveries conducted in the accredited private health institutions were eligible for JSY cash transfers.

- **Family Planning:** From the year 2008 to 2010 sterilization shows 4.2% increase. IUD Insertion – 6.3% decrease. Condoms – 13% increase. Oral Pills – 20.4% increase. Services of abortions and family planning, particularly, supplies of OC pills, EC pills, condoms, IUDs, sterilization are also provided during PNC and OPD.
- **Maternal Death Review:** Nodal persons identified for MDR at 5 institutions. Orientation of all officers has been undertaken. PGI conducts MDR and IDR.
- **Name-based Tracking:** Name-based tracking is not fully operational.
- **School Health:** The total number of students examined has increased by 212%. There is good coordination between the health and the education departments.

CHHATTISGARH

- **Maternal Health:** ANC care is good in CHC Tilda and satisfactory elsewhere. Hb estimation and urine examination is not universally done by ANM in SC. All the PNC cases are discharged within 6 to 8 hours. Vitamin A and IFA are being provided but dosage is an issue. There is no record of identified high risk cases of pregnant women and their referral. There is no use of partograph across the facilities and abuse oxytocin to induce labor is in practice. Labour room staff has very poor knowledge of emergency management. SBA training is very poor in the state. Except in DH, there are no assisted deliveries. Mostly planned LSCS are being conducted at the rate of 3 percent only in day time and emergency CS patients being referred to Raipur. There is increasing trend of institutional deliveries, utilization of facilities, laboratory, FP and other services. The designated FRUs – CHC Tilda and District Hospital, Raipur does not have blood storage facility. Counselling on breast-feeding, nutrition, family planning, immunization is not being done adequately. Cows milk found to be given to the newborns at the institutions even at DH. There is no record of post-natal visits.
- **Child Health:** New Born Care Corners are not available. At most of the facilities radiant warmer are out of order. New-born hygiene is not taken care of. Availability and administration of Injection vitamins K is doubtful. JDS money used for construction rather than the procurement of heaters for the new borns. Staff has very poor orientation on using the medical equipment including life saving devices like ambu bag, mucus extractor etc.
- **Janani Suraksha Yojana – Payments:** There are issues in JSY payment to the beneficiaries – e.g. community interaction revealed that there no institutional deliveries at HSC Keshavnagar but register was showing payment given to the beneficiaries. Discrepancy between records maintained at HSC regarding JSY payments and feedback from community members.
- **Name-based Tracking:** Name-based tracking of pregnant women and children is yet to be started. It is being done offline.

JHARKHAND

- **Maternal Health:** ANC registration increased from 36% (2006) to 44% (2009). Only around half of them are converted to institutional deliveries. Post Natal stay especially at PHC/APHC level, less than 24 hours (mainly because of lack of facilities to stay). Very few HSCs (15%) conducting deliveries in Palamu.
- **Family Planning:** Acceptance and use of IUD is very low, even after the introduction of new IUD with 10-years life.
- **Name-based Tracking:** Name-based tracking started in Gumla, but not in Palamu. Pregnant women and NBW tracking not started in Palamu. The due list, at places, was found incomplete and as tracking it was ineffective. Immunization coverage seems to be slipping after the discontinuation of alternate vaccine carriers and vaccinators due to paucity of funds.
- **Maternal Death Review:** Maternal death review needs strengthening and more detailed probing for clinical and social causes. Especially maternal/infant deaths related to malaria not getting tracked.
- **JSY Payments:** JSY payments in DH and some of the CHCs were on time. But payments for deliveries in APHCs and SCs at made at PHC and are delayed.
- The process of JSY payment varies at places.

KERALA

- **Maternal Health:** Most women including BPL women use the district level facilities for antenatal care services; ultrasounds etc., but choose to have their delivery only at the Medical College or other larger teaching facility. Institutional deliveries have reportedly decreased in the current year in the public facilities. Ratios of normal vs. C-sections is greatly skewed (In district Kottayam and Kozhikode, as against 48% caesareans in the state the percentage of caesareans is nearly 65% and 54% respectively. The figure quoted by District Hospital Ernakulam was an alarming 70%), No RTI/STI fixed day clinics were observed, also the registers for the same were not maintained.
- **Family Planning Services** is one of the weaker links of the delivery system; e.g. Limited IUD insertions observed; almost all CHCs have reported nil PPS in Kozhikode. IUD insertions were reported to be done by LHV. Compensation for post partum sterilization (PPS) was low in 2009/10 at 40%, but in 2010/11 only male sterilization remained at this level, while female sterilization compensations indicate overachievement with a variance of 35.7% in Kottayam and a seven-fold achievement above allocation in Kozhikode (69.9%).
- **School Health Program:** Vitamin A supplementation is through the school health programme and AWC.
- **Maternal Death Audit:** No committee structure was found on maternal death audit during the visit.
- **Name-based Tracking:** No structured name-based tracking system established. State has 98% institutional deliveries. 2% home deliveries are concentrated at the block level.

MADHYA PRADESH

- **Maternal Health:** All EMOC, LSAS trained MOs are being posted at FRUs after state level counselling. Model Labour Room established. 83 functional CEmOC centres against the target of 120, BEmOC centres have increased from 296 in 2005-06 to 430 in 2010 November. Dominance of private sector in Divisional and District head quarters. In Khargone there are 4 Private Hospitals accredited under PPP – *Janani Sahyogi Yojana*. Under-utilization of Blood Banks and Blood Storage Facility. Skill based training not on priority. Reluctance in management of complicated cases.
- **Family Planning:** A declining trend of male sterilization from the year 2007-08 up to current year. Whereas a rise is being observed in the female sterilization from year 2007-08 to 2008-09, but then in the year 2009-10 there has been a decrease. The annual % achievement is as low as 39% up to November 2010,. Very few health institutions providing sterilization. Lack of skilled paramedical staff for IUD insertion. Contraceptive Corners are being established at the District Hospitals.
- **MCH centres:** Level I – 623 all of them are SHCs. Level II – 814, Level III – 184.
- **Maternal Death Audit:** Maternal death audits started this year in MP. There is no specific format and their reporting too is dissimilar.
- **Janani Surakhsha Yojana – Payments:** The JSY payments are being regularized and the payments are being done within a week after delivery through bearer cheques.

MAHARASHTRA

- **Maternal Health:** Institutional deliveries have increased in the State. Many lower level facilities showed evidence of practice of MH technical protocols in labour room while others did not. In sub- centres and in PHCs irrational use of oxytocin and antibiotics is a disturbing factor.
- **Child Health:** Equipment are in place with regards to new born care. But the quality of care in itself requires greater focus. Trained staff nurses were not aware of the step-by-step procedure for neonatal resuscitation. There is lack of specialized staff for exclusively providing new born care. SNCUs are not functioning upto the mark. The neonates brought to the hospital who have not been delivered in that hospital are being kept at places which are not suitable for new born care and where chances of nosocomial infections, hypothermia were very high.
- **Family Planning:** Minilap sterilizations and NSVs are being done at PHCs in Gondia. Male sterilizations have shown an increasing trend in Gondia district. Ac Kolhapur there are hardly any NSVs.

- It was observed that there is no focus on in-house tubectomy in immediate Post partum period due to a state policy and directions that dissuades the above. Interactions with the state authorities revealed that this is due to an understanding that tubectomy in immediate Post partum period would increase the chances of infection. There was no evidence of promoting IUD insertion/spacing methods.
- **Maternal Death Review:** District committees have been constituted but the process is yet to start as per GoI Guidelines.
- **Janani Suraksha Yojana – payments: Timely.**

NAGALAND

- **Maternal Health:** In the labour room partogram was not being used. New born care corner was seen along with the labour room but utilization of these corners is questionable. Blood Storage Units were not available in the FRUs.
- **Child Health:** IMNCI program has not been implemented yet. The training sessions have not been completed as yet and necessary forms and formats have not been printed and supplied.
- **Family Planning:** It will be imperative to mention that demand for family planning is there in the community but lagging due to no supply. Last one month that all the women registered for ANC and who have delivered a child have accepted family planning services; many of them have undergone tubectomy and few of them have accepted IUCD insertion and OCP. Family welfare services such as oral pills, IUCD, ECP and Nishchay were available up to the level of SC. Most of the CHC are not equipped to handle sterilization cases. The districts do not have a nodal officer for family planning. It does not have a plan for awareness generation or fixed day strategy. Till now 66 and 28 MOs have been trained in NSV and Minilap but performance in terms of people trained is negligible. In Mokokchung district the Gynaecologist of the District Hospital plans the camp and whenever she gets time from her hospital she, along with her team, conducts camps in coordination with the CHC.
- **Mother & Child Tracking System (MCTS)** were yet to be implemented. The training is completed NBITS/MCTS program is yet to be operationalized by state.

ORISSA

- **Maternal Health:** Prevalence of moderate anemia is about 80% and severe anemia is about 20%. IFA tablets are supplemented for anemia. Institutional deliveries are increasing each year for the last 3 years; though 48 hours stay is not maintained. It was observed that the L-1 facilities are not only recording the partograph but also are enclosing the same in case of referral. Total Delivery: 7556 (Institutional delivery: 4435; Cesarean Section in district hospital: 653 {15%}).
- **Child Health:** The major issues impacting under five morbidity and mortality in the district are malnutrition, neonatal survival, malaria, new born anemia. Malaria is the principal cause of morbidity and mortality in the district, also leading to high childhood anemia. Around 35% babies born in facilities visited weighed less than 2.5 kg. Under 5 children seen suffering from repeated attacks of ARI, repeated malaria-induced fever.
- **Family Planning:** The programme remains centered around adoption of permanent methods, with very little adoption of spacing methods. Female sterilization continues to be the dominant family planning method.
- **ARSH:** Establishment of Adolescent Friendly Health Clinics. Training on ARSH to all.
- **School Health:** 40 SSD schools have been covered under School Health Programme. Untied fund @ Rs. 10,000/- have been released to the schools. MHU team visiting the school fortnightly.
- **Janani Suraksha Yojana – Payments:** Payments of JSY are functioning well and the patients are receiving money in time.
- **Name-based Tracking:** Name-based tracking of pregnant women and children being started, though there is a huge quality gap in filling up the data in the tracking sheets.

PUNJAB

- **Maternal Health:** Persistent home deliveries are an issue – about 30 to 40%. High private sector case load in Jalandhar. Good number of FRUs – functional in Jalandhar but availability of blood for transfusions is a huge

bottleneck. Only one in Muktsar. Management of complications in both pregnancy and newborn weak. Specialists concentration needed at DH. Range of services – better at the higher level. PCPNDT implementation – structures and process in place – but examination of forms and follow-up action needed. Teen clinics at sub-centre level have trained male workers.

- **Child Health:** Facility-based child care has just not arrived. Newborn corners present at all levels. Still births high and newborn deaths also. At sub-centre reliable information was seen, but no systemic action. Cases appeared like asphyxia.
- **Family Planning:** NSV rates show very good progress in both districts. Sterilisation benefits being received by users.
- **Janani Suraksha Yojana – Payments:** Delayed at PHC level as powers of disbursement is at block level. Also delayed for lack of bringing along JSY card
- **Maternal Death Audit:** Maternal death review happening but not yet understood. Clinical death causation only and no follow-up actions. Under-reporting also.

RAJASTHAN

- **Maternal Health:** Rajasthan has recorded an impressive increase in Institutional Delivery (ID) from 28% in 2005-06 to 70% plus in 2009-10. An important shift was observed in JSY case load from secondary levels to the primary in the districts visited. There is a trend of sustained increase in institutional deliveries against estimated deliveries at the PHC, CHC and DH. Ajmer Medical College with a Janana Hospital which shares 24% of delivery load, 35% load being shared by DH, 2 SDH and 1 Satellite Hospital, the CHCs and PHCs accounting for 18% each and SCs taking up approximately 5%. The Labour Room as a general rule was clean with privacy. The maternity wards were clean. Quality of institutional deliveries and use of partograph in labor rooms and stay beyond 24 hours and most by beyond 48 hours in the hospital after delivery, was noted. % of BPL visa vis normal delivery as well as C-section as a proportion was found to be low in district Pali.
- **Child Health:** Newborn Corner with warmers, Ambu Bag and Mask (two types). SNCU in all the District Hospitals present. The number of Nursing and Medical staff in these FBNCs not according to the number of SNCU beds, their capacity-building, retention, requires a fresh assessment. There is need to train nurses in short courses (2 months) for newborn nursing.
- **Family Planning:** The reduction of a relatively high TFR of 2.6 is being done through strengthening of Jan-Mangal Program, establishing of NSV Resource Centre and through the Rajiv Gandhi Population Stabilization Mission. State has increased the monetary incentive for all sterilisation. Multiple strategies to reach different segments of Eligible Couples.
- **Janani Suraksha Yojana – Payments:** The JSY payments are all up to date and the Mothers as a rule receive payments through cheques at the time of discharge.
- **Maternal Death Review (MDR)** has been reported to be initiated in all the districts with the constitution of MDR Committees in the two districts visited (to check for Pali).
- **MCH Planning:** Ajmer – 7 centres as Level 3 with availability of 740 beds. 25 Level 2 facilities.
- **Pali:** 7 centres as Level 3 with availability of 620 beds, 22 Level 2 facilities.
- **Name-based Tracking:** The State has started capturing the information in specified formats There is a decision to link this up with the EC register with UID starting with the ECR. Implementation of the common Mother and Child Protection Card has not been initiated yet. Novel online scheme like Hamaribeti.com has to be followed up for its desired effect. While this has been made visible at higher levels, the gaps in services and utilization but not much enthusiasm was observed amongst the ANMs and their supervisors. In places this has also been reduced to a mechanical activity of entering the data for transmission upwards, defeating the purpose of better planning and follow-up to ensure completion of the set of activities for pregnant, newborn and children.

TAMIL NADU

- **Maternal Health:** Institutional deliveries are discouraged in the sub- centres thus none of the VHNs of the sub-centres visited, has conducted any deliveries in the last 6-8 months. Antenatal registers in some facilities were

found incomplete. Screening and recording of details of the high risk cases needed improvement. The state has identified 42 MCH centres for strengthening the services for Maternal and Child care.

- **Child Health:** Newborn care corners were established in all the PHCs and above, mostly in the labour room or just outside the labour room. NICUs were also recently established in selected centres and are working well. In Virudhunagar, two hospitals had established SNCUs. The equipments in these SNCUs was well functioning. The average daily admission in NICU, KAPV Medical College is around 10 cases during the current year, average intramural and extramural admission per day is around 7 and 3 cases respectively. The % of death among the intramural and extramural cases during the current year is 64% and 36% respectively.
- **Stillbirths:** Stillbirth rate is 10.9 per 1000 deliveries, which is on a higher side. In PHC Pulivalam of Tiruchirappalli District, 45% babies born during September 2010 – November 2010 were Low Birth-weight babies. This needs immediate attention. Analysis of the infant deaths data of the districts for the year 2009-10, shows that a large number of the post neonatal deaths are occurring at home. 65% of all the post neonatal deaths in Virudhunagar HUD, 43% in Sivakasi HUD and 49% in Tiruchirappalli District occurred at home. This indicates that identification of danger signs at home by the mother or the frontline health functionaries and timely referral to higher centres is compromised and is a major training issue. The reporting of infant deaths in the sub- centres needs improvement.
- **Family Planning:** The Total Fertility Rate is 1.6. Family Planning is essentially carried out by Camp approach. Male participation in FP needs to be improved.
- **Referral transport:** 108 services are widely available, promptly for referral transport. Interactions with the VHNS conveyed that many women who were in labour preferred to travel by a hired vehicle over 108 ambulances. Nearly 40-50% of the VHSC funds could be spent for arrangement of referral transport including transport for such pregnant women in labour. The main reason was understood to be the anxiety created by the sirens of the ambulances in pregnant women. Women preferred to travel by regular vehicles because of this, when in labour. This needs to be explored further, to increase utilisation of 108 services in the state.
- **Janani Suraksha Yojana:** Majority of women are being registered in the third trimester according to the Concurrent Evaluation of NRHM published in 2009. Accordingly 65.6% of all the beneficiaries received the JSY cash incentive after a week of delivery. A similar delay was also seen in the facilities visited with many beneficiaries not receiving the benefit even after 2 months. Although, the reason provided was delivery of the beneficiaries at the maternal homes, the delay could be reduced by encouraging the payments of the benefits in the institution of delivery and early registration of the beneficiaries, micro-planning of birth and issue of JSY cards. Payment in Top Sengattuipatty PHC was not being made at the time of visit.
- **Name-based Tracking of Mothers and Children (PICME)** is being done, but data entry especially of infants is not complete.

UTTAR PRADESH

- **Maternal Health:** Safe abortion services were not widely available, modern methods like MVA and medical abortion were not being used. A scheme to engage private providers for provision of free delivery service on a voucher basis for BPL women has been initiated, but has faced problems with withdrawal of providers shrinking the provider base. Given the small number of beds in the wards, a 48 hour postnatal stay was found to be impossible.
- **Family Planning:** There also seemed to be attitudinal problems in providers where abortion services were seen to be given conditionally with family planning surgeries. Family planning surgeries were provided largely through camps. In Sonbhadra, there were only one qualified laparoscopic surgeon but camps reporting more than 200 women undergoing laparoscopic tubal ligation in a day. Targets were allotted at each level from the district right up to the ASHA. Minilap tubectomies were not being performed regularly. Male sterilizations were found to be very few. The use of IUD needs to be promoted. Emergency contraceptive pills supply were not in stock.
- **Janani Suraksha Yojana – Payments:** JSY seemed to have contributed to an upswing in the number of institutional deliveries. Payments for JSY were largely seen to be transparent and prompt, and lists of beneficiaries were seen to have been put up for public display in one facility.

- **Maternal Death Audit:** No maternal death review processes were seen to be happening in the state.
- **MCH centre:** Plans have been drawn up for the state, however, ownership of this programme was lacking.

UTTARAKHAND

- **Maternal Health:** The percent of institutional deliveries varies between 35 to 40% out of the expected pregnancies (Chamoli 39%, Uttarkashi 35.6%). MTP services are not being provided at the PHCs and most CHCs. Increase in reporting of RTI/STIs cases in the last quarter (27→ 249 this quarter) as a result of recent training. Poor quality of ANC care at the sub-centre level. 48 hours stay post-delivery reported at most of the facilities. Some facilities visited did not have a functional baby warmer/new born corner (CHC Joshimath, CHC Gairsen). However all facilities in Uttarkashi till PHC level had functional baby warmers.
- **Family planning:** Number of RCH camps was below the target. Possibly there is a high unmet need for family planning service.
- **Janani Suraksha Yojana – Payments:** Payments mostly on time. Some discrepancy between institutional deliveries and JSY payments because of LAMA/not staying 48 hours.
- **Maternal Death Audits:** (FBMDRs & CB MDRs) not being conducted in districts despite many Maternal Deaths.
- **Name-based Tracking:** Tracking of pregnant women being done; huge discrepancies between data of pregnant women being tracked, institutional deliveries, home deliveries and deliveries at private facilities.
- The ANM were perturbed by the member of fields to be filled up in the report, as well as demand for date of birth and age of the beneficiary. Every time they have to get this form copied and thus lot of paper work takes a toll.



NUTRITION AND INTER-SECTORAL CONVERGENCE

ARUNACHAL PRADESH

- Although the state is doing well on general trends in nutrition but no specific plan was observed for the management of underweight, malnourished infants and children. In addition, the micro-nutrient supplementation plan is weak and requires more efforts to strengthen its implementation.

ASSAM

- State has taken up new initiatives to address the malnutrition among children in the age group of 7 to 60 months. On a pilot basis, Nutritional Rehabilitation Centres are set up in three districts (Udalguri, Darrang and Kokrajhar). State has also set a target to bring down the percentage of severely malnourished children to less than 1 percent. However, efforts are needed in guiding the frontline workers and district programme management units for incorporating the detailed micro plan to address the uses of malnutrition at VHND.

CHANDIGARH

- The UT has established good coordination between the ICDS, Health Department and PHD which has resulted in organizing VHNDs successfully. Growth charts of the children in the Anganwadi centres prepared by AWWs are also screened by ICDS supervisors and medical officers from the Health Department. Screening and counselling of the pregnant mothers is being done by the team of ICDS medical officers. Iron and Folic acid is being given to the mother, children and adolescents. Nutritional Counselling is also one of the components of its school health programmes. Comprehensive and targeted IEC materials are also prepared by the IEC cell for different audiences.

CHHATTISGARH

- Acute and chronic under nutrition is a major problem in Chhattisgarh. 20 NRCs have been established in the state and 18 of them are functional. Treatment of Grade IV SAM is provided by these NRCs. However, AWWs need orientation on SAM classification standards for the rational and effective referrals from AWCs and AWWs. The AWCs, in remote areas need to be strengthened, specially to make item functional as many of the AWCs lack equipment. Many of AWWs were not able to record the growth chart of children. State Health Department needs to take initiatives to establish good coordination with the State Department of Women and Child Development.

JHARKHAND

- The Malnourished Treatment Centres (MTCs) in Palamu are not utilised to the fullest. The state has a large number of malnourished children and MTCs role in tracking these children is not up to the mark. In this regard, the capacity of MTCs needs to be strengthened.
- State has not taken adequate measures to promote infant and young child feeding practices. Lack of coordination between the ICDS and Health Department is affecting the various strategies like issuing Mother and Child NRHM cards and capacity-building of the AWWs to record the grade- III & IV malnourished children. The *Sahiyas* are doing good work but they require further capacity-building.

KERALA

- The state has not adopted any structured and organized program to promote the nutrition among children, adolescent and pregnant women, except the involvement of the ASHA in creating awareness about the nutrition and some IEC/BCC activities. Department of Social Welfare is carrying out the routine activities for promoting the nutrition levels of children and women through ICDS centres. The progress on nutritional supplementation is done efficiently through Anganwadi centres and they are maintaining the growth charts. In addition, distribution of micro-nutrients namely Iron, Folic Acid, Vitamin A and Zinc is done with great efficacy by health department.

- State also needs to build the capacity of the ANMs at sub- centres to maintain and track the records of low-weight babies. State has yet to address the issue of providing curative and rehabilitative care for grade III & IV malnourished children.

MADHYA PRADESH

- The state has a well developed network of Nutrition Rehabilitation centres (NCRs) and is following all the guidelines properly. The districts are in a position to enhance the coverage of malnourished children and follow-up mechanisms.
- The state reports a manifold increase in the number of NCRs from 8 in 2002-03 to 230 in 2011. These NCRs are effectively treating (34,031) the malnourished children even beyond their set targets (25700).
- The state has also taken some initiatives by launching new schemes like *Bal Shakti Yojna* to address malnutrition. In addition, ICDS centres are working effectively for promoting healthy dietary habits, breastfeeding, and nutrition among pregnant and lactating mothers. The state has also given priority for early identification of malnourished children.

MAHARASHTRA

- The nutrition program is being implemented in the state through effective convergence mechanism between the health department, ICDS and self-help groups. AWWs are well trained and active to track the malnourished children by using the growth charts. State has taken new initiatives are yielding positive results like compensation to those mothers who are bringing their children to Child Treatment Camps for the loss of their wages and providing the counselling for nutrition by dieticians at DH Gadchiroli and Gondia.

NAGALAND

- The VHNDs in the state is done at regular intervals, every month but there is lack of coordination of different departments like ICDS, and Health. Nutrition as a public health problem does not seem to be a priority for the state.

ORISSA

- The state has developed a good number of Nutritional Rehabilitation centres which are providing quality nutritional services. The ASHA, AWCs and ANMs are providing nutritional support through AWCs, VHNDs and home-based counselling. For example, in Gajapati district Block-wise micro-plan for VHND has been developed. 6706 VHNDs were planned till November 30th 2010, but only 76 percent of such VHNDs held. However, the efforts regarding adolescent girls, to improve maternal health are yet to be operationalised emphatically.

PUNJAB

- AWCs are functional in the state and effectively providing services like health check- ups, supplementary food, nutrition and health education to women (age 15-45 yrs), supply and use of medicine kits, referral services to children and women under ICDS. However, inadequate knowledge on how to use medicines which are provided with the medicinal kit needs to be addressed. In addition, non-establishment of Nutrition Rehabilitation centres, effective referral for malnourished children, and growth monitoring as per the WHO standards are some other issues which the state has yet to address.
- State has put in serious efforts to build the capacity of its staff, so, about 29 Medical Officers and 77 Staff Nurses have been trained as middle level trainers from the health sector. They could act as a support system for any referral and provide counselling on breastfeeding and complementary feeding. The fact that more than 55% of the lactating mothers received advice from the frontline workers shows the value of training on IYCF in building local capacities. State has further incentivised the ASHA for Rs. 25 per pregnant women to act as IFA provider and to ensure HB of pregnant women is above 10 gm, for reducing the anemia among pregnant women.

RAJASTHAN

- The state has adopted policies and strategies to improve nutrition; it is not certain whether improving nutritional status of children is a priority. Critical shortage of trained AWWs and effective convergence between Health and Women and Child Department are some issue before the state, for successfully addressing the issue of malnutrition. Most of AWCs are under-performing as they were only being able to register 50% of the expected numbers of clients. Despite having good system for tracking malnutrition among the children registered in its AWCs, AWWs lack the capacity to influence the dietary patterns and habits of mothers and children.
- State's initiative of "Swasthya Chentna Yatras" has increased the uptake of services on VHNDs, but Malnutrition Treatment centres are still under-utilised.

TAMIL NADU

- The state has initiated the 'Name-based tracking of mothers and children' (PICME) but data entry of infants under PICME is yet to be completed.
- IEC materials related to early breast feeding practices are well displayed.

UTTAR PRADESH

- The state has taken up steps to establish NRCs and so far 16 NRCs are functional. Out of those, 8 NRCs are in Lalitpur, 1 in Farrukhabad and 7 in State Medical colleges. In addition, 4 districts have been selected for additional NRCs, 2 per district (in Banda, Badaun, Gonda and Pratapgarh). However, there is a need to increase the pace at which NRCs are established.
- Measures like the celebration of breast-feeding week, "*Bal Swasthya Poshan Mah*" strategy; School Health Programme and the "*Saloni Swasth Kishori Yojana*" have been taken up to address the issue of malnutrition. However, regular growth monitoring, diagnosis and management of malnutrition did not seem to be happening through the Anganwadi workers regularly.
- The state is doing well in micro-planning for VHNDs. These plans are publically displayed in most facilities. However, in one district it was reported that micro-plans are not followed regularly. The AWCs are required to be strengthened with proper equipment as it was observed that weighing scales were not functional.

UTTARAKHAND

- Insufficient funds for Take Home Rations programme have disturbed the supply of rations for pregnant, lactating mothers and children less than 3 years old, for the last one year. Fair amount of BCC on IYCF have been carried out in the state and ASHAs are also well aware about it.
- The Anganwadi centres are functional except THR. The Mid-day meal program the is doing well and functional in the state. The establishment of Nutrition Rehabilitation centres is yet to be seen as these were not visited.

NATIONAL DISEASE CONTROL PROGRAMMES (NDCP)

ARUNACHAL PRADESH

- **RNTCP:** The district officials are informed about 2010-11 budget.
- **NLEP:** Four cases of Leprosy has been detected in Tawang District.
- **NPCB:** Outreach activities are carried out for detection of refractory error but no special camps for cataract detection.
- **IDSP:** Trainings of IDSP has been completed, however, in Changlang the district IDSP incharge acknowledged the fact of delayed reporting as attributed to lack of computers at the facilities.

ASSAM

- **NVBDCP:** ASHA using for PF and also prepare slides for PV and for which incentives were to be given. Lakhimpur is giving incentive for ASHA under NVBDCP. ITN are provided 14,000 per assembly constituency however inadequate kaothin is not available for community-based impregnation. Both districts have second line treatment but artemisin tablets are date expired.

CHANDIGARH

- **RNTCP:** Has achieved expected levels of new Smear Positive case detection and treatment rate. The expenditure against the ROP approvals for honorarium, equipment maintenance and trainings are above 50%.
- **NVBDCP:** The number of Dengue positive cases in the UT increased from 25 in 2009 to 202 in 2010 but no deaths were reported due to dengue. the Annual Blood Examination Rate increased from 7.6 to 9.0 in the last 5 years, with 92202 slides collected till November this year. With 347 slides positive, the SPR is 0.4.
- **NLEP:** The UT NLEP also conducted house-to-house survey under Project Foundation in 2 slum areas with a population of 35000, where 6 cases were identified and put on treatment. Also 6 reconstructive surgeries of patients with grade 2 deformities were done and MCR footwear provided for patients with grade 3 deformities.
- **IDSP:** The number of private reporting sites has remained steady at only 10 since the beginning of IDSP programme. There is no evidence of epidemiological analysis and action and it also lacks monitoring mechanism.
- **NIDDCP:** Household Survey among 2466 households for Goitre showed a decline in prevalence from 142% to 5.54% under NIDDCP. Samples failing the tests have dropped for the salt samples from 8% in 2009 to 3% till November in 2010, and from 2% in 2009 to 1% till November in 2010 for the urine samples.
- **Non-communicable Diseases:** Health workers are trained in Non-communicable Diseases for early screening and referral. Diet clinics are also established with dieticians providing counselling services.

CHHATTISGARH

- **NVBDCP:** Annual parasite index (API) was more than 5 districts viz Dantewada, Baster, Kanker, Korea, Sarguja, Korba and Jaspur. Dengue is also an emerging public health problem in the state. However, 32 deaths have been reported from designated low endemic areas.
- The absence of critical human resources like lab tech, MPW, health supervisors, district malaria officer, have been said to be major hurdles for implementation of the programme.
- **NLEP:** Drugs under NLEP were available in all facilities visited. Vacant post like NMS (17) in Raipur district alone and non-rational distribution of NMA posts. The treatment completion was upto 92% for Raipur and 95% for the state. 27 for Raipur and a total of 182 for state – reconstructive surgeries were conducted. 881 MCR (Micro cellular Rubber) footwear provided in the current year.
- **NPCB:** implemented in all districts for eye check-ups in schools included drop-outs.
- **IDSP:** IDSP has been implemented in all districts and there is reporting and analysis. However the information on outbreak is limited and also emergency or epidemic preparedness is also limited.

JHARKHAND

- **RNTCP:** Vacant staff position are hurdle to success for RNTCP (e.g. Lab tech). Designated microscopic centres are limited and availability of consumables. 129 positive cases were detected out of 1311 sputum check ups.
- **NVBDCP:** RDK are highly utilized in the state under NVBDCP. The quality of slide preparation, adherence to treatment protocol and IRS availability was limited. Maternal and infant deaths related to malaria are not getting tracked.
- **NLEP:** In Palamu, 193 cases of Leprosy were registered and under treatment (between April and Nov. 2010) in Patan block (Palamu district).
- **NPCB:** A total of 7565 school children were screened and 253 children were enrolled at Vision Centre for treatment.
- **IDSP:** Epidemiologists are posted under IDSP, however reports are prepared manually due to lack of infrastructure (computer and printer) and prescribed formats are not followed.

KERALA

- **RNTCP:** RNTCP has a well established reporting structure. There are 17 TB Clinics/ centres (total 176 beds) and 3 TB hospitals (608 beds).
- **NVBDCP:** One interesting factor is that JPHNs are guiding ASHA regarding house-to-house larval survey. Dengue cases are on the rise and needs significant improvement in control measures. In the field visit only the block PHCs, TLHs and GHs had functional laboratories. In NVBDCP programme, the prescribed time cycle for the visit of JPHN is once in 20 days and that of the male MPW is 40 days. The active surveillance is at best inadequate and mostly at a very low level.
- **NLEP:** New cases of Leprosy are being detected among children and this indicates a considerable active transmission that needs to be addressed.
- **NPCB:** Spectacles were provided under NBCP, However, in the last few months the spectacles have not been made available in Kozhikode district (visited district).

MAHARASHTRA

- **RNTCP:** TB cases detected/cure rate increased and also the fund allocation for the programme.
- **NVBDCP:** Malaria cases are also increasing and the availability of beds and nets is limited in Gondia (visited district). The alarming issue that was observed by a team in Goregaon hospital is that patients are asked to purchase injections and drugs for PF as well as PV Malaria.
- **NLEP:** Leprosy cases have high prevalence in districts like Gondia with large number of Multi Bacillary cases still being detected.

MADHYA PRADESH

- **RNTCP:** Programme performance has shown improvement in case detection which has increased from 120 in 2008-09 to 131 in 2010-11. The default rates have declined from 7 to 6% and success rate increased to 88% from 86% and cure rate to 85% from 83%. However in the district Damoh, the default rate increased from 5.53% in Dec 2008 to 6.47% in 2010.
- **NVBDCP:** Under NVBDCP 756 selected sub-centres have been provided with RDKs. MPWs and ASHAs (8873) are trained for referral cases of servers malaria. District Malaria Officer are appointed in all 44 sanctioned places. However, vacant posts exit – 184 malaria inspectors, 2 entomologists, 300 lab tech, 334 MPWs, hindering the programme. A total of 386 positive cases detected in cross check of 1, 53,149 negative blood slides received.
- **NLEP:** 79 new cases of leprosy were detected under NLEP in Damoh district. Reconstructive surgeries have increased from 147 (2007-08) to 282 (2009-10). Awareness generation fortnight celebrated in 21 blocks (9 districts) with **ANCDR** < 20. In the district Khargone, 42 cases underwent RCS in NGO Umroi Singh, and treatment completion rate was 93.7%. The amount approved was Rs. 255 lakhs while the utilization is Rs. 29.82 lakhs, accounting for a percentage utilization of 11.69%.

- **NPCB:** The total cataract operations done in (NPCB) 2010–11 (up to November.) are 188827 (83.92%), against the expected 450000. Which is less than previous years achievement of 40,9601.
- **IDSP:** 48 DSUs has been established with contractual staff. 103 computers received from GoI for SSU, Medical Colleges and DSU. Training completed for 20% MOs and 46% lab technicians.

NAGALAND

- **RNTCP:** Case detection rate increased from 61% in 2005 to 85% in 2010.
- **NVBDCP:** NVBDCP has complete set of human resource and most of them are trained as per new malaria guidelines. 13 deaths have been reported during 2010 (Jan-Oct), decreased from 75 (2006). In Zuhneboto, 20,326 blood smears were collected out of which 112 slides were positive for *P. vivax* and 20 were positive for *P. falciparum*. API was 0.81 and ABER was 12.2. PHC Akuloto was reported as malaria endemic with SPR of 4%.

ORISSA

- **RNTCP:** The case detection rate in TB is more than 70% and the cure rate is >85% as per the objectives of the programme. Default rate is 1.7%. The LTs have not received the revised salary despite the approval of the same by CTD, 1-1.5 yrs back.
- **NVBDCP:** ASHA are supporting the program efforts through providing testing services by RDK and providing treatment for the positive cases. They are also supporting as FTDs. There is a shortage of 50% of LTs in the district visited.
- **NLEP:** Leprosy is still a problem at prevalence of 1.8 per 10, 000 population and the ANCDR is increased to 19.2 10, 000 population, owing to increased efforts for detecting new cases, with high prevalence in children at 8.9, and deformity of 5.3 and MB at 48.5.
- **NPCB:** 1488 surgeries have been conducted under NPCB program in Gajapati district which is 82% of current years target.
- **IDSP:** Cases are being reported by ANMs on a weekly basis. S, L, P forms are being maintained as per guidelines. The district health authorities are aware of the issues related to IDSP.
- **NIDDCP:** Awareness campaigns are being held and iodized salt is available in the market.

PUNJAB

- **RNTCP:** Case detection rates for TB are good at Muktsar, but poor at Jalandhar. The main problem seems to be inadequate chest symptomatics examined, both by public sector and by private sector. There is a MDR-TB problem but the programme for this has not started as yet.
- **NVBDCP:** The main vector-borne disease is dengue. In some blocks of Jalandhar, malaria is still a persistent problem.
- **IDSP:** Typhoid and hepatitis are reported on IDSP – but again there is no public health response. One CHC visited had a large number of typhoid reports which were used for clinical management, but not for public health action. The main issue with the IDSP is that it is more seen as a means for generating and sending up reports, rather than to undertake local action. Thus measles outbreaks are being reported, but there is no public health response, and even the awareness of the protocol of response is weak.

RAJASTHAN

- **RNTCP:** The state has constantly performed well and has exceeded the target of 70% case detection and 85% cure rate. In general, RNTCP has performed consistently well in the State.
- **NVBDCP:** Malaria is endemic in 19 districts and dengue is endemic in 14 districts. Chikungunya is endemic in Jaipur district. Two case of JE have been reported this year from Udaipur, still Rajasthan is not endemic for JE. There is a need for 1288 additional LTs based on population norm including the current vacant posts of 309.
- **NLEP:** Existing prevalence rate of Leprosy in the state is 0.18/10000 population and 0.72/10000 at the national level. The state proposes that the resources under the programme will be slowly phased out with just a skeletal structure to cater to the needs of the leprosy control programme.

- **NPCB:** 39.31% of cataract operations done against target of 3.00 lacs. Currently 9 government eye banks and 14 private eye banks are functional in the state.
- **IDSP:** 88.63% major hospitals enrolled, are sharing the IP, OP and Lab Surveillance and P & L forms. Toll free no. 1075 can be accessed by all districts and is used by the community in reporting of any outbreaks. 5 reputed major private hospitals are sharing weekly surveillance reports.
- **NIDDCP:** The iodine consumption in the state is below national average and therefore the state has indicated following strategies such as Laboratory monitoring (strengthening with UNICEF support) of iodised salt and urinary iodine excretion, Health Education and IEC/BCC will be undertaken throughout the State.

TAMIL NADU

- **RNTCP:** There was no shortfall of drugs and consumables during the visit. DOT provider was functioning independently and did not report to VHN of the sub- centre. RNTCP cards were found to be incomplete in some sub- centres.
- **NVBDCP:** A sharp rise in the cases of Dengue is reported in the state over the last 5 years. Currently 1126 suspected cases of Dengue reported from the state. Interactions with MPW on the field suggested that on an average one MPW looked after minimum 2-3 sub- centres' areas. As part of anti-larval measures "Malaria Mazdoor" are hired @ 500 p.m.
- **NPCB:** 4.8 lakhs of cataract surgeries done in 2009-10 alone, however it was below state target of 6.5 lakhs.

UTTAR PRADESH

- The National Disease Control Programmes are operating under NRHM at both state and district levels. ASHAs, ANMs, MPWs and other supervisory staff in the field level are involved in implementation of various NDCPs.
- **RNTCP:** Case detection rates are in par with the national average. However, huge manpower shortage in RNTCP programme has affected the surveillance unit.
- **NVBDCP:** Filariasis control in 50 Districts, Kala Azar in 4 Districts bordering Bihar and for Japanese Encephalitis (JE) in 34 Districts mainly in eastern UP. 476 deaths have been reported due to JE in the state and vaccination against JE has been reported to be given to approx 3.5 million children in 7 affected districts.
- **NLEP:** 44 districts achieved elimination level. Two districts Kanpur Dehat and Baharaich have Prevalence Rate more than 2/10,000. 376 Re-Constructive Surgeries (RCS) performed in 2009-10. Micro-Cellular Rubber (MCR) footwear is being procured in the districts.
- **NPCB:** The state achieved 100% of the target for cataract surgeries in 2009-10 with 50% of them conducted in private sector. State has established 18 Eye Banks. Shortage of Eye Surgeons at Block CHCs (IOL centres) is a bottleneck of the Programme.
- **IDSP:** IDSP is implemented in all districts and regular monthly reporting of communicable and non-communicable disease are sent to NCDC, Delhi. Out of 289 episodes reported, 209 were reported same day, 77 within 24 hours, 2 within 48 hrs and 1 within one week.
- **NIDDCP:** 54 Districts in the State have been surveyed for Iodine Deficiency Disorders out of which 24 have been found to be endemic. 25,000 diagnostic kits (for diagnosis of Iodine Deficiency Disorders) yet to be procured (one kit to be provided to each ANM).

UTTARAKHAND

- **RNTCP:** RNTCP well functioning, TUs, DMCs, and DOTs centres are functional. The lag in payment of incentives to the ASHAs for completing the treatment of patients might be responsible for under-achieving the desired treatment completion.
- **NPCB:** Optometrist available at CHCs, BPHCs however Follow-up of referred cataract patients was not being done.
- **IDSP:** Lab support for IDSP was observed to be adequate. (Chinyali Saur and Naugaon CHC laboratories were functional and performing tests for typhoid, sputum for tuberculosis etc.). At sub-centre level ANMs reported that they were sending IDSP reports on phone directly to the district head quarters. Validation of these reports by medical officers was lacking.
- **NIDDCP:** Awareness and focus on importance of using iodised salt is poor.
- **Others:** HIV screening, detection, treatment facilities (ICTC, ART centre) were apparently adequate. ICTC functional at district hospital and Naugaon CHC.
- The HMIS data is not being analyzed or used at the district/MO level for feedback of programme action.



INSTITUTIONAL MECHANISM AND PROGRAMME MANAGEMENT

ARUNACHAL PRADESH

- SPMU and DPMUs are in place but having some vacancies. As observed by the team, in Tawang district, poor understanding of the PMU staff's regarding the programme management.
- Supply Chain Management of drugs is poor. Lack of comprehensive and sustainable plan for procurement of equipment.
- Monitoring mechanism is in place and team found adequate in RNTCP and NLEP but due to vacancies in other programmes monitoring is not satisfactory. There is lack of adequate supportive supervision and monitoring from the state level.
- Verification of reported data is not adequate and also HMIS data analysis is not undertaken for improving program management.
- RKS meeting held at irregular periodicity; participation of PRI members is found to be less.

ASSAM

- Meetings of State Health Mission were held during 2009-10 including in the current financial year. Similarly, very few District Health Mission Meetings as well.
- PPP model is working well in Lakhimpur at Harmoti tea garden.
- Evening OPD, a good initiative. It is catering to the needs of the community and has more than 50% attendance of the morning OPD.
- In Lakhimpur, computerised/web-based drug utilisation monitoring system initiated. Training of concerned staff have been completed to improve quality of data.

CHANDIGARH

- Regular meetings of State Health Society were held regarding the monitoring & evaluation and monthly review and action taken. These meetings of Governing Body were attended, inter-alia, by the Mayor, Municipal Corporation; Health Secretary; Finance Secretary; Secretary, Indian Red Cross Society; UT, Mission Director; Chief Engineer UT; and PA to Chairman, Zila Parishad.
- Rogi Kalyan Samiti funds are mostly used for supply of free drugs to the poor patient. Prior approval of RKS is taken for use of this fund. In deserving cases, ex-post facto approval is taken. PRI involvement in VHSC meetings is satisfactory.
- SPMU coordinates and supervises the activities of District level hospital.
- The procurement and logistics system is in place and which is responsible for assessment of required inventory items, constituting the purchase committee and also constitution of an inspection team which approves the specification and quality.

CHHATTISGARH

- SPMU and DPMUs are generally in place and fifty percent of SPMU staffs are in position, one fourth of DPMU staff are in position and two thirds of block programme unit positions are lying vacant. Infrastructure for SPMU and DPMUs are reasonably good.
- SHRC is well in place and involved in various activities like Mitatin programme, system strengthening, and action research.
- Procurement of medicines is as per essential drug list; however, none of the stores in Surguja district were having a copy of EDL except DH and awareness regarding the same could not be witnessed. It was also noticed that there was higher out-of-pocket expenditure mainly for drugs.
- There are problem of store management, like expired drugs, irrational distribution of drugs, medical equipment, costly suture material in huge amounts supplied to the facilities.

- PRIs are members and part of JDSs; however, it was found during the visit that meetings are most often organized on the basis of needs of the BMO or institution in-charge.
- State has developed system for supervision and monitoring activities such as check-list for field visit, preparation of visit report, feedback system etc; though, frequency and intensity of visit varies across districts e.g. it was found in Raipur district but not in Surguja district. In bigger districts such as Surguja DPMU is not able to conduct various monitoring visits.
- The online system for monitoring developed by the state is at initial stage.
- Although, the state has rationalized various registers, but so far there are not in use. Use of HMIS data for programme improvement could not be seen at district and below levels.

JHARKHAND

- District Health Mission not meeting frequently. District Health Societies meet frequently, but need more substantial discussions and decision-making on public health and program issues, apart from targets and financial matters.
- *Panchayats* not in place, so coordination with PRI/local govt. not happening presently.
- Decentralized procurement observed at facility level, procured locally from approved stockists, as per state/district rate contracts.
- Supervisory visit plan/schedule not observed.
- HMIS is manual below the block, and gets compiled as per the HMIS format at block level, which is entered in the web portal of NRHM. Feedback of HMIS reports down the reporting channel not observed.

KERALA

- Management systems are established till the block level; the coordination between district, district health office and block level is good.
- HMC/RKS committees combine of the heads of health institutions and members of the PRI and voluntary organisations.
- District health missions are conducting meetings but not found to be regular.
- Supervisory schedules are not structured for facilities.

MADHYA PRADESH

- High level State health mission meeting was held which is chaired by Chief Minister of Madhya Pradesh. The meetings for The District Health Mission have increased over the years but this year's data shows that very few meetings have been held.
- The Programme Management Unit structure by NRHM i.e SPMU, DPMUs, BPMUs are in place. Their role with the inter-disciplinary skills needs to be recognized and valued.
- PMUs are in place and involved in various programmes but there are some vacancies. Currently the position of the SPM is vacant, out of 50 positions of the DPM 16 positions are vacant, 38 out of 313 Block Programme Managers are vacant.
- At state level, the Joint Directors were made in charge of the seven divisions in the state. Their role was mainly to monitor and supervise the functioning and performance of the various districts in their divisions. Also, trained staffs in SBA and IMNCI are not being monitored for the outcomes.
- In Khargone district, there is an established system for supervision and monitoring activities. The reports are regularly checked and feedback given. However, in Damoh district, the monitoring and supervision was one of the weak areas.

MAHARASHTRA

- It has been observed that DPMU and district health officials are functioning as a team
- In DH Satara, poor planning, financial management and accounting of various flexible funds was seen. Large scale district level purchase of medicines and supplies have been made on behalf of RKS of PHCs and sub-centres in the district.

- VHSC funds are being spent on AWC upgradation and supplies for malnourished children and referral transport. ICDS funds could be preferred for this purpose.
- There is a distinct disparity in the cleanliness and general management seen between the PHC and hospital levels and addition of a hospital manager may improve the conditions.

NAGALAND

- Procurement system is not satisfactory in the state where Village Health Committees and SCs are given responsibility to purchase equipments and drugs. The team observed that so many agencies involved in drug procurement.
- Many planned training session could not be organized. In the year 2010-11, as a retrograde step, the DHAP of the Zonheboto listed only the activities but did not budget.

ORISSA

- Supply Chain Management of drugs is weak. Lack of comprehensive and sustainable plan for procurement of equipment.
- The extent of utilization through Rogi Kalyan Samiti is improved but variable. The expenditures are backed by formal decision with due consent from the PRI members.
- The district and block programme management units in data validation is done at the block level. It is further analysed at the district level to support planning and decision-making. The completeness of data quality facilitates decision-making at district level.
- The supportive supervision activities of the PMU, needs to be strengthened for its capacity to supervise and assist the field workers on a regular basis. System for accreditation of private hospitals for JSY, MH and FP services has been established.
- Zila Swasthya Samity: ZSS has worked well in mobilizing resources through convergence like NBC equipment from the RSBY fund.

PUNJAB

- DPMUs are integrated with CHMO office and seamless integration will be strengthened if the new tasks are also managed adequately e.g. planning, logistics etc.
- A technical pool of seven persons at state level acts as the SHSRC.
- SIHFW is having good infrastructure and involved in various trainings.
- RKS meetings, about once in a quarter and its composition has PRI, professionals and NGOs. Only the NRHM RKS grant is brought under this purview.
- ANM reporting on mobiles – both daily and monthly is a major advance. Use of daily data is questionable and it is causing tensions out of proportion to any possible benefits. Monthly reporting is adequate, if utilised well.
- Considerable lack of clarity on pregnancy tracking but no systems in place yet.
- Private sector accreditation weak. Only few facilities linked up to, though large numbers of private facilities are providing RCH services including delivery.

RAJASTHAN

- RKS (Medical Relief Societies) are functional at all levels – PHCs, CHCs and District Hospital; but their role and nature of their participation has not been fully understood.
- Rajasthan has initiated steps to partially devolve financial and administrative authority of Health and WCD department up to the district level to the PRIs. In a three tier format, the staff of the health and nutrition programmes at the district, block and village level will be accountable to the corresponding levels of PRIs, the Zilla Parishad, the Panchayat Samitis and the Gram Panchayats.
- State has reasonably good involvement of PRIs in health-related activities.

- SPMU and DPMUs are in place, however, few vacancies observed in BPMU around 18 percent.
- SHSRC is in place and involved in various technical assistance in the area of quality certification of health facilities.
- SIHFW is functional and with the support of NGOs provided training to 1,09,303 members of 17,655 VHSCs.

TAMIL NADU

- Commitment of the Senior Management Staff is appreciable. Regular staff is given the responsibility for Programme Management at the respective levels of healthcare facilities.
- HMIS system is in place and regular feeding of data in the system is taking place. But utilisation of data at the local level is to be promoted.

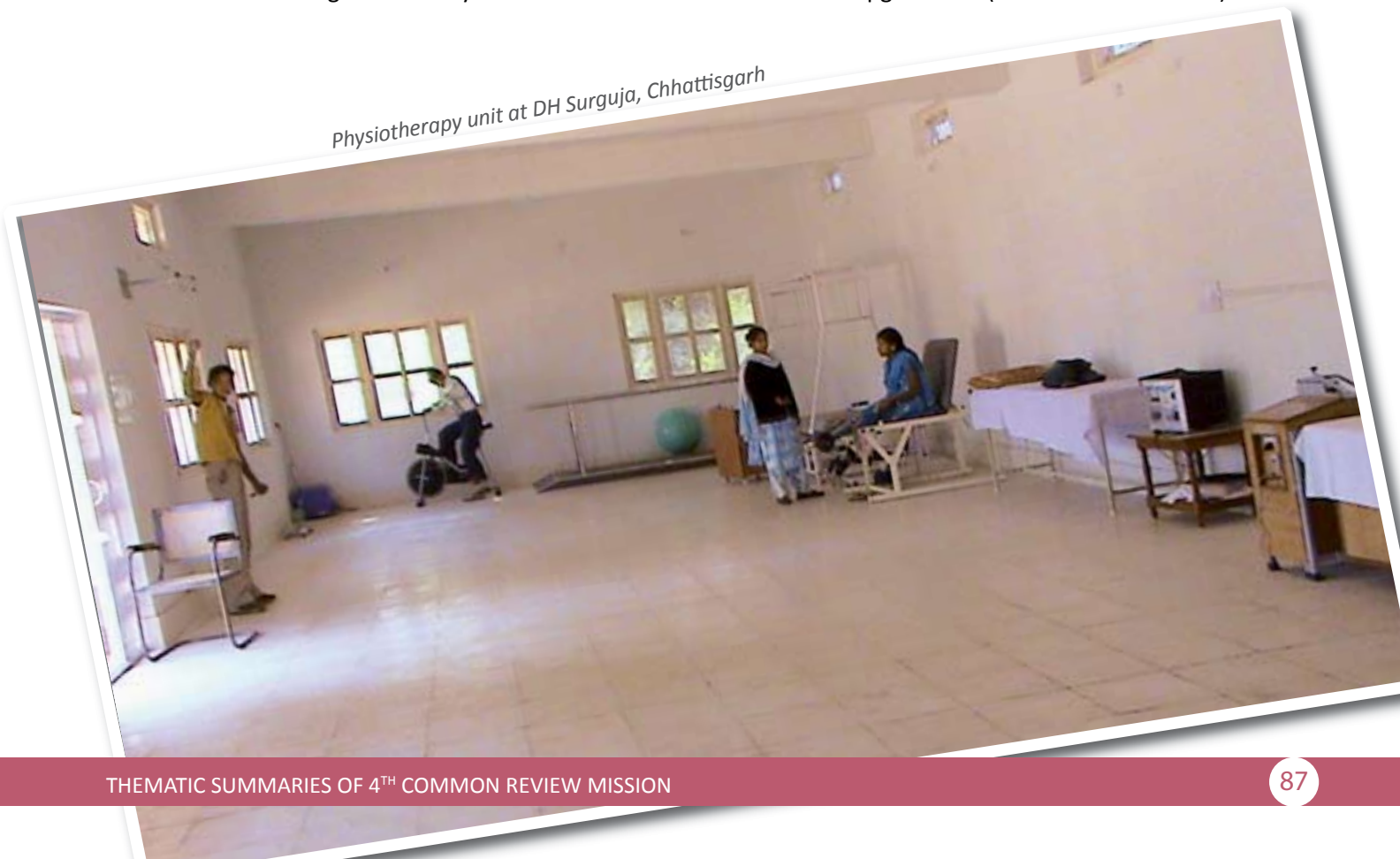
UTTAR PRADESH

- The programme is manned by two Ministers, two Secretaries and DG (Medical Health) at state level and two CMOs at district level. There are two CMOs in the district. The CMO (Medical Health) looks after work of CHC, PHC, and sub-centre. Various national health programmes are also looked after by the CMO (Medical Health). The CMO (FW) looks after NRHM-related activities which also includes RCH and Family Planning.
- The SPMU consists of administration, finance, M&E, IEC, PPP, MIS cells and National Health Programme Cells. At the 17 Division level, Programme Management Unit is established which consists of DPM and Data Assistant.
- At the Block level, posts of Block Programme Manager and Accounts Assistant do not exist. At some places, Health Education Officer is designated as Block Programme Manager. Post of Accounts Assistants is vacant.

UTTARAKHAND

- No evidence of adequate use of available data for planning by PMUs.
- Roles and job responsibilities of DPMU/BPMU not uniformly clear. Induction and refresher training not being carried out systematically.
- The RKS institution appears to be in place in most of the facilities, the presence of PRI is significant.
- Untied funds being used mostly for maintenance and infrastructure upgradation (furniture and fixtures).

Physiotherapy unit at DH Surguja, Chhattisgarh



FINANCIAL MANAGEMENT

ARUNACHAL PRADESH

- The reporting from district and state is done on TALLY. Transfer of funds is done online from state to the district and by cheque from district onwards. RKS, AMG untied funds, VHSC funds released from the district to the concerned institution on time. There is a significant increase in expenditure across quarters. Concurrent audit being done but the periodicity is irregular. The progress in program management is also good (97%), BCC/IEC (62%) etc. All units are submitting Utilization Certificate and Statement of Expenditure except for the VHSC funds. Records and registers for all funds from DH to SC are available but there are no standardized registers and formats. Cash book is either not available or inadequately maintained in many facilities except at DH.

ASSAM

- The overall fund utilization in the state has improved especially with regard to RCH Flexi pool. Due to slow progress in fund absorption under NRHM Flexi Pool, overall utilization level is around (51%) 2010. Although the absorption of untied funds at various levels has improved, every year there are leftover untied funds in most health facilities. The state is having a shortage of finance and accounts staff, especially at the lower levels, and because of this, the existing staff is overburdened regarding financial management. Maintenance of accounts and payment to the beneficiaries is unmanageable by the same official interested with the implementation of new schemes.

CHHATTISGARH

- The state of Chhattisgarh is managing its financial management at state level with the help of State Finance & Accounts Manager and two assistants. Funds are being e-transferred to all the districts and other implementing agencies. The post of Director (Finance & Accounts) from the State Finance/Accounts wing is vacant. Books of Accounts (Cash Book) are being maintained but not kept up-to-date. Reporting is very weak from the Sub-District Levels. The advances in the shape of untied funds with PHC/Sub-Centre and VHSC are lying unspent for 2 to 3 years at few places. The utilization of budget is low due to lack of understanding and also due to activity-wise transfer of funds.

JHARKHAND

- The state does not have the position of Director (Finance & Accounts) as the same has not been created. Hence, the said position is lying vacant. Also the position of State Finance Manager is also vacant. The State has initiated the process to fill up the vacant position. The state is transferring funds to District Health Societies electronically. But the state is using different banks for different programmes for making electronic transfer of funds. It is also noticed in spite of electronic transfer, there was a delay in clearance from one bank to another. Hospital Management Society funds are getting utilized as per guidelines, but state utilization of untied funds under VHSC is only 36 per cent.

KERALA

- In the initial phase 2007-08, the spending from NRHM funds in Kerala has been reluctant 49%. This increased to 59% in 2008/09 and has already reached 66% in the current financial year 2009/10 until December 2010. It is acknowledged by the state that untied funds have brought about visible changes in the peripheral institutions, a notion that is supported by commoners in the field. Annual Maintenance Grants and untied funds are spent at block and ward levels in the CHC, PHC, SC and W (V)HSC in a decentralized manner, spending is at 80-90%. The system of management of accounts and finances being adopted by the different functionaries of Kerala Government under NRHM is a robust one, with the mobilization of ICICI fund transfer mechanism put in practice unlike other states. However, the transfer of funds to the lowest functionaries in the hierarchy like ASHAS is still being done through manual cash transactions. Electronic accounting in TALLY ERP 9 at district level is established and fully operational. There occurs to be some weakness in managing the balance between planning and spending, which led to high variances in implementation.

NAGALAND

- The post of Director Finance is vacant at state level and the post of District Accounts Manager is also vacant in many districts. Although e-banking is in place, it is not properly implemented at the state and district level. Tally ERP9 is implemented at state level and books of accounts are maintained at district level both on manual basis and Tally ERP9 software basis. At the district level, no proper advance control and monitoring system is existing and in many places advances under AMG, RKS, UF are treated as expenditure in district level. Districts were not uploading the FMR on HMIS portal and there exists lack of monitoring of funds transferred to CHC/PHC/SHC/VHSC level.

ORISSA

- State is having Joint Director-Finance on Deputation but the position of State Accounts Manager and MIS Officer is vacant. All four posts of Audit Cell approved in PIP of 2010-11 are also vacant. State is using e-transfer of funds through State Bank of India for transfer of funds from state to districts. State has decided to implement open source web-based accounting software in place of Tally ERP 9. Funds are transferred to all the districts electronically, and out of 314 blocks in 290 blocks funds are transferred through e-transfer. It was observed that books of accounts were maintained properly at district and sub district levels. Even sub-centre and Gaon Kalyan Samiti (GKS) is maintaining cash book. The records were updated and were properly kept.

RAJASTHAN

- At state level all positions are filled. At districts level also position of District Accounts Managers are filled. But below the districts at blocks and CHC/PHC, accounts staff is not sufficient. Electronic fund transfer system is used for fund disbursement from state to all districts through Bank of Baroda and ICICI Bank. Tally ERP 9 is used at all districts and training has been given to District Accounts Managers at state level. Training sessions are organized by the state for all district finance officials, but it should be more frequent.

TAMIL NADU

- The Financial Management is weak. Report of concurrent audit is not being shared with facilities. Book-keeping is absent or poor. Proper monitoring and supervision of utilisation of innovative funds should be there.

UTTAR PRADESH

- There is huge shortage of finance manpower in the state. Out of 71 districts 21 positions of District Account Managers are vacant and positions of 401 block accountants out of 823 blocks are vacant. All the funds are disbursed through e-transfer up to the PHC level which is a good practice followed by the state. Tally software has been procured and training has been conducted up to the district level. But it is not implemented at the state and district level. Manual system of accounting is followed across the state. Concurrent Audit has been conducted and 30 districts have submitted their concurrent report for September 10 in 2010-11. Training plan has been prepared for 2010-11 but does not include training programme of finance personnel. The state has issued delegation of financial powers up to the sub-centre level. The state is not uploading the financial data on HMIS portal. Out of 71 districts only six has uploaded the FMR on HMIS portal.

UTTARAKHAND

- State is having Joint Director- Finance on Deputation. Position of State Accounts Manager and MIS Officer is vacant. At the district and block level, district and block accounts managers are in position but they have not received training in Financial Management. There is a lack of interaction and training between state, district and block level Accounts staff. No field visits have been undertaken by SFM/DAM to monitor utilization of funds. Funds are transferred electronically from state to districts and districts to blocks through e-transfer. It was been observed that the utilization of funds under the activity of untied fund – sub-centre and GKS (VHSC) is very low.

CHANDIGARH

- The post of Director of Finance is lying vacant and the rest of the posts are in place at state/UT level i.e. State Finance Manager, State Accounts Manager, Finance Consultant, Accountants and Junior Accountant Health Society maintains bank accounts with two banks i.e. ICICI Bank and Bank of Baroda. All the funds from Govt. of India are received in ICICI Bank but there is no e-transfer of funds so far at SHS to down-level i.e. CHC to sub-centre. Funds from SHS to CHC to sub-centre are released through cheque or demand draft only. Tally ERP9 has been procured and customized for NRHM but for RCH it is yet to procure it at state level. In terms of release of funds, it has been noticed that there is no integration between the same, as IDSP, RNTCP and NLEP are not receiving funds through NRHM. It has been observed that UT is not analyzing any Statement of Expenditure Report or Financial Monitoring Report.

MADHYA PRADESH

- In the state the position of Financial Advisor is in place, that is from the State Government. State Finance Manager, State Accounts Manager and Audit officer have been appointed in the month of July 2010 which has strengthened the financial management at state level. Funds from state to district are transferred through e-transfer. Funds transfers from district to blocks are also being done through e-transfer. From block to peripherals level funds are being transfer through cheque. Tally ERP 9.0 has been procured at state as well as district level. Same is installed and training is also imparted. But Accounts is being maintained manually at state as well as district level, reasons for the same is non availability of customized version of Tally ERP 9.0. Books of Accounts at state level are being maintained manually and there is no financial monitoring and evaluation done by the district and state level. And it was observed that there is no formal visit of District Accounts manager to CHC and PHC level.

MAHARASHTRA

- E-transfer of Funds at district, SDH and RH and block levels is available and timely. However this is not available at PHC level and delay in transfer of funds at PHC level in some instances was observed. The use of Tally at block levels needs to be promoted. There is need for greater focus on training in financial management for the service providers and accounts staff.



DECENTRALIZED LOCAL HEALTH ACTION

ARUNACHAL PRADESH

- Plan documents are available.
- PRI involvement reported to be sub-optimal, apparently due to lack of interest on the part of the PRI members. 50% VHSCs have been formed although they have limited functionality.
- Community monitoring has not started.
- RKS funds flow has led to improved service delivery.
- Some Programme Officers were not aware of sections of district plan relevant to them.

ASSAM

- Plan documents are available at the district level and salient points are communicated to block officials. Village level needs are only partially incorporated.
- VHSCs have been formed in all villages, with 1-day orientations for members.
- District plans depend on central approvals/clearances.
- PRI involvement could be strengthened. Untied funds received twice but expenditure pattern sub-optimal. RKS formed up to PHC level, but mostly non-functional.
- Community monitoring had been suspended for 2 years.

CHANDIGARH

- Planning done with inputs from health departments. HMIS data not used. No information on quality and feasibility of DHAP is available. PRI involvement in VHSC and RKS is present to a limited extent.
- RKS have been formed at GH and CHCs (chaired by DC and SDM respectively). Meetings are conducted regularly but documentation can be improved.
- RKS provides free drugs to patients.
- VHSCs function erratically. Good VHSC functioning is seen at places like Sarangpur SCs, which had multi-stakeholder coordination and used funds to develop infrastructure. Other VHSCs could follow this model. No community monitoring initiated.

CHHATTISGARH

- DHAP is available. Plan preparation has been known to exclude Programme Officers. Staff's limited capacity and rigid guidelines have been cited as constraints to decentralized, participatory planning. Initiative to make planning participatory by integrating DHAPs for PIP preparation is underway.
- 97% GPs have formed VHSCs, with funds transferred into joint accounts. Funds disbursed earlier have not yet been used, which has limited release for this year.
- VHSC members know of ongoing health programmes but are not informed about their own roles in the system.
- PRI involvement could be strengthened especially for participation in JDS and VHSCs.
- Community Monitoring is not being conducted.

JHARKHAND

- Decentralized plan process is being followed with support from DPs and NGOs. Block level inputs are regularly incorporated in DHAP.
- VHSC have been formed but are not functional, pending settling-in of recently elected PRI members.

KERALA

- DHAP is available for reference but may possibly be delinked from actual deliverables. Implementation needs strengthening. Micro-level needs have to be factored in to developing plan.
- Strong PRI involvement at all levels. High visibility in RKS. However, their extent of involvement may vary across districts. Have key role in ASHA selection. Also active in innovative incentive schemes like award for cleanest PHC etc. (in coordination with Municipal Ward leaders).
- RKS/HMC: have representatives of all stakeholders and wield administrative and financial decision-making powers. Funds flow is streamlined and has been used for development of infrastructure, palliative care. Regular meetings are conducted and decisions made by quorum.
- VHSC members require clarity and orientation about their roles.

MAHARASHTRA

- Although the Plan is said to be top-down, mechanism for participatory monitoring is quite effective. Community Monitoring has been practised since 2007. Expansion of CBM is planned this year.
- Structured tools for feedback on services have been used for Jan Sunwais.
- Adequate representation of vulnerable and marginalized sections.
- CBM has increased service utilization, positive rating of PHC, and more transparency in all aspects of facility functioning. PRI involvement in VHSC is satisfactory.
- RKS: Functional across all facilities, and composed mainly of PRI and government officials. Funds utilization nearly 100%.

MADHYA PRADESH

- The DHAP is prepared at district level with consultation with block officials.
- PRI involvement: Visible in VHSC and RKS functioning and ASHA selection.
- RKS: Status varies across districts. Have user fee charges and these funds are used for facility upkeep. Functioning hampered by delayed funds transfer.

NAGALAND

- Concept of decentralization and communitization predates NRHM by passing of the *Communitisation of Public Institutions and Services Act 2002*.
- Committees thus formed were active in fulfilling their mandated roles of facility development and upkeep, but need to adapt to duties under NRHM. DHAP 09-10 could use only 44% of budgeted funds (Rs. 11,840,990).

ORISSA

- In DHAP use of data for planning is evident. Highly participatory.
- RKS functional and effective. Meetings are conducted regularly and minutes maintained and circulated. Equivalent bodies at GP and district levels also work well. Renovation plans, rate fixing for services etc. are also decided at ZSS meetings. Free drugs provided to patients by RKS funds.
- VHSCs formed in all GPs. Joint accounts active and funds available.
- Untied funds have been used for referral transport and sanitation drives.

PUNJAB

- DHAP is available but links between physical and financial achievements are mismatched. HMIS and IDSP data should be used for planning. Plans show good understanding of objectives and indicators.
- CBM: Not started.
- RKS Functioning hampered by erratic funds flow.

RAJASTHAN

- No involvement of PRI members, although role of community representatives increases as one moves to the periphery.
- PRI: Active role in village health plans.
- RKS: Medical Relief Service MRS (equivalent of RKS) functional across all facilities. Perceived as funds generating mechanism rather than representative body by beneficiaries. Meetings conducted regularly but agenda largely restricted to monetary issues. VHSCs formed in most GPs but functionality varies widely.
- CBM: Not effective yet.

TAMIL NADU

- No information available on DHAP preparation.

UTTAR PRADESH

- Village plans were available but queries revealed lack of clarity.
- DHAP preparation needs to be in participatory process.
- Plans not adequately implemented, possibly on account of unrealistic targets.

UTTARAKHAND

- DHAP non-participatory.
- RKS formed only in selected places.
- Meetings should follow “due diligence” norms when they occur, e.g. meeting minutes should be circulated.
- VHSCs are not fully functional yet. Barriers include 1 Pradhan heading 5-6 GPs.
- Scope of VHNDs needs to extend beyond Immunization and ANC.





4

State-wise Key Findings

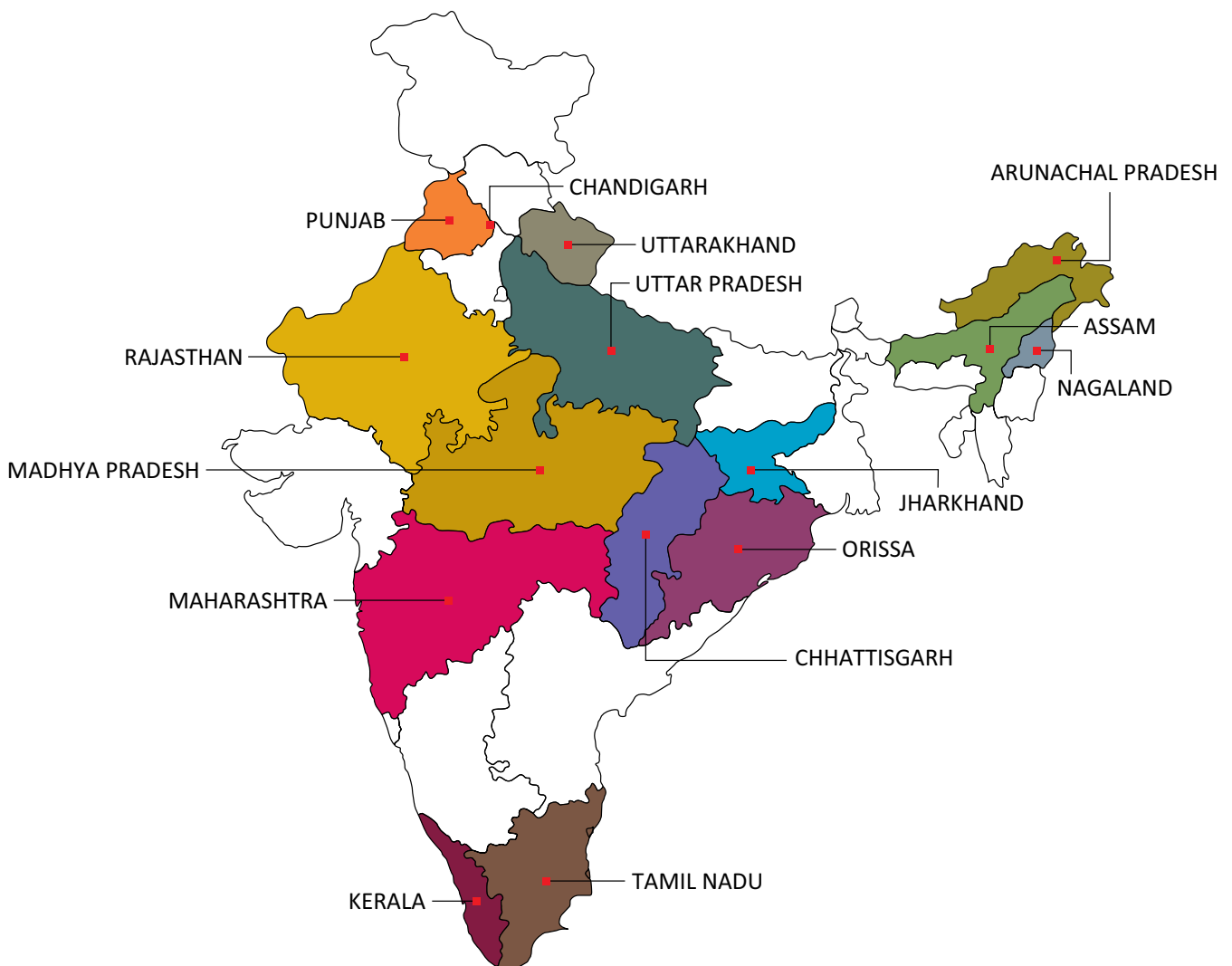




4

STATE-WISE KEY FINDINGS

STATES OF INDIA VISITED BY CRM TEAMS



ARUNACHAL PRADESH

THE REVIEW TEAM

1. Dr. Himanshu Bhushan, Asst. Commissioner, Maternal Health, MoHFW, Govt. of India, New Delhi
2. Dr. G. Lakshmaiah, C.M.O (NFSG), NVBDCP
3. Dr. Jayant Pratap Singh, Consultant, MoHFW, Govt. of India, New Delhi
4. Ms. Asmita Jyoti Singh, Consultant, MoHFW, Govt. of India, New Delhi
5. Dr. Vaibhao Ambhore, Consultant, MoHFW, Govt. of India, New Delhi
6. Mr. Dipankar Bhattacharya, Manager, Deloitte
7. Dr. Shilpi Sharma, Consultant, Planning Commission, Govt. of India, New Delhi



Lumla PHC - PPP working at selected places in Arunachal Pradesh

THE DISTRICTS/INSTITUTIONS VISITED

1. Tawang District: Tawang District Hospital, Primary Health Centres – Jang and Lumla, sub-centres – Lhou, Kitpi, and Lembardung, Village/Community – Kungba, Bomdila District Hospital, Community Health Centre – Dirang, Primary Health Centre – Bhalukpong, sub-centre – Shangti.
2. Changlang District: District Hospital Changlang, Community Health Centre Bordumsa, Primary Health Centres (upgraded to CHC) Jairampur, Primary Health Centres Khimiyang, Primary Health Centres Nampong, sub-centre Yinman and village, sub-centre Longran and village, Community Health Centre Bordumsa.

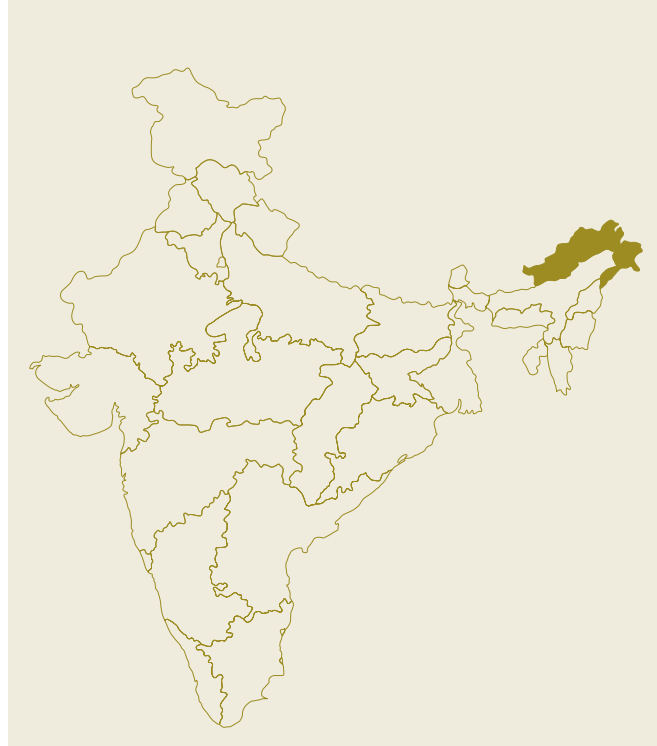


Labour Room upgradation at D H under NRHM



POSITIVES

- ◆ Good quality of ASHA training, and they are available in all villages, active and have good knowledge of roles and responsibilities.
- ◆ Facilities are well maintained and clean infrastructure including toilets with round the clock water available up to the sub-centre levels.
- ◆ Adequate equipment in the facilities visited.
- ◆ Online transfer of funds from state to the district, and by cheque from district onwards.
- ◆ T.B. monitoring, supervision and drugs are available, 100% detection, treatment and cure rate.
- ◆ Nischay Kit available at all sub-centres and with ASHAs
- ◆ Good PPP model seen at PHC Khimiyang, District Health Plans available.



ARUNACHAL PRADESH

AREAS OF IMPROVEMENT

- ◆ Comprehensive Plan and institutional support for infrastructure development is required.
- ◆ Special drive and strategies needed for recruiting specialists, medical officers and nurses with higher salary/incentive, especially for hard to reach areas, quicker and more regular recruitment process (Medical Graduates/ANMs are available at least to fill some of the gaps) and linking PG seats to rural service bonds for serving in difficult terrain.
- ◆ HMIS data shows high percentage of unreported delivery (63%) in the state; this needs to be looked into. Indicative of poor coverage of services especially for home deliveries as most reported deliveries are institutional. No internet connectivity below district Level.
- ◆ Training of ANMs on SBA, IMNCI, NSSK, etc needs to be expedited.
- ◆ Blood banks need to start up.
- ◆ In financial management, cash book maintenance should improve, clear guidelines needed for RKS and VHSCs,
- ◆ Need to strengthen mentoring by supervisors and monitors, if needed by establishing regional monitoring units.

- ◆ Improve Logistics and Supply Chain Management of drugs and put in place a comprehensive and sustainable plan for procurement of drugs and equipment.
- ◆ District office infrastructure and staff needed alongwith training of DPM, Data Manager, Finance Manager and Other Programme Managers on Monitoring with a checklist.
- ◆ IDSP and malaria programmes need strengthening.

Upgraded lab in Tawang D H with support from NRHM



THE REVIEW TEAM

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4. Dr. Swati Jaywantrao Bute, Assistant Professor, NIHF, New Delhi
5. Dr. Loveleen, Sr. Reproductive Health Advisor, USAID, New Delhi
6. Dr. Abhijit Das, Centre for Health and Social Justice, New Delhi
7. Dr. Ravindra Kaur, Lead Consultant, Maternal Health Division, MoHFW, Govt. of India, New Delhi
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9. Mr. Padam Khanna, Sr. Consultant PHP, NHSC, New Delhi

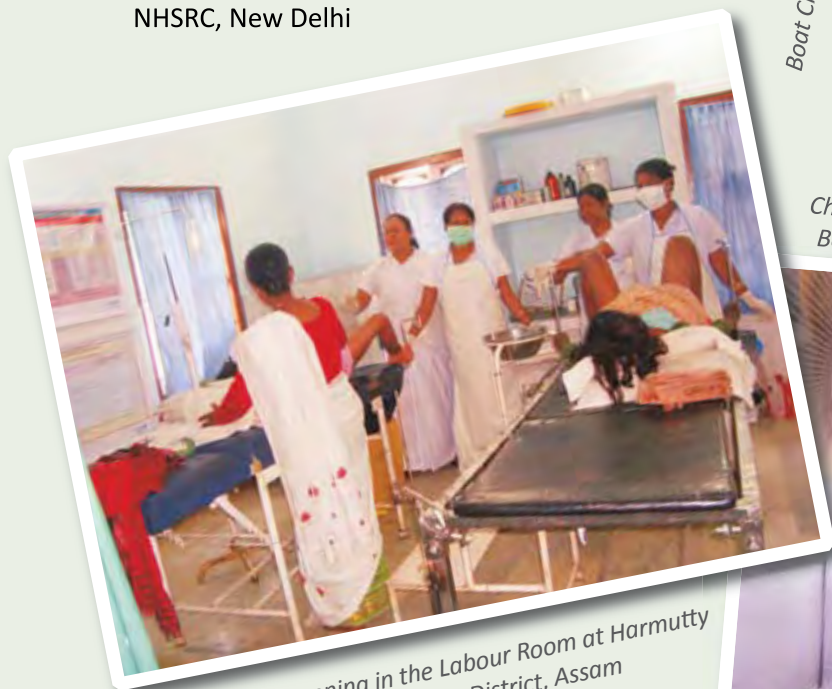
THE DISTRICTS/INSTITUTIONS VISITED

1. Lakhimpur district: Sonapur sub-centre, Tunijan sub-centre, Gobindpur Health Day at AW centre, Harmoti Mini PHC, PPP with Harmoti Tea Estate Hospital, Dhalpur Block PHC & CHC, North Lakhimpur Civil Hospital, Boat Clinic: NRHM and C-NES village-Amaraibari (char area) Missing community tribal belt(under Bihpuria Block PHC and Boangmora CHC), Bongalmora CHC, MMU (Mobile Medical Unit): Location: Laholial Village, Bihpuria Block PHC.
2. Dhemaji District: Silapathar MPHC, Silapathar SC, Dhemaji Civil Hospital, Lamajan SC, Dekapam MPHC, Telam MPHC, Jonai CHC, Jonai PHC, Raichaori SC, Gogamukh CHC.

Boat Clinic at Aunibari village, Lakhimpur District, Assam



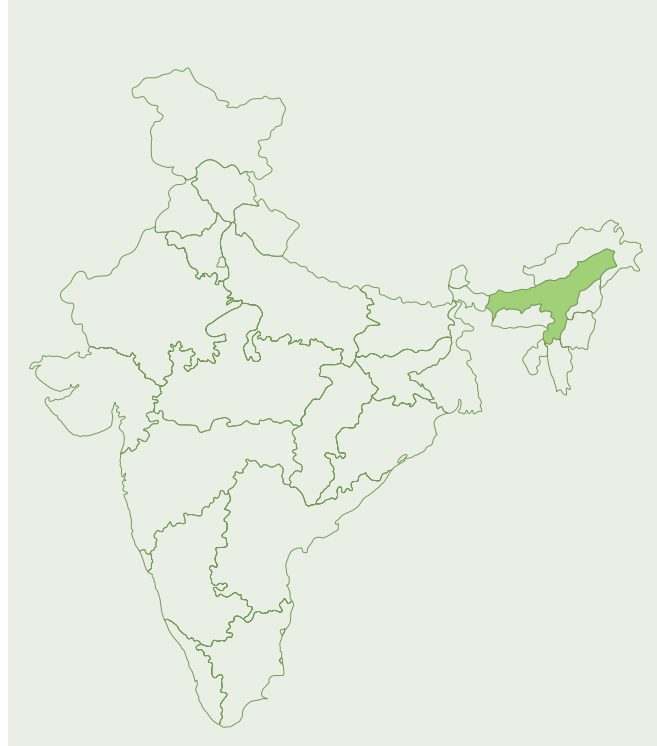
Check-up room and bio-medical waste management in the Boat Clinic at Aunibari village, Lakhimpur District, Assam



Deliveries happening in the Labour Room at Harmutti Mini PHC, Lakhimpur District, Assam

POSITIVES

- ◆ ASHA programme has all support structures in place and payments are good. ASHAs are proactive and knowledgeable.
- ◆ All 4592 SCs are functional with one ANM and 3699 SCs are functional with 2nd ANMs.
- ◆ Substantial additions to workforce: contractual appointments of 1067 doctors, 2295 staff nurse, 698 paramedics, 4921 ANMs & 117 specialists are positioned.
- ◆ 343 PHCs are functioning on 24x7 basis and 60 facilities functioning as FRUs (21 DH, 2 SDH and 37 CHC). Another 103 CHCs and 22 DHs are selected for upgradation.
- ◆ Interesting outreach innovation in form of boat clinics.



ASSAM

AREAS OF IMPROVEMENT

- ◆ Reported maternal deaths high. Maternal death review quality needs improvement.
- ◆ Design of infrastructure and utilization of infrastructure both need improvement.
- ◆ JSY payment leakages should be enquired into and improve process by prompt on-day-of-delivery bank payments.
- ◆ High number of deliveries going unreported and tracking system not oriented to capturing this information.
- ◆ Full immunization coverage is less than 50%, it needs to be focussed upon.
- ◆ Need to improve acceptance of other F.P. methods than OCPs for spacing, increase service providers for IUCDs, and to introduce post partum tubectomy more widely.
- ◆ IUD insertion training to be provided to service providers who are manning the facilities. So far only doctors have the training.
- ◆ No clear HR policy to close gaps. Even existing nursing institutions need to be utilized optimally – one to two batches per year for nurses, instead of the current one batch in three years!!.

ASHAs with Radio Sets, Sonapur sub-centre, Lakhimpur District, Assam. They get a weekly programme on radio about their work and new knowledge on various health issues

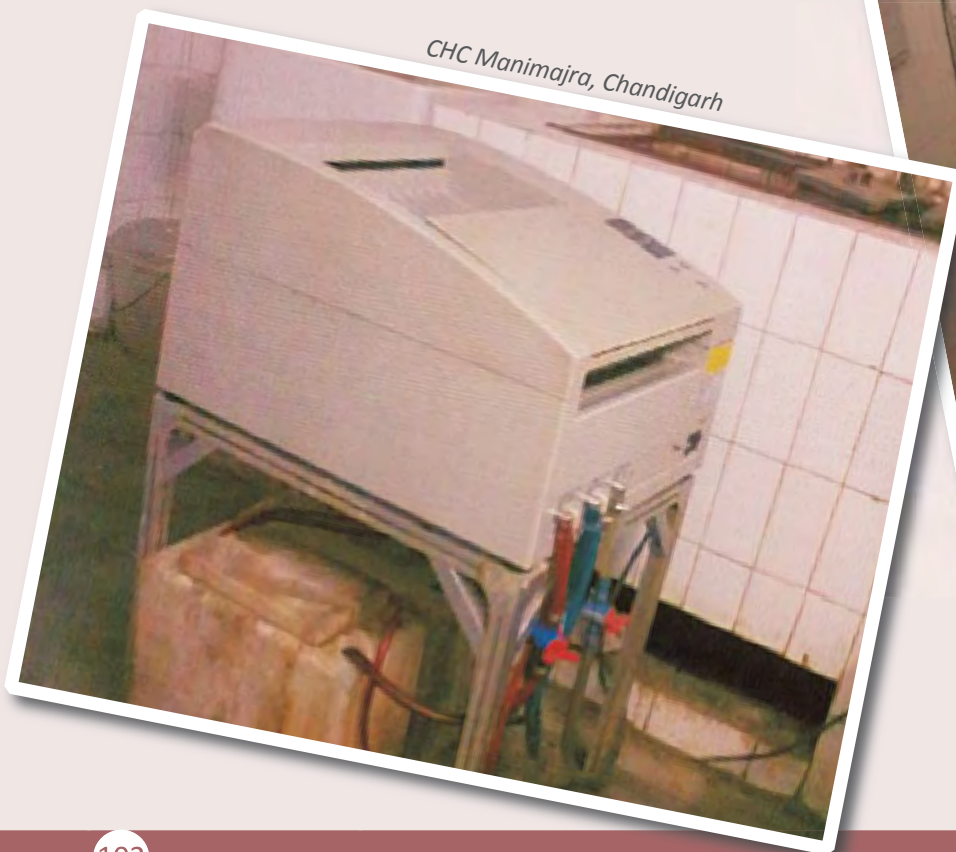


THE REVIEW TEAM

1. Mr. Rakesh Nayal, Under Secretary (Food & Adulteration), MoHFW, Govt. of India, New Delhi
2. Dr. Sanjeev Kumar, MIS Manager, Health of the Urban Poor Program, Population Foundation of India (PFI), New Delhi
3. Dr. Vivek Singh, Public Health Specialist – Assistant Professor, IIPH – Hyderabad, Public Health Foundation of India
4. Mr. Sanjiv Rathore, Consultant, Finance, 510-D, MoHFW, Govt. of India, New Delhi
5. Mr. Sumit Asthana, Consultant, NRHM Division, 510-D, MoHFW, Govt. of India, New Delhi
6. Ms. Shilpy Malra, Consultant, NRHM-I, 526-C, MoHFW, Govt. of India, New Delhi

UT/INSTITUTION VISITED

- ◆ Government Multispeciality Hospital, Sec-22
- ◆ Mani Majra and Sec-22 CHCs
- ◆ Sector-19 and Phase-2 CDs
- ◆ Maloya SC/CD, Sarangpur, Khuda Lahora
- ◆ Kaimbwala Rural Dispensary
- ◆ Colony-4, Mauli Jagran AWCs

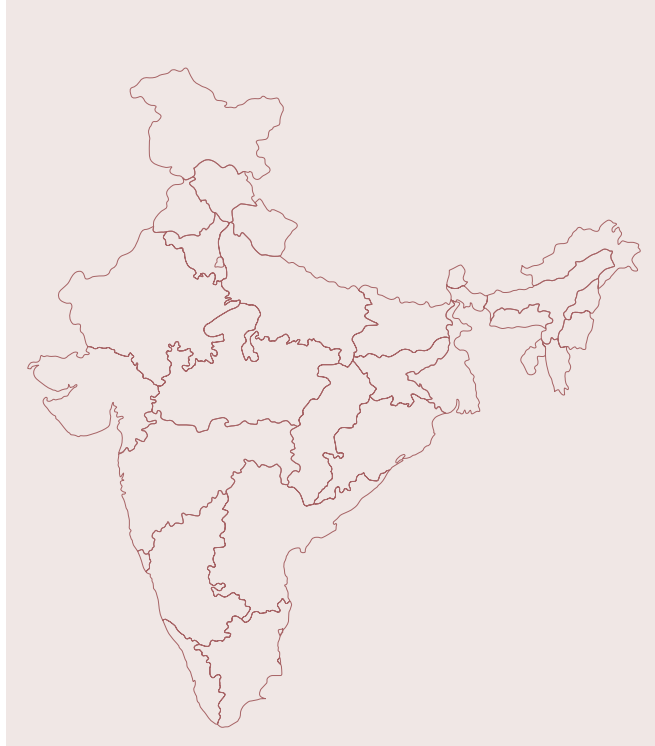


POSITIVES

- ◆ Increased utilization of services observed in facilities at all levels.
- ◆ 85 ANMs, 22 MPHs, 9 LHV, 3 Consultants, 10 Lab Technicians, 1 Office Assistant, Ward Attendant, Computer Assistant and Statistical Assistant hired on contractual basis under NRHM
- ◆ Progress on mainstreaming of AYUSH in CHCs. Six Ayurvedic and six Homeopathic centres are functioning with 60-70 OPD.
- ◆ Good coordination between ICDS and Health Dept. AWWs and MOs active in identifying Grade 3 malnourished children and providing supplementary diet. Screening and counselling of pregnant women carried out.
- ◆ Nutrition Rehabilitation centre C functional in Medical College and PGI.
- ◆ Procurement and logistics system operational with dedicated staff in place.
- ◆ Engagement of NGOs (Foundation for Developmental Research) and PGIMER for external monitoring and patient satisfaction surveys.

AREAS FOR IMPROVEMENT

- ◆ Increasing load in the facilities needs to be met with improvement in infrastructure and personnel. Closing the gaps through rationalization of existing work force, partnership with existing specialized institutions and private providers may be planned.
- ◆ The benefits of the JSY is to be extended to the underserved and other needy who do not have the BPL card.
- ◆ Training of AWWs as Link workers should be completed on priority. All 7 ASHA modules to be covered for the AWWs and an orientation of all programme management units should be planned.
- ◆ Community monitoring needs to be initiated for infusing accountability and effectiveness in programme implementation.
- ◆ Implementing PROMIS to strengthen procurement and logistics system may be considered.
- ◆ Under RNTCP, treatment success rate and default rate in re-treatment cases in the slum



CHANDIGARH

areas, especially in the migrant population should be monitored.

- ◆ Recruitment of staff for IDSP to be completed and capacity building of new staff to be planned. IDSP data needs to be used for epidemiological analysis for feeding into facility/area plans.
- ◆ Low financial utilisation of 25.43% under RCH Flexi Pool and 18% under Mission Flexi Pool indicates the need to strengthen financial management system. Tally ERP 9 needs to be procured and operationalised.

New OT in upgraded CHC Manimajra, Chandigarh



THE REVIEW TEAM

1. Dr. Sila Deb, Assistant Commissioner – Child Health, MoHFW, Govt. of India, New Delhi
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6. Mr. Anil Garg, Consultant Finance, FMG, MoHFW, Govt. of India, New Delhi
7. Dr. Anil Agarwal, UNICEF, Chhattisgarh
8. Mr. R. S. Sharma, JD-NVBDGP, MoHFW, Govt. of India, New Delhi

THE DISTRICTS/INSTITUTION VISITED

1. Raipur district: District Hospital, Raipur, Raipur, Tilda CHC, Kharora PHC, Kesla SC, District Health Office/NRHM Office, Champaran PHC, Navagaon SC, Hasda No. 2 SC
2. Surguja District: Hospital Ambikapur, Udaipur CHC, Batauli CHC, Sitapur CHC, Bishrampur CHC, Surajpur CHC, Bhaiyathan CHC, Salka PHC, Raghunathpur PHC, Batra PHC, Ajabnagar PHC, Dandgaon SHC, Kot SC, Sudamanagar SHC, Jaynagar SHC, Kevra SHC, Amgaon SHC, Tendupara AWW, Parpatia AWW

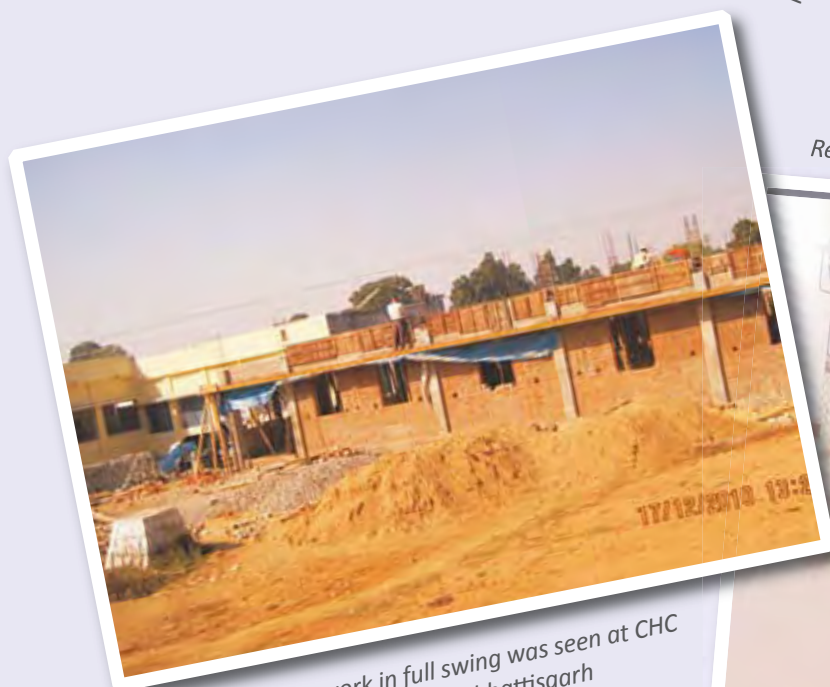
Referral transport for pregnant women at Sitapur CHC, Surguja, Chhattisgarh



Registration counter at upgraded D.H. Surguja, Chhattisgarh



New building work in full swing was seen at CHC Udaipur, Surguja, Chhattisgarh

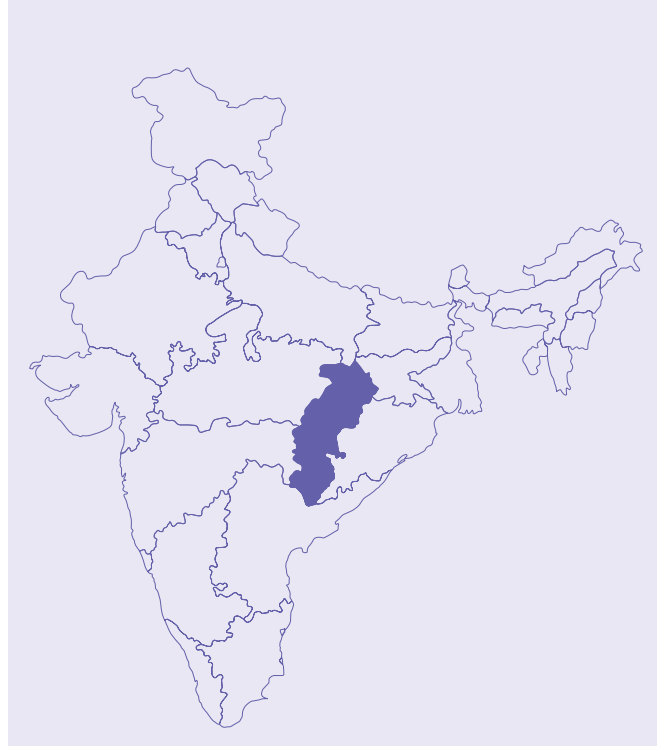


POSITIVES

- ◆ ANM and GNM training schools have increased from 3 to 38 in the last five years plus 25 MPW schools. The possibility of closing the nursing and MPW gaps is only now emerging.
- ◆ Graduates of three year Rural Medical Assistant course have been used to close gaps of second medical officer in PHCs and skills/knowledge/performance satisfactory. Chhattisgarh Rural Medical Corps and associated incentives increase retention of skilled professionals.
- ◆ Significant achievement in the training of Mitnins; undergoing 13th round of training comprising 36 days. 457 Mitnins admitted in ANM training schools and 31 in Nursing schools.
- ◆ There has been substantial increase in number of Nutritional Rehabilitation Centres within the last year. The state currently has 18 functional NRCs., one in each block.
- ◆ Jeevan Deep Samiti funds are being well utilized for providing free medicines, surgical aids to patients and improvements are visible.
- ◆ State is putting efforts to upload facility level data in the state's web portal for ensuring greater accountability. Facility wise progress is being monitored through the web-based reporting system. At most of the places monitoring is strengthening the health services.
- ◆ Infrastructure progress is improving – work completed on sanctioned civil works rose from 5.8% in 2008 to 64% in 2009-10
- ◆ Decentralized action through various community participation strategies like Mitnin programme, Swasth Panchayat initiatives, preparation of Village plans have considerably improved community's participation in the health services.
- ◆ Adequate and responsive referral transport system. Mahatari Express is available for pregnant women.

AREAS OF IMPROVEMENT

- ◆ There is a need to expedite the pace of trainings related to RCH such as SBA, IMNCI and multi-skilling. Clinical procedures and related supplies in labour room to be ensured to conduct safer deliveries.



CHHATTISGARH

- ◆ Placement of multi-skilled doctors in FRUs for managing complicated deliveries needs to be ensured. The training of the MOs in multi-skilling needs to be resumed and bottle-necks in certification and postings of those already trained needs to be overcome.
- ◆ State needs to get the second ANM and three nurses per PHC in place. Needs to modify service rules to be able to recruit available ANMs and nurses. (10th class in any stream as pre-nursing qualification, should be adequate). Need to sanction more regular nurse posts at all levels.
- ◆ Mitnin incentives to be streamlined.
- ◆ Infrastructure management cell/wing to be put in place, and expedite work further – 15% of civil works is yet to start.
- ◆ Facility-based child care needs to improve, New-born corners and NBSUs to be established at all facilities immediately.
- ◆ Vacancies in DPMUs and SPMU need to be filled urgently. PMUs needs to be appraised and rewards to be given timely. A transparent HR policy may be helpful to retain the contractual staff.
- ◆ User fee need to be reduced in terms of rate of services and should be for selected services only-if at all.

THE REVIEW TEAM

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3. Ms. Deepika Shrivastava, OSD, WCD and Nutrition, Planning Commission, New Delhi
4. Mr. Gautam Chakraborty, Advisor, Healthcare Financing, NHSRC, New Delhi
5. Mr. V. Ramesh Babu, USAID, Embassy of USA, New Delhi
6. Dr. Mona Gupta, PMSG, RCH-II, MoHFW, Govt. of India, New Delhi
7. Mr. Jayanta Kumar Mandal, Finance Analyst, FMG, NRHM division, MoHFW, Govt. of India, New Delhi

THE DISTRICTS/INSTITUTION VISITED

1. Gumla district: Bishunpur BPHC, Chhatarpur BPHC, Kishanpur APHC, Jairagi APHC, Nowdiha Chawkri Nadiain Manihatoli HSC, Palkot BPHC, Basia BPHC, Dumri BPHC.
2. Palamu district: Daltonganj DH & ANMTC, Patan BPHC, Chainpur BPHC, Chainpur MTC, Hussainabad BPHC, Nawdiha Bazar APHC, Hydernagar APHC.



Maternity ward at CHC Chainpur, Jharkhand



Shaiya (ASHA) Bhawan at CHC Chainpur, Palamu, Jharkhand

POSITIVES

- ◆ State has initiated engineering wing at state level which takes care of all infrastructure development-related work under NRHM. Many facilities now have new buildings with residence for staff and more are under construction. Number of facilities are coming up with new buildings.
- ◆ Large number of contractual staff put in place under NRHM: 457 MOs, 362 SNs, LT 332, 244 pharmacists and 4098 ANMs.
- ◆ Good Sahiyya Programme, completed 5 rounds of training, help desks and shelters established in CHCs and DHs. Good coordination with ANM and AWW.
- ◆ Trainings related to RCH under NRHM is showing improvement in performance and quality of the services.
- ◆ Considerable increase in the numbers of facilities conducting deliveries. Also, increase in bed occupancy rate has been observed. Patients' amenities are increased.
- ◆ Malnutrition treatment centres (MTCs) in PHCs are functional; food for children alongwith incentive for mothers as well as IYCF training are addressing the issue of malnutrition.
- ◆ Reporting of diseases under IDSP has been increased.
- ◆ Strong motivation, commitment and leadership at individual levels, vibrant and effective PMUs.
- ◆ State innovations are promising – e.g. Adolescent Week and Yuva Maitri Kendra, Family Friendly Week, Sahiyya Help Desks in DH/CHCs.

AREAS OF IMPROVEMENT

- ◆ Progress of infrastructure construction needs further improvement.
- ◆ A comprehensive HR policy to be developed to close HR gaps over the coming years.
- ◆ Strengthen hands-on training for the district and state level use of HMIS. Improve the use of HMIS for decision-making, and integrate hospital-based indicators.
- ◆ Inventory management needs strengthening – especially with regard to stock-outs and re-ordering.



JHARKHAND

Waste management system to be improved in facilities.

- ◆ Quality of ANC needs to be improved.
- ◆ Strengthen the existing mentoring and support network for Sahiyyas and there is need to enhance incentives for trainers at block and district level.
- ◆ Build up a strong management support function in the state-PMUs and include institutionalisation in next plan
- ◆ Expedite Concurrent Audit in the districts; Uploading of FMR in HMIS portal on regular basis should be done, by all the 24 Districts. Create a position of Director Finance at state level.

New born resuscitation unit at district hospital, Palamu



THE REVIEW TEAM

1. Mr. Amit Mohan Prasad, JS (P), MoHFW, Govt. of India, New Delhi
2. Dr. S. K. Sikdar, AC, Family Planning Division, MoHFW, Govt. of India New Delhi
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4. Ms. Sushma Rath, Principal Administrative Officer, NHSRC, Munirka, New Delhi
5. Dr. Ute Schumann, European Commission, 65, Golf Links, New Delhi
6. Dr. Ravi Kumar, Office of the Regional Director, NVBDCP, Bangalore, Karnataka
7. Ms. Kavita Narayan, Head, Hospital Services Unit, PHFI, Vasant Kunj, New Delhi
8. Mr. K.V. Hamza, General Secretary, Delhites' National Institute in Palliative Care, New Delhi
9. Ms. Nirmala Mishra, Consultant, NRHM, MoHFW, New Delhi
10. Dr. Sumegha Sharma, Consultant, NRHM, MoHFW, New Delhi

THE DISTRICTS/INSTITUTION VISITED

1. District Kozhikode: Govt W & C H Kozhikode, Institute of Pain and Palliative Care Kozhikode, The Child Development centre-IMHANS, IDSP Unit, Ernakulum DH, Aanganawadi AWC, Kinaloor Sub-centre, Balussery CHC, Perambra TH, Maruthonkara PHC, Kunnummel CHC, Choyimadam sub-centre, Thalakulathur CHC, Cherupa MCH unit, Kanniparamba sub-centre, Narikkuni CHC, Valiyaparamba sub-centre, Ernakulum district Floating Dispensary.
2. District Kottayam: District Hospital, Vaikkom TH, Arumootimangalam PHC, Thalayolaparambu CHC, Peruva PHC, Kozuvanal PHC, Maruvanthuruthu PHC, Kadanadu PHC, Karumannu sub-centre, Keezher sub-centre, Orekkal Village field visit, Orekkal sub-centre, Kezhuvamkullam sub-centre, Katti kunnu village facility.

Dr. G.I. Sapna, M.O. PHC Maruvanthurath with her team on a village visit



Happy mother and child at village Orekkal, Kerala



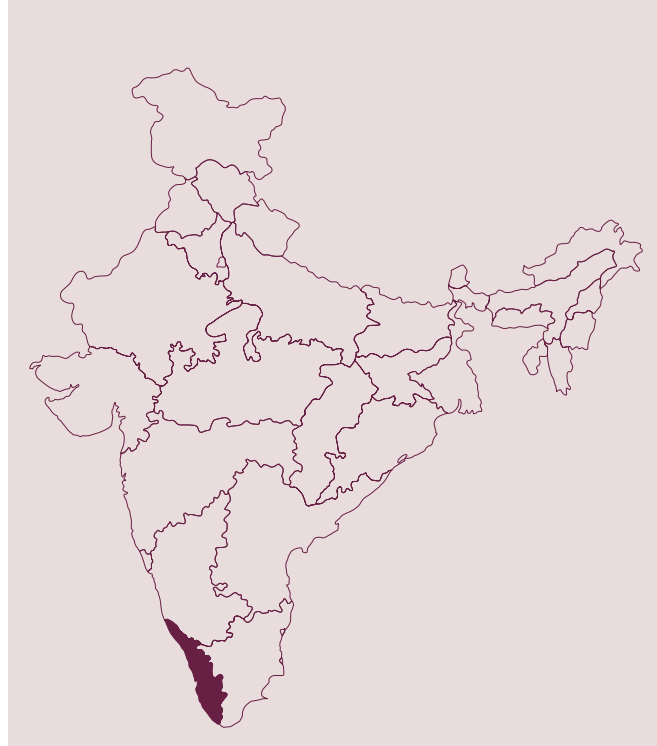
Interaction with people in village Orekkal, district Kottayam, Kerala

POSITIVES

- ◆ Public Health Infrastructure show near adequacy – only few SDH gaps remain.
- ◆ Human resource gaps in sanctioned posts are minimal, except for specialists in CHCs. The Compulsory Rural Service has ensured regular yearly supply of MBBS doctors in rural areas and one year internship for B. Sc nurses with two years post-training bond provided adequate nursing staff.
- ◆ ASHA programme is active and they spend 2-4 hrs a day and get an average honorarium of Rs. 350 per month.
- ◆ The Ward Health and Sanitation Committees (WHNDs) are active and integrated with ICDS and conduct household visits for source detection and chlorination. Village Health Plans were available in Kottayam. Awards and incentives being provided to Panchayat for cleanest PHC, Cleanest ward etc.
- ◆ The Palliative Care programme is set up in the medical colleges and 130 MOs are trained at WHO recognized resource centre for the same. A district model of pain and palliative care is being run at PHCs through volunteers. A district model for non-communicable diseases is also developed in pilot districts.
- ◆ OPD case load has increased due to evening OPD timings extended to 8 PM with adequate drug supply. However we note some of the institutional deliveries have shifted to private sector.
- ◆ MMUs are functional in 7 districts and floating dispensary (with IEC activity) is an innovative approach taken in Panchayats of Ernakulam and Alapuzha.
- ◆ RKS well functional, with minutes recorded, and there were additional sub-committees for palliative care or the Rapid Response Team.
- ◆ State plan fund provides Medical Care for Victims of Gender based violence/social abuses in selected institutions with an objective to provide counselling to victims.

AREAS OF IMPROVEMENT

- ◆ The doctor population ratio in the public health sector varies from 1:6252 in Pathanamthitta district to 1:11486 in Malappuram district. There is need to address this uneven development.



KERALA

- ◆ Institutional deliveries have declined in public facilities as a result of private facilities participation in JSY. Long term implications of this need to be understood, even as peripheral public health facilities are geared to provide safe and comfortable delivery services.
- ◆ Percentage of C-sections in the districts visited was nearly 65% (Kottayam) and 54% (Kozhikode) which is more than the state average of 48%. C-section audit to be considered. IEC/BCC needed to encourage women to opt for normal delivery.
- ◆ Monitoring and mentoring mechanisms for ASHAs and to design incentives for NCD programmes to make the programme more outcome-based.
- ◆ Sub-centres from which RCH work has been shifted away may be re-skilled as counselling and screening centres for lifestyle diseases and addressing alcoholism and related domestic violence
- ◆ Better reporting on IDSP, its integration into district health system and analysis of and use of reports needs to be strengthened.
- ◆ External evaluations for new interventions to optimize and scale up the strategy – in particular, palliative care, child development service and district-based non-communicable disease strategy.
- ◆ Systematic and consistent process in health services delivery is needed.

MADHYA PRADESH

THE REVIEW TEAM

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3. Ms. Yasmin Zaveri Roy, Senior Programme Manager, SIDA
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THE DISTRICTS/INSTITUTION VISITED

1. Damoh district: 1 DH (Damoh), 4 CHC (Tendukheda, Hatta, Jabera, Patheria); 3 PHC (Abhana, Sarra, Raneh); 7 SC (Taradehi, Raseelpur, Harduga, Battkhamariya, Kodakala, Gaisabad, Basa). Other: 5 NRCs, 1 ANM Training school; Regional HFW Training Centre; College of Nursing Indore. *Community interaction in 7 villages.*
2. Khargone district: 1 DH; 2 SDH (Sanawad and Barwah); 2 CHC (Mandleshwar, Segaon); 4 PHC (Padliya; Choli, Oon, Bamnala); 6 SC (Gaisabad, Basa, Dhargaon, Bablai, Kavdia, Dodwa, Lal Kheda, Ghugriya Khedi); 2 NRC; 4 VHSC; 1 MMU; 1 Leprosy Camp; 5 villages for community interactions.

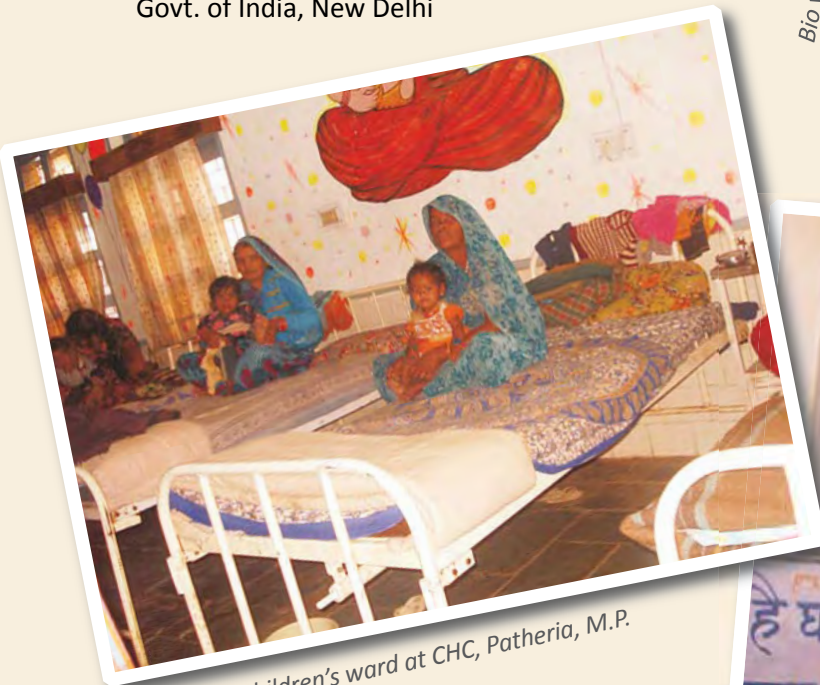
Bio waste management in place at PHC Sarra, Damoh, M.P.



Display of information for public at SHC, Raseelpur, M.P.

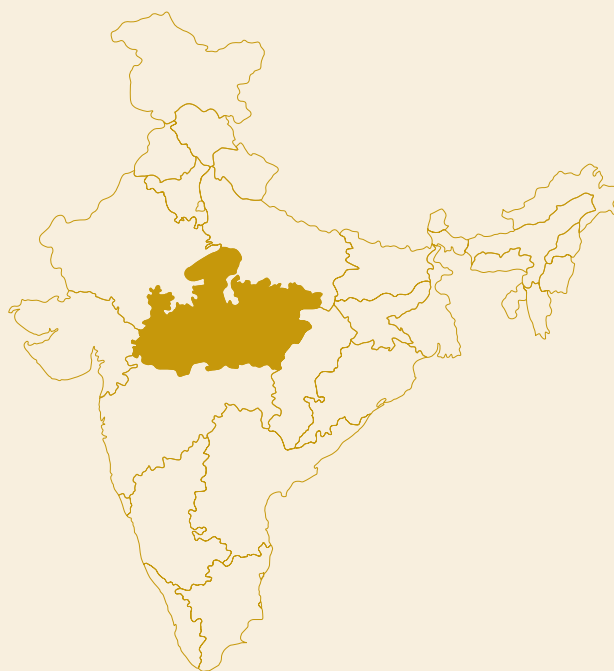


Children's ward at CHC, Patheria, M.P.



POSITIVES

- ◆ Infrastructure Development Wings established at state, division and district level. Good progress in constructions: 792 new constructions completed and another 717 in progress.
- ◆ Under NRHM, there has been an addition of 106 skilled workers in Khargone over a baseline of 864 and a similar addition in Damoh – an about 12% increase.
- ◆ Massive shortfall of all Health Sector providers being addressed by contractual staff (specialists, MOs, SNs, others like LHVs), extending retirement age to 65 years, extending recruitment pool to other states, differential remuneration for difficult areas for doctors and nurses have been initiated.
- ◆ Considerable expansion of nursing and medical education – there are now 81 ANM schools, 2 LHV schools and 112 GNM schools, 7 MPW schools, 31 post-basic BSc nursing colleges, 24 M.Sc. nursing colleges and 95 B.Sc. nursing schools in operation, as against a total of less than 15 at the start of NRHM.
- ◆ In-service training for health providers is ongoing and needs to be followed by refresher sessions and suitable postings. 4000 (ANMs+SN+LHV) women trained in SBA. 40 MOs given LSAS and 570 doctors trained in EmOC.
- ◆ Steadily increasing proportion of Institutional deliveries since 2005. (68000 in 2005 to 219,912 in 6 months of 2011). Increase also seen in the number of outpatients and inpatients.
- ◆ MMUs providing primary care as well as BCC/IEC and edutainment health messages in under-served areas.
- ◆ 50,113 ASHAs in place. 85% are trained up to 4th Module. 47000 ASHAs have drug kits issued to them. Active role confirmed by community. 47,080 VHSCs formed as of 2010.
- ◆ Excellent convergence between ASHA, ANM and AWW in conducting VHNDs.
- ◆ Janani Express – referral transport innovation, covers 530 vehicles in 303 blocks with 53 functional call centres. 54% Institutional delivery cases used Janani Express.
- ◆ Maternal death audits initiated this year. 162 community-based and 169 facility-based audits conducted.
- ◆ 230 NRCs established by 2010 from 8 in 2005. Cases of SAM treated in NRCs in 2010 (34000) exceeded target of 25,700. Bal Shakti Yojana to be



MADHYA PRADESH

launched combining facility and community-based management of malnutrition.

AREAS OF IMPROVEMENT

- ◆ Only 3000 second ANMs available at SC and PHCs. This 16% second ANMs should be rationalized for providing midwifery services. Similarly three nurses not sanctioned or deployed in most designated 24 X 7 PHCs.
- ◆ Critical HR gaps need to be addressed. 61% shortfall of specialists, over 50% of doctors at PHCs; 53% SN, 17-36% support staff like LTs, pharmacists etc.
- ◆ As institutional delivery rates rise, there should be better monitoring to ensure that complications are being monitored adequately.
- ◆ Need to address consistently declining male sterilizations from 2005 to 2010; female sterilization shows recent decline. Achievement in 2009-10 only 39% of target.
- ◆ ASHA programme requires to be strengthened, Needs regular training teams and supervisory mechanisms yet to be put in place, and expedite trainings for modules 5-7.
- ◆ PRI involvement in RKS/HMS sub-optimal. Perception of RKS is as a fund-generation mechanism, not used for improving public participation or quality of care. Poor utilization of RKS funds persists.

MAHARASHTRA

THE REVIEW TEAM

1. Shri P. A. Sawant, MoHFW, Govt. of India, New Delhi
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4. Dr. V. K. Manchanda, World Bank
5. Dr. Subrato K. Mondal, PFI, New Delhi
6. Dr. Abhay Shukla, NRHM Advisory Group for Community Action
7. Dr. Santhosh S., Public Health Expert
8. Dr. Pushkar Kumar, MoHFW, Govt. of India, New Delhi
9. Dr Salima Bhatia, Consultant, MoHFW, Govt. of India, New Delhi

THE DISTRICT/INSTITUTIONS VISITED

1. Kolhapur District: HFWTC, Public Health Lab, 2 District Hospitals, District TB Centre, 2 Sub District Hospitals, 2 Regional Hospitals, 5 PHCs, 2SC, 1 Anganwadi Centre.
 2. Gondia District: 3 District Hospitals, 1 Sub District Hospital, 3 Regional Hospitals, 6 PHCs, 2 SC, 1 Anganwadi Centre.
- Also Nagpur HFWTC, Public Health Laboratory, Women's Hospital.

Lakshmi Aali Ghari scheme for protection and promotion of Girl Child, Kolhapur, Maharashtra



Labour room at D.H. Satara, Maharashtra



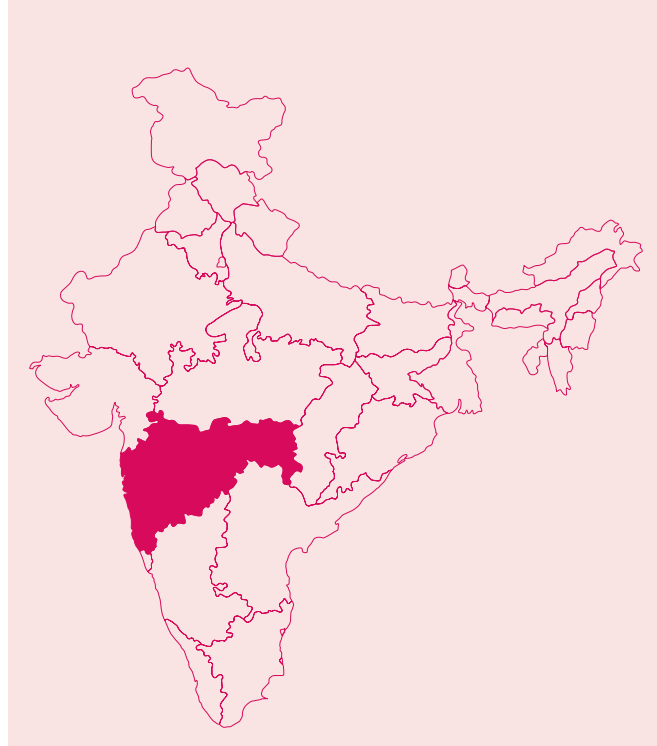
Outreach services, women gathered with their babies for immunization at a VHND, Maharashtra

POSITIVES

- ◆ Significant contribution to infrastructure improvement with new PHCs and sub-centres, labs, OPDs and wards construction. Infrastructure Development Wing functioning well.
- ◆ Initiatives taken up to improve availability of specialists like seats for PG for MOs in service, withdrawing specialists deputed to Medical Colleges and ensuring hardship allowance for serving rural areas. Efforts to be taken to sustain skills of EMOC trained doctors where C-sections had not started up – through elective C-section opportunities.
- ◆ ASHAs have completed 5 training modules in tribal districts and 2 modules in non-tribal districts, Development of supplementary training modules involving NGOs, Sathi/Cehat.
- ◆ Village Health and Sanitation committees have been set up and are functioning satisfactorily in the state.
- ◆ Well established Eye Care surveillance and good quality Dental Care services are also available at designated facilities.
- ◆ OP, IP, immunization, institutional delivery, Family Planning, reduction in DOTS defaulters are activities showing positive trends.
- ◆ AYUSH doctors are employed at facilities from DH to PHC levels.
- ◆ Maher scheme to promote institutional delivery is working well in tribal areas.
- ◆ Good 1056 system for referral transport is present in tribal district (Gadchiroli).
- ◆ Currently Community-based monitoring is being implemented in five districts, encompassing 23 blocks and 510 villages.

AREAS FOR IMPROVEMENT

- ◆ Issues like lack of supportive staff for Engineers in the Infrastructure wing needs to be addressed to ensure that the momentum is maintained.
- ◆ Infrastructure planning/location needs to be linked, village micro planning/tagging of hard to reach areas with more rationalization
- ◆ District Hospitals that have been converted into Medical Colleges have not been integrated into NRHM.



MAHARASHTRA

- ◆ There is need for a good HR Policy especially for contractual appointments. Clearly defined TORs are also a must.
- ◆ Training on use of partographs and other key skills was not a part of the SBA training, this serious issue needs attention. Training plans for all skill-based training needs to be developed for every district.
- ◆ Strengthening of state Procurement System through formation of an autonomous body and transparent procurement. Enhanced financial allocations for medicines, may be considered to improve availability of medicines.
- ◆ In Family Planning activities have to be streamlined in accordance with latest policy directives from the Government of India, especially with regard to post partum sterilizations.
- ◆ Greater focus on neonatal health at the facility and community levels is the need of the hour.
- ◆ Financial Management capacity of facilities to use untied funds needs to be strengthened. Grievance redressal mechanisms needed.
- ◆ State is advised to make appropriate proposals of AYUSH for obtaining funds from the Department of AYUSH and appropriate training to be given to AYUSH doctors in emergency medicine at large number of co-located AYUSH facilities.

THE REVIEW TEAM

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4. Dr. Dhananjay Gupta, Health Specialist, UNICEF, 73, Lodhi Estate, New Delhi
5. Dr. Narendra Gupta, Secretary, PRAYAS, Chittorgarh, Rajasthan
6. Ms. Neidono Angami, Convenor & Ex-President, Naga Mothers' Association, Kohima, Nagaland
7. Mr. Sanjeev Gupta, Finance Controller, (NRHM-Fin), MoHFW, Govt. of India, New Delhi
8. Ms. Preety Rajbangshi, Consultant, RCH (DC), MoHFW, Govt. of India, New Delhi

THE DISTRICTS/INSTITUTION VISITED

1. Zunheboto District: District Hospital, Zunheboto, Aghunato CHC, Satakha, Block PHC, Akuluto and Poghoboto, PHCs, Sukahlu, Asukhomi, Lumani, Shitsumi, SC.
2. Mokokchung District: Changtongya and Mangkolemba, CHCs Mongsenyimti, Longjang, Sabangya PHCs, Kumlong, Dibua, Mopongchukit and Yaongyimsen SCs.
3. Wokha District: District Hospital, Chukaitong PHC, Longsachung SC

*Mopungchuket sub-centre,
Mokokchung, Nagaland*



Well maintained labour room in Mokokchung D.H., Nagaland



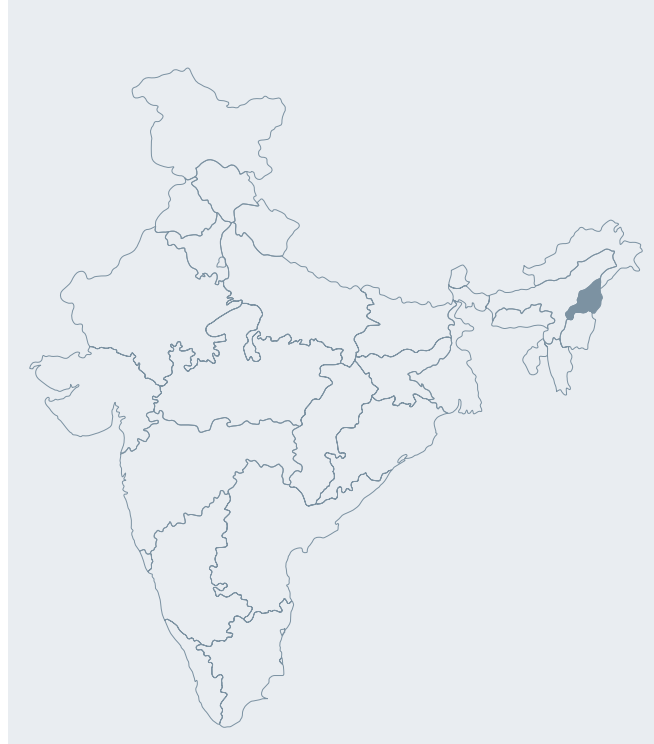
Baby warmer at Mokokchung D.H., Nagaland

POSITIVES

- ◆ Health Institutions show high degree of sanitation, cleanliness and well maintained.
- ◆ Committed and motivated staff even when they were posted at facilities located at remote locations.
- ◆ Sanctioned civil works have been completed -for 56% facilities. State has filled 68% positions of skilled health providers (including specialists).
- ◆ AYUSH providers available in most of the PHCs and CHCs.
- ◆ Vibrant ASHA programme. ASHAs trained till Module 5. Block Coordinators appointed in 48 blocks for mentoring the ASHAs. Training on 6th and 7th module completed for District/Block trainers. Translated into 3 local languages. ASHA radio, diary and kits provided to all ASHAs. Electronic payment to ASHAs done in most districts.
- ◆ Strong communitization in the form of active participation of Village Health Committees and Village Management Committees. Contribution from civil society/community for building of health facilities, donations, materials for health facilities.
- ◆ Prompt and transparent payment of JSY. List of beneficiaries displayed in facilities.
- ◆ Early and exclusive breastfeeding was observed widely in the field.
- ◆ Tally ERP 9 operationalised; concurrent audit carried out; e-transfer of funds from state to district and periphery facilities. Time completion of statutory audit for 2009-10.

AREAS OF IMPROVEMENT

- ◆ Despite increase in numbers of facilities, full functionality still an issue, especially bed occupancy rates, blood bank at DH and blood storage at FRUs, and availability of specialists/multi-skilled Medical Officers.
- ◆ Newborn care yet to start up. Equipment should be quickly installed and staff trained.
- ◆ Several sub-centres do not have government building. Pace of construction and renovation needs to be improved.



NAGALAND

- ◆ Lack of referral transport system affects access to health services. Free referral transport from habitat to health facilities is needed.
- ◆ Stay arrangements for ASHAs in the health facilities need to be set up. The ASHA support mechanism needs to be put in place at the earliest.
- ◆ Training programmes should be planned for Village health committees for engaging them in village health planning, community mobilization and monitoring.
- ◆ Bio-medical waste management system needs to be operationalised. Training of providers should be planned.
- ◆ Irrational drug supply, stock-outs are an issue. EDL needs to be followed along with the strengthening of supply chain management.
- ◆ Micro-planning for immunization needs to be strengthened. Alternative Vaccine Delivery mechanism needs to be explored for improving access.
- ◆ The concept of district planning, allocation of resources needs to be imbibed by the authorities. Capacity-building on district plan for district level managerial would be useful.
- ◆ Vacant positions of District Accounts Managers needs to be filled at the earliest.

THE REVIEW TEAM

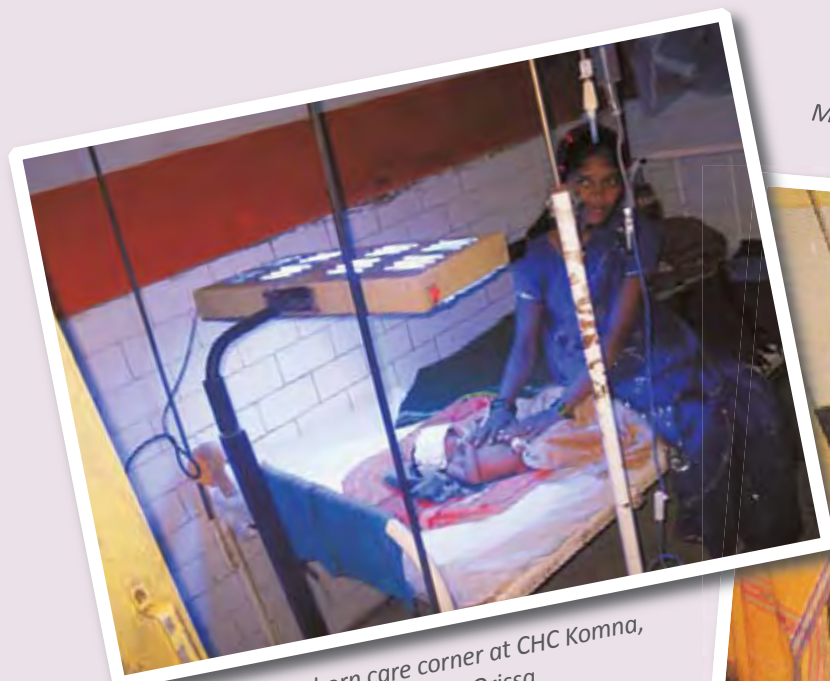
1. Dr. Sajjan Singh Yadav, Director NRHM, Govt. of India, New Delhi
2. Dr. Pradeep Halder, Assistant Commissioner, Immunization, Govt. of India, New Delhi
3. Dr. J. N. Sahay, Advisor, Quality Improvement, NHSRC, New Delhi
4. Prof. Dr. M. Bhattacharya, HOD Public Health, NIHF, Govt. of India, New Delhi
5. Dr. Shyama Nagarajan, Health Specialist, The World Bank.
6. Dr. Sanjay Pandey Chief of Party, Population Foundation of India
7. Deepak Techchandani, Financial Management Group, NRHM, Govt. of India, New Delhi
8. Hena Chakrabarty, Consultant, Planning & Policy Division, NRHM, Govt. of India, New Delhi

THE DISTRICTS/INSTITUTIONS VISITED

1. Gajapati district: 1 DHH (Paralakhemundi); 4 CHC (Kasinagar, Gurandi, Raygada, Chandragiri); 4 PHC(N) (Hadubhangi, Garabandha, Ramagiri, G Udaygiri); 4 SC (Haripur, Narayanapur, Uppalada, Machamara); Other (MHU Point, Didinguda, Maternity Waiting Home R. Udayagiri).
2. Nuapada District: 1 DHC (Nuapda); 5 CHC (Khariar Road, Komna, Kharia, Bhella, Boden); 3 PHC-N (Biomal, Tarbod, Domjhar), 10 SC (Parkod, Samarsing, Tarbod, Bhojpur, Bhulia. Sikuan, Nagpada, Khudpet, Bhainsadani, Sorbong).

Pathology rate chart displayed at PHC Domjhar, Orissa

ROGI KALYAN SAMITI P.H.C (NEW) DOMJIHAR		
PATHOLOGY RATE CHART		
Sl.No	Test	Rate
1	Hb	
2	DC	Rs. 10/-
3	TLC	Rs. 10/-
4	ESR	Rs. 10/-
5	Blood Grouping & RH Typing	Rs. 10/-
6	BT & CT	Rs. 20/-
7	Blood Sugar	Rs. 15/-
8	ICT (Malaria)	Rs. 40/-
9	Urine Pregnancy Test	Rs. 60/-
10	Urine Routine & Microscopic	Rs. 40/-
11	Bile Salt & Bile Pigment	Rs. 20/-
12	Widal	Rs. 20/-
13	HBs Ag	Rs. 30/-
		Rs. 60/-



A new born care corner at CHC Komna, Nuapada, Orissa



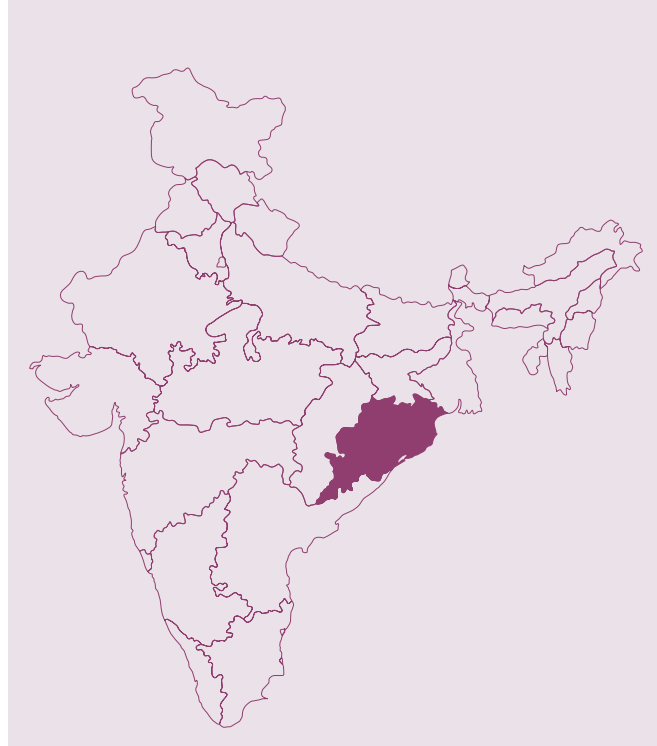
Mothers with their babies having drip were found on floor due to shortage of beds at CHC Khariar, Nuapada, Orissa

POSITIVES

- ◆ Remarkable gains in health indicators: 55 point decline in MMR since 2003; 9 point decline in IMR in 4 years, TFR target (2.1) already attained. Similar trend in disease control programmes (1.2% fall in API and static rate at elimination level for leprosy). Equity-driven approach aligned with spirit of NRHM – priority to under-served areas, special focus on tribals (year-round school health program).
- ◆ Enthusiastic community response to NRHM: increased service utilization, 19.5 lakh JSY beneficiaries, 45% Institutional deliveries, 1.6 lakh malnourished children treated.
- ◆ HR shortfall (only 30% doctors, 28% nurses are in place) addressed by:
 - fast-track recruitment of contractual personnel.
 - differential remuneration and incentives.
 - Increase in sanctioned posts.
 - Multiskill training for all cadres.
 - Rational post-training deployment.
- ◆ Major expansion in nursing education – 16 govt. and 35 private ANM schools, 5 public and 40 private GNM schools. And 13 nursing colleges opening up. Availability of nurses for public sector much less of a problem now with about 2600 annual output.
- ◆ 98.5% ASHA posts are already filled. All have received training on modules 1 to 5. Highly motivated and effective workforce with visible effect on community mobilization. Convergence with AWW and ANM, active role acknowledged by all. Most VHNDs are attended by ASHAs.
- ◆ Community ownership shows encouraging trend: Utilization of Corpus grant to RKS/HMS reported to be “good”. RKS recruit doctors locally with own funds, and also pay for outsourced support services like sanitation etc. 45,000 functioning GKS. 22 PHCs in 13 districts being managed by NGOs.
- ◆ SCs design changes to twin residential quarters to ensure round-the-clock ANM availability.

AREAS FOR IMPROVEMENT

- ◆ State level Infrastructure Development Wing is urgent necessity: 3 District HQ Hospitals haven't been built despite approval in 2008-09. Ongoing improvement in infrastructure – new constructions



ORISSA

and renovations have led to operationalization of 14 SNCUs, 261 24x7 facilities, 264 New Born Corners, 96 FRUs, and construction of 296 SCs, but this is still short of requirements. Design of buildings needs to conform to medical requirements. Need for a well planned strategic initiative.

- ◆ Coverage of fully immunized children has decreased – 62% (DLHS-3 2007-08) to 59% in 2009 (CES). Areas of concern.
- ◆ State has initiated only 2 additional ANM schools in public sector but refurbished 16 old ones. Reliance on only private schools expansion for nursing could be a problem. Seats for incoming students in pre existing institutes have been increased by 18 and 24% (GNM and ANM respectively) without a concomitant increase in faculty strength. Also a need for faculty development programmes.
- ◆ Need to increase sanctioned posts – especially for staff nurses and medical officers. Need to put in place comprehensive strategy to attract and retain skilled professionals in rural areas as part of HR plan.
- ◆ Most of the gaps observed are related to managerial skills and quality issues. Capacity building with supervision and refresher sessions would be useful in resolving issues such as lack of conceptual clarity, M&E, documentation, problem-solving, quality issues, financial and program management.

THE REVIEW TEAM

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7. Ms. Divya Shree, Consultant, NRHM, Govt. of India, New Delhi

THE DISTRICTS/INSTITUTION VISITED

1. Jalandhar district: District Hospital Jalandhar, Sub Divisional Hospital, Nakodar, Bakoli Mini PHC, Kalabakra, Adampur, Kartarpur CHCs, Kingra and Fatehjalal SCs, Subsidiary Health Centre, Ladhra, Kalbakra
2. Muktsar district: District Hospital, Muktsar, Sub Divisional Hospital, Malout, Sarawan bodhla and Chak Shere Wala CHCs, Thandewali and Kanianwala PHCs, Burjsidhwan, Tamkot, Sarainaga SCs, Subsidiary Health Centres, Kanianwala and Bhangewala, NSV camp, Thandewala, 3 AWCs in BHangewala

Upgraded O.T. at Sub Divisional Hospital, Nakodar, Punjab



Waiting area at CHC Sarawan bodhla, Muktsar District, Punjab



Female Ward at DH Muktsar, Punjab

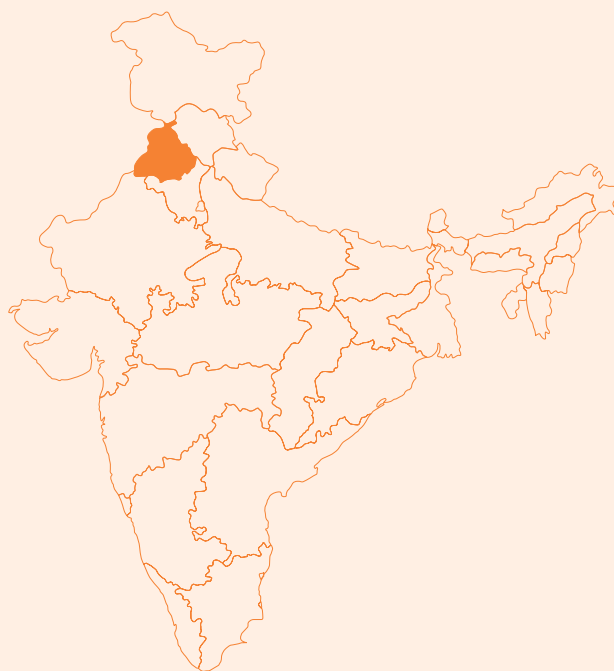


POSITIVES

- ◆ All infrastructure gaps would be closed by 2011. Excellent institutional arrangements for infrastructure development.
- ◆ 25 CHCs upgraded to FRU alongwith 21 DHs and 35 SDHs another 114 CHCs are selected for upgradation. Adequate density of FRUs in most districts. 56% of total PHCs functioning as 24x7 basis; adequate density of institutional delivery sites in many districts. Good volume and range of services in most public facilities.
- ◆ Considerable improvement quality of services delivered at facilities: clean facilities with lab services; laundry services adequately managed, good signages and display of Citizen's charter, privacy for women assured.
- ◆ Good progress on filling in contractual staff positions: 91 doctors, 45 paramedics, 1099 staff nurses, 44 specialists & 1856 contractual ANMs recruited.
- ◆ Bio-medical waste management system in place and practices followed in facilities.
- ◆ AYUSH collocation carried out effectively; increase in OPD substantially.
- ◆ 17229 ASHAs selected of which 81% trained up to 4th module; 14500 ASHAs provided with drug kits.
- ◆ 970 sub-centres, out of the total 2950 SCs in the state, are functioning with 2nd ANMs.
- ◆ VHSCs in all villages.
- ◆ Well established HMIS with mobile connectivity and fair amount of block and facility level use of data.

AREAS FOR IMPROVEMENT

- ◆ High home delivery rates, despite good access to facilities indicates need to consider exclusion due to social or financial barriers.
- ◆ Facility-based child care in terms of training and facility-based development needs to be operationalised.
- ◆ Management of complications in both pregnancy and newborn in public facilities weak, except in DH. Specialists' concentration needed at DH for effective management of large load of complications.
- ◆ Assured referral transport services need to be put in place.



PUNJAB

- ◆ High out-of pocket expenditure at the public hospital by NSSO rural 9774 – urban – 10323, pvt hospital 13,044, confirmed at facility visit. Over Rs. 25 crores of user fees mobilized per year. Scope for full exemption of user fees and providing untied grants for facility level expenditures. Cashless services at public health facilities should be aimed for, in view of one thirds of population getting excluded from qualified public or private care.
- ◆ Provision of diet and security in the facilities needs to be ensured.
- ◆ Training of ASHAs on 6th h module should done on priority in order to equip them with skills of home based care and management of childhood illnesses.
- ◆ Progress on training of all other cadre is slow. Processes for community monitoring needs to be established.
- ◆ IDSP should be used for district level public health response to disease and for this capacity building and protocols needs to be put in place.
- ◆ Flow of resources to the district should be as projected in plan and not on line item basis. Facilities with greater volume and range of services would need more funds, especially if they cut back on user fees as recommended. Over all absorption of funds weak largely as a result of poor guidelines and low areas of expenditure affecting the overall performance.

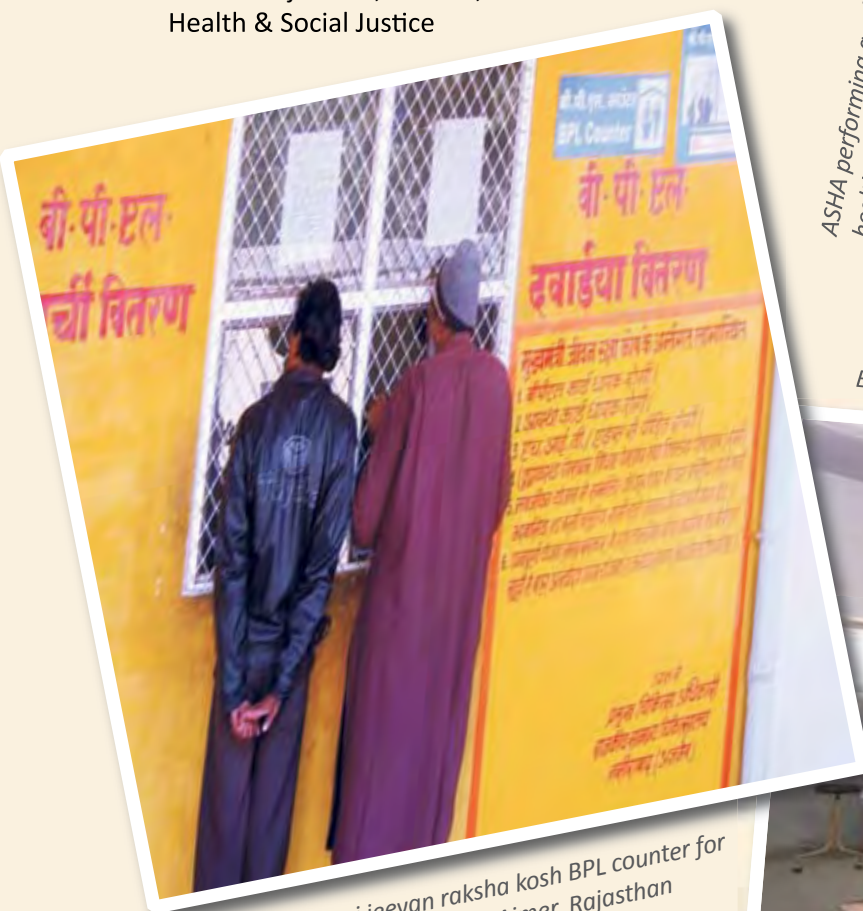
RAJASTHAN

THE REVIEW TEAM

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4. Dr. Preeti Kumar, Associate Professor & Project Director, HIV/AIDS Project, PHFI
5. Dr. J.N. Srivastava, Sr. Consultant – QI, NHSRC, New Delhi
6. Ms. Shifali Parmar, Finance Assistant, NRHM-Finance Division, MoHFW, Govt. of India, New Delhi
7. Dr. Amitrajit Saha, Advisor, Centre for Health & Social Justice

THE DISTRICTS/INSTITUTIONS VISITED

1. Pali district: Gurha Padamsingh AWC, Musaliya sub-centre, Falna sub-centre, Kotbaliyan sub-centre, Khemara sub-centre, Koselao PHC, Nana PHC, Chopra Referral Hospital/ Bali CHC, Pali DH.
2. Ajmer district: Village Jajota VHSC, Jajota sub-centre, Rasulpura sub-centre, Kesherpura sub-centre, Lamana sub-centre, Saradhna PHC, Srinagar PHC, Sarana PHC, Bijaynagar CHC, Nagphani Urban RCH Centre, Ajmer Satellite Hospital, Beawar District Hospital, Nasirabad Sub-divisional Hospital, Ajmer Jawaharlal Medical College, SMS Medical College Jaipur.



Mukhya mantri jeevan raksha kosh BPL counter for dispensing medicines, Ajmer, Rajasthan

ASHA performing a role play on women's health, Shrinagar PHC, Ajmer, Rajasthan

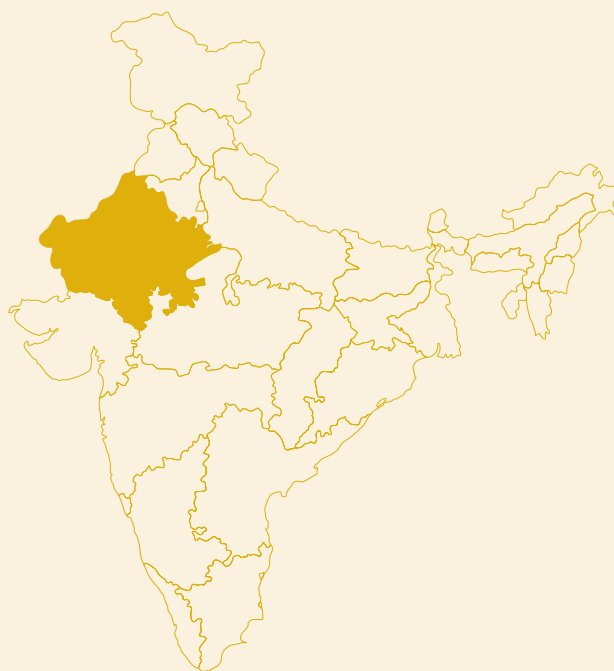


Eye OT at Bijainagar upgraded FRU, Ajmer, Rajasthan



POSITIVES

- ◆ An important shift observed in JSY case load from secondary levels to the primary.
- ◆ Hospital development committees functional across all facilities, visible stakeholders participation with fair understanding of functions, roles and responsibilities. Facilities are clean, with adequate privacy arrangements. There were functional newborn corners and quality of care for institutional delivery was also improving.
- ◆ NRHM has added 136 medical officers, 668 paramedical staff, 10694 nursing staff and 1469 Ayush staff, 31 district programme managers,– and still there are large vacancies in planned posts under NRHM- 73% in medical officers, 49% paramedical staff, 5% in nurses, 30% in AYUSH, 31% district programme management staff and 18% at block level.
- ◆ Expansion of nursing institutions – there are now 32 ANM schools and 15 GNM schools and govt. BSc nursing school in govt sector with ten times as much private GNM schools and 68 B.Sc nursing schools.
- ◆ Jan Aushadhi Kendra – the novel scheme of promoting generic medicines present in most facilities. 80% of the sanctioned posts on contract basis for AYUSH doctors, and nursing staff is filled adding substantially to seal the HR gaps.
- ◆ Financial Management systems much better functional. Quarterly return formats, 100% filled till district level. Electronic fund transfer system is used for fund disbursement and Tally 9 is in use till district level.
- ◆ Multiple malnutrition containment measures visible in field: good system for tracking malnutrition among the children registered in its AWCs, MTC functional, Swasthya Chetna Yatras organized. Nutritional schemes – Kalevo, Desi Ghee scheme functional.
- ◆ IDSP well functional: 8 labs for outbreak detection, 88.63% major hospitals enrolled, 5 reputed major private hospitals are sharing weekly surveillance reports, Toll free no. 1075 is accessed by all districts and is used by the community in reporting of any outbreaks.
- ◆ Rate of facility-based child health expanding far too slowly.



RAJASTHAN

AREAS OF IMPROVEMENT

- ◆ Second ANM has not been planned for. And outreach services especially antenatal care and immunization being one of the lowest rates and problems in geographic access.
- ◆ Major gaps in finding staff even under NRHM contractual positions because of reluctance to work in difficult areas. Needs to be addressed by mix of measures for attraction and retention of skilled professionals, which Rajasthan has been slow to introduce.
- ◆ The district and village planning still continues to be template-based despite huge amount of information available. Budget allocation to district not as per PIP
- ◆ The equity issue is still eluding the Health System inspite of several schemes- percentage utilization by BPL is consistently very low at different levels and across different schemes. High user fees
- ◆ A huge pool of malnourished children (Grade II and III) found on examining records of well maintained GM at AWC while the MTC (now renamed NRC) remains vacant. Needs to improve management of SAM.
- ◆ Despite 108, assured referral transport for emergency obstetric care and newborn emergencies remains a challenge and needs to be addressed in most blocks.

THE REVIEW TEAM

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3. Prof. J.K. Das, NIHFW, Govt. of India, New Delhi
4. Dr. Hemant Sharma, NRHM, Govt. of India, New Delhi
5. Dr. Ashoke Roy, Advisor, Public Health, RRC – NE, Guwahati
6. Dr. Rattan Chand, CD (Stats), MoHFW, Govt. of India, New Delhi
7. Mr. Sunil Nandraj, WHO
8. Dr. Thelma Narayan, SOCHARA, Bangaluru, Karnataka
9. Dr. Rachana Parikh, Consultant, MoHFW, Govt. of India, New Delhi

THE DISTRICTS/INSTITUTIONS VISITED

1. Virudhunagar District: Hospital Virudhunagar, Taluka Hospital-Arupakottai, CHCs-Kunnur, Pandalkudi, PHCs Kottaiyur W. Pudupatti, Kilavikulam, Mallanginar, Naranapuram, HSCs-Ramachandrapuram, Ayyanarediapatti, Valayamgulum, Senkettai, Moolipatti, E. Pudupatti, Sukravarampatti, Anuppankulum, Sankaralingapuram and Muthuliyapuram.
2. Tiruchirapalli District: Nandivaram UPHC, Kanjivaram District Kulmani CHC, Community Hall Possampatty Village, Kodiyalam HSC, Chetiapatti Additional PHC, Sengatupatti Additional PHC, Sikkathambur AWC, Kannanur Additional PHC, Kalyampatti AWC, Pagalawadi HSC, Venkatachalapuram SHC, Uppiliyapuram, UPHC, Top Sengattupatty PHC, Puthur SHC, Pulivalam PHC, Mannachanallur Govt. Hospital, Oolaiyyur SHC, Oolaiyyur, AWC, Kattur APHC, Sagyamatha ANMTC (PVT.), Periyampuram Hamlet and Kandiratheertham Village.



SNCU at Taluka Hospital Arupakottai, Virudhunagar District, TN

108 EMRI in action, Virudhunagar, TN

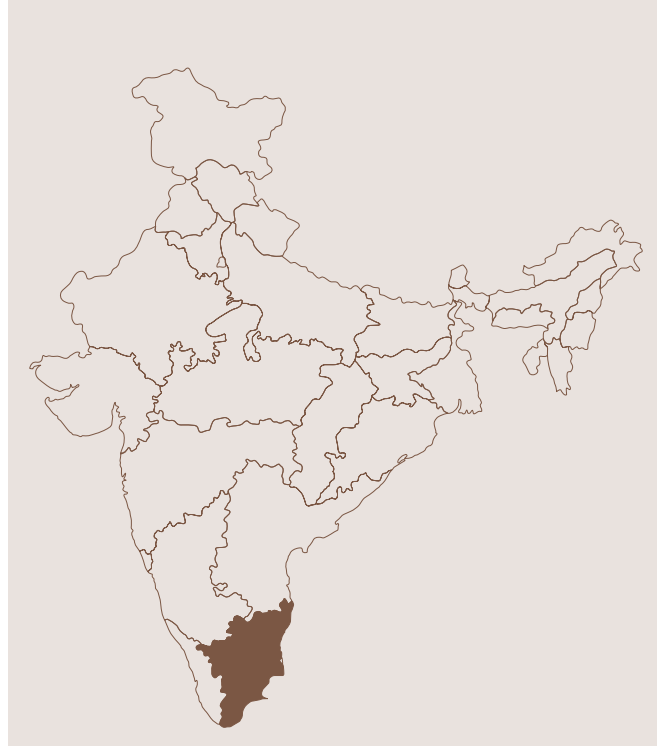


ANM using computers to maintain records at SCE. Pudupatti, under PHC M. Pudupatti, Virudhunagar District, TN



POSITIVES

- ◆ Pre-appointment counselling ensures availability of employee and reliance is on increasing regular rather than contractual appointments.
- ◆ Adequate number of FRUs achieved and SNCUs functional in two places in each district.
- ◆ The health facilities have been strengthened and quality certified with ISO certification to many of the facilities and NABH accreditation for few facilities.
- ◆ Infrastructure gaps are almost closed – at least adequate for basic services to be delivered. For example in Tiruchi district, the infrastructure development of 12/14 block PHCs to CHCs have been completed.
- ◆ Implantation of mechanised laundry is in process of being operationalised in the Taluka Hospital. However, basic infrastructure facilities have still to be improved in facilities visited in Virudhunagar district like availability of water, sanitation and landscaping, security, encroachments etc.
- ◆ Most of the equipment, mainly in the HSCs like Labour table and associated instruments were found to be lying unutilised. Instances of equipment like dental chairs, treadmill, generator set, etc., lying unutilised at Health Facilities were observed.
- ◆ Commitment of MOs/staff at health facilities are high and one interesting policy on HR in the state is AWW are eligible for ANM training.
- ◆ Certain state schemes are supported by NRHM support for eg. correction of refractive errors; Dental treatment, cardiac surgeries etc.
- ◆ Increase in incidence of Dengue has to be addressed with measures for vector control, especially mosquitoes.
- ◆ Male participation in FP needs improvement.
- ◆ HMIS system reporting is regular, however, the use of information is limited.
- ◆ Electronic fund transfers are upto district level. However, certain areas like Financial Management has been weak and needs monitoring and supervision mainly in the areas of utilization of innovative funds.
- ◆ JSY payments were made on time.



TAMIL NADU

AREAS OF IMPROVEMENT

- ◆ Facilities in the state need improvement in infection control and clean environment including bio-medical waste management.
- ◆ Residential accommodation, duty room for night duty staff for 24X7 facilities and security.
- ◆ MPW (male) vacancies to be filled.
- ◆ Existing Immunization policy needs to be reviewed in view of drop in total immunization
- ◆ Provision of Accountants at the facilities may help in financial management reform and in book keeping – computer savvy commerce graduate may also help in data management.
- ◆ ASHA scheme and community action for health needs to be expanded. Provision of ASHAs in NRHM may be utilized for community empowerment.
- ◆ Payment of RCH Sanitary worker, Trained Dias may be reviewed.
- ◆ Though IEC activities are quite visible in the district, however son preference dominates, which needs more counselling for gender equality.
- ◆ Special efforts may be made to step-up health promotion for non-communicable & life style diseases.

UTTARAKHAND

THE REVIEW TEAM

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3. Dr. Paul Francis, NPO FCH, World Health Organization Country Office
4. Dr. Vandana Prasad, National Convener, Public Health Resource Network, Delhi
5. Ms. Vijayluxmi Bose, Specialist in Health Communication, PHFI
6. Dr. Anuradha Jain, Senior Consultant, PHP, NHR
7. Mrs. Sulekha Kulashari, Consultant, (FMG), NRHM
8. Dr. Amar Ramdas Nawkar, Consultant, NRHM

THE DISTRICTS/INSTITUTIONS VISITED

1. District Chamoli: Lungsi sub-centre, -Mayapur AWC, Pipalkoti APHC, Chamoli BPHC, Garsain CHC, JoshimathCHC, Karnprayag CHC, Gopeshwar DH.
2. District Uttarkashi: - Mansiyari Saur sub-centre, Harshil sub-centre, Judi Dunka VHND, Dunda BPHC, Bhatwari BPHC, Purola CHC, Naugaon CHC, Chinayali Saur CHC, Uttarkashi DH.

SOP and protocol near new born corner at CHC Purola – paediatrician is present at the CHC



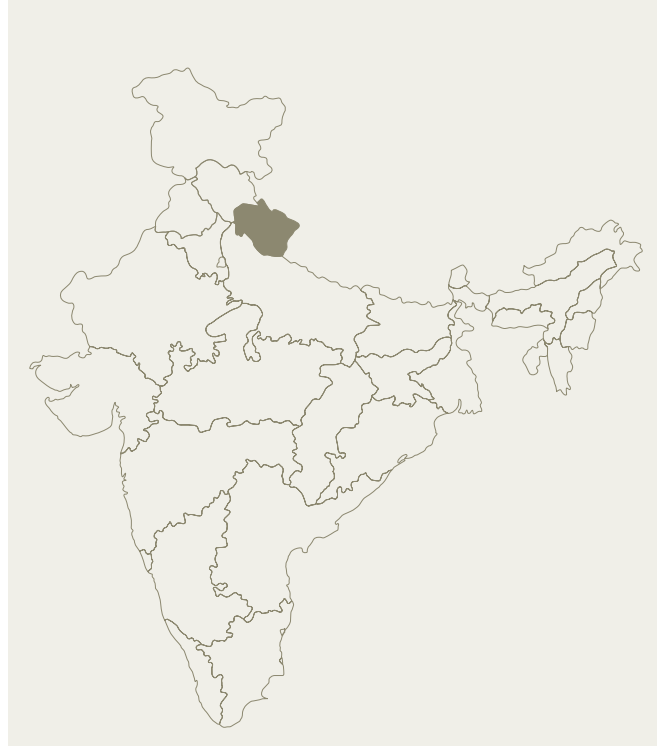
Excess stock of anaesthesia drugs was seen at Naugaon BPHC, Uttarakhand

POSITIVES

- ◆ Multi-skilled doctors trained in EMOC and LSAS are functional.
- ◆ ASHA training well on schedule and 6th module training has started and is doing well in districts esp Chamoli, though more inputs may be required in Uttarkashi.
- ◆ JSY payments made in time.
- ◆ 80/100 new MBBS who will be graduating from Govt Medical College, Srinagar have signed bond with government to serve in remote areas thus adding to HR pool.
- ◆ Laboratories of DH and BPHCs are functional and performing a range of test.
- ◆ RKS was in place in most of the facilities.
- ◆ School Health Programme through dedicated teams was functional in government schools.

AREAS OF IMPROVEMENT

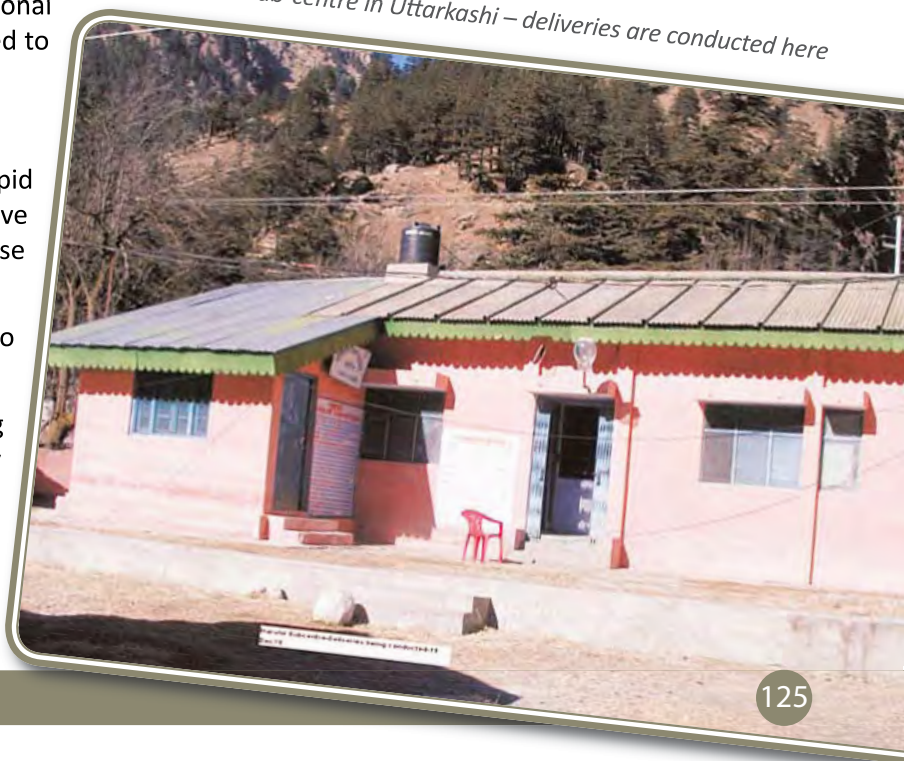
- ◆ Take home rations for children below 3 in Angawadis needs to start up.
- ◆ Need HR plan that would specify ways to increase recruitment of permanent staff, as well as rational, gender-sensitive and supportive policies to retain contractual staff.
- ◆ Infrastructure gaps at sub- centre level and staff quarters need to be closed. An institutional arrangement at state level would be needed to expedite this.
- ◆ Develop training infrastructure and faculty.
- ◆ IDSP: though infrastructure and rapid response teams are in place and supportive labs present, disease reporting and response are still an issue.
- ◆ Utilisation of existing infrastructure needs to improve.
- ◆ Maternal Death Reviews are not being conducted in districts despite many maternal deaths.
- ◆ Despite EMRI availability, assured transport a challenge due to difficult terrain.



UTTARAKHAND

- ◆ Support structures for quality in service delivery in terms of electricity, water, diet is a great challenge.
- ◆ Few Medical colleges and no Nursing colleges is a larger challenge for state, as it leads to poor HR availability, and poor in-house training capacities.

Harshil sub-centre in Uttarkashi – deliveries are conducted here



UTTAR PRADESH

THE REVIEW TEAM

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2. Dr. P. Saxena, Sr. Chief Medical Officer (SAG), Central TB Division, Govt. of India, New Delhi
3. Mr. Billy Stewart, (Health Advisor), DFID, British High Commission, New Delhi
4. Mr. V.K. Tiwari, (Professor), National Institute of Health & Family Welfare, New Delhi
5. Dr. Almas Ali, Independent Public Health Consultant
6. Dr. B. Subha Sri, (Civil Society Member)
7. Dr. Rakesh Rajpurohit, Consultant, NRHM, Govt. of India, New Delhi
8. Ms. Isha Rastogi, Finance Assistant (NRHM Finance), Govt. of India, New Delhi

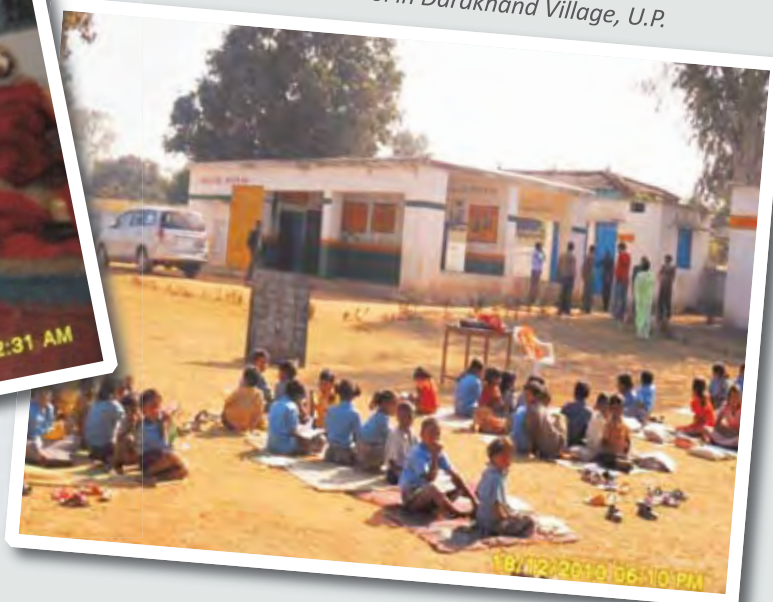
THE DISTRICTS/INSTITUTION VISITED

1. Lakhimpur Kheri district – District Hospital, District Female Hospital, FRUs, CHCs, BPHCs, APHCs, SCs.
2. Sonbhadra district – District Hospital, Urban Health centre, FRUs, CHCs, BPHCs, APHCs, SCs.

An improvised baby corner at CHC Dudhi, U.P.



VHND Session at school in Darakhand Village, U.P.



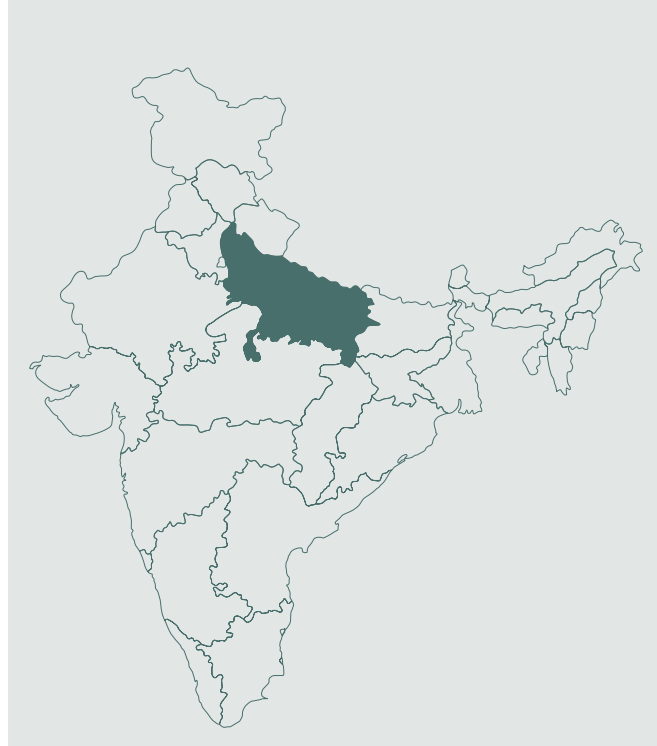
Eye operation (Cataract) at CHC Mayorpur, U.P. The Quality needs to be maintained.

POSITIVES

- ◆ Satisfactory progress in upgradation of public health infrastructure (out of 3692 PHCs,, 3187 are in Govt. buildings.
- ◆ Out of 942 JSY, 133 have been completed and rest 774 are under construction, out of 26344 sub-centres 20621 are operational.
- ◆ Contractual posting and multi-skilling have been adopted as strategies to reduce the gap in HR (a total of 3,248 health care providers were made available through NRHM Funds, including doctors, nurses, ANMS and lab technicians.
- ◆ Increased trends in Institutional deliveries and utilization of services which includes OPD, IPD and Lab services.
- ◆ Sufficient supply of essential drugs and equipment especially for maternal and new born care are made available at health facilities.
- ◆ ASHA programme in state is expanding well. 100% ASHAs have been recruited against the sanctioned posts. ASHA programme in the state is highly visible and effective and well appreciated by the stakeholders.
- ◆ Programme structure of NRHM is well placed in the state. For an effective supervision and efficient implementation of the programme, teams have been formed at block, district, division and state levels.
- ◆ To make the system transparent, the state has adopted the policy of e-transfer up to PHC level. Its financial management is well supported by the modern methods and software.
- ◆ Public display of a list of the JSY beneficiaries and payment have made the JSY programme more transparent.

AREAS FOR IMPROVEMENT

- ◆ Critical shortage and irrational deployment of HR and equipment. state needs to introduce some reforms to attract and retain its man power especially doctors.
- ◆ With the mainstreaming of the AYUSH in NRHM program, huge numbers of the AYUSH doctors have been deployed. There is an urgent need of enacting a protocol and guidelines for the AYUSH



UTTAR PRADESH

practitioners to practice the medicine at PCH (under the modern medicine system). A large scale SBA training program and training for usage of life saving medicines is needed to be planned and rolled out for the AYUSH doctors.

- ◆ State budget for the upgradation of the public health infrastructure should be increased.
- ◆ To make the facilities functional, facilities development plan at the state level should be in logical sequence and as per the guidelines. (FRU with the blood storage unit would not be a functional FRU).
- ◆ Delivery load at sub-centres is very high, the state should act on priority basis to create more health facilities and sub-centres keeping in mind the demand and population size.
- ◆ Inadequate capacity-building efforts and absence of a rational workforce policy also hampers quality of care.
- ◆ VHSC needs to get involved in the district health planning process and should not be restricted only to community monitoring. Need orientation.
- ◆ More steps are needed to ensure the availability of Maternal and Family Planning services at the health facilities (effective supply-chain mechanism, training, equipments, BCC for the provider and takers for the maximum utilization of safe abortion and family planning services).

Infrastructure upgradation under NRHM





The Mission has achieved a great deal, especially in the areas of putting in place an ASHA for every 1000 population; creating greater awareness about ante-natal care, institutional delivery, post-natal care and child immunization; raising institutional deliveries; raising the number of out-patients being provided with healthcare services in the health facilities; provision of untied funds at all levels of facilities and providing the much needed flexibility for outreach of services and so on. These are all very commendable achievements. However, the scale of the challenge that remains is immense, but so too, we believe is India's capacity. It is for the first time in post independent India that a rural public health program as ambitious as NRHM has been put in place to address real issues on the ground with real resources, both financial and human, though there is much more needed on both the fronts as our study argues.

*Improving access, service delivery and efficiency of the public health system in rural India,
Mid-term evaluation of the National Rural Health Mission, conducted by
the International Advisory Panel (IAP), October 2009*

Indian policy researchers and academics had identified the need for health service development to recognise socio-cultural, political, and sociological perspectives, in order to balance the biomedical and techno-managerial framework. The National Rural Health Mission, has provided this balance by using community monitoring, women as social health activists, village health and sanitation committees, mainstreaming of AYUSH, convergent action on other determinants of health and pro-people partnership with civil society.

*Ravi Narayan, Universal Health care in India,
Missing core determinants, Lancet January, 2011, pg 14.*

The National Rural Health Mission is the most ambitious public health programmes in India's history with several unique components that distinguish it from previous national programmes, most notable is that it is centrally financed but implemented in the districts. An external mid-term assessment of this programme in 2009 has noted substantial achievements and suggested priorities that still need to be addressed.

*Towards Achievement of universal health care in India,
Call to Action, Lancet, January 2011, pg 107*

The National Rural Health Mission (NRHM) has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people.

National Rural Health Mission, Meeting people's health needs in rural areas, Framework for Implementation, 2005-2012, MoHFW, GOI, Section II.3. Pg8

As a result of increased expenditure and interventions made under NRHM, some improvements have been reported in the form of increased service utilization at OPDs, increase in the number of institutional deliveries and increased use of emergency transport and ambulances provided under the programme. Providing quality health care to remote, inaccessible areas is the most difficult task and all around enhanced effort needs to be made during the remaining period of the Eleventh Plan.

Report of the Mid Term Appraisal of the 11th Plan, Planning Commission, 2010

“ The launch of NRHM has provided the Central and the State Governments with a unique opportunity for carrying out necessary reforms in the Health Sector. The reforms are necessary for restructuring the health delivery system as well as for developing better health financing mechanisms.

National Rural Health Mission, Meeting people's health needs in rural areas, Framework for Implementation, 2005-2012, MoHFW, GOI, Section III.6, Pg 14 ”

“ India has made much progress in the past few years, with several innovative pilot programmes and initiatives in the public and private sectors, and the establishment of the National Rural Health Mission in 2005 being the most noteworthy government-led initiative. This initiative has signalled the repositioning and rejuvenation of the public health system and in doing so has resulted in the inclusion of the health needs for the disadvantaged individuals, and health equity on the agenda.

Health Care and Equity in India, Lancet, January 2011. Pg 75 ”



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