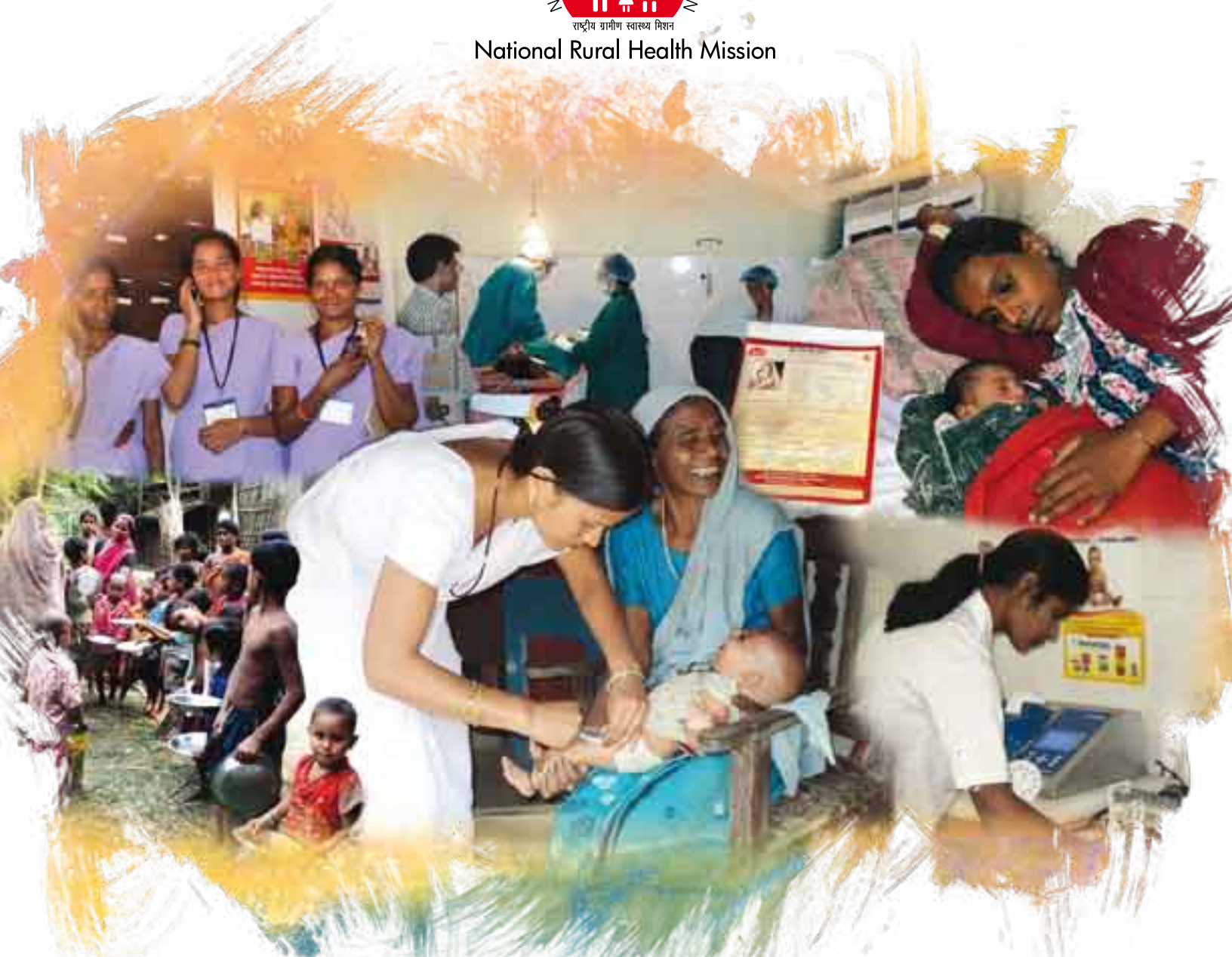






National Rural Health Mission



FIFTH **C**OMMON **R**EVIEW **M**ISSION

Report 2011

This report has been synthesised and published on behalf of the National Rural Health Mission by its technical support institution; National Health Systems Resource Centre (NHSRC) located at NIIHFW campus, Baba Gangnath Marg, New Delhi-110 067.

We gratefully acknowledge the contributions made by consultants and officers in the NRHM Division of the MoHFW. We also place on record our deep appreciation and gratitude to participants from other Ministries, Public Health Institutions, Civil Society and Development Partners who have all contributed to this Common Review Mission Report.

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MESSAGE



It is very heartening for me to know that National Rural Health Mission (NRHM), one of the flagship programs of our government, has been able to make a positive impact on the quality of life of the common people.

As we are coming close to the end of the 11th Plan period, this report of the Fifth Common Review Mission (CRM) provides us an opportunity to take stock of the program and helps us shape the 12th Plan.

It is a matter of satisfaction that the field visits report a substantial improvement in physical infrastructure and equipments as well as the human resources. Though this has been supported by NRHM in a major way, the political will of the leadership in states and efforts put in by the department staff have been critical to the process.

The states have made significant progress in further deepening of the reform process initiated in last few years under NRHM and now moving ahead to enhanced focus on improving the quality of care, though there is a great amount of work that still needs to be done and some states especially have to show much greater commitment to these processes.

I am confident that, the states will take a positive look at the program lacunae and operational challenges in the states which the report highlights, and undertake the corrective measures in time, so that we usher in the 12th Plan period with enhanced capacities to further undertake the reform process.

I am happy that this annual review exercise has also become a platform for shared analysis and feedback from experts, within and outside the government, and I thank all of them for their active participation and valuable contributions.



(Ghulam Nabi Azad)

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MINISTRY OF HEALTH & FAMILY WELFARE

NIRMAN BHAVAN, NEW DELHI - 110108

MESSAGE



This report of the Fifth Common Review Mission (CRM), conducted in 15 States, presents the findings by multidisciplinary teams of public health experts drawn from government functionaries, civil society organizations and development partners. This year there was participation of experts from departments of Rural Development, Women and Child Department and School Education.

The visits undertaken in November 2011, report on the whole range of program components of health systems reforms, including both outcomes as well as the processes. They try to assess not just the efficacy and efficiency of the implementation of the program as structured through the mechanism of annual PIPs, but also the underlying policy environment in the states in terms of commitment to different components of reform processes, innovations and strategies. The review teams have had wide ranging discussions with officials and policy planners at state level, as well as with service providers and civil society in the districts.

The recommendations made by the teams have taken a holistic view of the health systems reform processes and cover aspects of infrastructure and human resources, service delivery and community process on one hand and frameworks of governance management and accountability on the other.

At the present juncture, when we are embarking on the next Five Year Plan, this review report would be a valuable contribution.

I thank all the members of the review teams for their inputs and suggestions. I am sure the recommendations of the report will help in taking us forward in achieving the goal of universal healthcare.

(P.K. Pradhan)

Date: 6th January, 2012



National Rural Health Mission

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ABBREVIATIONS

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



Executive Summary

Background

The Fifth Common Review Mission (CRM) was held between November 8 and November 15, 2011, and covered ten high focus and five non high focus states. Fifteen teams that comprised of 171 resource persons and public health experts were briefed by the state leadership on the progress made on NRHM objectives, and then the teams visited two districts in each state to review the progress at the field level, to learn from their experience and understand the constraints. The Terms of Reference for the CRM covered fifteen major components of the NRHM. The teams shared observations and recommendations with key stakeholders in the state and then submitted reports to the national centre where these reports were analyzed and synthesized into this National 5th CRM Report. Detailed state reports are included in the attached CD.

Findings

i. Infrastructure

Gaps in sanction of adequate number of facilities remain highest in Uttar Pradesh and Bihar. Jharkhand, Uttarakhand and Chhattisgarh have yet to close gaps based on norms for hilly/tribal areas. Even in these states the focus has been on making existing facilities functional rather than the sanction of more facilities.

Constructions to close gaps has been directed mainly to the block and district hospitals. At the level of the PHCs the problems appear to be issues of location, quality and handover. In Bihar, Jharkhand and Chhattisgarh, much more remains to be done for this level. There has been least progress in closing sub-centres building gaps in most states.

As highlighted by the 4th CRM, an institutional mechanism at the state level that has the skills to recognize and plan for hospital architecture, with the mandate for timely, good quality constructions in appropriate locales is urgently needed in most states. Only four of the 15 states had this in place and in two states this is being planned for. Even these did not have sufficient recognition of the specificities of hospital design.



Co-location of sub-centres within a primary or secondary facility enables the provision of outreach services and home care to adjacent populations, while reducing infrastructure needs by 20% and makes for synergy in human resource requirements.

Lack of residential accommodation is a major hindrance in ensuring 24/7 service availability, more so in remote areas. Only Sikkim, Uttarakhand, Odisha, and Chhattisgarh have made arrangements for stay arrangements for ASHA escorting mothers and children to facilities.

ii. Human Resources

The increase in human resources marked from the first CRM on is sustained and substantial progress is visible in all states for both contractual and regular positions.

States have launched a slew of innovations that include financial incentives for providers in difficult areas as seen in Haryana, Himachal Pradesh, Karnataka, Chhattisgarh, Odisha, Sikkim and Rajasthan through ensuring compulsory rural service for medical graduates, as seen in Assam and Haryana, rotational posting, regulation of transfers and postings by a legislative Act, in Karnataka and increasing retirement age for health personnel in Gujarat and Haryana. Other solutions include addressing barriers in recruitment processes, increase in the number of educational institutions and courses, introduction of a three year diploma, and enabling a career progression for the ASHA as seen in Chhattisgarh. However not all innovations are necessarily effective, and it is important to study what works and what does not work in specific contexts, and move towards a package of measures rather than a single solution. Some states with particularly difficult vacancy problems, like Uttarakhand, have not even begun to address this issue. It has not been easy to promote, scale up or generalize learnings from successful innovations such as multi-skilling, locality based selection and deployment of service providers, to address the problems of skilled providers for rural and remote areas.

This increase of human resources however is still not sufficient to meet the requirements, and lack of human resources continue to remain an obstacle in providing service delivery in existing facilities, in operationalizing new facilities, and in provision of skilled obstetric and neonatal care. Barriers identified include inappropriate deployment of staff, slow pace and poor quality of in service training programmes for multiskilling, lack of supervision and supportive environment for trained providers, disparity in service conditions between regular and contractual workforce and poor service conditions.

Uncertainties related to the long term commitment of the centre for financing additional service provider and managerial cadre appointed under NRHM, and the lack of clear state commitments to supporting these staff have also led to a slow-down in HR reforms. For example while there is an urgency for rational utilization and deployment of the 50,000 second ANMs currently in position, any policy shift needs to be carefully done so that the positive energy and outputs that have been generated, are not affected.

iii. Facility Development and Service Delivery

NRHM investments have yielded high returns in terms of increasing access to facilities in almost all states reported by the teams and reflected in the HMIS data. The two exceptions to this are in Gujarat where there appears to be a decline in OPD as well as in IPD data and in Chhattisgarh's where there is a drop in inpatient admissions (from HMIS data). Andhra Pradesh's IPD figures also appear to be stagnant.

One indicator that can be used to compare performance across states and against expectations is the "annual per capita OPD attendance". Himachal and Sikkim fare best with 1.25 OPD visits per capita per year against a benchmark of three visits per capita. Other states are in the region of 0.5 per capita. This translates to about 20% of all OPD visits with the rest either using the private sector- formal or informal or not seeking care.

For inpatients, using a benchmark of 75 admissions per 1000 population (including normal deliveries), Himachal Pradesh has about 54; and Sikkim, Goa, Rajasthan, Odisha, and Karnataka have about 37/1000. These are consistent with the patterns seen in NSSO figures. (one caution is that these figures are an underestimate of public sector utilization as figures from medical colleges and other government hospitals are not consistently factored in). Cross-state comparisons show that the figures are poorest for Jharkhand, followed by UP, Gujarat, Chhattisgarh, and Bihar. The formal private sector in Gujarat is likely providing services, but not so in other states.

Improvements in drug availability were seen in Andhra Pradesh, Bihar, Chhattisgarh, Goa, Gujarat, Haryana, Odisha, Himachal Pradesh and Uttarakhand. Persistent high out of pocket expenses on drugs and diagnostics was

noted in most states, and this continues to be a barrier to facility utilization by the poor. In one state, families with their babies admitted in Sick Newborn Units were facing considerable expenses. Lack of equipment was reported from Uttar Pradesh, and poor utilization of available equipment from Chhattisgarh, Gujarat, Jharkhand, Odisha, Rajasthan and Uttarakhand.

One of the significant positive developments of the NRHM period is the emergence of an assured referral transport systems in all the states visited- all except in Sikkim and Uttar Pradesh. Andhra Pradesh, Assam, Chhattisgarh, Gujarat, Goa, Himachal, Karnataka, Rajasthan and Uttarakhand have the referral transport function integrated with an emergency response system on the EMRI model. The number of vehicles needed for a comprehensive coverage is large and often the reach remains more peri-urban. Utilisation for pregnancy transport seldom exceeds 25%. Haryana has an EMRI like approach but it is government managed, with a more exclusive focus on pregnancy transport, and without trained para-medics available in the vehicle. In Bihar, Jharkhand, Odisha it is based on tie-ups with local transport providers- and in the first two of these it is a fee for service model and focused only on transport for pregnant women and newborns. In all these models the challenge now is improve the efficiency and effectiveness of these systems.

There is notable but insufficient progress in functional laboratory services and availability of laboratory technicians. Gaps are mainly on the range of tests offered and in the user fees being charged. Except for Goa there do not appear to be 24/7 laboratory services in any state. In biomedical waste management and infection control procedures also the progress is mixed, with some states showing fair progress and others yet to begin. Diet facilities are available upto the level of the CHC with high caseloads in Andhra Pradesh, Goa, Gujarat, Haryana, Himachal Pradesh, Odisha, and Rajasthan whereas in Bihar diet facility is available upto DH only. Quality assurance committees are not sustained though efforts to have formal quality management systems do relatively better. Citizen charters and JSSK benefits are displayed prominently in all states except in Uttarakhand and Uttar Pradesh and a few states have put in place grievance redressal mechanisms.

There is significant improvement in the use of untied funds- especially at more peripheral levels, and a lessor reliance for user fees. But out of pocket expenses remain high due to drugs, diagnostics and transport costs. Pointers from the Himachal report regarding the contribution of the RSBY to social protection from costs of care needs to be carefully assessed before scaling up to other states. Though the CRM has not examined this in great detail, a few observations from the reports indicate concerns related to both failure to pass on the benefit to the users, persistence of exclusion and inappropriate care.

iv. Outreach and Sub-Centre Services

There is significant improvement in the availability of outreach services in all states as measured by the rise in immunization, antenatal care, and contraceptive access. This is attributable to increasing the number of ANMs, provision of untied funds to the sub-centre, and to the ASHA. 95% of the sub-centres are functional with at least one ANM, and 35% of sub-centres have a second ANM.

The Village Health and Nutrition Day is operational across the states, but often serves only as a platform for immunization despite the potential for the provision of an expanded service package for mothers and children. In many states, the Village Health, Sanitation and Nutrition Committee is not adequately involved in the organization or mobilization for the VHND.

Sub-centre based service delivery shows increasing variation depending on size of population served, on ease of access to better equipped and better staffed facilities, on health care seeking behaviour, on disease patterns

(e.g. malaria endemic area) and case-loads related to RCH - number of pregnant women and children needing outreach services. In some states such as Himachal, sub-centres serve mainly as an outpatient clinic with RCH service delivery work being provided only one or two days per month. In other states the caseload of children to immunize and antenatal care is overwhelming and this alone merits more staff. In all states only 5% to 10% of sub-centres or fewer provide delivery services.

461 Mobile Medical Units are functional across the states but both task definition and effectiveness shows variations. Three patterns of MMU services are seen: provision of outreach services in areas where ANMs are not present, provision of services of a medical officer with ANM/ASHA playing a mobilizational role, and MMUs as a vehicle for provision of specialist services and referral back-up to an existing and functional primary health care system. The problems relate to mismatches between tasks envisioned, the services actually provided, and the design of the MMU in terms of vehicle size, equipment and staff.

v. ASHA Programme

The findings affirm and reinforce those of the previous CRMs. The ASHA is seen by providers and community as having enabled increased access to the health system and providing community level care for mothers and children. There is progress reported on almost fronts of the programme including setting up of support structures, active training, streamlined incentive payments, better regularity, and improved collaboration with AWW and ANM, in all states. Non high focus states like Andhra Pradesh, Haryana, Karnataka, Gujarat are managing the programme with existing staff, which is emerging as a barrier to effective outcomes. Attrition rates are low in most states and attributed primarily on account of ASHAs moving into other career paths.

The role of the ASHA is more pronounced as a facilitator of services, with home visits for newborn and post partum care reported from in Uttarakhand, Odisha, Sikkim, Rajasthan, Uttar Pradesh and Chhattisgarh where the ASHA training in Module 6 or equivalent has been initiated. Andhra Pradesh, Assam, Chhattisgarh, Odisha and Sikkim have established grievance redressal systems for the ASHA. Replenishment of drug kits is a problem in all states. Performance monitoring of the ASHA programme was reported from Chhattisgarh and Rajasthan.

vi. RCH-II (Maternal Health, Child Health & Family Planning Activities)

All states have shown increasing trends in institutional deliveries since 2005 to 2011 ranging from 2.6% in Andhra Pradesh (where the baseline was itself close to 90%) to 50% in Bihar.

In a number of districts visited- Emergency Obstetric Care services are not being provided even at the level of the district hospital. This was seen in Mewat, Haryana, Deoghar in Jharkhand, Kinnaur in Himachal Pradesh, Barmer in Rajasthan. All of these are poor performing districts. In Gujarat and Goa the private sector closes the gap, but the downside is that C-section rates are 18%.

The provision of safe abortion services is still limited to District hospitals, except in





Karnataka, Goa and Uttar Pradesh. This gap is attributed mostly to lack of providers trained in Manual Vacuum Aspiration (MVA), and to lack of sensitization of administration on this issue.

The availability of Sick Newborn Care Units in districts has shown an increase since the last CRM, with most districts reporting SNCUs. However in Bihar, Uttarakhand, Uttar Pradesh, and Chhattisgarh neither of the two districts visited had a SNCU. Newborn Care Corners were seen in many facilities but functional corners are still not universal. There is also a lack of FIMNCI trained staff. States that report Newborn Stabilization Units include Goa, Gujarat, Jharkhand and Odisha.

Progress in the provision of family planning services is varied, with a majority of states reflecting positive achievements over the NRHM period, for both limiting and spacing

methods. But states such as Haryana show a decline in female sterilization and Sikkim shows a decline in IUD insertions. Likely reasons appear to be the shortage of doctors, slow progress in training for multi-skilling, and the lack of attention to providing fixed day services.

The JSSK scheme has been officially been declared started in almost all states except Bihar and Sikkim, although the difference between not charging user fees- and true cashless delivery – which means eliminating out of pocket expenditure is still not seen. In Goa, Gujarat, Himachal Pradesh, Jharkhand, Odisha, Uttarakhand, Uttar Pradesh, women continue to incur out of pocket expenditure mostly on travel, diagnostics and drugs. Long delays in JSY payments are still seen. There are several reasons ranging from lack of funds in UP and Haryana, non-issue of cheque book in Dhubri, Assam, and making the PHC the centre of payment in Bihar and Goa.

Maternal Death Audit has been initiated in Gujarat, Goa, Haryana, Himachal, Odisha, Sikkim, but not in the other states. Even in these states the MDRs need to go beyond clinical causes to a more creative probing of remediable health systems causes.

vii. Preventive & Promotive Health Services Including Nutrition and Inter-sectoral Convergence

Convergence between field staff of ICDS and Health is found to be synergistic and effective in Andhra Pradesh, Odisha and Sikkim. Facility based Nutritional Rehabilitation Centres were seen in Bihar (2), Chhattisgarh (2), Gujarat (2), Jharkhand (2), Rajasthan. In Gujarat and Bihar the NRC was managed well, but in the case of Bihar there is a mismatch between the high numbers referred for NRC care and limited facilities. In Rajasthan the NRCs were well equipped but underutilized. Functionality of NRCs is dependent on their linkages with the field for identification, referral and follow-up. Where efforts are made to link community based programs or working with NGOs, as seen in Gujarat, Jharkhand and Bihar, the results are better.

In most states VHSCs have been renamed as VHSNC. Functionality is varied. In Andhra Pradesh, Sikkim and Odisha, they appear to be effective. They are in a rudimentary phase of development in Bihar, Jharkhand and Uttar Pradesh. In Goa and Odisha the VHSNCs have undertaken cleanliness drive to control vector borne diseases. Overall the potential of VHSNC as a platform to address social determinants remains inadequately untapped. Bihar, Jharkhand, Andhra Pradesh, Gujarat and Odisha have involved NGOs or programs such as Mahila Samakhyas (in Andhra Pradesh), to address both nutrition and social determinants of health and appear to have positive outcomes. More examples of village health plan and village health committees whose functioning can act serve as exemplar for others to emulate need to be built up.

School Health programmes are present in most states, but effectiveness and coverage continues to be inadequate. Sustaining large school health programmes requires its own process of monitoring, its own staff and referral support systems, and effective coordination with the education department.

viii. Gender Issues & PCPNDT

NRHM interventions whether in human resources, infrastructure, quality, community processes have all contributed to improved access and quality of services for women, as seen in the proportionate increase of female inpatient admissions in all states. The NRHM has also led to a major increase of employment for women especially in the most remote and underprivileged areas. The PCPNDT act is being implemented in letter and spirit with all four components: registration of ultrasound facilities, submission of completed Form F, regular review meetings and IEC taking place in Assam, Goa, Gujarat, Karnataka, Uttarakhand and Sikkim. Only Goa reports the tracking of second trimester abortions.

Few states appear to be cognizant of the pervasive excess female mortality in the 0 to 4 age group which is contributing in a major way to the declining child sex ratio. In Assam, Haryana, Himachal, Gujarat and Uttar Pradesh, the state has schemes to incentivise limiting the family size even if there are only girl children.

On the issue of gender sensitive services such as provision of privacy in outpatient and inpatient services, and separate toilets for women, all states have a long way to go, with non high focus states faring as poorly as the high focus states. However where there is a will, change is possible. So Kishanganj in Bihar, which has so many handicaps in other areas- does one of the best in privacy. Karnataka also attracted favourable comment on this parameter. Vishaka guidelines to redress issues of sexual harassment are in place only in Goa. Only Himachal amongst the states visited has undertaken any sensitization or training of providers in gender issues and violence. Adolescent anemia programmes were operational in Gujarat, Jharkhand, Odisha and UP. The adolescent clinic has been set up in these four states and Haryana and Himachal- but attendance is a problem. In the Menstrual Hygiene programme training for ASHA is ongoing in all states except Bihar and Assam.

ix. National Disease Control Programmes

Vector borne diseases continue to be a major public health menace with stagnant or increasing malaria incidence reported from most of the states. This increase could be only a reflection of more adequate surveillance. High out of pocket expenses are reported for diagnosis and treatment of malaria in the private sector, given inadequate facilities in the public sector. In UP 18 districts are in the grip of Japanese Encephalitis. Kala Azar is being reported from Bihar, Jharkhand, Sikkim and Himachal and Rickettsial infection from Himachal Pradesh. Under the NVBDCP, states have been allocated a large number of additional contractual posts, but there are persistent vacancies.

In the case of tuberculosis there is improvement in all states except Uttar Pradesh, where there are shortages of human resources and microscopy centres. In Assam there appears to be a shortage of sputum collection centres.

In the case of leprosy, active cases continue to be reported from Assam, Uttar Pradesh, Bihar and Andhra Pradesh. In other states there is a decline in cases reported. Late diagnosis appears to be a problem in Odisha, given the increased number of patients with deformity. ASHAs are involved in case detection and motivation for reconstructive surgery. Goa reports nil backlogs for reconstructive surgery, and in Karnataka regular camps are held for prevention of deformity.

In the IDSP, reporting on all three forms- from the sub-centres, from the primary health facilities and from the laboratories has shown steady improvements across the states, but a common trend observed is that of lack of analysis and use of data for public health action. Infrastructure and human resource gaps for IDSP have also been narrowed. However such gaps are persistent in Sikkim, Bihar, Karnataka and Jharkhand. There is no reporting from the private sector in all the states.

In the area of non-communicable diseases, Goa has established a registry and a mobile unit for screening for diabetes, breast and cervical cancers through mammography and pap smears. The state also has a gestational diabetes screening programme. In Sikkim the ASHA are involved with multipurpose health workers in home visits for the chronically ill and in management of hypertension and diabetes.

x. Programme Management

All states have functioning state and district health societies. Regularity of meetings is however the exception rather than the rule and the active participation of non-government sections is still limited. Panchayat representatives are part of these committees. Gujarat and Karnataka report good functioning of these structures.

The state and district programme management units are established in all states except Goa. Coordination with directorates of health and family welfare is also improved- but more active and periodic supervision of the facilities by scheduled visits by officers at state and district level is required in almost all states. The contractual staff in these units function well and such an arrangement has been extended in most states to block level. Considering the variation in the nature of work assigned to BPM and BAM, combining the two positions is not desirable. Moreover, with the increasing need of uploading extensive data for MIS, MCTS and other regular obligations there is an emergent need of a personnel for Data management at block level.

xi. Procurement & Logistics

Efforts to strengthen procurement systems and improve supply chain management are only now beginning to have some effect. Andhra Pradesh, Bihar, Chhattisgarh, Karnataka and Rajasthan have or are in the process of developing a separate corporation/society for drug procurement along the lines of the Tamil Nadu model. Gujarat and Himachal Pradesh also have a central procurement agency. Drug availability in the public health facilities is reported as improving across all states. Andhra Pradesh, Odisha, and Rajasthan are taking serious steps to improve access to essential drugs at fair prices through experiments like "Jan Aushadhalaya". However stock-outs are still being reported and there continues to be a high prevalence of outside prescriptions. Irregularity in medical supplies is on account of the use of a top-down, normative allocation system rather than one based on actual demand.

States have not yet switched over to scientific systems of inventory management, which are widely prevalent. Infrastructure inadequacy continues, in terms of lack of proper storage facility and drug warehouses. IT based

solutions for inventory and supply chain management (like ProMIS) are increasingly being adopted by states. Jharkhand, Odisha, Sikkim and Uttarakhand are in various stages of adopting ProMIS. Other states like Haryana, Karnataka and Rajasthan have developed their own software for inventory and supply chain management.

Procurement reforms are focused more on the tendering process, and quality assurance systems are still not well developed. Preventive maintenance is still absent in most states, leading to substantial machine downtime and awaiting engineers from state headquarters or sometimes outside the state. District/regional maintenance workshops were not reported from any state.

xii. Use of Information Technology

Regular reporting on a standardized health management information system from across all 640 districts of the country and a national Web-portal that acts as a central repository of information service delivery in the public health sector and reproductive and child health are firmly established. About one third of the states have instituted systems for analysis and use of information at district and sub-district levels. Systems to support HR management, hospital management and use of mobile applications are also growing across states.

One of the reasons for poor data quality and completion is inadequate design of primary registers is an issue in few states, and lack of proper authorization of officers (as reported in Sikkim) for timely confirmation. Another constraint is the lack of availability of manuals that provide details of data definitions and collection and reporting rules. This constraint also applies to IDSP and malaria reporting. In Himachal and Gujarat Hospital information systems have been developed. In Rajasthan, a data entry initiative using mobile phones by ANMs and peripheral facilities is underway.

All states are making serious efforts at putting in place a Maternal and Child Tracking System (MCTS). The problems of shortage of manpower, infrastructure and maintaining the systems at sub-district level specially in blocks that facility level data entry has already created are accentuated with the maternal and child tracking system, given the – higher volumes of data. The MCTS data is not currently integrated with HMIS, and it remains a parallel stream. The huge backlog of



data to be entered in many districts, leads to a situation where the data entered is not usable for service delivery follow up. More clarity and systems design inputs are needed at the field level for the high burden of this task to add value to programme implementation.

xiii. Financial Management

Expenditures have picked up across states, especially under the Mission flexi-pool head, showing a greater understanding of system reforms and ability to translate the reform agenda to specific actions based on local

context and need. Integration of various programs under NRHM and financial decentralization in the form of untied funds, has enabled targeting local problems related to shortage of consumables, minor repair, and mobility support. States have also put in place the financial professionals at state, district, block, and (in some states) at the PHC level. This has enhanced fund absorption capacity and expenditure tracking. States have adopted e-transfer of funds, thus speeding up funds flow, and in conjunction with the use of Tally ERP-9 software, this has greatly improved the way programme finance is being managed at scale. Compliance with statutory audits has enabled increasing transparency and accountability, although these are off-budget transactions. There are however, large amounts of funds blocked as advances under civil works and in the VHSC and RKS accounts. This results in slowing of submission of Utilization Certificates (UC) with the lowest performing unit (health facility or block) holds the entire system to its pace.

xiv. Decentralized Local Health Action

District Health Action Plans are in place for most districts but their quality is varied. Involvement of non-state actors and stakeholders limited in preparing DHAP and their participation varies across districts. Use of HMIS district reports in the planning process is improving in many states, but there is little available evidence on its use in planning for intra-district differences.

The majority of districts visited had functional VHSCs. Often the ANM/AWW is the co-signatory and are functional in all states. The village health plan is not yet institutionalized anywhere – and there are no clear models or clarity in its role and utility. There is increase in the utilization of untied funds for VHSCs and RKS. The involvement of PRI in health planning process and in the function of VHSNC and RKS is limited. Of the 15 states visited the only state with Community monitoring was Karnataka and was reported to be starting up in Bihar.



xv. Mainstreaming of AYUSH

Co-location as a strategy has helped improve utilization of public health facilities and give users a greater choice between systems. Utilization of AYUSH services in co-located facilities is higher when AYUSH drugs are available. AYUSH Drug supply was inadequate in most of the States under CRM. Co-location of AYUSH in PHCs/CHCs has not taken place in some states in spite of release of funds. Contribution of AYUSH Doctors in School Health Programmes was noticed in many States. Availability of AYUSH doctors for recruitment has been utilised to fill up medical officer vacancies across a large number of states, especially in the most high focus of districts. Capacity building efforts for strengthening AYUSH practice as well as for implementing National Health Programmes including RCH are inadequate and there are no specific training centres with competencies for doing so. Contribution by AYUSH doctors is unnoticed and not reported in the Information systems.

xvi. Overall Outcomes and Gaps

There has been acceleration in child and maternal survival and reduction of fertility rates in the last five years. The rate of improvement is better in rural areas. Rural IMR increased by two points in the first two years of the NRHM, (SRS 2006, 2007) by three points in the next two years (SRS 2008, 2009) and by four points in the last year for which data is available - (2010 SRS). Further in terms of rate of change the poor performing states, as compared to national average rate of improvement is higher. Thus states which are lagging behind the national average are all doing so because of the very poor baselines with which they entered the NRHM and prima-facie the NRHM has made the difference.

In terms of NRHM outputs the most important observation is the steady increase in caseloads and range and quality of services rendered by the public health system across the states. However the improvements are far short of the range of services indicated in the NRHM framework and by no means comprehensive. The improvements in facility based services are predominantly in the area of RCH services, and even here, providing Emergency Obstetric Care for maternal complications and safe abortion services is proving to be a struggle.

The challenge in the twelfth plan period is to complete the task of achieving universal access to the entire range of RCH services, especially comprehensive emergency obstetric care and safe abortion services and the provision of assistance to states to achieve similar universal access to trauma care and emergency services, and all communicable and non communicable diseases, through an integrated district health plan.

In terms of strengthening community participation and mobilisation, the ASHA programme, the VHSNC and the RKS have brought about a major change. The measures needed to strengthen the effectiveness of these institutions are discussed earlier. Areas such as community participation and increased NGO involvement have not picked up.

Facility development to achieve quality of care remains a major issue. Some of the high focus states like Jharkhand, Chhattisgarh, Uttar Pradesh and Bihar are particularly lagging behind not only because of poorer baselines, but because the internal institutional capacity to generate, recruit and train the human resource required are all weak.

The Social protection role of the public sector has been enhanced in most states, but out of pocket expenditures are still high. A start at checking this has been made by the JSSK scheme, which aims for cashless services for pregnant women and newborn. But even this initiative is at an early stage and would need much more assistance for success. This approach to cashless service should then be expanded to include a more comprehensive list of basic health care services.



Recommendations

Recommendations

i. Infrastructure

- ◆ The states should operationalize an “Infrastructure Wing”/“Medical Services Corporation” where they are not functional. A hospital planner and hospital architect should be appointed to these organizations and the existing technical staff and administrators of this cell/corporation should be sensitized to hospital design issues.
- ◆ A comprehensive facility development plan should be developed for each district so that in most states the infrastructure requirements of essential facilities are completed in the 12th Plan period. The Plan should clearly plan the construction so that facilities with greater caseloads, and areas with less access to services are prioritized for up-gradations. Construction work could be phased, subject to availability of funds.
- ◆ States should involve service providers and community representatives in the choice of locale, design, monitoring quality of construction, and insist on quality check programmes for infrastructure. This includes for example, compliance with National building codes or BIS norms and fire safety protocols.
- ◆ A room or guest facility for ASHAs to rest and if needed to stay overnight when they accompany mothers as escorts and birth companions should be insisted upon wherever there is likely to be frequent occasions for use of this facility.
- ◆ Residential accommodation for service providers is emphasized yet again, with the recommendation to prioritise those facilities where this is identified as the single most important, even if it is the only reason for not being able to operationalise a 24*7 services.
- ◆ There is a case for designing fund flow for infrastructure such that the creation of an infrastructure cell is encouraged and made conditional on a comprehensive five year facility development plan with prioritization of facilities.
- ◆ The infrastructure of stand-alone AYUSH dispensaries and hospitals should be strengthened including construction of own buildings. In this regard states can avail the Centrally Sponsored Scheme of the Department of AYUSH, Government of India.

ii. Human Resources

- ◆ The first priority should be to fill up all sanctioned posts which are vacant and create additional posts in the state budget which are necessary and in keeping with IPHS norms and increasing caseloads. Clarity on which posts the central government will continue to fund for the long term is needed. A positive step forward is the proposal of the NRHM Working Group for the XII plan, to undertake the funding of the first ANM and the male worker and support a second ANM in those facilities that provide institutional delivery. There is also a case for supporting three



nurses in all PHCs providing midwifery services, nine nurses in all CHCs providing inpatient care and laboratory technicians through central contribution, since the availability of these cadres is essential for several national programmes. But in synergy with this move the state government should create and fill up other required posts.

- ◆ Regular appointments including those of AYUSH doctors & paramedics should be streamlined and expedited with current vacancies being advertised every six months and recruitment completed by state service commissions or other acceptable, fair and legally sustainable means – but within a six month period.
- ◆ In all cadres, powers for contractual appointments against approved/sanctioned posts - whether under state government or under NRHM funds should be immediately devolved to the district health societies, with states helping only where districts are unable to find suitable candidates.
- ◆ Of these vacancies, the most critical are those of nurses and ANMs, and creating the necessary posts as well as filling up these posts must be prioritised.
- ◆ To move the male worker agenda forward- there is a need to define the male multi-purpose worker and the work expectation of such a worker such that there is sufficient work to fill an 8 hour working day on a regular basis. Based on this the competencies required, the training syllabus, the training institutions needed, the career path and cadre policy needs to be developed. There is also a need for clarity vis a vis the proposed BHRC and to explore the potential of merging these options.
- ◆ Given the shortage of specialists available in the system and in the market for recruitment, multi-skilling of doctors and distance education family medicine training programmes should be scaled up with an emphasis on post-training posting and professional support. States should give due emphasis to the capacity building and skill development of AYUSH doctors for their utilisation in health programs.
- ◆ There needs to be a greater emphasis on setting up of Medical Colleges, and Nursing and ANM Training Institutes, at terms which would help close the human resource gaps in under-served regions within states. This would imply greater public financing, choice of location of colleges and admission policies so that candidates from such areas and with a commitment to serve in these areas are preferred. Building in basic quality standards during such rapid scale up, also requires faculty development programmes and institutional development at all levels.
- ◆ Considering the emerging demand and popularity of AYUSH for the management of chronic ailments, it is advisable for the states to create specialist cadre of AYUSH. The specialist AYUSH doctors may be preferred for posting in CHCs, District and other hospitals where co-location has taken place as well as in stand-alone State/Regional/District level AYUSH Hospitals.
- ◆ Measures for attracting and retaining skilled service providers in rural and difficult areas need to be further expanded and built upon so as to eliminate vacancies in the public health system. Every state and district plan should specify the package of financial and non-financial incentives, workforce management reforms and the preferential admission to educational and training institutions and educational reforms it would be putting in place for achieving these ends. Existing measures which are assessed to be working well must be documented, publicly recognised, reinforced and encouraged- so that they are not reversed easily.
- ◆ Strengthening of SIHFWs, RHFMTs, ANMTCs and DTCs in terms of good quality faculty development and building up the work organization, work culture and dynamism needed for these centres to make an impact in planning and implementation of need-based skill-upgradation trainings with assured quality.

- ◆ Staff remuneration, incentive structures, and career paths, need to be defined and assessed for reform. Some states are in the process of forming separate specialist and public health cadres and others may adapt, adopt or replicate. Cadre reform in terms of an assured, dynamic career progression path will also be a positive step.
- ◆ Similarly, a robust Human Resource Management Information System is an urgent need so as to create an efficient and transparent HR recruitment, and transfer and posting mechanism. A few states are already working towards having this system in place.
- ◆ Semi-furnished accommodation for residences of staff posted in difficult and hard to reach facilities should be prioritised.

iii. Facility Development

- ◆ There is a need to improve quality of monitoring of outpatient and in-patient attendance with disaggregation for gender and under fives across the states.
- ◆ The social protection role of the public hospital has improved with reduction of user fees and better availability of drugs but to prevent financial barriers to care there must be a careful planning for each state to reduce all out-of-pocket expenditure at the public hospital.
- ◆ RSBY financing to the public hospital was studied in only a few of the states. However it is clear that there is urgent need to build up some systems of monitoring, preferably community based or civil society based to prevent moral hazards and ensure that benefits are passed on to the intended beneficiary and that the poor are fully included.
- ◆ Quality assurance committees at state and district level need to be reiterated. There should be clear policy commitment for all hospitals to have quality management systems in place, and to measure and score and publicly display progress against quality of care standards, and to have external certification of those hospitals which have achieved the defined target for quality of care in that state. A check-list based monitoring of facilities is necessary but not sufficient to either achieve quality of care, or even to keep the quality agenda alive and the quality assurance committee active.
- ◆ The need for a procurement and supply side chain management system benchmarked to the TNMSC is critical.
- ◆ Once again, as in every CRM earlier, the need for making essential drug lists and drug formularies and standard treatment guidelines available on the desk of every provider and mechanisms to promote and monitor their use is reiterated.
- ◆ The basic minimum set of diagnostics to be made available at every facility level needs to be assured. However to reduce the practice of using it as the prime vehicle of user fee generation, and to universalize access to essential diagnostics, a differential financing of health facilities would be important.
- ◆ Clinical quality of care in terms of clinical competence need more than access to drugs, diagnostics and skills. These include the organization of supportive supervision which specifically reviews these issues, and practices such as death reviews, medical audit and prescription audits which need to be institutionalized and linked to continuing medical and nursing education programmes.
- ◆ Quality of care in terms of patient comfort and safety leading to user satisfaction requires financing of diet, laundry, security, sanitation, biomedical waste management, water supply and electricity services, signages and grievance redressal systems in a flexible and responsive manner and their incorporation into appropriate quality management systems.

- ◆ Emergency response systems have leapt forward in the last five years and their momentum needs to be sustained. The overlap and the distinction between an ERS and a referral transport system needs to be kept in mind. ERS is most efficient when it attends to emergencies- whether medical, surgical, obstetric or trauma, within an half hour range of each of the vehicles stationed. Thus it is most visible and works best in the urban and peri-urban milieu. Referral transport for pregnancies are elective and most needed in areas distant from sites of institutional delivery, where tie-ups with local operators work faster, where present. ERS uses pregnancy transport to build up its volumes. In some nearly 25%-of pregnant women access the ERS as their vehicle to reach the facility, but is less than 10% in most states, particularly in distant areas.



On elective long distance driving to pick up pregnant women the emergency response function appears to be lost. Local tie-up with operators works best where the service is cashless to the user, where there is swift reimbursement of the transport provider and some element of pre-payment. The recommendation is therefore to allow ERS to transport pregnant women when it is available and within 30 minutes to pick up, but in all other situations, use an extensive local tie-up with providers as the mainstay of the assured referral transport for pregnant women at the time of labour.

- ◆ Better guidelines and differential untied fund allocation would help improve expenditures in the PHCs, sub-centres and VHSCs. At higher facilities, using untied funds to underwrite expenses in diagnostics and patient amenities would help utilize these funds. Untied fund usage must be consciously directed towards improved quality of care and closing gaps and facilities should be provided with funds only after their current fund is utilized. The non-utilized fund of low caseload facilities can be used as part of a district pool to reimburse operational expenses of high caseload facilities.
- ◆ Renewed emphasis is needed for separate grievance redressal systems to address patient as well as provider grievances.

iv. Outreach Services

- ◆ For sub-centres, human resources, infrastructure and norms must be made flexible and responsive to caseloads (e.g. number of deliveries conducted), health systems context (the presence of a higher level/better staffed facility nearby) and epidemiological context (how many children need immunization? or is it a malaria endemic area?).
- ◆ Sub-centres providing Institutional Delivery services are to be reinforced with adequate infrastructure, equipment and training inputs with two ANMs being a necessity.
- ◆ A vast majority of sub-centres do not conduct deliveries and the task allocation of 2nd ANMs needs more planning. With over 50,000 such 2nd ANMs in place an abrupt withdrawal would be disruptive.

- ◆ Home deliveries look set to continue and there is a need to persist with training of ANMs as SBA to conduct home delivery in inaccessible areas. This is most required in hilly terrains, where homes are spacious and warm and sub-centres are not.
- ◆ There must be clarity on whether a MMU is being used to
 - a. Deliver outreach services where MPWs are not available or find it difficult to reach.
 - b. Deliver outpatient care services by a doctor where MPWs and ANMs and ASHAs are in place.
 - c. Deliver specialist referral care where PHCs and sub-centres exist.

Depending on the context, the MMUs should be delivered, staffed and financed. Current MMUs planning lacks this clarity and also there are no clear cut outcome measures in place.

v. ASHA

- ◆ There is a need for sustained advocacy to explain the characterization of the ASHA. It is the particular combination of roles- as facilitator of services, as a person working for health rights and as a community level care provider- that makes for effectiveness and sustainability. Over-emphasis on any one of these dimensions and failure to recognize the others makes for a sub-critical programme that leads to lower coverage, functionality or effectiveness.
- ◆ There is need for building capacities in the support structures that have been built up already. States that have not built up the support structures need to start this up immediately. Similarly community based training sites and training teams which have been initiated in most states as part of training for module 6 and 7 need to be institutionalized.
- ◆ Regular monitoring and support to ASHA functioning is important at the local level to replace non functional ASHAs and at the block level to provide additional support and resources with greater challenges. The use of functionality indicators and the process of gathering data for this are critical and need to be rapidly introduced. Another aspect of this is creation of an ASHA database at all levels to track and replace drop-outs and to facilitate certification and create career options for those who require it.
- ◆ Ensure achievement of the minimum skill sets required for an ASHA as defined by modules 5, 6 and 7 within the coming year, with some process of certification of ASHAs who have achieved the prescribed skills.
- ◆ Improve mechanisms of timely performance based payments and rapidly put in place payments for newborn visits.
- ◆ Reiterate once more the need for regular replenishment of drug kits- especially life saving first line drugs of ORS and Zinc, Cotrimoxazole, Chloroquine and equivalent, as well as drugs for management of anemia.
- ◆ Functioning of the Village Health and Sanitation Committees are to be revitalized with the ASHA playing a central role
- ◆ Creating facilities for the ASHA to stay-in during facility visits is likely to improve access of the community to health facilities.
- ◆ The administrative willingness for long term planning for the ASHA programme is essential for most of the above reforms. Too much of the ASHA planning has a mindset that views her as an ad hoc passing phase. The other problem in administrative will is the failure to understand the diversity of expectations

of stakeholders and the ASHAs themselves from the programme. As we complete the seventh year of the ASHA programme, and the programme gets a five year mandate which would take it to its 12th year by 2017, such a long term 'operational' plan is an urgent necessity.

- ◆ Long term planning requires planners to provide space for those ASHAs who are happy to remain local volunteers indefinitely with the performance based incentives acting as social recognition. At the same time, those ASHAs who aspire for regular employment and incomes, must be enabled to enter into training programmes for becoming ANMs, nurses, ASHA facilitators, anganwadi workers etc. Options for voluntary ASHAs to opt out and be replaced by next generation volunteers after ten years could also be encouraged. Certification of ASHAs for having acquired minimum skills and opportunities for them to upgrade skills would be an important component of this plan. It is likely that over the long term, an ASHA who provides a much wider level of community care and health care facilitation, including non-communicable diseases, geriatric care, and palliative care, is likely to emerge. This is in keeping with international experience with planning for human resource requirements.

vi. Reproductive and Child Health

- ◆ Persist with careful prioritisation of facilities for providing a full package of high quality, facility based RCH services as appropriate to that level of care. The prioritisation should be such that emergency services are available within one hour travel time of any primary care facility and that there is one primary care facility that is within 30 minutes travel time of any habitation.
- ◆ Both primary care in terms of outreach services and the outpatient clinic, and higher level of secondary care in terms of the district hospital have developed in the period of the NRHM. However the middle tier level, prescribed for CHC/block PHC in terms of basic emergency obstetric care and newborn stabilisation units have not started up in almost any state and this gap needs to be addressed in the coming years. All 24*7 facilities should be developed to be able to deliver this level of care.
- ◆ In states with persistent high fertility, the gaps are mainly in the supply side and they need to be addressed through creating a larger pool of service providers trained in mini-lap and NSV. There is a need to persist with the goal of fixed day services and examine district plans to see how they propose to achieve this.
- ◆ There is a need for much more attention to spacing methods, especially like long term IUCD. IUCD insertion on fixed days by ANMs and supervision by LHV for new ANMs/Staff nurses has to be encouraged.
- ◆ Availability of MTP by MVA technique and medical abortions has to be ensured starting with fixed points where minilaps are provided and being scaled up to include other sites and providers. Integration training in MVA, minilap and basic emergency obstetric care is essential.
- ◆ Findings of MDR and Infant death audits has to be essentially used in closing health systems gaps and gaps in skills and service provision.
- ◆ Control and management of communicable diseases like malaria, TB and HIV/AIDS directly related to maternal mortality, needs integration with RCH service delivery. There is a need for centrally supported and facilitated capacity development in the high focus districts within the high focus states. These districts do not have the internal human resources or institutional capacity to make the transition and such external assistance is essential to realize this within the short to medium time frame.

vii. Preventive and Promotive Health and Inter-sectoral Convergence

- ◆ NRCs are starting up in district hospitals as part of facility based care but it can optimally function only if there is community demand. This demand generation could be spontaneous or facilitated. Examples from states show that NGOs, CBOs or SHGs with active participation of community can be a driving force not only in enabling access to the facility but in post discharge follow up. This linkage is still not possible without support of community (VHSNC), ASHA and AWW.
- ◆ Continuum of care in service delivery is important not only for pregnancy but also for infant and child nutrition. There needs to be clarity in understanding and planning for the roles for child care: that it is the ASHA -supported by VHSNC who is responsible for the under two, the AWW for the child over two years, and the school for the child at six and thereafter. A continuum of care from home through the AWC and facility and back also needs to be established.
- ◆ The role of VHSNC must be emphasized to be on social determinants. Examples from states highlight that while communities do rise to the occasion, the need is for capacity building that is more process oriented and based on experiential learning, to enable understanding of the root cause of problems such as poor sanitation for vector borne disease (Goa) or domestic violence. This process needs to involve village communities at large so that they also realize their role and support the VHSNC members, and needs active facilitation by NGOs.
- ◆ Screening, identification and management of illnesses among school children should be undertaken through periodic (quarterly) visits of a team of doctors (including AYUSH doctors) or through MHUS in their schools. Once an illness is identified and the treatment prescribed, most common ailments (except for dental extractions, management of visual and hearing problems) can be easily treated at the sub-centre (where deliveries do not take place). Follow up in the school is possible by pharmacist/MPW/ANM. School health programmes should also address social determinants (through subjects such as civics, environmental health and hygiene, and life skills training).
- ◆ Midday meals should be linked to nutritional rehabilitation process as a follow up children identified with Grades II, III and IV malnutrition. Growth monitoring is the basis to effect this recommendation, and VHSNCs need to be made accountable for ensuring growth monitoring during VHNDs.

viii. Gender Issues and PCPNDT

- ◆ All four components of the PCPNDT implementation need to be assured- setting up statutory committees, registration of ultrasound facilities, Completing and Analysing Form F and IEC. The functioning of all private sector mobile ultrasound clinics should be halted immediately.
- ◆ The contribution of excess female mortality in the age group 0–6 years should be studied in each state where it is a problem, and community processes through the ASHA and VHSC should be leveraged to address this.
- ◆ Gender sensitivity in service provision should be made part of quality management protocols and



should be certified. This also includes training of service providers, instituting Vishaka guidelines and mandating district level committees to take action on sexual harassment.

- ◆ Adolescent friendly health services need further innovation and development to develop community centred approaches to improve utilization.

ix. Disease Control Programme

- ◆ Efforts at integration need to improve by a) including disease control programmes into district plans at the levels of facility development, outreach services and community processes, b) improved sharing of data across the MIS systems of the different programmes c) flexible financing to facilities so that those hospitals handling higher caseloads of these diseases can get more.
- ◆ Preventive measures for disease control need to be based on epidemiological understanding of the diseases, and IDSP data, mortality reporting and analysis of hospital based information need to be strengthened. The information from these sources should be used for epidemiological profiling and planning for disease control programmes that are reflected in district plans.
- ◆ Better integration of NRHM with HIV control programme is required in order to benefit the objectives of both programmes.
- ◆ Human resource planning in the district plans need to take into account the needs of disease control programmes especially at a time when attention to non-communicable diseases is increasing.
- ◆ Where specialist care is required but cannot be organised at sub-district levels- either specialists should be encouraged and supported to visit block hospitals on scheduled days for the referral or patients should be supported through transport and free care to reach the specialists at appointed times. This particularly refers to services like eye surgery, and reconstructive surgery.
- ◆ Source reduction programmes for vector control need much better entomological and epidemiological support linked to functional VHSCs and district societies. The high degree of vacancy in difficult districts needs to be overcome by recruiting from available nearly qualified persons and then closing knowledge skill gaps through an appropriate distance education strategy.

x. Programme Management

- ◆ An assessment of how best to operationalize/utilize State and District Health Missions as separate from the governing board of these societies is required.
- ◆ Greater effort to ensure that regular meetings of the governing board and executive committee of state and district health societies take place and the minutes are submitted to the next higher level on a regular basis is needed.
- ◆ Ensure that the Programme Management Units (PMU) at the district and state level have medical officers of requisite seniority, trained in public health and public health management in addition to the contractual staff. This could be part of developing a public health cadre, but even where a policy decision for such a cadre is not made, medical officers could be trained to enable such qualifications.
- ◆ The Chief Medical Health Officer is one of the most important positions for the NRHM. It would be useful to find ways to ensure good governance criteria in making this appointment. A fair and transparent process and an insistence on public health management qualifications would be a step forward. Similarly a three year experience at the level of this position should be made mandatory for higher state level management positions.

- ◆ Integration of Directorates with state PMUs and the supporting institutions requires formation of working teams/committees led by Directorate officers with inter-disciplinary staff from these organisations as members.
- ◆ There should be a career path and a HR policy in place such that those in programme management, data management and financial management positions are able to upgrade their skills and be retained within the health sector. The State should have orientation, capacity building and ongoing training for relevant staff of SPMU, DPMU and BPMU in areas identified through proper



needs assessment, with an ability to cater to a high variation in the level of trainees (ranging from new entrants to highly experienced). Considering that most of the contractual PMU staff are well qualified academically, and are computer literate, there is immense scope to provide structured online capacity building courses and distance learning options.

- ◆ Developing policies for governance and human resources management in para-statal organisations (such as SIHFW, SHSRC, ARC, TNMSC) that provide the additional technical capacity needed for the public health sector is an area of need. Areas where such organisations are needed are infrastructure development, procurement and logistics, community processes support, training and continuing medical education, knowledge and change management, and for data management. Some of these functions could be combined within fewer institutions but the importance is in ensuring that all such functions have a state level institutional capacity in place.

xi. Procurement and Logistics

- ◆ Accelerate the establishment of procurement and logistic systems on the model of TNMSC. The processes that need to be benchmarked with TNMSC include (a) Process of tendering, (b) Pre-qualification of suppliers and blacklisting of errant ones, (c) Quality Assurance of suppliers, (d) Monitoring inventory levels at warehouses and facilities, (e) Ensuring three months' supplies in every facility and warehouse, and ensuring that suppliers are automatically responsive to changing consumption patterns.
- ◆ Ensure capacity building for staff handling stores and supplies.
- ◆ Institute SOPs and guidelines in place for day-to-day processes in line with the best practices of inventory and Supply Chain Management.
- ◆ Expand the scope of ProMIS to make it an effective IT solution for comprehensive inventory and assets management, with interoperability that helps relate it to HMIS.

xii. Information Technologies

- ◆ There should be a rapid shift of effort to use of information and related data quality issues. Increasing granularity of data and increase in level of computerization should be attempted only when the infrastructure and HR is able to support it.
- ◆ There should be greater attention from the Centre to setting up data policy, data quality standards, and standards of interoperability with more autonomy to states to develop state specific systems.
- ◆ HMIS data should be analyzed at all levels and be used for planning and decision making. Root Cause Analysis should be undertaken for any deterioration in indicators and time bound action plans should be formulated to take action. The focus needs to be on “hands-on” training for HMIS from district to block levels on priority.
- ◆ The speed of the central server needs to be increased. States need to get access to back generated reports (at least for administrative log-in). Query builder needs to be provided so that states can generate reports in any combination. A Ready made dashboard to be provided in the MCTS portal for help in analysis.
- ◆ Considering the huge amount of data that needs to be entered under MCTS along with the costs and time of manpower related with it, it may be worth testing this more extensively in few selected districts across the country to devise solutions for specific problems. Based on this experience specific strategies/ solutions for country wide application or for groups of states with similar problems can be worked out. The districts where MCTS has been rolled out with comparatively more success should be studied to understand the secret of success.
- ◆ There should be a clear base paper on MCTS that spells out:
 - How MCTS will work to improve maternal survival?
 - What are HR requirements?
 - How much time service providers like ANMs are expected to provide to this work and how this would benefit service providers?
 - What are the levels of software requirements and level of computerization needed?
 - How will this be integrated with other systems?

xiii. Financial Management

- ◆ Cross training of technical/public health staff in basics of financial management and orientation of finance staff in health issues, is necessary to develop better coordination in achieving physical and financial progress. The regular government staff (especially accounts and finance personnel) also needs to be oriented to the special nature of NRHM and its special accounting needs.
- ◆ Expenditure units (health facilities, blocks and districts) that have more needs (larger population, caseload) and greater capacity (reflected in terms of low outstanding balances) should get more funds. This needs to be accompanied by building the capacity of other non-performing and under-performing units. Such an arrangement would be possible if there is a shift away from strictly “norm based” financing to “differential financing” within broader norms (parameters with a defined range rather than strict and definite parameters).
- ◆ In future, the overall NRHM funds may be divided into two separate streams of Revenue and Capital accounts (similar to treasury route), wherein releases of funds for items in capital account (civil work,

procurement, etc.) may flow separately over an extended time-frame (more than a year). This will ensure that funds for routine activities like JSY, VHND, ASHA, salary of contractual staff, etc. are not held up due to non-submission of UCs on items with larger expenditure cycle (like civil works and procurement).

- ◆ Increase focus on supporting peripheral institutions (RKS and VHSC) in reconciling their funds position. This might be done by (a) more accounting staff at the block level, and (b) increasing the scope and resource support for Concurrent Audit to cover a larger sample of peripheral institutions.
- ◆ Onus should be fixed for channelizing mainstreaming of AYUSH funds and implementation of the activities approved in the state/district PIP.
- ◆ Absorption of funds is a function of two aspects - (a) the choice/mix of programmes and activities that are taken up for financing, and (b) the financial management. A critical appraisal of the last 5 CRMs show that if (i) the accounting staff and related structure is put in place, (ii) there is differential financing, as different from norm or quota based financing, and (iii) there is a separation of capital and revenue funds (items with large expenditure cycle like civil works separated from routine and fast flowing items like salaries, JSY payments, etc.) - the financial management is no longer a limiting factor. Some attention has been given to the first (staff), but the other two needs to be addressed.

xiv. Decentralized Health Action

- ◆ The district plans as proposed by the District Health Society (DHS) and as modified by sanctioned funds must become a public document owned by the DHS. The district health plan must remain the actual guide for program management and review. HMIS and IDSP data need to be analyzed and utilized for planning at all levels.



- ◆ The process of planning must involve consultation with different stakeholders and understanding of the health situation as gleaned from village health planning exercises. A platform should be developed for inclusive, meaningful and proactive participation of stakeholders, non- State actors and community representatives in the planning process of block and district health action plans.
- ◆ Active involvement of PRI members in the functions of VHSNC should be ensured by district and state authorities. PRI members must be involved in preparation of health plans and planning and management of Rogi Kalyan Samitis (RKS). Capacity building and orientation of members of VHSNC, PRI and RKS is the need of the hour.
- ◆ VHSNC and village plans should focus on social determinants, preventive action and ensuring access to care of marginalized sections.
- ◆ District Vigilance and Monitoring Committee needs to be constituted in most states.
- ◆ Community monitoring by VHSNCs, Community Based Organizations, supplemented by NGOs is a model that has shown positive results in states where it has been tested. This needs to be persisted with.

xv. AYUSH

- ◆ There is a need to persist with co-location and add two additional features- better drug supply to co-located AYUSH facilities and insistence on co-located practitioners providing AYUSH remedies and not switching over to allopathic drugs, unless these are part of a national program for which the AYUSH providers have been trained.
- ◆ More systematic, planned use of AYUSH staff in all national programs with special emphasis on preventive and promotive components.
- ◆ Adequate training and certification in skills for AYUSH practitioners who are asked to play the role of MBBS medical officers due to lack of availability of the latter.
- ◆ Incorporation of AYUSH service data into HMIS and building an MIS for AYUSH services.

xvi. Overall Outcomes

- ◆ There is a need for bringing in technical and managerial resources from the rest of India to the high focus districts of the eight states who lag behind- Uttar Pradesh, Bihar, Jharkhand, Chhattisgarh, Madhya Pradesh, Rajasthan and Assam. These resources should be used to build up training and knowledge institutions within these districts, so that when they are withdrawn, the programmes would be sustained the build up of internal capacity. The first four of these states (Uttar Pradesh, Bihar, Jharkhand, Chhattisgarh) would require more infusion of resources than others. A special purpose vehicle or national programme management unit may be placed in charge of such a transfer of resources. The other states in the high focus group like Odisha and Uttarakhand may also require such increased resource transfers to high focus districts, but potentially they could find these resources from within the state.
- ◆ The other main strategy is that for all posts except specialists local recruitment for training/educational programmes with incentives for working in these districts are most likely to solve the constraints of skilled service providers. For specialists a scale up of the family medicine programme – such that every medical officer is potentially trained into a basic specialist - and then retained here through a package of incentives and progressive workforce measures is likely to yield results.

- ◆ The private sector presence in these districts is minimal; however in some instances, Mission Hospitals play a very important role- and one must consider a PPP approach that can harness them- at least for limited goals like emergency obstetric care, safe abortion and sterilisation services. A national programme management unit could facilitate this.
- ◆ The other major recommendation which applies to all other areas – is to develop a model of horizontally integrated district planning which incorporates the control of communicable and non-communicable diseases. This would be the major part of the thrust towards universal health care. The NRHM has by far remained RCH-centric, which was understandable given the urgency of achieving RCH goals. But in all states, except for these eight, though RCH concerns are still important- the time has come to expand facility development strategies that go beyond RCH.



Mandate and Methodology of the 5th Common Review Mission

Mandate and Methodology of the 5th Common Review Mission

The Common Review Mission (CRM) is a mechanism to enable monitoring of the NRHM. With the NRHM into its seventh year, the CRM has become institutionalised as an annual event, undertaken in November each year. The series of CRM reports enable an understanding of the progress that states have made towards the NRHM objectives. In conjunction with other surveys they enable tracking of the achievement towards NRHM goals. The CRM reports are valuable resources that provide a historical perspective of implementation over the period of the Mission. The CRM's focus is on process and outputs, and it then correlates this with outcome measures as derived from the surveys.

This report is the fifth in the series, and the last for this phase of the NRHM.

Mandate of the 5th CRM

1. Undertake a critical review of the functioning of NRHM vis-à-vis its goals and objectives, and identify the changes that have occurred in the last six years.
2. Assess the health care delivery system in the states and explore the main reasons for successes and failures.
3. Document the lessons learnt in implementation of NRHM over the last six years for achieving better results in future, and highlight areas that need further study.
4. Conduct In depth study of major programme components including programme management, planning and design, governance, community ownership, monitoring & evaluation, to inform the design of the next phase of the NRHM.
5. To identify and assess state led strategies and outcomes beyond those specified in the Mission.
6. To identify areas that have not been addressed or which have not been implemented.

Geographical Coverage and Time Line of the 5th CRM

A total of fifteen states were included in the fifth CRM. Eight of these were high focus states, two were from the North East, and the remaining five were non high focus states. Amongst the high focus states Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand were included. The only two high focus states outside the north-east which were excluded were Madhya Pradesh and Jammu and Kashmir, both of which had been covered repeatedly in past CRMs. The non high focus states were included were Andhra Pradesh, Goa, Gujarat, Haryana, and Karnataka.

Himachal and Goa were included for the first time in the CRM. Chhattisgarh, Odisha, Rajasthan and Uttar Pradesh have been part of the last four CRMs. Bihar and Assam have been part of three CRMs, and Jharkhand, Gujarat, Andhra Pradesh and Uttarakhand of two CRMs. Haryana, Sikkim and Karnataka have been visited once before.

On November 8th 2011, a briefing workshop of all team members travelling to the fifteen states was organized at the National Institute of Health and Family Welfare in Delhi, with detailed discussions on the Terms of Reference and presentations made by subject matter experts.

The teams then travelled to their respective states, and on November 9, a day long presentation was held in the state capital on the progress of the NRHM at the state level, including the provision of data on pre-designed

formats. From November 10 to November 13, the teams, divided into two groups and travelled to the selected districts. Their mandate was to visit in each district, the District Hospital, sub-district Hospital, two CHCs/Block PHCs, three PHCs, and five sub-centres. In addition they were to conduct focus group discussions with village communities in ten villages to review outreach activities and the ASHA programme. The teams interviewed the staff and beneficiaries in the facilities, conducting rapid assessments



of the facilities, interacted with communities and ASHA, and reviewed the outreach services. In all districts, the District Medical Officers made a detailed presentation on the programmes of the NRHM in the district. The focus of the four day visit was to collect data primarily through discussions, interviews and observations and obtain secondary sources such as outpatient records, inpatient case summaries, minutes, and reports, that enabled the understanding of the processes and strategies deployed by districts and the state, and the perceptions of providers and beneficiaries on the range and quality of services.

On November 14 the teams returned to the state capitals to review the summary findings of each sub team and develop a presentation of key observations and recommendations. These were then presented to the state officials, staff of the State Health Society, and other stakeholders. Their inputs were incorporated into the presentations and the draft reports were submitted to the National Health Systems Resource Centre and the NRHM division of the MOHFW.

Composition of Teams for the 5th CRM

The fifteen teams constituted for the fifth CRM included 171 resource persons. Of these 72 were government officers, 36 were public health experts, including 11 from civil society organizations, 22 were from the Development Partners, and 41 were consultants with the MOHFW, who served as research associates. Representatives from other government departments also formed part of the teams.

Terms of Reference for the 5th CRM

The teams reviewed 16 components of the NRHM listed below:

1. Infrastructure development.
2. Health Human Resources.
3. Health care service delivery- facility based- quantity and quality.
4. Outreach services.

5. ASHA Programme.
6. RCH II (Maternal Health, Child Health & Family Planning Activities).
7. Preventive & Promotive Health Services including Nutrition and Inter-sectoral Convergence.
8. Gender issues & PCPNDT.
9. National Disease Control Programmes.
10. Program Management.
11. Procurement System.
12. Effective use of Information Technology.
13. Financial Management.
14. Decentralized Local Health Action.
15. Mainstreaming of AYUSH.

A detailed terms of reference given to each of the team members, detailed a number of questions relating to each of these themes that the teams needed to study closely. In addition to specific comments on each of these themes, the report was expected to include information on outcomes achieved, against specific objectives as outlined in the Project Implementation Plans. Reports were also expected to include photographs with appropriate captions and case study narratives.

What is presented in the following pages are the reports and recommendation on each of these 15 themes and a final concluding statement on outcomes followed by a summary of findings from each of the 15 states. While discussing each theme we first present the NRHM mandate, then briefly present the progress made with respect to this mandate and then an analytic summing up of the observations from across all 15 states. After this the findings on that theme from each state are presented and the recommendations as derived from the trends analysis are presented. We note that due to constraints of space, many interesting observations from the 15 states have been left out in this document, but as is the custom, these state reports as summarized and presented by the state teams is made available in a CD that is enclosed with this publication.





Key Findings of The 5th **COMMON REVIEW MISSION**

“There should be a health sub-centre in every 5000 population, a primary health centre for every 30,000 population, a 30 bedded Community Health Centre for every 120,000 population and a 100 beds at the district hospital level for every 10 lakh population. (In tribal and hilly and desert areas, the norms are further relaxed). The Indian Public Health Standards defines the minimum infrastructure, human resources, equipment and supplies that each of these facilities would have and the package of services each facility would provide. The NRHM was committed to helping states achieve these objectives by financing them to close the gaps between where they were in 2005 and where they ought to be by IPHS.”



Public Health Infrastructure

Public Health Infrastructure

Progress Under NRHM

There are three aspects of this- the creation of facilities, the adequacy of civil works infrastructure and the progress in closing gaps. In the first table we present the adequacy of facility creation (sanction) to meet the IPHS norms for desired density of each type of facility, when adjusted for the current population. In the second table, we present the number of facilities which are in their own buildings – that is not operating out of rented space. This does not mean that all own buildings are adequate- but it is still indicative of the gaps for achieving adequacy in infrastructure in terms of buildings. In the third table we present the % of the infrastructure gaps that was addressed/ closed in the NRHM period. The gap refers to the sanctioned facilities without buildings.

Table 1: The adequacy of facility creation

State	No. of sub-centres	Population per sub-centre	Rural Population per sub-centre	No. of any primary care facilities	Density of any primary care facility-Population per any facility {PHC+CHC+SDH}
Andhra Pradesh	12522	6761	4497	1987	42610
Assam	4604	6770	5870	1126	27681
Bihar	9696	10706	9496	1934	53674
Chhattisgarh	4776	5348	4105	889	28729
Gujarat	7274	8301	4766	1496	40363
Haryana	2484	10207	6655	466	54406
Himachal Pradesh	2071	3311	2978	558	12288
Jharkhand	3958	8329	6326	524	62913
Karnataka	8143	7507	4612	2654	23033
Odisha	6688	6272	5226	2034	20623
Rajasthan	11487	5974	4487	1872	36657
Uttar Pradesh	20521	9726	7559	4618	43218
Uttarakhand	1765	5732	3981	313	32322
Sikkim	147	4134	3102	27	22507
Goa	172	8475	3206	54	26995

Table 2: Adequacy of civil works infrastructure: CRM states

State	Sanctioned Sub-centres functional in Govt. Building (%)	PHC functional in Govt. Building (%)	CHC functional in Govt. Building (%)
Andhra Pradesh	34	82	100
Assam	47	100	100
Bihar	50	92	100
Chhattisgarh	42	50	77
Gujarat	72	94	84

State	Sanctioned Sub-centres functional in Govt. Building (%)	PHC functional in Govt. Building (%)	CHC functional in Govt. Building (%)
Haryana	60	70	99
Himachal Pradesh	62	77	100
Jharkhand	46	56	100
Karnataka	55	98	92
Odisha	41	98	100
Rajasthan	89	95	98
Uttar Pradesh	51	84	100
Uttarakhand	52	75	100
Sikkim	95	100	50
Goa	27	100	100

Table 3: Progress in closing Infrastructure gaps under NRHM: Progress in closing infrastructural Gaps: CRM states (to be verified with states)

State	Sub-centres		PHC			CHC			DH		
	SC building GAP	SC New building work taken up	% of completion of work achieved	PHC building GAP	PHC New building work taken up	% of completion of work achieved	CHC building GAP	CHC New building work taken up	% of completion of work achieved	New work sanctioned	% of completion of work achieved
Andhra Pradesh	9681	1081	18.4	310	100	0	104	124	90	0	0
Assam	1796	1292	NA	0	NA	NA	60	NA	NA	6	NA
Bihar	4875	2350	33	–	352	30	NA	201	NA	12	83
Chhattisgarh	33+2724*	2603	45	110+251*	305	38	8+24*	105	89	8	87
Gujarat	0+2062*	258	46	0+61*	99	67	0+45*	14	36	15	NA
Haryana	0+982*	210	68	0+132*	76	49	0+1*	20	30	8	25
Himachal Pradesh	14+783*	184	64	39+63*	76	50	0	8	50	11	45
Jharkhand	1314+835*	410	40	58+87*	101	28	NA	149	10	36	42
Odisha	3958	820	19	0+31*	98	57	NA	10	20	35	27
Rajasthan\$	652+590*	931	30	35+44*	123	56	3+3*	14	57	30	97
Uttar Pradesh	14053	13262	61	NA	858	59	NA	466	28	21	100
Uttarakhand	849+7*	300	100	NA	10	NA	NA	15	NA	2	100
Sikkim	8	5	80	0	2	100	0	2	100	2	100
Goa	148	64	0	NA	19	33	4	4	NA	2	NA

* SC, PHC, CHC functional in Panchayat building for which no rent is paid.

\$ Data based on RHS 10.

Main Observations

- ◆ Using the 2011 census population figures as the reference point, most states have less facility than is required by norms. However if we assume that these facilities serve only the rural population the situation is much better. The gaps are largest in Bihar and Uttar Pradesh and least in Himachal and Sikkim. In Jharkhand, Chhattisgarh and Uttarakhand, in that order, the gaps are still high as measured against the norms for hilly and tribal areas.
- ◆ In all states DHs were in their own building and gaps were small. Where there are gaps- these have been closed at least in the districts visited.
- ◆ CHCs and SDHs are as a rule, in their own building, though in terms of space many of them are not upto the Indian Public Health Standards. The focus of NRHM has been on upgrading CHCs upto IPHS and in every district visited- this gap is either completed or there is work ongoing.
- ◆ In terms of PHCs also most states have narrowed down the gaps. The two recently formed tribal states of Jharkhand and Chhattisgarh do poorest. Bihar too has large gaps in this “PHC” level (called APHC in Bihar). This is confirmed by CRM’s field observations also- except in Himachal and Haryana where the situation in the districts visited is significantly better. PHCs face most problems in terms of handing over, meeting quality specification, rational location and even HR- and this may be a reason for many states which started with very poor baselines, to have not given this a priority.
- ◆ sub-centre buildings where built are up to or close to IPHS norms. Here gaps are large and though states have made an effort to close gaps, the progress has been slow.
- ◆ States which have formed an empowered institutional framework for development of infrastructure are Andhra Pradesh (autonomous body), Gujarat, Jharkhand, Odisha, (empowered cell), Bihar, Chhattisgarh (under formation). In terms of pace of work, creation of such a body has been a clear advantage to closing the gaps. Even in Andhra though pace is slow the gaps are much nearer to closure. However, quality of construction especially with respect to the needs of hospital design has been poor and there has been no effort to build such a capacity in these bodies.
- ◆ Many states have co-located a sub-centre in PHC or CHC or even district hospital building to provide outreach services and home visits to the 5000 population living in adjacent areas. In other states, a separate sub-centre has been set up some distance away- in which case the sub-centre utilization is poor. There is merit in such co-location which would decrease infrastructure requirements by about 20% and make for synergies in human resource utilization and this should be encouraged. But for HMIS purposes and HR allocation a sub-category of “co-located sub-centre” would be useful.
- ◆ Non-availability of residential accommodation for the essential staff within the health facilities’ premises is a major hindrance in operationalising the facilities on 24x7 basis. This is a problem in all states visited- and at all facility levels. In contrast to earlier CRM reports, most state reports mention that available accommodation is being used- and the problem now is therefore creation of enough accommodation.
- ◆ Non-availability of night-stay arrangements for ASHAs at the facilities remains a problem, except in Sikkim and Uttarakhand. Chhattisgarh and Odisha have made progress on this score.
- ◆ Stand-alone AYUSH dispensaries/hospitals in some states are accommodated in rented or donated buildings with weak infrastructure and in many instances these are located away from the communities’ habitation. Own buildings should be constructed for such units near to the communities for better access and delivery of services.

State Findings

ANDHRA PRADESH

- ◆ The state has formed A P Health, Medical, Housing and Infrastructure Development Corporation which is responsible for the construction and maintenance of the buildings. However, it has not materialized into the speedy completion of the sanctioned projects.
- ◆ Though, the number of sub-centres in the state is adequate (107%), only 33.7% of the sub-centres have residential quarters for the ANM. The State has shortage of PHC by 15% and CHCs by 39% in the State.
- ◆ Equipments for the newborn corner, including radiant warmer, were not available at many facilities, visited by the CRM team.
- ◆ Total sanctioned buildings for new construction were 1479 out of which only 865 are completed. Work in progress at 614 facilities.

ASSAM

- ◆ Number of sub-centres in state is stagnant since 2005, after launch of the NRHM. At present, one sub-centre caters to app. 6,770 population, though the state has inaccessible areas and considerable geographical barriers in availing the facilities.
- ◆ Only 61% of sub-centres functions from Government Building. During NRHM period, 1078 new healthcare infrastructures were made functional and 1511 facilities are under construction.
- ◆ There were 1343 new construction works to be undertaken in the State of which only 349 works have been completed. Construction work has been started in 346 projects and 648 works were yet to be started during the time of the visit.

BIHAR

- ◆ The number of sub-centres in the state is short by 47% and APHC by 55% of total requirement. Number of available CHCs/ referral hospitals in the state is 70 (11.5%) against the total requirement of 604 such facilities, which would hamper state's efforts in operationalisation of FRU in every block.
- ◆ 50% of the available sub-centres do not have their own building.
- ◆ The Government has created 'Bihar Medical Services and Infrastructure Corporation' to address the infrastructure related issues. However, its effectivity is yet to be seen.
- ◆ Total sanctioned buildings for new construction were 2915 out of which only 872 are completed. Work in progress at 2043 facilities.



CHHATTISGARH

- ◆ The state has created a separate 'Infrastructure Wing' under auspices of Chhattisgarh Medical Services Corporation. However, quality of the civil work at many visited facilities was not of good standard.
- ◆ The state has collocated Health sub-centres with level 3 facilities, to provide outreach services to adjoining population. This planning initiative is appreciated.
- ◆ Residential accommodation for the key staff at health facilities is deficient.
- ◆ Total sanctioned buildings for new construction were 287 out of which construction is completed nowhere. Work in progress at 256 facilities.

GOA

- ◆ For Level 2 and Level 3 facilities, available infrastructure is good. However, there is 33% shortfall in the number of sub-centres in the State.
- ◆ Implementation of sanctioned infrastructural upgradation work is slow, such as, at 14 PHCs; 2 separate issues out of the work sanctioned at 19 locations, the actual work had not begun.
- ◆ Total sanctioned buildings for new construction was 3 out of which only 1 is completed. Work in progress at 2 facilities

GUJARAT

- ◆ The state has established a PIU (project Implementation Unit) which is a nodal agency for the infrastructure development in the State. This has helped in reducing time in getting approvals and completion of projects.
- ◆ 14.5% of PHCs and 5.6% of CHCs do not have their own building.
- ◆ Total sanctioned buildings for new construction was 435 out of which only 76 are completed. Work in progress at 46 facilities. 15 DH are under renovation.

HARYANA

- ◆ There is shortfall in number of sub-centres in the state. As per latest census data, the state should have 6,654 sub-centres (Rural Population – 1,65,31,493), while the state has total 2630 sub-centres. The state has added only 197 sub-centres after the launch of NRHM.
- ◆ The state should add more beds in public health facilities because the availability of beds per thousand populations has fallen from 0.52 in the year 2005 to 0.39 in 2011.
- ◆ Total sanctioned buildings for new construction were 385 out of which only 166 are completed. Work in progress at 170 facilities. 6 DH are under renovation.

HIMACHAL PRADESH

- ◆ Though, the state does not have a separate health infrastructure wing, quality of construction has been found good at the visited locations.
- ◆ The state has good health infrastructure with all District Hospitals and CHCs, having Government building. However, only 75% of PHCs function from the Govt. building and only 463 AYUSH functionaries out of total 1159 are functioning in Government buildings.
- ◆ There is shortage of residential accommodation at the CHCs as well as PHCs.
- ◆ Total sanctioned buildings for new construction was 87 out of which construction is completed nowhere. Work in progress at 87 facilities. 6 district hospitals are under renovation.

JHARKHAND

- ◆ The state has operationalised 12 more ANM training institutions during last one year under the PPP mode.
- ◆ The state has added 194 CHCs and 136 PHCs after April 2005. However, no sub-centre has been added during this period, though one sub-centre in the state caters to approx 7000 population and the state also has inaccessible and difficult areas.
- ◆ Pace of construction is slow in general, at many locations; the PDC of the work has been exceeded by two years or more.
- ◆ Total sanctioned buildings for new construction was 86 out of which construction is completed nowhere. Work in progress at 86 facilities.

KARNATAKA

- ◆ The state has formed a robust functioning engineering cell to oversee infrastructure development in the state.
- ◆ Construction of the residential quarters do not seem to be part of the normal new constructions, which may be hindrance in operationalising the facility on 24 X 7 basis.

ODISHA

- ◆ The state has established an Engineering Wing, integrated with planning and monitoring process.
- ◆ 8.0% of the PHCs and 40% of the sub-centres are functioning in rented buildings. The state has added 98 sub-centre buildings after April 2005, still having deficiency of 1357 sub-centre buildings.
- ◆ There is overcrowding in the wards of District Headquarter Hospitals, which requires planning for filling the gap at district hospitals.
- ◆ Total sanctioned buildings for new construction was 354 out of which only 205 are completed. Work in progress at 68 facilities. 30 district hospitals are under renovation.

RAJASTHAN

- ◆ The state has 11487 functional sub-centres, while as per population norm for sub-centre, the state should have higher number of sub-centres, more so to cater for the need of inaccessible areas.
- ◆ In Barmer district, 155 new labour rooms have been constructed, but have not been put to use.
- ◆ Total sanctioned buildings for new construction were 1068 out of which only 357 are completed. Work in progress at 265 facilities. 30 DH are under renovation.

SIKKIM

- ◆ There is an Infrastructure Development Wing at Health Directorate for the construction, maintenance of Infrastructure in the state.
- ◆ The state has shortfall of 02 CHCs in the State.
- ◆ Total sanctioned buildings for new construction were 9 out of which only 8 are completed. Work in progress at 1 facility. 1 DH is under renovation.



UTTARAKHAND

- ◆ There is a separate planning cell at the State Directorate for monitoring of Infrastructure related work.
- ◆ In view of hilly terrain of the state, average population covered by one CHC – 1,27,737 is high. There is shortfall of sub-centres as per population norms, 1847 in place against the requirement of 3372 sub-centres and 55 CHCs existing against the requirement of 126 facilities.
- ◆ Lack of residential facilities for the ANM, Staff Nurses and MOs is a constraint. Out of the 1765 sub-centres, 879 sub-centres (50%) does not have ANM quarters.
- ◆ There has been a lot of delay in construction works in the districts. In Rudraprayag, the district hospital and a PHC have been under construction for over 2 years.

UTTAR PRADESH

- ◆ The state has added 8638 sub-centres, after launch of NRHM. However, still one sub-centre caters to approx. 7500 population.
- ◆ In Badaun District, two newly constructed PHCs have not been fully operationalised due to lack of manpower as well as problems with electricity, sewage connection etc. The newly constructed but unused infrastructure was slowly withering away due to lack of maintenance. Compound walls were found to be damaged to allow cattle and other animals to graze in.
- ◆ State has given priority to construction of 77 modular operation theatres which was not the need of the hour in the districts (Badaun and Jalaun) visited.

Recommendations

- ◆ The states should operationalize “Infrastructure Wing”/“Medical Services Corporation” where they are not functional. A hospital planner and hospital architect should be appointed to these organizations and the existing technical staff and administrators of this cell/corporation should be sensitized to hospital design issues.
- ◆ A comprehensive facility development plan should be developed for each district so that in most states the infrastructure requirements of essential facilities are completed in the 12th Plan period. The plan should clearly prioritize construction so that those having greater caseloads, and areas with less access to services have building up-gradations done earlier. Construction work could be phased, subject to availability of funds.
- ◆ Further concerns are involving service providers and community representatives in the choice of locale, design and monitoring quality of construction. Also to insist on quality check programmes for infrastructure, like complaints with National building codes or BIS norms and fire safety protocols etc.
- ◆ A room or guest facility for ASHAs to rest and if needed to stay overnight when they come as escorts and birth companions should be insisted upon wherever there is likely to be frequent occasions for use of this facility.
- ◆ Residential accommodation for service providers is emphasized yet again, with the recommendation to prioritise those facilities where this is identified as the single most important, even as the only reason for not being able to operationalise a 24*7 services.
- ◆ There is a case for designing fund flow for infrastructure such that the creation of such a cell is encouraged and making it conditional on a comprehensive five year facility development plan with prioritization being presented.

“One of the central issues of human resource planning is the challenge of getting skilled professionals to join in public health systems and agree to stay and work in rural and remote areas. Since most doctors come from urban middle class backgrounds, the economic loss and professional and social isolation of rural service, deters them from public service. NRHM has begun to change this scenario with multiple strategies for attracting and retaining the skilled providers in the rural and remote areas. Initial results have been very encouraging.”



Human Resources for Health

Human Resources for Health

Progress Under NRHM

- ◆ In the last six years period of the NRHM, 82 medical colleges have been added and 9751 seats increased. Further 595 ANM Schools, 1227 GNM Schools, 1026 B.Sc. Nursing Courses; 405 post basic B.Sc. Nursing Courses, and 327 M.Sc. Nursing Courses have also been added
- ◆ One of the major contributions of the NRHM has been the addition of 148361 contractual skilled service providers (as on 31/3/2011) to the public health services. The break-up of category of service providers added is given below. This is particularly remarkable because the baseline on which this addition has taken place is estimated to be 1.5 lakh. Further the majority of staff added are women.

Sr. No.	Category of contractual staffs posted at public health facilities	Total Number added in last 6 years
1.	MBBS doctors	9432
2.	Specialists	7063
3.	AYUSH doctors	11575
4.	AYUSH paramedics	4616
5.	Staff nurses	33667
6.	Paramedic	21740
7.	ANM	60268

- ◆ This is in addition to the substantial increases in workforce that has resulted by filling up of regular vacancies under the state governments. In addition this period has seen the addition of 8.5 lakh ASHAs.
- ◆ NRHM has also inducted 583 District Programme Managers, 565 District Data Managers, 575 District Accounts Managers, 3771 Block Managers, 4143 Block Accountants and 5458 PHC Accountants in addition to 500 Management and Public Health Consultants at State Management Roles.

Main Observations

- ◆ Despite the dramatic increase in human resources, in comparisons to IPHS norms, there is still a long way to go. International standards for health worker density are even higher. Also most of the staff are contractual, and the expansion of service providers to reach minimum requirements by state governments lags behind.
- ◆ Many states have creatively addressed the problem of attracting and retaining professional service providers in rural and remote areas. Financial Incentives (Difficult Area Allowance) have been introduced in some states such as Haryana, Himachal Pradesh, Karnataka, Odisha, Chhattisgarh, Rajasthan and Sikkim particularly for medical officers/specialists serving in difficult to access areas. For example in Haryana, difficult area allowance is being given to Doctors posted in Mewat and Hathin block of Palwal (Rs. 25,000 per month for Specialist, Rs. 10,000 per month for other Doctors) and in Karnataka, special remote area allowance had been budgeted in the PIP wherein incentive of Rs. 300–Rs. 8000 has been built in for various health personnel starting from Group D to doctors. The Haryana state policy offers Rs. 3000 to MOs working in rural areas, Rs. 6000 to MOs working in difficult areas and Rs. 9000 to MOs working in most difficult and tribal areas. This is now raised to Rs. 6000, Rs. 9000 and Rs. 12,000 respectively. In addition, non-financial incentives including credit marks in PG Entrance examinations is being provided to doctors

working in the rural & remote areas in states such as Himachal Pradesh, Chhattisgarh and Odisha. In Himachal Pradesh, MOs completing 3 years as an MO in a hard or difficult area, qualify for being selected as a PG student, while only two years is enough to do so from a most difficult area - and five years is needed for any rural area. There is quota in PG entrance selection for state sponsored in-service candidates and there is a provision of posting the spouse of a PG student as Senior Resident or Junior Resident in the same medical college. In spite of remedial measures being undertaken, shortage of health personnel remains a big impediment in optimal functioning of existing health facilities and operationalizing new facilities and special care unit like Newborn Stabilization Units, SNCU etc.



- ◆ Policy measures were adopted to address the shortage of HR in rural areas through compulsory 1 year rural service for eligibility to appear in PG studies in states such as Assam and Haryana. In Haryana, two years rural service at each stage of ACP was made mandatory. In state like Karnataka rotational posting in difficult areas has improved the worker morale and it has taken up systemic changes including enacting of few Acts (i.e. Transfer Act, 2011 etc) to improve the management of HR; creation of specialist cadre, amendment of recruitment rules which paved the way for direct recruitment of specialists through Karnataka Public Service Commission (KPSC). Some states such as Gujarat and Odisha have increased the retirement age of health personnel so as to retain them in service for a longer period.
- ◆ Simplification of recruitment process in Haryana and Odisha has yielded positive results in filling up vacancies. Several other States are also following in the footsteps and adopting policy changes to make recruitment process an on-going decentralized procedure, reduce appointment time-frame while at the same time, making it more transparent. Inordinate delays in recruitment process is responsible for large number of posts remaining unfilled in many of the states and the need of the hour is delegation of powers to facilitate decentralized recruitment.
- ◆ Measures to preferentially admit only those students who are likely to serve in under-served areas and moulding education to retain this commitment are also most successful. The experiences of 3 year course of Assam are particularly notable. Career progression for Mitans and ANMs has also been devised through training of Mitans to ANMs, ANMs to Nurses, and Nurses to Teaching Faculty of Nursing Schools as in Chhattisgarh.
- ◆ In area of educational reform, Assam has introduced three year diploma courses with the objective of filling in vacant positions in the remote, far flung and rural areas with skilled providers for primary care services. The state has deployed 261 Rural Health Practitioners (RHP) in sub-centres. Chhattisgarh has filled up PHC posts with similar outcome but it has been stopped.
- ◆ Irrational deployment of available resources mean that a majority of health care workers are concentrated in urban areas, SBA trained nurses are not posted in delivery points, LSAS & EmOC trained doctors have not been allocated to designated FRUs and the number of personnel are not proportionate to the caseload in health facilities.

- ◆ The state governments have increased the number of Medical Colleges, Nursing Colleges, ANM Training Centres to ensure that there is adequate availability of qualified health care workers for recruitment.
- ◆ Though states have upgraded skills of health personnel such as MO; due to lack of screening, pre-training counseling, lack of training follow up, supervision and supportive environment etc.; there is low utilization of learned skills. Besides, LSAS & EmOC trained doctors have not been allocated to designated FRUs and the number of personnel are not proportionate to the caseload in health facilities.
- ◆ Although multi-skilling and skill upgradation trainings are core strategy of NRHM, insufficient training facilities and lack of proper training calendars result in inadequate trainings being conducted and no quality check on the trainings which have a direct impact on the skills & performance of health workers.
- ◆ Even though, NRHM, by way of contractual appointments has improved overall availability of human resources at all levels of health facilities, a general sense of lack of motivation has been observed due to poor service conditions, outdated renewal policies and a clear demarcation between regular and contractual employees. Also, there is an avoidable shortfall in filling up long standing vacant posts of doctors and paramedics (including AYUSH) in a time-bound manner.

Findings from States

ANDHRA PRADESH

- ◆ The state has added 663 AYUSH doctors, 81 specialists, 1163 staff nurses and 10613 ANM as in September 2011 on contractual basis.
- ◆ There is a glaring gap of 4901 between the required and the number of MPW (male) posts sanctioned. Even among the sanctioned posts, there is a vacancy of more than 23% and no new recruitments are currently being made to this cadre.
- ◆ The vacancies in the General Duty Medical Officers (6.5% posts vacant of the sanctioned posts) and LHVs (3.1% posts vacant of the sanctioned posts) are low in the state and there are no vacancies in the ANMs and Obstetricians in the State which is appreciable. The low vacancies in the GDMOs may be attributed to their policy of giving additional weightage during selection post-graduation to the MOs who have served in public health facilities, particularly in hard and difficult areas.
- ◆ Though the posts of the doctors on study leave does not get recognised as a vacancy, it remains unmanned. To address this challenge, the state recently has sanctioned additional posts in lieu of leave vacancy.
- ◆ There are huge HR crunches in the Specialists, Radiographers, Laboratory Technicians and Nursing Staff at PHCs and CHCs and practically no facilities are providing 24 hour lab services for emergency investigations in both the districts visited as there are more than 17% vacancies in the posts of paramedics and lab technicians and no pool of lab technicians is created at the facility level in secondary care institutions.
- ◆ Issues related to irregular payment of contractual staff were brought to light, particularly for ANMs originally funded by the European Commission.
- ◆ Steps taken by the Government to address the shortage of Human Resources include compulsory rural service after completion of PG study, addressing vacancies due to doctors on PG-leave, sanctioning of new posts for paramedics in the areas with acute shortage.
- ◆ A large number of training institutions are in the private sector, especially for training nurses and other paramedical staff. Only 6.24% of the total intake for nursing and paramedical training in the State is in the Government Institutions. Further, the quality of the training being provided by such institutions is not being ascertained and monitored.

- ◆ Training Plan/Training Calendars are not available. Many trainings like Multi-Skilling of Doctors (LSAS and EmOC), Training for IUD and Spacing Methods are not taking place. LSAS training of the Mos is being opposed by the Anaesthetists' Association in the State and the trainees were denied certification. The State is in process of resolving the issue with the Association. High attrition rate of trained staff has been identified as the main reason for continued high training load in the state. Regional Training Centres are conducting in-service trainings for all Medical & Paramedical staff including Induction trainings, BCC/IEC trainings, IMNCI trainings and ARSH trainings.

ASSAM

- ◆ The state has made efforts in meeting the requirements of HR through various innovations though there is lack of a human resource policy.
- ◆ The state has MIS for human resource in place, which is used for management of human resources in areas of transfer and posting. There is also a process to consider the proposal for creation of a specialist cadre in 2012.
- ◆ Assam has rolled out the three years rural health course to ensure that skilled manpower is available in rural areas.
- ◆ The state has added 896 MOs, 2987 staff nurses, 584 laboratory technicians, 279 pharmacist and 4921 ANMs on contractual basis as in September 2011. There are shortfall of 633 MO (16%), 389 (29%), 4315 (43%), 1344 (51%), 1064 (43%) and 312 (3%).
- ◆ The recruitments of medical officers and specialists from medical colleges have ensured their availability in public health facilities through enforcement of the compulsory government service bond.
- ◆ There is irrational deployment of manpower particularly staff nurses and paramedics.
- ◆ State is planning to start a two years diploma course in Maternal Health, Paediatric Medicine, Clinical Anesthesiology and Radiology with an intake of 156 on annual basis to be initiated in 2012 onwards.
- ◆ The LSAS (36) and CeMOC (24) trained doctors are not practising due to lack of proper follow up and supervision post trainings, lack of support from concerned specialists or either due to lack of facilities to practise etc.
- ◆ Upgradation of skills of health personnel through capacity building initiatives needs improvement.

BIHAR

- ◆ Though the human resource position has improved considerably since 2005, on account of hiring of contractual staff, and beginning to implement progressive HR policies, there is still substantial ground to cover.
- ◆ State has instituted certain measures to recruit, post and retain staff as follows: walk in interview every Wednesday, on-site application facility, reorganizing and rationalizing existing trained manpower, posting of AYUSH doctors in APHC/HSC, web enabled system to capture district level cadre information and recruitment, provision of three dynamic ACP at interval of 6, 12 and 24 years, cadre rules notified and revision of pay scales for staffs such as GPMO, specialists, contract nurses, ANM etc., rational deployment of LSAS and



EmOC trained medical doctors to FRU, IT enabled HR data base for medical and non-medical staff, cadre review and campus recruitment for MBBS students. Of 8858 HSCs, in the state, 3640 have two ANMs, and 138 have three or more ANMs.

- ◆ Part of the problem with staff shortages is also due to delays in the recruitment policies. Districts have not yet been able to place the required numbers despite the decentralization of recruitment of certain categories of staff due to delayed approval of reservation rosters, difficult living conditions, delays in recruitment etc.
- ◆ There is a purposive effort to build in service training capacity by expanding the numbers of medical colleges & nursing schools in the state and reviving state run ANM training schools.
- ◆ Annual training calendar for skill upgradation is developed at the state level and sent to the districts, though training does not always go according to plan. The state also plans to set up skill labs in 4 districts on the line of the one that has been set up in the Guru Gobind Singh Hospital in Patna city. AYUSH doctors have been oriented to NRHM, and trained in IMNCI, HMIS, and family planning.

CHHATTISGARH

- ◆ There is acute shortage of health human resources at all levels and vacancy is 74% for specialists; 50% for MO, 74% for staff nurses. Huge gaps exist in almost all categories of health personnel in terms of sanctioned posts - MBBS Doctors (1193), Specialists (683), Staff Nurses (3734), Paramedics (1795), ANMs (608). In fact there has been no contractual recruitment for Specialists, LHVs and Pharmacists.
- ◆ In view of severe shortage of Medical Officers, the state decided to post all Medical officers at CHC level while posting Rural Medical Assistants (RMA) and AYUSH MOs at PHCs, under the supervision of Medical Officers at CHCs. There are 1287 Rural Medical Assistants (RMAs) in place.
- ◆ Efforts have been also made to improve recruitment procedures and since April 2011 recruitment for doctors is open all time and a committee has been made which will review applications received and recruit doctors on quarterly basis (56 appointments have so far been made in the State).
- ◆ Chhattisgarh Rural Medical Corps (CRMC) has been constituted under which provisions for monetary and other incentives (Life Insurance Coverage, Marks for PG examinations - 10% of marks for each year of service upto maximum of 30%, Facilitation of spouse posting in the same areas/institutions, Choice of Posting after 3 years working in difficult and most difficult areas etc.) are being given to motivate and retain health personnel working in rural & difficult to access areas.
- ◆ There is around four fold increase in B.Sc. Nursing and GNM-TC and around nine-to-ten fold increase in ANM-TC and MPW(M) Training centres in the last 3-4 years.
- ◆ Career progression pathway for Mitans and ANMs has also been devised through training of Mitans to ANMs, ANMs to Nurses, and Nurses to Teaching Faculty of Nursing Schools.
- ◆ Training requirement is developed but there is no integrated training calendar. 31 specialists have been relocated after training for utilization of Skills and rational deployment. To fulfil the need of specialist doctors, 32 EmOC and 15 LSAS Doctors have been trained. 15 in EmOC and 10 in LSAS are undergoing training.

GOA

- ◆ There is no hard-to-reach area defined in entire Goa. Staff positions are almost filled against sanctioned posts except dearth of Gynaecologists, Anaesthetists and Surgeons.
- ◆ AYUSH doctors are well placed. Mostly Homeopathy doctors are placed at CHC and PHC level. They have a separate unit well operating and are not replacements for MBBS MOs.

- ◆ State has no documented personnel policy in regard to recruitment process, performance appraisals/ performance/termination and exit interviews of contractual employees. Rules of engagement of contractual staff are not clear.
- ◆ To meet the availability of Gynaecologists, the state has revised their emoluments to meet their expectation level and make them available in public health facilities.
- ◆ Nursing and ANM training facilities are in place. However, the state does not have SIHFW, RHFWTCs, MPWTCs and training is the most overlooked component.
- ◆ The State has decided not to train their doctors in LSAS and CeMOC as all patients are referred in case of emergencies to secondary and tertiary care hospitals in view of the easy access to both.

GUJARAT

- ◆ Shortage of human resource is one of the biggest challenges faced by the state, particularly specialists - Obstetricians & Gynecologists, Pediatricians and Anaesthetists. The state has added 8 contractual specialists at DH/SDH (gap is huge at 60.9%); 886 contractual AYUSH doctors at CHC/PHC (gap is 3.6%) and 65 contractual staff nurses at CHC & others (gap is 28.9%)
- ◆ Low remunerations for both regular and contractual MOs and Specialists offered by the public sector in to private hospitals coupled with the fact that no additional allowances are given for working in underserved areas have been demotivating factors for those working in these areas.
- ◆ There is a lack of definite plan for rational deployment of skilled human resource in the district to ensure services in the high caseload facilities.
- ◆ Few of the initiatives undertaken by the state to address the HR gaps include enhancement of retirement age to 65, appointment of staff nurses from other state institutions, walk-in interview every Monday/Tuesday for MOs/Specialists, outsourcing of paramedical staff under PPP.
- ◆ AYUSH doctors are managing the National Health Programmes extremely well. Knowledge of the programmes, surveillance activities, education/awareness provided to the community is admirable and records were well maintained.
- ◆ State Government plans to establish 7 New Medical Colleges as self-financing institutions under the Gujarat Medical Education Research Society (GMERS). The Post-Basic Course in Nurse Practitioner Midwifery is one of the recent initiatives to train ANMs & GNMs in midwifery skills.
- ◆ SIHFW, is located in Gandhinagar and provides support to training centres at different levels all across the state. But currently the institute is facing difficulties due to frequent shifting of premises and poor infrastructure and there is no provision for accommodation for trainees.
- ◆ NSSK and IMNCI training has been done in significant numbers across the state and post training follow up for IMNCI is being conducted by SIHFW, but training of doctors on LSAS and EmOC is one of the areas where the state requires improvement.

HARYANA

- ◆ The State had adopted certain changes in their recruitment policies in November 2008 to fill the huge gaps existing for Doctors including continuous process of web enabled recruitment system where applications & interviews are ongoing events and time span for appointment was curtailed. Under this merit-based transparent procedure 2254 Doctors have been recruited out of which 811 are Specialists till August 2011. The state has added 113 doctors, 246 specialists, 1295 staff nurses and 155 AYUSH doctors on contractual basis.

- ◆ The state has initiated other recruitment measures such as pay scale revision for MO, three ACP introduced with 25% NPA, 2 years rural service at each stage of ACP, minimum 6 years of rural service, additional increment for specialists and difficult area allowance for doctors are introduced.
- ◆ The state has also introduced placement policy and accountability such as stable tenure of at least 3 years, posting of doctors as per specialization and increased strength of specialists at DH/SDH & CHC.
- ◆ There are adequate Nursing and ANM Training Schools and 3 new Govt. Medical Colleges are being established in the State.



HIMACHAL PRADESH

- ◆ Admittedly the central problem of health care in Himachal Pradesh is the availability, skills and performance of its skilled human resources.
- ◆ Of 1597 sanctioned MBBS MOs, there are 834 filled, 153 on State contract and 287 on RKS contract with a remaining gap of 323. The vacancy problem is most acute in specialists- where every level including the medical colleges is affected. 380 out of the 2067 HSCs are without ANMs and of these 180 HSCs are without any worker. The State has not recruited ANMs for quite a long time now and only recently has sent its recommendations to the state service commission for recruitments. Similar is the position in AYUSH side where posts of Ayurveda medical officers, specialists, pharmacists and paramedics are lying vacant since long affecting the service delivery adversely.
- ◆ Lack of delegation of contractual appointments to the district health society coupled with an irrational informal cap to keep recruitment low lest there is over-staffing of government facilities means that substantial gaps exist in spite of skilled personnel available on the open market e.g. paramedical staff.
- ◆ Substantial difference in remuneration paid to the MOs and SNs recruited by RKS and those from the state has only resulted in creating a sense of disparity.
- ◆ The bright spot in the scenario is the progress made in filling up medical officer vacancies. Clearly innovation and determination yield results, even in what are very old problems, and posts have been filled in difficult-to-access postings.
- ◆ The state currently offers graded financial incentives to MOs who work in difficult areas depending on the extent of difficulty. Moreover, completing 3 years as an MO in a hard or difficult area, qualify for being selected as a PG student, while only 2 years is enough to do so from a most difficult area.
- ◆ These schemes though successful for medical officers have made no dent in specialists. State officials informed the team that in spite of offering a big amount of Rs. 98,000 to Specialists; no one comes up for high focus districts.
- ◆ To make it further attractive the state has a provision of posting the spouse of a PG student as Senior Resident or Junior Resident in the same Medical College. In addition there is an informal understanding to give

preference to posting persons to their native towns/blocks and this was no doubt a reason why many of those posted very happy to stay there.

- ◆ Training roll out has been slow. There has been very little IMNCI training and F-IMNCI training is yet to start up. There has also been slow training for BEmONC and none for NBSUs or SNCUs. Even SBA training shows limited progress.

JHARKHAND

- ◆ The status of Human Resources in the state presents a grim picture. If the current number is gauged on the IPHS standards, the shortage is to the extent of 1297 Specialists, 512 MBBS MOs, 1751 Staff Nurses and 353 pharmacists. Apart from this, the state also requires 1828 ANMs, 1904 MPW (M), 188 Laboratory Technicians and 955 AYUSH Paramedics.
- ◆ The distribution of available human resources is highly skewed and concentrated mostly in the urban centres.
- ◆ The process of recruitment of Medical officers and paramedics is lengthy and takes about four to six months.
- ◆ Compartmentalization of work sphere means that laboratory technicians under disease control programs perform investigations limited to their program only.
- ◆ Districts visited lacked training plan resulting in absence of need-based trainings.

KARNATAKA

- ◆ The state has taken up systemic changes including enacting of few acts (e.g. Transfer Act, 2011 etc) to improve the management of HR; creation of specialist cadre; amendment of recruitment rules which paved the way for direct recruitment of specialists through Karnataka Public Service Commission (KPSC).
- ◆ The State is also in the process of building up a public health cadre and has plans to provide comprehensive training to the doctors.
- ◆ The HR situation in Karnataka is satisfactory and gaps in availability of Gynecologist, Anesthetist, and Pediatrician are overcome by in-service training of EmOC, LSAS and F-IMNCI. The state had a total of 53 EmOC and 67 LSAS trained doctors and 57 LSAS and 39 EmOC doctors who are posted in FRU/DH are practicing the skills.
- ◆ Karnataka State Civil Services (Regulation of Transfer of Medical Officers and Other staff) Act 2011 has been enacted which has come into effect from 2nd May, 2011 with provisions for compulsory posting in rural areas and transfer of specialists to appropriate posts.
- ◆ Steps have been taken to rationalize the HR situation - Specialists have been redeployed in FRUs. 233 Doctors from PHCs having more than one MBBS doctors have been placed in PHCs having no MBBS doctors.
- ◆ Special remote area allowance is being paid to all categories of staff.
- ◆ Karnataka has adequate number of Medical Colleges, Nursing and ANM schools run by both government and private sector. The state has more than required number of staff nurses.
- ◆ SIHFW is the nodal agency for all the training under NRHM and there is good linkage between the SIHFW and ANM schools.
- ◆ The vacancies in DTCs remain high. The DTC at Bijapur has only one clinical trainer who is the Principal of the DTC.
- ◆ There is still a need for charting out a career path for ANMs as most of the newly trained ANMs are not able to get jobs in the state.

ODISHA

- ◆ The State is making good efforts to expand its HR base by creating new posts and recruiting health personnel against various cadres through contractual staff. However gap is especially seen in the case of specialists (Anesthetist & Radiologists), MPW (M), Laboratory Technicians etc.
- ◆ The vacancy against various sanctioned positions for health personnel ranges from 7% to 51%. However the vacancy situation worsens on comparing it to the IPHS norms.
- ◆ The state has increased the number of sanctioned posts from 824 specialists in 2005 to 1819. Even though only 1123 posts could be filled, this is an increase of nearly 90% from the numbers available in 2005. Most of the doctors are in regular positions and only 278 out of 3575 doctors across the state are contractual. Presently 1123 AYUSH doctors are also in place against 1819 sanctioned positions.
- ◆ The state has adopted a decentralized recruitment process and RKS is empowered to recruit critical personnel, as and when the need arises.
- ◆ The State Government has also established a State Human Resource Management Unit (SHRMU), and a Nursing Management Support Unit (NMSU) and brought about changes in terms of increasing retirement age, financial incentives and non-financial incentive including credit marks in PG Entrance examinations for those working in difficult districts.
- ◆ There are 16 government ANM training institutions, while 50 schools are in private sector with an overall intake of more than 2000 students per year. There are also 5 GNM schools in government sector besides 41 private institutions and the annual intake of students' number about 700. However many of the private institutions are yet to be recognized by NCI.
- ◆ The skill up-gradation trainings especially for family planning (IUCD insertion, Minilap, PPIUCD, NSV) need to be improved to increase the contraceptive acceptance.

RAJASTHAN

- ◆ There is acute shortage of health human resources including Doctors, Specialists, Nurses, Pharmacists, X-ray technicians, especially in hard to reach areas. Over 70% of the specialist posts in Chittaurgarh and 80% specialists positions in Barmer were found vacant with no anesthetists available in either district. Multi-Skill trained doctors need to be rationally deployed and optimally utilized.
- ◆ There are adequate number of GNMs, ANMs and Paramedics in both the districts visited.
- ◆ To increase availability of healthcare workers in the rural remote areas, the State is going to post the recently recruited 130 MOs in health facilities located in such areas. In addition, the state has also provided for special allowances and incentives for staff working in remote, hard to reach areas as a measure to retain skilled HR.



- ◆ Currently 18593 contractual staff has been recruited at different levels including 100 MOs, 44 Specialists, 7069 GNMs, 5648 ANMs and 585 Paramedics. However there is low motivation among the contractual staff working under NRHM both at state and district level, because their salary package is low as compared to other states. Though AYUSH Doctors are posted under Ayurveda Department and at PHCs, CHCs and DHs, the utilization of their skills is poor.
- ◆ In Chittaurgarh district, the availability of training facility at district level needs strengthening. The ANMTC was also facing severe dearth of adequate infrastructure like residential quarters for the ANM trainees. In the absence of training material, study material, nursing articles, projectors etc., the quality of training is highly compromised.
- ◆ Training capacity needs to be strengthened at the district level. Training calendars are either not maintained or not being followed. SBA training of ANMs, GNMs and IMNCI training should be fast-tracked.

SIKKIM

- ◆ Doctors are in place in the state as per the IPHS requirements and most of the MO positions (87 out of 98) are filled by regular post.
- ◆ Shortage is mostly for the specialists (only 29 out of 94 filled), Nurses (101 out of 309 required), and Pharmacists (11 out of 52 required). Even for the positions filled, the distribution is skewed; with maximum shortage in North Sikkim, where the shortage is addressed to a great extent by contractual staff.
- ◆ Recruitments of contractual staff are done only at State level, annually, with the districts communicating their requirements. However, due to limited number of health personnel available in the State, there is inter-district and inter-program movement resulting in gaps being created while some are being filled. For entry into the regular service, there is a single point available and there is no separate career progression for Specialists, Public Health Cadre etc.
- ◆ State has attempted various innovative measures for posting and retaining staff in difficult areas including salary increments (5% yearly), compulsory PHC posting for 3 years before applying for PG course, allowances for difficult areas etc.
- ◆ For the incentive scheme to succeed in the Sikkim, the state desires that a separate set of criteria be applied to ascertain difficult and inaccessible areas.
- ◆ Training calendars are available and there has been good progress in its achievement but post-training evaluations are not done for any training.

UTTAR PRADESH

- ◆ Severe shortage of human resources, which was one of the major findings emphasized in every previous CRM, persists to this day in Uttar Pradesh with a majority of new PHCs found to be non-functional due to inadequate doctors or nurses to manage these facilities and a failure to establish special newborn care units/stabilization units even in District Hospitals.
- ◆ The state has shortfall of 57% for MOs (i.e. as against 15455 posts of MO required as per IPHS 2011, 6622 are in position); the shortfall is 59% for specialists (against 8599 specialists required, 3528 are on position), 81% shortfall for MPW (M) and 76% for staff nurses. The extent of shortfall is of such a large magnitude that this gap cannot be bridged by normal recruitment procedures e.g. not enough doctors graduating every year to fill this gap and inordinate delays in recruitment process has not helped either.

- ◆ Despite the shortage of staff, irrational deployment of available personnel prevails e.g. excess staff in low caseload facilities, SBA trained ANMs not posted at delivery points and EMONC/LSAS trained doctors not allotted to FRUs.
- ◆ Lack of incentive/reward for staff to serve in hard to reach and inaccessible areas.
- ◆ The continuing deployment of traditional dais in some health facilities such as CHC, PHC and sub-centres is an area of concern and the labour room nurses at some CHCs are using retrograde dais kits to undertake deliveries reflecting the influence of dais in the health facilities.
- ◆ Low priority given to training - No training programs in the last 5 months in the state and no training calendar in the two districts visited. Number of training institutions available not commensurate to the requirement of the State. The quality of training was not upto the mark as evident during interaction with field functionaries such as SBA trained ANM.
- ◆ There was shortage of 6860 MPW in the state and the state has capacity to train only 660 MPW in a year.

UTTARAKHAND

- ◆ The state has added 132 MOs, 10 specialists, 218 staff nurses and 236 ANMs of which 130 are second ANMs. Besides 550 ASHA facilitators and 47 ASHA Coordinators have been recruited.
- ◆ While there is a shortfall of all staff, the maximum shortfall is for MOs at 52% and specialists at 24% against the sanctioned positions. There are only 195 regular MPW (M) in the state and there is a need to revive this dying cadre especially in view of the remote and hilly areas.
- ◆ The state has also adopted strategies for improved recruitment: includes 2 year compulsory rural posting bond for medical students, who will start passing out after two years; Continuous recruitment thorough walk-in interviews for MOs held every Tuesday- but their effectiveness is to be seen etc.
- ◆ Despite high vacancies, no strategies to address the issue of retention of skilled service providers, and not even difficult area allowances for doctors, specialists and paramedical staff are in place.
- ◆ Specialists are being hired at higher packages on contractual basis but as their performances are not being monitored, they are not under pressure to perform.
- ◆ The state has adequate AYUSH doctors, pharmacists and dental surgeons. AYUSH units with a full team of MO, Pharmacist and an MPW are functioning in the PHCs and CHCs.
- ◆ Two additional medical colleges proposed in Dehradun and Almora. 1 GNM college is functional in Dehradun apart from 6 ANMTCs in the state.

Recommendations

- ◆ The first priority should be to fill up all sanctioned posts which are lying vacant and create the additional posts in the state budget that is deemed necessary with respect to both IPHS and increasing caseloads. The central government may also indicate clearly which of these posts are to be supported by the national centre indefinitely. The proposal of the NRHM working group to undertake the funding of the first ANM and the male worker as well as support a second ANM in those facilities which have institutional delivery is a way forward. Similarly there is a case for bringing the three nurses in all PHCs providing midwifery services, the nine nurses in all CHCs providing inpatient care and the laboratory technicians could be brought under a central contribution - as availability of these is essential for many national programmes. But in synergy with this

move the state government should create and fill up other required posts.

- ◆ Regular appointments should be streamlined and expedited with current vacancies being advertised every six months and recruitment completed by state service commissions or other acceptable, fair and legally sustainable means – but within a six month period.
- ◆ In all cadres, powers for contractual appointments against approved/sanctioned posts - whether under state government or under NRHM funds should be immediately devolved to the district health societies, with states helping only where districts are unable to find suitable candidates.
- ◆ Of these vacancies, the most critical are of nurses and ANMs, and creating the necessary posts and well as filling up these posts must be prioritised.
- ◆ To move the male worker agenda forward- there is a need to define the male multi-purpose worker and the work expectation of such a worker such that there is a 8 hour working day on a regular basis. Based on this the competencies required, the training syllabus and the training institutions need and the career path and cadre policy needs to be developed. There is also a need for clarity vis a vis the proposed BHRC and to explore the potential that these options could be merged.
- ◆ Given the shortage of specialists available in the system and in the market for recruitment, multi-skilling of doctors and distance education family medicine training programmes should be scaled up with an emphasis on their post-training posting and professional support.
- ◆ There needs to be a greater emphasis on setting up of Medical Colleges, and Nursing & ANM Training Institutes, at terms which would help close the human resource gaps in under-services regions within states. This would imply greater public financing, choice of location of colleges and admission policies so that candidates from such areas and with a commitment to serve in these areas are preferred. Building in basic quality standards during such headlong expansion, also requires faculty development programmes and institutional development at all levels.
- ◆ Measures for attracting and retaining skilled service providers in rural and difficult areas needs to be further expanded and built upon so as to eliminate vacancies in the public health system. Every state and district plan should specify the package of financial and non financial incentives, the workforce management reforms and the preferential admission to educational and training institutions and educational reforms it would be putting in place for achieving these ends. Existing measures which are assessed to be working well must be documented, publicly recognised, reinforced and encouraged- so that they are not reversed easily.



- ◆ Strengthening of SIHFWs, RHFUTCs, ANMTCs and DTCs in terms of good quality faculty development and building up the work organization, work culture and dynamism needed for these centres to make an impact in planning & implementation of need-based skill-upgradation trainings with assured quality. Need-based AYUSH training programs may also be conducted from these centres using faculty from AYUSH colleges.
- ◆ Staff remuneration, incentive structures, and career paths, need to be defined and assessed for reform. Some states are in the process of forming separate specialist and public health cadres and others may adapt, adopt or replicate. Cadre reform in terms of Dynamic Assured Career Progression will also be a positive step.
- ◆ Similarly, a robust Human Resource Management Information System is the call of the hour to address the need for an efficient and transparent HR recruitment, transfer & posting mechanism. Few states are already working towards having this system in place.
- ◆ Semi-furnished accommodation for residences of staff posted in difficult and hard to reach facilities should be prioritised.

“The Mission seeks to establish functional health facilities in the public domain through re-vitalisation of the existing infrastructure and fresh construction and renovation wherever required. The mission also seeks to improve service delivery by putting in place enabling systems at all levels. This involves simultaneous corrections in human resource planning and infrastructure strengthening.”



Health Care Service Delivery-Facility Based- Quantity and Quality

Main Observations

- ◆ Trends over years since 2005 show a clear increase in OPD caseloads for almost all states- both by HMIS and by reports to the visiting teams. The caution is in Gujarat where HMIS shows a 20% fall, even though the figure reported to the visiting team showed a modest rise. This is the only state that exhibits this pattern. In Karnataka HMIS shows a substantial rise whereas the figures presented to the team which probably represented only primary care showed a stagnation in outpatient numbers. Kawardha in Chhattisgarh and Giridih in Jharkhand and Dubri in Assam also showed a decrease in reports to CRM. In each of these cases the decline is related to non availability of doctors and irregular supply of medicines.
- ◆ Trends over years since 2005 show the same pattern as for OPD. In addition Andhra which showed a rising outpatient performance but a stagnant caseload for IPD. In HMIS data both Gujarat and Chhattisgarh show modest declines in IP caseloads.
- ◆ One index we used for cross state comparisons to indicate degree of public sector utilisation is to calculate per capita OPD attendance and inpatient attendance. Himachal has the highest, followed by Sikkim – both of which have about 1250 per 1000 population. (1.25 OPD visits per capita) Most other states fall in the region of 500. If we use a norm of 3 OPD visits per capita as the benchmark- then in most states it is about 20% of expected OPD visits occur in the public sector- the rest either going to private or not seeking care. This is in concordance with NSSO figures. The states that do poorly are Chhattisgarh, Gujarat, Uttar Pradesh, Jharkhand, and then Bihar.
- ◆ In inpatients if we compare against a benchmark of 50 hospitalisations per 1000 population and 75 including institutional deliveries then Himachal is almost there (75%) and Sikkim, Goa, Rajasthan, Odisha, Karnataka are all above 50% of expected in-patients being seen in the public sector. (this is in line with NSSO figures). The bottom is Jharkhand, then UP and then Gujarat, Chhattisgarh, where only about 30% of expected in patients are seeking public sector hospitalisation. In Gujarat it is likely that the private sector soaks up the rest, whereas in the other three states, it could be a failed access to any sort of care. We note that in many states the medical college data and other govt hospitals not under the director of health are often not fully incorporated and the public sector performance in many of these states may be better if this were added in.
- ◆ Improvement in drug availability in districts visited by CRM teams in states of Andhra Pradesh, Bihar, Chhattisgarh, Goa, Gujarat, Haryana, Odisha, Uttarakhand and adequate supply in Himachal Pradesh were reported. States like Assam-stock outs, Jharkhand (Giridih) reported poor supply, and Sikkim reported available drugs not being dispensed. However many states there was considerable out of pocket expenditure even for pregnant women due to costs of drugs. Odisha mothers in SNCU reported out of pocket expenditure on drugs.



- ◆ Most of the states reported increase in functional laboratories and lab technicians but still range of services either limited or not available 24x7 to patients. State reporting poor range of services are Odisha, Rajasthan, Uttarakhand, Himachal Pradesh. Assam and Giridh in Jharkhand reported even lack of basic services. Chhattisgarh, Goa and Karnataka have better service and range available. Non availability of 24x7 lab facility has been reported from all states except Goa, thus leading to out of pocket expenditure on diagnostics. Erratic reagent supply for non availability of laboratory services was reported from Andhra Pradesh, Assam and Bihar.
- ◆ Poor safety measures against radiation exposure to staff in X-ray labs were reported from states like Jharkhand Odisha, Rajasthan.
- ◆ Equipments either present in excess of requirement or present but not used due to lack of trained human resource has been reported across states of Chhattisgarh, Gujarat, Jharkhand, Odisha, Rajasthan and Uttarakhand. Lack of equipment reported from Uttar Pradesh only.
- ◆ EMRI and Referral transport is present and is contributing to transport of pregnant women to facility and between facility in substantial way in states of Andhra Pradesh, Goa, Haryana, Karnataka. In some other states like – Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Odisha, Rajasthan and Uttarakhand the services have been established but are too inadequate to make a substantial difference to decrease out of pocket expenditure for pregnant women. Sikkim and Uttar Pradesh do not have this facility available yet. Drop back facility is not available in any state.
- ◆ Diet facility for pregnant women till CHCs with good caseload is being provided in state of Andhra Pradesh, Bihar, Goa, Gujarat, Haryana, Himachal Pradesh, Odisha, and Rajasthan. The quality of food differs from hot cooked meal in Andhra to bread and milk in Odisha. PPPs, SHGs and voucher being some of the modes of providing these services.
- ◆ Some of the states report functional state quality cell- these include Bihar, Gujarat, Karnataka, Jharkhand, Odisha. Health Facilities' preparedness for handling Emergency cases - in term of availability of drugs & equipments, emergency response system, skill & knowledge in managing emergency patients, etc., continues to weak.
- ◆ Compliance to Biomedical Waste (management & handling) Rules 1998 at the facility level has been found to be inadequate, especially in states of Andhra Pradesh, Assam, Chhattisgarh, Jharkhand, Odisha, Rajasthan, and Uttar Pradesh. Lapses are most frequent in the following areas (a) Non-availability of colour coded containers & liners (b) Non-provision of mask, gloves and boots to the waste handlers and its usage by them (c) Non-adherence to approved waste segregation scheme at the point of generation, and lastly (d) Absence of monitoring of the services, provided by the out-sourced organisation, operating CWTF.
- ◆ Periodical Calibration of measuring equipments has not been undertaken and laboratory reports validation systems not in place. Number of AERB approved Radiology Departments in the facilities is far too low & usage of TLD badges by the workers has been poor.
- ◆ Citizen Charters and JSSK guidelines displayed prominently in states of Andhra Pradesh, Assam, Bihar, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Odisha, Rajasthan (Chittaurgarh) and Sikkim. Non-prominent or no display were observed in Uttarakhand and Uttar Pradesh.
- ◆ Utilisation of Untied funds to provide amenities to patients and thus improve service quality in facilities were observed in states of Chhattisgarh, Gujarat, Himachal Pradesh, Jharkhand, Odisha, Rajasthan and Sikkim.

Findings From States

ANDHRA PRADESH

- ◆ **OPD:** State recorded a annual increase of 2.6% from 2006 to 2011 in public sector.
- ◆ **IPD:** District Guntur has 1332 beds in Public sector which means one bed per 2300 people. The admission statistics however shows 74.5 patients per bed has admitted in 2011. In Warangal however 113 patients per bed has been admitted in 2011. 30% beds in Guntur and 8.9% of beds in Warangal have been allocated to maternal care.
- ◆ **Diagnostics:** Round the clock lab services were not available in any of the 24x7 facilities or even in the District Hospital of Guntur. At designated centres, tests for malaria and tuberculosis diagnosis was being done and at PHCs Hb urine sugar and albumin tests were being done. In secondary care hospitals which are primarily under the APVVP are very rudimentary. Many patients were noted to have been tested outside. Pooling of LTs and provision of quality lab services has not taken place. User fees for laboratory services was being charged from the patients. There was a shortage of reagents at many facilities visited.
- ◆ **Diet:** Diet services were being given to all the pregnant women who were admitted for natal care. It was being purchased as there was no kitchen facilities in the PHCs.
- ◆ **Biomedical waste management:** Infection Control protocols were not being followed in the state at any level including Operation theatres. BMW guidelines not displayed and not being used. No mechanism for storage before disposal.
- ◆ **Quality assurance:** District Hospitals at Chittoor & Eluru have been certified to ISO 9001:2008 Standards. APVVP has taken initiative of district hospitals' laboratories to be certified to NABL standards.
- ◆ **Cleanliness and Hygiene:** Overall facility maintenance was good. Admission of both male and female patients in the same ward was seen in some facilities.
- ◆ **Sinages:** Citizen's charter was displayed. Grievance redressal mechanism is not set up.
- ◆ **Referral Transport and EMRI:** 752 Emergency Transport Service Vehicles running, average response time is 24 minutes. Many pregnant women had commuted to the hospitals and some of the beneficiaries were dependent on the ANM to call the ambulance.
- ◆ **Use of Untied Fund:** Knowledge of the Medical officers and ANMs is poor in terms of effective utilization of untied funds.

Findings From States

ASSAM

- ◆ **OPD:** Average increase in OPD since 2005 is 25% per year. Dhubri district shows a declining trend in 2011–2012 as compared to 2009–2010 and 2010–2011. Main reason being non-availability of doctors and irregular medicine supply.
- ◆ **IPD:** An absolute 75% increase in IPD caseload from 2005 to 2011 has been recorded in state but a comparison of data from April to September in 2011 and April to September in 2012 shows fall in IPD caseload. District Dhubri also recorded fall in IPD caseload in current year. The reason being lack of doctors and regular supply of medicine. Major bed occupancy is for delivery cases.

Determinants of Quality of Care

- ◆ **Drug and supplies:** Drug stock out in periphery such as Hisingmiri civil hospital, Mankachar CHC reported.
- ◆ **Diagnostics:** The basic laboratory and diagnostic services are not available either due to lack of reagents/equipments or due to lack of water/electric supply.
- ◆ There was no infection control committee in any of CHC and district hospital and there has been no orientation on universal safety precautions. No quality assurance committee being constituted at district hospital.
- ◆ **Biomedical waste management:** Non-functional and the concept of bio-medical waste management as regards to segregation and safe disposal of waste materials is lacking among the staffs. At most facilities reviewed, only one single colour three waste baskets were placed though the guidelines on BWM is displayed.
- ◆ **Cleanliness and hygiene:** There were common toilets for male and female patients in almost all facilities except at the district hospital. Toilets for general wards were dirty with irregular water and electric supply.
- ◆ **Emergency referral transport** is in place and used for referral purposes. The incentive under JSY is paid mostly through cheque or e-transfer. Almost 50% of the fund for ASHA and for patients under JSY cannot be encashed since the bank refuses to issue cheque books with zero balance. There is no SOP found in the hospital.
- ◆ **Diet and other support services:** Diet at district hospital is outsourced however the same kind of arrangement is not available at CHC/PHC.
- ◆ **Signages** are present. Citizen charter and Janani Shishu Suraksha Karyakram (JSSK) guidelines were displayed only in some facilities in Nagaon while in Dhubri, citizen charters was found everywhere). There are proper IEC materials/posters displayed at almost all facilities visited.

BIHAR

- ◆ **OPD:** Bihar shows increasing trends of OPD attendance since 2006 to 2011. Except that in 2008 and 2010–2011, there has been fall in OPD attendance compared to its previous years.
- ◆ **IPD:** There is a substantial increase in IPD caseload from 7.98 lakh (2007–08) to 24 lakh (2010–11). The HMIS shows that nearly 4 lakh of 24 lakh is delivery (normal + C-Section) in public sector. The rest 20 lakh (75%) of IPD load is other diseases. State has bed occupancy rate of 62 days per bed per year.

Determinants of Quality of Care

- ◆ **Drug and supplies:** Drugs were available in all facilities in Kishanganj, although there were complaints of stock-outs a few weeks ago. Kit A and Kit B have not yet reached sub-centres. In some facilities the drugs listed in the essential drug list were not available. Drug inventory management systems were not in place in any facility, including tracking of expiry drugs. HSC ANMs saw on an average at least ten outpatients per clinic day.
- ◆ **Diagnostics:** The state has entered into PPP arrangements for provision of laboratory services. The supply of reagents supply is erratic, but no effort is being made to use RKS funds to procure this. Begusarai district, it was apparent that asepsis and quality protocols were not being adhered to.
- ◆ **Diet:** Outsourcing of housekeeping, laundry and diet is working well and the overall impression of the DH and PHCs is one of relatively clean facilities. However the contracts and payments are made from the district level, leaving the blocks with little monitoring authority.

- ◆ **Biomedical waste management:** Infection control procedures are generally in place, (such as three coloured dustbins), and disposal pits – biomedical waste management needs to be instituted soon.
- ◆ **Signages:** Service guarantee lists are displayed on most facilities including HSC, visited by the team.
- ◆ **Grievance redressal Forum:** The state has instituted e- grievance redressal, phone number for this purpose. The state has formed a State Quality Cell and has taken an initiative of getting its health facilities, certified to FFHI and ISO 9001:2008 standards.
- ◆ **Referral transport and EMRI:** Transport is an issue- ambulances are available in eight of the nine facilities, and at the DH in Kishanganj district. There is one private ambulance (102) and another is 108. This service is not provided free of cost except to those that are able to demonstrate that they are BPL and produce a BPL card. Transport for pregnant women is free but only upto the first facility. In case of onward referral they are required to pay. Generally patients pay the transporter for a drop back facility.

CHHATTISGARH

- ◆ **OPD:** Chhattisgarh state shows slow but steady increase in its OPD attendance since 2005 to 2011. It has risen from 1.09% to 12.62%. The districts of Khawardha however shows a steep fall in OPD in 2008–2009 and 2009–2010. Even compared to 2005 OPD attendance is less in 2011.
- ◆ **IPD:** 17% increase in IPDs since 2006 in the state but in Kawardha the trend over years has not been continuous. Kawardha shows continuous fall in IPD caseloads over last two years. (Up to -19% in 2010–11 as compared to 2009–10).

Determinants of Quality of Care

- ◆ **Drug and Supplies:** No proper assessment of drug requirements and utilization of drugs. Currently drugs were available, though there was evidence of gross irregularity in supply in the recent past. The IFAs are still in short supply; Kit A and Kit B drugs are not fully available with the sub-centres.
- ◆ **Equipment:** Essential equipment needed for ANC were available at sub-centres, but essential weighing machines and height measurement rods were not functional or inaccurate at PHCs. Records showed that ANC was not done appropriately.
- ◆ **Diagnostics:** Majority of the health facilities are having functional laboratories and are doing routine tests. Strengthening of labs in terms of relocations of manpower, training, procurement required.
- ◆ **Diet:** Ancillary services (diet, laundry) are not being provided regularly in all facilities across the state.
- ◆ **Biomedical waste management:** Infection control, sterilization of equipments and bio-medical waste disposal guidelines and practices are not being followed in the state including the districts visited. System for waste segregation and disposal non-existent. Awareness and knowledge building is required at all levels (low even at the district hospital level). Placenta and blood-stained/soaked waste handed over to family.



- ◆ **Cleanliness and Hygiene:** Cleanliness was reasonably good in many facilities. Asepsis was suboptimal, and fumigation was patchy.
- ◆ **Grievance Redressal:** There is no Grievance Redressal System at the facility level however a SMS based grievance Redressal system has been constituted by the State in one district on pilot basis.
- ◆ **Referral Transport and EMRI:** Travel and transport assistance is being provided to the seekers but referrals are very less due to lack of awareness. Referrals done through Mahatari Express for pregnant women. Log books of these ambulances needs to be maintained.
- ◆ **Use of Untied Fund:** The hospitals and health centres are clean and utilize NRHM funds for up keeping the same.

GOA

Determinants of Quality of Care

- ◆ **Quality Assurance Committee** for RCH services has not been formed. However, there exist a QAC pertaining to Family Planning Services in the state. Practice of maintaining Partograph is not there in the state.
- ◆ **Drug and Supplies** All drugs are completely free across all levels of facilities. Out of pocket expenditures are minimal. EDL is not displayed and it could not be seen at any of the visited facilities.
- ◆ **Diagnostics:** USG facilities are available at DH and certain CHCs. All other routine blood investigations are done at the PHCs itself. All diagnostics are free of cost. Antenatal screening for gestational diabetes is also done. HIV testing is available at all PHCs.
- ◆ **Diet:** All pregnant women are provided diet free of cost.
- ◆ **Biomedical Waste Management:** Biomedical waste management and disposal protocols in place. However, there is need to ensure better implementation of the protocols especially at the GMC.
- ◆ **Cleanliness and Hygiene:** Facilities are neat & clean with adequate amenities for patients and well displayed signages.
- ◆ **Referral Transport and EMRI:** Assured referral transport through 108 ambulances is available for all pregnant women, however drop back facilities are not yet made available. State is in the process of tying up with Goa State transport buses which can provide drop back facilities to the pregnant women.
- ◆ **Use of Untied Fund:** Involvement of community in the form of hospital visiting committee is in place where *Panchayat* members are involved.

GUJARAT

- ◆ **OPD:** There has been a progressive increase from 2005–2011 in OPD, from 0.56% to 9.32%.
- ◆ **IPD:** 9% increase in IPD since 2005 to 2011

Determinants of Quality of Care

- ◆ The state has formed Quality Assurance Cells at District & State level and has also launched a programme of Quality accreditation of identified facilities.
- ◆ **Drug and Supplies:** Supply of Drugs and disposables were found to be adequate at all the facilities visited. Essential Drug list was available. Facilities were able to cope with the minimal shortages whenever encountered with the help of RKS fund.

- ◆ **Equipment:** The public health facilities (PHCs/CHCs/SDHs) through endowed with infrastructure, equipments and supplies were generally found to be under utilised. There were no batteries in laryngoscope. Emergency does not have life saving equipments (Oxygen, suction, Defibrillator, cardiac monitors, pulse oxymeter etc.) and drugs.
- ◆ **Diet:** Two meals are provided to patients. Rajkot, meals are being provided to patients in DH and SDH. Diet is distributed in tiffin boxes supplied by the local MP at Morbi SDH. Charitable groups also provide food to the patients attendants, free of charge.
- ◆ **Biomedical waste Management:** The state has outsourced health care waste management to Govt. treatment facilities which will cover district hospitals, SDH and CHCs health centres in a phased manner, though there was segregation of waste being observed in many facilities, it was variable across. The lower level facilities and relatively newer staff were not observing safe needle disposal practices. Use of deep burial pits and sharp pits were observed. Use of safety clothing for health workers managing the waste (storage and disposal) were not observed. Training and retraining of staff in HWM practices needs to be done. Mixing of waste and mismatching of bins and liners were also observed at all the facilities visited. 1% sodium hypochlorite solution is placed in liners at State General Hospital Devgarh Baria. Staff is not fully aware about biomedical waste management. Facilities which are not provided with outsourced CTF (Common Treatment facilities) have no deep burial pits. Placenta is either being thrown in open spaces or put in shallow pits.
- ◆ **Cleanliness and Hygiene:** Sub-centres and PHCs visited were found to be reasonably clean. Cleanliness needs to be improved at District Hospital Dahod and State General Hospital Devgarh Bari. Toilets in the wards were found clogged and dirty. Stray animals (cows, dogs and goats) were found roaming inside the hospital premises. Heaps of garbage with coconut shells, food leftovers, plastic cups were found scattered throughout the premises. Laundry services are in house. All the beds were found with clean linen. Linen is changed daily or as and when required. 3 to 4 sets of linen were found.
- ◆ **Grievance Redressal:** The existence of Grievance Redressal Cell was not very evident in the two districts visited.
- ◆ **Signages:** Citizen charter: with service guarantee was displayed in Gujarati at all facilities visited. IEC on JSSK was displayed at all facilities and some places excellent IEC on health were displayed e.g. PHC Panchwada.
- ◆ **Referral Transport and EMRI:** 506 Service is currently available. Response time in urban areas is between 7–14 minutes and rural areas between 30–45 minutes depending on remoteness. More than 400 hospitals in the state collaborating with EMRI to stabilize the patient brought in, free of charge. Areas where motorable roads are not available, Mamta Doli provides means of transport to the pickup point for 108. However most of beneficiaries accessing CY facilities arrange their own transport on which the cost incurred is approximately Rs. 300 one-way. JSY component of Rs. 200 is paid to each CY beneficiary. There is no separate arrangement for drop back home from private Chirenjeevi (CY) facility. Ambulances from the Red Cross and DH are utilized by CY doctors in case of referrals. There are 254 ambulances at CHCs available with the health facilities which are often utilized for referral from one facility to another. There are various NGO Grant-in-aid hospital ambulances also available in the state for referral services in the state. There are 24 ICU on wheels also available in the state
- ◆ **Use of Untied Fund:** Untied grants are utilized for various activities at the facilities which include local purchase of drugs, medicines and consumables, minor civil works etc.

HARYANA

- ◆ **Equipment & Diagnostics** Essential drugs and equipments in place in most of the facilities visited.
- ◆ **Clinical Quality of Care:** District Quality Assurance Committees have not yet been constituted. Supervisory staff uses monitoring check-list, while undertaking the field visits. Essential drugs and Equipments are available at the facilities. Quality of services provided in labour rooms through maintaining privacy, clean & separate toilets for women, availability of essential drugs and equipments etc. Lack of manpower at district level and block levels was brought out as the major constraint for regular QA and quality improvement initiatives in Mewat.
- ◆ **Signages:** Signage's generally in place at all the facilities visited. Citizen charter and Janani Shishu Suraksha Karyakram (JSSK) guidelines displayed only in DH. Entitlement under Janani Shishu Suraksha Yojana (JSSK) especially free delivery, referral transport, and free treatment for sick neonates is in place

HIMACHAL PRADESH

- ◆ **OPD:** Himachal records an overall increase of 4.79% per year which may seem less as compared to other states but the per capita visit being very high. Scattered and scarce population and government sector being dominant player leads to this high utilization of facility per capita OPD visits in Kinnaur. Hamirpur has private sector but still per capita OPD visits is 1.68 equal to state average. The difference is visible in utilization of services at sub-district level which tends to be more in Kinnaur till sub-centre level, the likely reason being good stock of drugs being available than Hamirpur where CHC is offering more primary level of services but not sub-centre due to drug stocks not being adequate below CHC level.
- ◆ **IPD:** Hamirpur has utilisation of about 10 episodes per 100 population which is about twice the state average. Kinnaur has 2.5 per 100 population which is half state average. Secondary level services are available at DH and SDH with one private sector hospital in Kinnaur which is difficult to reach for many it not being central point of district. In Hamirpur the range of services being offered in DH is large. Multi specialty surgical clinics twice a year is an innovation.



Determinants of Quality of Care

- ◆ **Drugs:** Supply of drugs was found to be adequate in all facilities of Kinnaur including a useful range of antibiotics. This was so even in the sub-centres and Ayurveda hospitals. The drugs in this district are supplemented by almost 70 lakh rupees from the tribal sub plan along with state and central funds. In contrast, shortage and a more limited range of drugs was seen in district Hamirpur, especially in the sub-centres. The problem of a typical supply determined logistics with all the attendant interruptions was evident- even more so in sub-centres of Hamirpur which are dependent on Kit A and B supplied by the centre. It was pointed

out to us that expenditure on drugs is about Rs. 112 per capita in Kinnaur and about Rs. 12 per capita in Hamirpur and this no doubt explains much of the divergence in availability between the two districts. There is a list of 38 drugs which are available free for BPL families in all institutions under Pandit Deen Dayal Nisulk BPL Aushadh Yojna.

- ◆ **Equipment:** This seems adequate in all facilities visited. The main observation is that the limitations in human resources overshadowed inadequacies of equipment.
- ◆ **Diagnostics:** The range of diagnostics in use was very limited across facilities of the same level- and even where the institutional capacity to do the tests were in place. TB programme technician was performing two sputum examinations per day. In other PHCs even basic haemoglobin- which is a sub-centre level test was not done- on the plea that there is no laboratory technician. This was a general problem- though one had enough numbers of support staff, the lack of one or other category of staff becomes an excuse to not provide the service. Yet if the technician is in place the work load per technician does not provide more than one hour work per day. Clearly in the PHC and in low volume CHC there is case to prepare a multi-skilled support paramedic who can dispense drugs, do dressings and do a basic set of laboratory tests as well as provide symptomatic care for simple ailments at the ANM/MPW level of skills. Then the PHC would be fully functional with or without the doctor- and if the latter is available a higher range of services can be aimed for.

At the district hospital and sub-divisional hospitals and potentially in the CHCs the caseload is adequate to merit separate technicians- but here vacancies plagued the system. Where human resource was not the limiting constraint a wider range of diagnostics were in use but still far short of what the IPHS would prescribe.

- ◆ **Clinical Quality of Care:** The general outpatient clinic function was largely based on drugs provided in the public facility and consistent with rational practice. However when it came to in-patient care at the sub-divisional hospital and DH there was a trend to write many outside prescriptions – and many of these were clearly excessive. The protocols of care were not adhered to in some key aspects for care in pregnancy and there was concern that RSBY could lead to inessential admissions. The introduction of multi-speciality surgical clinics- occurring in the form of camps is an innovation and it seems to provide a much greater access to elective surgery for a section of the population. But there is caution as regards hysterectomy surgery. There is a need to put in place district level clinical review of care. The quality of supervision and on the job training as a form of ensuring adherence to protocols of care is missing- and there is no schedule of visits for this purpose. Standard treatment protocols and essential drugs lists were once made by the state, but are not readily available indicating current non-use of these essential tools of clinical quality of care.
- ◆ **Diet:** This is being provided in facilities- at the higher levels- SDH and DH and some of the CHCs.
- ◆ **Biomedical Waste Management:** These systems are in place in almost all facilities visited and they are being used.
- ◆ **Cleanliness and Hygiene:** Overall cleanliness in the hospitals was very good. This was one of the pleasing aspects of the visits. This was so even in facilities visited- which were off route.
- ◆ **Signages:** Signages were found to be good; Citizens charter prominently displayed.
- ◆ **Security** This was good. The facilities had compound walls and larger facilities had security arrangements. There was no problems of stray animals.
- ◆ **Referral Transport and the EMRI:** There are 112 ambulances for emergency response transport in the state, distributed across the 12 districts. There is general appreciation of the EMRI service and the service is no doubt very active. The log book of two EMRI vehicles at Theog and Spilloo and interviewing the

paramedical persons on the vehicle, ANMs and PHC medical officers/showed that in the previous one week- about 14 cases were transported of which 5 were pregnancies of which one delivered, when the ambulance was still 30 km away and one delivered on the way. On an average it takes two hours to reach and two hours to return and hence it is timed out for much of the day- and can seldom do more than three or four per day. Other than pregnancies, trauma was the next common (4) and then one case of fits, one of chest pain, two were diarrhoea and one of fever. In pregnancy with complications or in the fits, the trend is to send the vehicle from Theog and then it takes the patient all the way to Shimla, which is 90 minutes away. In Spillover paramedical on the vehicle had delivered over 8 deliveries in the preceding months and about 20% of deliveries at least happen on the vehicle. Substantial usage of the vehicle for inter-facility transfer or a long distance relay transfer. Sample of pregnant women with or without complications in the secondary care institute, reflected that less than 10% of pregnant women have come by EMRI and most have had substantial out of pocket expenditure. Reasons for non-use are mainly related to a quicker option being available through local arrangements and the lack of certainty or availability of the EMRI van. Hospitals vehicles are under-utilised,. There is a clear case for local tie ups with service providers at rates negotiated by the hospitals- with a voucher or similar arrangement by which the pregnant women can avail of this service.

- ◆ **Use of Untied Funds:** This is good at the sub-centre, PHC and CHC levels. The main use of funds was for maintenance of the building and closing small but critical gaps in provider or patient amenities and equipment. Kerosene fuelled room-warmers are one popular item of purchase. The funds utilisation at the civil hospital at Rampur and even at the district hospitals was however poor.

JHARKHAND

- ◆ **OPD:** Services have been utilized in last two years. From 2005 to 2011 OPD has increased from 13.1% to 27.4%. On the contrary, the Giridih district has shown a decline of 30% in the last few years in the OPD caseload.
- ◆ **IPD:** 35% increase in IPD caseload since 2005 till 2011. In Giridih functional bed per 1000 population is 0.83 against 1.5 sanctioned. Bed occupancy rate in DH was just 34% for 2010–11 the sub-district facilities showed similar trends

Determinants of Quality of Care

- ◆ **Drug and Supplies in Giridih:** The essential Drug list was available at most of the facilities visited however the availability of the drug was to the extent of 50% and at some PHCs and HSCs where delivery is conducted the attendants have to buy their own medicines and gloves etc. increasing the out of pocket expenditure of the beneficiaries. **Essential drug list booklet and the standard treatment guidelines issued by the state in the year 2004 were not available of any of the facilities visited.** There is no evidence of measures taken to ensure rational use of drugs.
- ◆ **Diagnostics:** The diagnostic services in the facilities in the state provides for a very few tests. Although the number of lab technicians present in the facilities is reasonably better as compared to that for other services still the caseload and the number of tests are minimally low. Essential hematological and pathological tests are not performed. ECG and ultrasonography services are rarely witnessed across the state. In District Giridih Ultrasound machine at District Hospital is non-functional since last eight months. Whist AERB clearance has been applied for lead aprons and TLD badges are not in use at the Radiology department of District Hospital. Use of Personnel Protective Equipments by laboratory personnel was not evident.

- ◆ **Clinical Quality of Care:** Many of the labour rooms did not have the facility of toilets. Privacy of patients is compromised in absence of curtains. Giridih District hospital has a formal close loop complaint management system in place, whereas no such provision at other peripheral level facilities. Diet: Ancillary services like laundry, diet, sanitation and housekeeping are carried out somehow without clear cut objectives and there is no institutional mechanism to monitor the same. Availability of drinking water was there at district hospital and upto PHCs however many of the labour rooms did not have the facility of toilets. Running water and power were predominantly absent at the sub-centres although power lines were available in the area near the facility. Biomedical waste management: Management of Bio-medical Waste across the state as well as Giridih District hospital is either nonexistent or in early state of operation. The district hospital does have an incinerator which is not operational due to technical reasons and efforts are being made to start its operations. The other issues are lack of adequate bins, training of personnel involved in outsourced segregation, intramural transport carrier, puncture proof boxes, non standard deep burial pits, Liners and disinfectant. Cleanliness and Hygiene: Maintenance services are outsourced in piecemeal fashion. e.g. the outside cleaning of the District hospital is done by the own staff but occasionally whereas inside cleaning is done by outsourced party. Signages Patient related information in the hospital -Citizen Charter was visible only at the district hospital.
- ◆ **Referral Transport and EMRI:** 167 Govt. Ambulances, 1822 through PPP-Mamta Vahan Operating, 10890-Benefecieries, Average response time of the vehicle-30 minutes to 1 hr.
- ◆ **Use of Untied Fund:** The utilization of RKS funds, untied fund is at the level of 50%.

KARNATAKA

- ◆ **OPD:** Utilization of OPD services in Karnataka showed a slight increase till 2008 after which it actually stagnated. In 2010 the utilization actually declined by 17% as compared to 2009.
- ◆ **IPD:** Bed occupancy rates have been falling in state since 2005 from 63% to 39.37% in 2011.

Determinants of Quality of Care

The state has taken an initiative of implementation of Quality Management System, leading to certification to ISO 9001:2008 Standards at 36 Health Facilities, without any external assistance. In addition, few facilities are currently being prepared for NABH accreditation.

- ◆ **Diagnostics:** A range of services pathology and microbiology available at CHC/FRU. Specialized services like X-ray and USG also available. At sub-centres ANM also performing Hemoglobin estimation through strips provided. ICTC well functional.
- ◆ **Biomedical waste management:** This was found to be adequate at most of the places visited. It has been outsourced at District Hospital.
- ◆ **Cleanliness and Hygiene:** Facilities were clean and maintained well. Adequate waiting area, provision of drinking water, TV available till PHCs.



- ◆ **Signages:** Citizen Charter including JSSK entitlement and service guarantee displayed prominently in all facilities.
- ◆ **Referral Transport and EMRI:** Referral transport available at most places except far flung areas of Chamrajnagar. Drop back facility still not completely operational.

ODISHA

- ◆ **OPD:** There has been a steady increase in caseload of 43% from 2008 to 2011. In district Rayagada the OPD caseload slightly increased but in DH it is slightly decreased as the peripheral facility become functional in last three years.
- ◆ **IPD:** 12% increase in IPD since 2008 to 2011. The Bed Population ratio ranges from 1/917 in Sambalpur to 1/5939 in Bargarh. The average bed to population ratio being 1/3184. Secondary level services were available in DH and SDH in Rayagada. The range of services extended from orthopedic, trauma care (under local anesthesia), Dental surgical procedures (under local anesthesia), pediatrics, physician. Due to lack of anesthetist major surgeries were not being performed. Non surgical admissions in IPD were observed in CHCs also.

Determinants of Quality of Care

- ◆ **Drug and Supplies:** Per capita drug budget has increased from 9.39 in 2007–08 to 15.66 in 2009–10. Total drug budget was 37.56 crore (total) in 2007–08 to 62.67 crore in 2009–10. Essential drug list is available at all facilities. All facilities had adequate stock of drug including ARV and Anti snake venoms. No stockouts reported in recent past. Storing facilities was a problem. Inventory management weak in state.
- ◆ **Equipment:** In most of the facilities equipments were found to be adequate. The portable machine was lying unrepared for months and due to lack of radiologist other USG machines were not being used at DH in Rayagada. Bargarh however had unusable broken equipments locked in rooms.
- ◆ **Diagnostics:** District Hospital has some range available but other facilities do not have range of lab services beyond basic. Lab and imaging services are not complying with regulation related to safety of worker. Female – X-ray technician performing more than 30 X-rays per day in DH Rayagada without a lead apron. TLD not practiced anywhere in state.
- ◆ **Diet:** It is being provided in form of milk, bread (1 packet of milk and bread and egg (occasionally) but no kitchen or gas cylinders, stove and fridge to help patients to warm or store this. Kitchen was found to be non functional in DH Rayagada.
- ◆ **Biomedical waste management:** Variable across facilities, but over all inadequate in most facilities in both the districts.
- ◆ **Cleanliness and Hygeine.** Facilities were clean but toilets were common in most facilities in Rayagada district. Wards due to lack of adequate number of beds were combined for male and female in all other facility than DH. Malaria patients without protective nets or sieve on windows shared room with pregnant women.
- ◆ **Signages:** In Rayagada it was found that single signage in local language both JSSK scheme and citizen charter had been displayed.
- ◆ **Referral Transport and EMRI:** Among the two districts visited Rayagada had problems with referral transport due to difficult geographical terrain and very few. Emergency referral transports a weak link across the

district-utilization just 1% as per exit interview. High out of pocket expenditure being incurred by patient due to lack of these services. District starting voucher scheme soon. In rest of the state Janani Express is performing adequately.

- ◆ **Use of Untied Fund:** Being adequately utilized as reported by ANMs.

RAJASTHAN

- ◆ **OPD:** Increasing trends and free drug scheme in state has brought further upsurge in OPD. Services are available till PHC level.
- ◆ **IPD:** Most of the IPD services are restricted to CHC and above. Snakebites are the major reason for admission.

Determinants of Quality of Care

- ◆ **Equipment:** In Barmer most labour rooms did not have newborn corners, in Chittaurgarh it had been supplied recently.
- ◆ **Diagnostics:** Minimal lab facilities available. Lack of X-ray technician in Sheo CHC of Barmer, whereas in Chittaurgarh it has been outsourced at Nimbaher-SDH, but guidelines to protect staff against radiation are not being followed.
- ◆ **Clinical Quality of Care:** Overcrowded wards, no privacy for female patients and missing toilets in labour rooms seen in many visited facilities.
- ◆ **Biomedical Waste Management:** No system for Bio-medical waste management, sterilization of equipments and poor biomedical waste disposal systems. In PHC Ghosunda (Chittaurgarh) and PHC Dhanua (Barmer) waste is being disposed in open.
- ◆ **Grievance Redressal:** No mechanism in facility, even CMO Barmer had no idea about this system.
- ◆ **Signages:** Citizen Charters displayed in Chittaurgarh but not in Barmer.
- ◆ **Referral Transport and EMRI:** Services have been operationalised in state but call centre is located in Jaipur and those who receive calls at call centre do not tend to understand location where ambulance is to be sent. Services being confined to 35 kms of block, is a problem for large geographical blocks of Barmer. Most beneficiaries were using private vehicle because of both lack of awareness and since they were not sure if it would reach in time. The mock drill performed by CRM team at Majiwala Village actually proved that ambulance did not reach even an hour after the call.
- ◆ **Use of Untied Fund:** In past the fund has been used to buy equipment at SC to aid service delivery, but this year fund had not yet reached facilities.

SIKKIM

- ◆ **IPD:** 39% increase from 2005 to 2011.

Determinants of Quality of Care

- ◆ **Drug and Supplies:** The district hospital had a private medical store crowded when there were hardly any patients in the hospital pharmacy. Most of the medicines prescribed were not available in the pharmacy. But when stocks were checked, 73 types of medicines were available in the pharmacy. This could be due to the

fact (based on random checking of prescriptions by team members) that many doctors end up prescribing branded drugs rather than generic medicines which are available in the pharmacy.

- ◆ **Diet:** Canteen facility was available in district hospitals.
- ◆ **Biomedical Waste Management:** Biomedical waste management and laundry were done by the hospital staff only.
- ◆ **Cleanliness and Hygiene:** Separate toilets were also available for women in all facilities.
- ◆ **Signages:** Service guarantees and citizens charter were displayed in all institutions. Signages were also adequately put up. Separate toilets were also available for women in all facilities.
- ◆ **Grievance Redressal:** System is also in place. The state had not initiated any quality accreditation programme, but plans to take it up the coming year.

STNM Hospital Gangtok is certified to ISO 9001:2008 standards

- ◆ **Referral Transport and EMRI:** The state does not have an Emergency transport service (EMRI) available. The out of pocket expenditure incurred by pregnant women are mostly in the travel and by other patients it is for the drugs. This is basically because most of the patients can resort to public transport but pregnant women have to take a private vehicle or book seats in a shared cab (2 seats to ensure sufficient space).
- ◆ **Use of Untied Fund:** Records on RKS funds spending on patients amenities were available.

UTTARAKHAND

- ◆ **OPD:** There has been a steady increase from 2005 to 2011 but the annual increase has averaged out to 10% in the last four years from 2007 to 2011.
- ◆ **IPD:** Average 18% increase per year in IPD since 2005 to 2011. The trend has been very inconsistent over the years.

Determinants of Quality of Care

- ◆ **Drug and Supplies:** Generally available except IFA, Vitamin and Zinc which was found short.
- ◆ **Equipment:** Available but unused due to lack of manpower and training.
- ◆ **Diagnostics:** Basic services available at DH and CHC but not at PHC.
- ◆ **Diet:** At district hospital diet is provided below this level diet outsourced via voucher system. Rs. 85 is the ceiling. Community Kitchen" is an innovation of Paudi garhwal district. It is running in partnership with Bharat gas where attendants can cook/heat food at very nominal charges of Rs. 5 for 30 minutes and Rs. 10 for 60 minutes.
- ◆ **Biomedical Waste Management:** Protocols being followed.
- ◆ **Cleanliness and Hygiene:** Laundry services have been outsourced. Rudraprayad does not have linen at all.
- ◆ **Signages:** Citizen charter displayed JSSK IEC was not prominently displayed. No IEC on National Disease Control Program. No display through any other medium.
- ◆ **Referral Transport and EMRI:** 114 total vehicle plying. In densely populated 13 block 2 vehicles are placed. Average response time is 24 mins in Urban area and 36 mins in Rural area. 40% catering to pregnant women.



UTTAR PRADESH

- ◆ **Equipment:** Though episiotomy was being done in facilities in District Badaun but no instrument present to undertake procedure.
- ◆ **Biomedical Waste Management:** Management of healthcare waste grossly inadequate. Collection of waste has been outsourced to Common Waste treatment facility operator, but their schedule of visit to facilities has been erratic. Absence of pits for disposal of human tissue waste, non availability of puncture proof containers for collection of SHARP waste, non-usage of chlorine solution for on site disinfection.
- ◆ **Signages:** None of the facilities visited had a citizen charter displayed.
- ◆ **Referral Transport and EMRI:** 988 ambulance purchased but awaiting fabrication, equipping and deployment.

Recommendations

- ◆ There is a need to improve quality of monitoring of outpatient and in-patient attendance with disaggregation for gender and under 5s across the states.
- ◆ The social protection role of the public hospital has improved with reduction of user fees and better availability of drugs- but to prevent financial barriers to care there must be a careful state by state plan to reduce all out of pocket expenditure at the public hospital.
- ◆ RSBY financing to the public hospital was studied in only a few of the states. However it is clear that there is urgent need to build up some systems of monitoring, preferably community based or civil society based to prevent moral hazards and ensure that benefits are passed on to the intended beneficiary and that the poor are fully included.
- ◆ Quality assurance committees at state and district level need to be reiterated. There should be clear policy commitment for all hospitals to have quality management systems in place, and to measure and score and

publicly display progress against quality of care standards, and to have external certification of those hospitals which have achieved what is defined as the target for quality of care in that state. The check-list based monitoring of facilities is necessary but not sufficient to either achieve quality of care, or even to keep the quality agenda alive and the quality assurance committee active.

- ◆ Once again, as in every CRM earlier, the need for a procurement and supply side chain management system benchmarked to the TNMSC is reiterated.
- ◆ Once again, as in every CRM earlier, the need for making essential drug lists and drug formularies and standard treatment guidelines available on the desk of every provider and mechanisms to promote and monitor their use is reiterated.
- ◆ The basic minimum set of diagnostics to be made available at every facility level needs to be assured- but to reduce the practice of using it as the prime vehicle of user fee generation, and to universalize access to essential diagnostics, a differential financing of health facilities would be important.
- ◆ Clinical quality of care in terms of clinical competence would need other than access to drugs diagnostics and skills, the organization of supportive supervision which specifically supports this, and practices such as death reviews, medical audit and prescription audits to be institutionalized and linked to continuing medical and nursing education programmes.
- ◆ Quality of care in terms of patient comfort and safety leading to user satisfaction requires financing of diet, laundry, security, sanitation, biomedical waste management, water supply and electricity services, signages and grievance redressal systems in a flexible and responsive manner and their incorporation into appropriate quality management systems.
- ◆ Emergency response systems have leapt forward in the last five years and their momentum needs to be sustained. The overlap and the distinction between an ERS and a referral transport system needs to be kept in mind. ERS is most efficient when it attends to emergencies- whether medical, surgical, obstetric or trauma, within an half hour range of each of the vehicles stationed. Thus it is most visible and works best in the urban and near urban milieu. Referral transport for pregnancies are elective and most needed in areas distant from sites of institutional delivery, where tie-ups with local operators works faster, if they work. ERS uses pregnancy transport to build up its volumes, but in the distant area and even in the emergency it is weak and in most states less than 10%- with some states showing as high as 25%- of pregnant women access the ERS as their vehicle to reach the facility. On elective long distance driving to pick up pregnant women it loses out on its emergency response function. Local tie-up with operators works best where the service is cashless to the user, where there is swift reimbursement of the transport provider and some element of pre-payment. The recommendation is therefore to allow ERS to transport pregnant women when it is available and within 30 minutes to pick up, but in all other situations, use an extensive local tie-up with providers as the mainstay of the assured referral transport for pregnant women at the time of labour.
- ◆ Better guidelines and differential untied fund allocation would help improve expenditures in the PHCs, sub-centres and VHSCs. At higher facilities, using untied funds to underwrite expenses in diagnostics and patient amenities would help utilize these funds. Untied funds usage must be consciously directed towards improved quality of care and closing gaps and facilities should be provided with funds only after their current fund is utilized. The non utilized fund of low caseload facilities can be used as part of a district pool to reimburse operational expenses of high caseload facilities.
- ◆ Renewed emphasis is needed for separate grievance redressal systems to address patient grievances and provider grievances.

Social Protection and the Public Hospital

We present below a case study from one state to illustrate the problems being faced in most states.

Awareness of medical officers were about multiple schemes for supply of free drugs to the patients, the implementation was not uniform in one hospital visited. Random observation of physician prescriptions revealed that drugs (other than anti pyretics, IV drips, needles and emergency medicines) were being purchased by beneficiaries from medical stores co-located in facilities or from outside. The team observed many diagnostic facilities and medical stores in the vicinity of public institutions. User fees from APL patients form a considerable source of revenue for many facilities in Hamirpur.

Though there is a decision to provide free care to BPL patients, pregnant women and newborn, this becomes limited to not charge user fees for consultation and admission. User fees for diagnosis often remain and more important out of pocket expenditure on drugs and transport are not addressed. The need to ensure cashless service in a very proactive manner was not quite recognised. Many Government Hospitals in Himachal Pradesh are eligible for RSBY. Only a small percentage of the in-patients were eligible for RSBY and of these many got excluded for many operational and trivial reasons. The system is that if outside drugs are needed, the hospital should buy it from the Govt. organised pharmacy and give it to the patient free of charge. But there were many violations of this principle. Thus on the first days of the admission if the card was not produced they could land up purchasing medicines outside- and when the reimbursement came many months later, this would not be re-imbursed. Referral transport- to the hospital, or to the referred hospital or back home was not covered. There was a trend to convert outpatient care into inpatient care- and even a bit of unnecessary procedures- but admittedly these would be far less than in a private care setting.

There was no awareness of standard treatment protocol and the insurance company had no mechanisms in place to check any form of moral hazard. There was a huge amount of dues outstanding to the hospital. In Kinnaur district in a seven month period 244 patients in Reckong Peo and 17 in CHC Sangla were considered eligible for RSBY - and a claim of Rs. 8.81 lakh was submitted. Against which a sum of Rs. 2.93 lakh has been paid leaving Rs. 5.88 lakh outstanding. The RSBY card and eligibility on the same becomes by default the means test for BPL status- and therefore non-production of the card excludes from free care which would have been otherwise available to the non RSBY poor. The limitation of only 5 per family means that in larger families one or other would get excluded.

“Service delivery reforms are meant to transform conventional healthcare delivery into primary care, optimising the contribution of health services – local health systems, healthcare networks, health districts – to health and equity while responding to the growing expectations for ‘putting people at the centre of health care, harmonising mind and body, people and systems’.”

Primary Healthcare – Now More Than Ever The World Health Report 2008



Sub-Centres and Outreach Services

Sub-Centres and Outreach Services

Progress Under NRHM

Status of sub-centres across India					
States	Number of SCs (As Per RHS 2010)	In Govt. Building (RHS 2010)	With one ANM	Without ANM (RHS 2010)	With Second ANMs
High-Focus Non-NE States	71738	42073	68284	3454	23154
Non-High-Focus Large states	67762	38341	65270	2492	33075
Non-High-Focus Small states & Uts	314	229	308	6	211
High-Focus NE states	7255	4314	7080	175	4966
Total	147069	84957	140942	6127	61406

Status of MMUS	
States	Total No. of MMUs (MIS, NRHM 30.6.2011)
High-Focus Non-NE States	646
Non-High-Focus Large states	1044
Non-High-Focus Small states & Uts	9
High-Focus NE states	98
Total	1797

Main Observations

- ◆ Outreach services refer to services provided by ANMs in the sub-centres usually through outreach sessions held in Anganwadi Centres in the villages. These include immunization services, antenatal care; post natal care and access to temporary methods of contraception. Counselling and health education are also scheduled tasks. Mobile medical units are also a form of outreach services.
- ◆ Outreach services across states have improved in terms of achievements in deliverables - immunisation rates and antenatal care and promotion of small family norm and access to contraceptives. This is due to a) filling up of ANM vacancies in all sub-centres, b) the untied funds provision to sub-centres that has helped close gaps in minor equipments and amenities; c) due to the ASHA who has proven an effective approach to increasing demand. Of the total of 145,920 sub-centres, 95% are functional with at least one ANM whereas in 2005, one fourth of sub-centres were non functional. Further, 35% of current sub-centres (50,728 in number) have a second ANM. In 2005, no sub-centre had a second ANM.
- ◆ The Rs. 20,000 untied and maintenance funds to each of the sub-centres is reported as useful and as rule there is no problem with expenditure at this level. The exception was Rajasthan.

- ◆ Institutionalisation of the village health and nutrition day as a base to deliver all ANM, male worker and anganwadi services from a single convergent platform has been operationalised across all states. Over 58.7 lakh VHNDs were held in 2009–10 and 69.25 lakh during 2010–11. This works out to about 4.8 lakh VHNDs per month as against 6.38 lakh villages. State visit observations are consistent with reported figures. Major gaps noted by the CRM, remain the need for using the VHSC as the organising and mobilising vehicle for the VHNDs and to extend the package of services delivered in practice to include aspects like family planning counselling, adolescent health care, post natal visits, take home ration supplies etc. Often the VHND remains limited to the immunisation session.
- ◆ There has been considerable differentiation in the nature of sub-centres- between states and within districts. At one end we have a state like Himachal where the main activity is the out patient clinic. Immunisation and antenatal care occurs once or twice a month- once at the sub-centre and once in an anganwadi centre. Only three sub-centres in the entire state conduct delivery in the sub-centre though another small percentage not exceeding 10 to 20% provide midwifery services at home. Other than these there are unstructured home visits. At the other end we have states like Uttar Pradesh and Jharkhand and Bihar where the number of children to be immunised and pregnant women for antenatal care are very large- both because of adverse population ratio per sub-centre and because of high fertility. In these states there is little scope for sub-centre to do anything else. Within districts even in high fertility states, only about 5 to 10% of sub-centres conduct delivery at the sub-centre. Sub-centres that are not conducting deliveries have three reasons- the first is a delivery service in the sub-centre is redundant because there is enough transport and road connectivity to more assured and better quality services in higher/ alternative facilities nearby. Second is a situation where homes are preferred sites to the sub-centre because houses are large, clean and warm as compared to sub-centres and alternative delivery sites are not accessible. This is typical of the hilly states of Himachal and Uttarakhand. Home deliveries by SBA would be the option, but this has not happened. These states have sought and got – after much dialogue and debate- permission to train traditional birth attendants- but curiously after winning the argument at Delhi have not really rolled it out in the state. The third are sites where either for social cum geographic reasons, the sub-centre is needed for safe delivery, but lack of quality and public confidence as well as perhaps unchanged health behaviours remains a barrier. The load of disease control related work also varies widely related to endemicity of the disease and the availability of male workers. In short there may be nothing left called a normative sub-centre and one may have to create norms based on epidemiology, geography, health seeking behaviour and level of health systems development.
- ◆ 461 Mobile Medical Units are functional across all states- 66% of which are in high focus states, but their effectiveness and even their role allocation varies. At one end there are MMUs dedicated to providing outreach services- clearly ANM type tasks- and these are for areas which have no ANM or areas which ANMs have



difficulty in reaching. Second are a Out- patient clinic centred approach which works best where the ANM and ASHA is in position but the MMU brings in a medical doctor for curative care and some primary level tests and checkups. A third are MMUs which are trying to bring specialist care to the PHC- like what has been attempted by one model in Uttarakhand. The problem of lack of clarity in which type of MMU is intended, leads to design misfits- with large MMUs being procured for outreach areas where typically roads are poor and human resource for operating machines and interpreting images and tests is weak. The most common type is the second- the problem with this being - that though there is public welcome for outpatient services and some drugs, the actual health outcomes may be more limited.

Findings From States

ANDHRA PRADESH

- ◆ Sub-centres visited had adequate space and were well-maintained clean facilities. However, none of the SCs visited are conducting deliveries.
- ◆ The main activity performed by ANM is to conduct immunization session (every Wednesday) ANC and PNC. Sub-Centre micro plans for immunization were available at all the facilities visited. However, alternate Vaccine delivery system not in place. ANM/ASHA have to go to nearest PHC a day prior to collect the vaccines.
- ◆ Quality of ANC needs to be ensured particularly, the quality of hemoglobin estimation. ANMs are using paper method of hemoglobin estimation, which is less reliable compared to Sahli's method.
- ◆ VHNDs are organized on every 2nd Saturdays and there is good coordination with VHSC and with the all peripheral staff- ANM, AWW, LHV and ASHA. Convergent service provision also present.
- ◆ There are 475 Mobile Health Units of the Fixed Day Health Services (104) providing outreach services in the State. A team of 1 Medical Officer, 1 Pharmacist, 1 Lab technician, 1 driver and 1 data entry operator provides medical examination, laboratory services, and referral support at the village level. Each sub-centre is visited once in a month and the vehicle covers 1–2 villages in a day. Focus is on primary care for non communicable disease with blood tests for anemia, and sugar and screening, referral and follow up drugs for hypertension and diabetes being provided on a fixed day every month. Need for improving cost effectiveness and quality of services- by improvement in package and organisation of services.

ASSAM

- ◆ Overall there are 4604 health sub-centres in Assam as in September 2011 and 31 sub-centres are conducting at least 3 and more deliveries in a month.
- ◆ Rural Health Practitioners have been posted in more than 180 SCs and the experience is positive- not only for out-patient clinics but also on RCH services. In Dhubri, there were 246 sub-centres of which 119 (48%) have 2 ANMs, all have a MPW and 19 have a RHP. Of these last 19, 16 are conducting deliveries. OPD cases in sub-centres with RHPs are in the 30 to 40 per day range. But availability of essential drugs is a problem.
- ◆ 61% of all SCs are located in government owned buildings but many sub-centres lack water and electricity connections. There was no residential accommodation for ANM, who are mostly residing in another block/district.
- ◆ Health Services provided by the boat clinic services under PPP scheme of NRHM with C'NES is effective in geographically isolated riverine areas of the state.

- ◆ All 27 districts have MMUs, with each unit comprising of three vehicles, each unit equipped with x-Ray Machine, Microscope, ECG Equipment, Ultrasound Machine, and Mobile Pharmacy. These specially designed units have a complement of 2 MOs, 2 Nurses, 1 LT, 1 Radiographer & 1 pharmacist and since its launch in November 2007 till June'2011; 12,217 camps had been held and 18,55,450 patients treated. The Dhubri visit shows that the higher end equipment and even blood tests are not in use and only a general outpatient clinic occurs. In contrast the Dhubri boat clinics are providing outreach services - ANC, PNC, immunisation, Vitamin A- in other words substituting for the ANM who cannot reach the facilities.
- ◆ VHNDs are being held as Health Days at *Anganwadi Centres* providing services like immunization, family planning, ANC, counselling of mothers about nutrition and supplementary feeding.

BIHAR

- ◆ A majority of the HSC in Kishanganj district covers a population greater than 10,000, essentially covering the work of four ANMs. In Begusarai, most sub-centres have two ANMs. Only one sub-centre in Kishanganj is currently performing deliveries- but this conducts over 60 per month.
- ◆ The ANMs provide OPD services thrice a week, conduct VHNDs in their coverage areas, and in some cases also provide back-up for the PHC in which deliveries are taking place. They also are required to attend a weekly meeting on Tuesdays.
- ◆ The major services provided at the VHND include: ANC, immunization, Vitamin A for the children and dispensing IFA. However the ANMs do not have a hemoglobinometer and in most cases there is no space to conduct antenatal checkup.

CHHATTISGARH

- ◆ Sub-centres had adequate building and equipment, as noted in Kawardha district. They were maintaining records- but the detection of health issues was poor, both as reflected in the records and in the incidence of referrals even for such common conditions as severe anemia or hypertension in pregnancy or wasting in children, reflecting on poor quality of services.
- ◆ Out of 245 sub-centres in district Kanker only 11 had a second ANM and in these the work distribution between them is not clear.
- ◆ VHNDs are planned in coordination with ICDS. But this is limited to holding of the immunisation session and antenatal care and not yet evolved into a system that caters to the mother & child in particular and the community at large.
- ◆ There are no Mobile Medical Units and procurement of 30 MMUs underway.

GOA

- ◆ 2nd ANMs have been posted in 47 out of 192 sub-centres, based on the population covered. Deliveries are not being conducted in sub-centres even in those with 2 ANMs. None of the ANM is involved in Cu-T insertions. Male workers are in position and tasked with disease control functions.
- ◆ Main work of sub-centre seems related to outpatient clinics, other than some level of mobilisation in VHNDs which are held separate from immunisation sessions.
- ◆ Goa has two MMUs located at PHCs, which has fixed schedule to cover the villages. Functionality moderate to low.

GUJARAT

- ◆ VHNDs (*Mamta Diwas*) are conducted every Wednesday, as a platform for ANM and AWW services and in coordination with VHSC.
- ◆ Most sub-centres have one ANM only and a male worker. Second ANMs are exceptions rather than the rule in Dahod- but these sub-centres which have two are providing a full range of services including IUCDs. In the state as a whole records show 5159 SCs out of 7174 with a second ANM but there are also 861 without any ANM. As many as 25 sub-centres in Dahod district had no ANM in place. Clearly there is a problem that the more tribal dispersed areas which needs the additional ANM most has got it the least. The lack of willingness of available ANMs to work in this area seems to have been a limiting factor.
- ◆ 88 MMUs are functional in the state out of which 32 are for tribal areas. The services provided by the MMUs include, OPD services for minor ailments, Immunization, IFA Tablet distribution to mothers and children, ANC and referral to health facility for treatment. There has been a significant increase in the OPD cases attending the MMUs in the first four years with stabilisation last year. In tribal areas of Dahod, the focus is on outreach services as the MMU reaches areas where there are ANM gaps or inaccessible for ANMs to reach on a regular basis.

HARYANA

- ◆ Of 2484 sub-centres 1841 have a second ANM in place. A total of 455 sub-centres functions as delivery centres- known as delivery huts. However in Mewat out of 84 sub-centres only 6 function as delivery huts, and only 26 have a second ANM. One sub-centre has no ANM. Of the total of sub-centres in Mewat only – were conducting delivery services. The latter are known as delivery huts. Their main work was the immunisation sessions at once per week. There are also co-located sub-centres in PHCs. In contrast in the second district Hissar most sub-centres had a second ANM in place. But out of 198 sub-centres 23 are conducting deliveries.
- ◆ The state has got a total of 6 MMUs in place. The Unit comprises of 2 Staff Nurses, Pharmacist and a driver with the MO of the concerned health facility joining them for outreach activities in underserved areas - OPD, Immunization, ANC, Family Planning & Referral Services. There is one MMU in each of four districts and two in Mewat. The focus has been on outreach services. The areas are chosen as vulnerable areas where fixed services are weak.

HIMACHAL PRADESH

- ◆ The state has a total of 2067 sub-centres, of which 383 are without a single ANM and of these 188 have neither male nor female workers. The state has a conscious decision not to opt for the second ANM and given the fact that it has preferred to increase the number of sub-centres to reach a state level density of one per 3000 with as low as one per 1000 in low population density districts - this is a rational and well taken decision.



- ◆ The inability to fill existing posts of the single ANM and the lack of male workers is due to an administrative stance taken against filling up posts (a part of an earlier mind-set) which has recently been reversed.
- ◆ The major finding is the changing work pattern in these sub-centres. Across the entire state - only 3 sub-centres undertake delivery services. The whole emphasis on labour tables, labour rooms, newborn corners and SBA training in sub-centres seems completely redundant. Immunization sessions happen at the sub-centre only but in more dense populations it happens at one or more AWCs, in the month. In view of increasing access of sub-centres by families, this seems adequate for outreach and immunization as evidenced by its achievements
- ◆ The VHND however happens once every month in each of the 3 or 4 villages under the sub-centre - but it is no longer an immunization session or a platform for all services and more of a meeting with mothers.
- ◆ The major work that now devolves to the health worker is giving primary care to people in the form of an outpatient clinic, the caseload depending on the availability of drugs - supply of antibiotics at SCs has made a perceptible difference in treating the most common problem of respiratory infection. Apart from this, health workers visit the villages - but it is very unclear to themselves as well as their supervisors as to what exactly they transact and what the outcomes are to be. Clearly the demographic and epidemiological transition has happened, and RCH work has decreased to less than 20% of the time requirements. The leadership has to recognize this change and re-design the work of the sub-centre.
- ◆ There is one functional MMU per district in entire State with a special diagnostics van, which make occasional trips to provide outreach services, but additional benefit derived was not clear.
- ◆ As an effort for convergence, funds for VHNDs are being released to the AWCs through their department, but as the VHNDs are being primarily organized by the AWCs, the funds utilization and even the activity plans are inadequate.

JHARKHAND

- ◆ All the sub-centres visited by the team are performing well in outreach work, immunization services and conducting safe deliveries. More than 50% of SCs are conducting deliveries. Each of the SC has developed micro plans for immunizations and VHND.
- ◆ The state has 96 functional MMUs, which has helped in assisting over 13.7 lakh beneficiaries.
- ◆ ANMS coordinate well with ASHA/Sahiyya and AWW. There is interdepartmental convergence for the VHNDs and immunization, which is exemplary.

KARNATAKA

- ◆ SCs are functioning well and outreach services being provided on a daily basis as almost 40% of the ANMs stay in the SCs. Deliveries are being conducted at few sub-centres, however the state has a policy of not considering such deliveries as Institutional Deliveries. There are no sub-centres without ANMs and only about 10% have been provided a second ANM. No second ANM sub-centres were seen by the team.
- ◆ The viability and requirement of VHNDs in a state like Karnataka where regular services are available through SCs and outreach in most of the places needs to be revisited. The State may pilot VHNDs at some places and take decision accordingly. Good coordination between peripheral workers for the immunisation session. Much of the service delivery happens at the sub-centre premise itself.
- ◆ Immunization coverage improved from 71.3% in DLHS-2 to 76.7% in DLHS-3. Beneficiaries' List is prepared by ANM before the session (generally a day or two before) and ASHA is asked to gather the children on due list on the day of immunization.

- ◆ There are 96 MMUs in the State, 29 are under NRHM and rest under KHSDRP and they cover remote and hard-to-reach areas. Currently the NRHM MMUs are providing only OPD services (on an average 30 patients) and are not covering even the ANCs. No health education work. With four staff (MO, Female SN, Male SN and pharmacist) and a driver it seems to be over-staffed and under-utilized.

ODISHA

- ◆ Of 6646 sub-centres 1081 have a second ANM and only 42 are without any. Second ANM is preferentially in high load sub-centres and there is geographical work distribution between the two. In Rayagada, there are sub-centres of which 47 have a second ANM. Of the the total 13 are performing deliveries, but only three of these have a second ANM.
- ◆ VHNDs are planned in coordination with ICDS and ASHAs and information provided through *Village Kantha* (Wall Writing with Health Messages). But the coordination is limited to holding the event only and does not include follow up of mothers and children in the community.
- ◆ Identified malnourished children are referred to the nearby CHC to attend the *Pustikar Divas* on 15th of every month. However lack of Nutrition Rehabilitation Centre (NRC) and Dietician are affecting the follow up and care of the referred children.
- ◆ Micro Planning for Immunization Sessions are done at the sub-centres, prior to outreach immunization sessions. The beneficiaries' list is shared with ASHAs for information and mobilization.

RAJASTHAN

- ◆ 114887 sub-centres of which 328 without ANMs and 7228 with second ANM.
- ◆ Sub-centres are functional with focus on MCH services. ARI and diarrhoea management weak.
- ◆ MMUs reached 2 months back but not operational due to non selection of operator in Chittaurgarh. In the second district (Barmer) MMU has been outsourced to an NGO. No coordination with block health team.

SIKKIM

- ◆ SC functioning well but are not active in making birth preparedness plans. All visited centres had 2nd ANMs & MPW Male. Of their 147 sub-centres 60 have a second ANM. Immunisation session and follow up are well done.
- ◆ Monthly planning of outreach services is being done at all levels and VHND's, immunization are being conducted regularly. 96% of planned Outreach immunization sessions have been held, and 94% of planned VHNDs have been held.
- ◆ MMUs' are being used in a planned manner to provide outreach services in the form of camps for ANC, immunization, general checkups, screening of community for cataract etc. The State has 4 Mobile Medical Units, which make planned visits to difficult areas as per the requests received from BPHCs'.

UTTARAKHAND

- ◆ Of 1765 sub-centres, only 54 without ANMs and only 109 with second ANM. None of the SCs visited have second ANM and MPW. Moreover, the State does not have a MPW cadre. Pharmacists are posted and dispensing the medicine in SCs and ANMs are not running the OPD services. They are also not conducting deliveries either at home or SCs in these districts.



- ◆ VHNDs are generally organized on alternate Saturdays in Paudi district, and on all Saturdays in Rudraprayad district, either at AWC or in the village. The content is almost exclusively immunization sessions. Other components like counselling for nutrition, breast-feeding, ANC, PNC & Family Planning are lacking.
- ◆ Alternate Vaccine delivery system not in place. Either ANM/ASHA has to go nearest PHC one day prior to collect the vaccines. This affects their service delivery. Micros planning on immunization sessions were not available.
- ◆ Supplies have not been available for the last 6 months; hence nutritional supplementation (Take-Home Rations) was not given to children under three years, pregnant and lactating women.
- ◆ Mobile Health Unit (*Sachal Chikitsa Vahan*) is functional under public private partnership mode with a MoU signed between State government and Jain Videos, Delhi. State government provides the vehicle and all other recurring expenditure is being borne by private partner. There is 1 MHU per district with a team of 11 people (1 Physician, 1 Gynecologist, 1 Radiologist, 1 SN, 1 Pharmacist, 1 Radiology technician, 1 Lab technician, 2 drivers and 1 Cleaner) providing specialist and diagnostic services and drugs. About 40 OPD cases and 10 X-rays and Ultrasounds per day- but main function is ANCs. Vehicle is stationed at PHC, CHC campus- partly because of the size of the vehicle. Complications are referred to nearest tertiary level health facilities. As per state government rules, nominal user charges are collected to avail the services of MHU and the revenue generated goes to the private partner whereas BPL families and pregnant women are exempted from user charges.

- ◆ Mobile Medical Unit (*Arogya Rath*) is the alternate service carried out under PPP mode, with Rajbhara Medicare (Delhi). The vehicles have been bought with NRHM funds and basically covers hard-to-reach areas where the MHU is not able to reach. This provides largely outreach services.

UTTAR PRADESH

- ◆ Of 20521 sub-centres 1469 have no ANM in place and 1487 have two ANMs.
- ◆ Sub-centre activities limited to immunization and this scope needs to be widened. The high caseloads of children below 1 and pregnant women, and lack of privacy, the limited training and support, were all leading to inadequate focus on even ANC and family planning activities. Post natal care, and Newborn Care, ARI, Diarrhea and Nutrition are not being attended to.
- ◆ These VHNDs appear to be very effective in promoting immunization but their potential for delivering other preventative services is yet to be realized. VHSCs are hardly involved in mentoring support, financial support or planning processes.
- ◆ The 133 Mobile Medical Units functional in 15 districts are constructed to a high standard, but their large size of these units makes potential penetration into remote areas questionable.
- ◆ At present a relatively small number of school-based outreach services are provided under *Saloni Swasth Kishori Yojana*, offering Iron Folic Acid (IFA), de-worming and general checkup.

Recommendations

- ◆ In view of the Sub-Centres, HR, Infrastructure and norms must be made flexible and responsive to caseloads (e.g. No. of deliveries conducted), health systems context (is there a bigger and better facility nearby) and epidemiological context (how many children are there for immunization?, Is it malaria endemic area ect).
- ◆ Sub-centres providing Institutional Delivery services are to be reinforced with adequate infrastructure, equipment and training inputs and necessarily 2 ANMs in place
- ◆ A vast majority of sub-centres are not conducting deliveries and the task allocation of 2nd ANMs needs more planning. With over 50000 such 2nd ANMs in place any abrupt withdrawal would be disruptive.
- ◆ Home deliveries will continue and there is a need to persist with SBA trained ANMs providing home delivery in the most inaccessible of health facilities. This is most required in hilly terrains, where homes are spacious and warm and sub-centres are not.
- ◆ There must be clarity on whether a MMU is being used to
 - a. Deliver outreach services since there are no MPWs available or MPWs find it difficult to reach
 - b. Deliver outpatient care services by a doctor where MPWs and ANMs and ASHAs are in place
 - c. Deliver specialist referral care where PHCs and Sub-centres exit.

Depending on the context, the MMUs should be delivered, staffed and financed. Current MMUs planning lacks this clarity and also there are no clear cut outcome measures in place.

“ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals”.

ASHA Guidelines, 2006, National Rural Health Mission.



ASHA Programme

ASHA Programme

Progress under NRHM

The ASHA programme is operational in all states visited except Goa and Himachal Pradesh. Seven are high focus states where the ASHA has been in place since the NRHM was launched. The remaining six initiated the ASHA programme in 2008. ASHA selection has reached around 90% in 5 states and near 100% in the other 8 states.

Name of State	Required	Selected	Percentage of ASHAs selected
Andhra Pradesh	70,700	70,700	100%
Assam	29,693	29,172	98.2%
Bihar	87,135	80,967	93.0%
Chhattisgarh	60,092	60,092	100%
Haryana	14,075	12,857	91.3%
Jharkhand	40,964	40,964	100%
Karnataka	39,195	33,105	84.5%
Gujarat	32,806	29,731	90.6%
Odisha	41,102	40,942	99.6%
Rajasthan	54,915	48,736	88.7%
Sikkim	666	666	100%
Uttar Pradesh	136,268	136,182	99.9%
Uttarakhand	11,086	11,086	100%

Source: ASHA Programme Update July 2011.

In most of these states training has proceeded upto 5th module, and efforts at putting in place a trained support structure are underway. The ASHA programme has been evaluated in considerable detail and based on this modifications to the implementation have been incorporated.

Main Observations

1. The findings of the Fifth Common Review Mission (CRM) affirm and reinforce those of the previous CRMs. The ASHA continues to be a key part of the community participation component of the NRHM, and is also seen by providers and community as having enabled increased access to the health system and providing community level care for mothers and children.
2. Collaboration between the ASHA, ANM and AWW has improved, and there is increasing responsiveness to the ASHA and her contributions from the health facilities. Social and public recognition of the ASHA and her role is also growing. In Chhattisgarh where the programme is nearly a decade old, the state government has announced a special annual "Mitani Day". Many states call their monthly block level meeting with ASHAs as the ASHA Divas.
3. Though selection is near complete there is a reason for concern about where the last mile is located. Thus Haryana reports a 90% of ASHAs selected, but in Mewat, the very district where demand side problems are most acute in all of Haryana, only 60% of the requisite ASHA are in place. The state

had lowered the educational bar to the 5th class, but still did not find suitable candidates. Other states have overcome this by relaxation of criteria based on local context, with good results. In this respect Odisha's selection of ASHA in remote and inaccessible areas is commendable. With appropriate relaxation of literacy norms, the state has been able not only to secure ASHAs for the most challenged habitations, but also ensure proportionate representation of ASHA in the ST community.



4. All states in which drop out figures were available, report low attrition rates, and even these are primarily on account of the ASHA moving forward on a career path, the commonest being entering the Anganwadi system or becoming elected as a representative of the Panchayati Raj Institutions (PRI). Another reason is that there was a mismatch of expectations, and drop out on this account is to be seen as self-correcting measure. However systems to select, train and replace a new batch of ASHAs in their place is needed in most states. Most states have no systems of detecting ASHAs who are losing interest, or turned inactive since monitoring of functionality is not in place, and this needs to be kept in mind.

Name of state	Number of ASHA dropped out since 2006	Attrition rate (over 5 years)
Andhra Pradesh	4800	6.8%
Assam	583	2%
Chhattisgarh	1803	3%
Haryana	NA	NA
Jharkhand	1229	3%
Karnataka	1306	3.9%
Gujarat	402	1.4%
Odisha	388	1%
Rajasthan*		3% to 4%
Sikkim	0	0
Uttar Pradesh	5898	4.3%

*In visited districts

Of the 7 high focus states visited, all had a support structure in place, although more capacity building of the staff is urgently needed. Assam, Odisha, Uttarakhand, Rajasthan, Chhattisgarh, and Bihar, all have the specified structures at sub block, block, district, and state levels. In Bihar, Assam, Chhattisgarh and Odisha facilitators have been selected from amongst the ASHA, indicating yet another avenue for promotion. Dedicated training structures

are also in place in these states. In the non high focus states, the support structure is not in place in most states. Given that the numbers are high and that the form and content of the programme is similar, this aspect needs to be addressed soon.

Module 5 training completed for the majority of the ASHAs in all the 13 states, except in Bihar. Even in Bihar the state and district training agencies are in place and training of district trainers is scheduled to start in January 2012. In 8 out of 13 states modules 6 and 7 training has been initiated for ASHAs. Important states which have lagged behind are Jharkhand, Assam and Bihar. Assam which was one of the best performing states in ASHA shows signs of fatigue and slowing down on many parameters. Uttar Pradesh has initiated home based care in 17 districts, but now are synergising with the module 6 and 7 strategy and taking it to scale. In Himachal Pradesh anganwadi workers who exist at the one in 300 population level, and therefore perform many of the ASHA functions, have taken up a special module based on 6 and 7.

AP, Assam, Chhattisgarh, Odisha and Sikkim have established grievance redressal systems for the ASHA. In all states monthly meetings are more regular, incentive payments are being streamlined, and in some states bank transfers are the norm. Only Odisha and Uttarakhand have streamlined mechanisms for payment with regular payments. Delays in payments are reported from all other states with longer delays from states such as Andhra Pradesh, Chhattisgarh, Jharkhand, and Uttar Pradesh.

Incentive payments range from Rs. 200 in Chhattisgarh to nearly Rs. 4000 in Sikkim. Sikkim and Rajasthan provide fixed payment to the ASHA of about Rs. 3000 and Rs. 1000 respectively. In Chhattisgarh, incentive payments are low, but while active Mitranins who were met, said that they were not motivated by the money, district officials tended to dismiss those who had not claimed incentives as non-functional. The idea that community level workers could provide services on a voluntary basis is not clearly understood by programme implementers. Assam, Gujarat, Odisha, Haryana, UP, Karnataka, Rajasthan have bank accounts for payment to ASHA. Bihar and Jharkhand are in part and Andhra Pradesh is just starting up. In Assam many ASHAs and mothers are unable to open accounts and cash their cheques for reasons of rigid banking formalities. Uttarakhand uses bearer checks. Chhattisgarh and Sikkim find cash payment as the only possible and efficient way of delivering the payment.

While the promotion of institutional delivery and immunization are the two key tasks that continue to be seen as her most important responsibilities the ASHA is active on a range of tasks including malaria surveillance, nutrition, DOTS, home based newborn care, motivation for family planning, contraceptive counselling, DOTS. In Chhattisgarh, Sikkim, Uttarakhand, they are also serving as RSBY motivators. In Sikkim, ASHAs are also involved in supporting health workers on screening for diabetes, hypertension, and care of chronically ill patients. Routine home visits for post partum and newborn care are established in Uttarakhand, Odisha, Sikkim, Rajasthan, Uttar Pradesh and Chhattisgarh where the ASHA training in Module 6 or equivalent has been initiated.

Replenishment of the drug kit is an issue across the board, even in a mature programme such as Chhattisgarh. States will need to step up to this challenge and enable timely and regular replenishment of the drug kits.

Staying arrangements for ASHA in facilities and help desks are in place in Odisha, Assam, Sikkim and Chhattisgarh. In other states there is strong case for establishing these supports given that almost everywhere ASHA report accompanying pregnant women to the hospitals, and staying overnight with them.

The linkage of the ASHA with the Village Health and Sanitation Committees (VHSC) is peripheral. In no state did ASHA report being active in the VHSC.

The concept of ASHA as agents of social marketing is being introduced for contraceptives and oral pills and sanitary napkins. But these programmes are in too early a phase for comment. On the ground the programme

was seen only in Uttar Pradesh and Uttarakhand and the interesting observation from this state was that she was not accepting the payment for contraceptives as she did not want to alter the social image that she had built up. It would be interesting to see how the ASHA herself would respond to efforts to shape her role in this direction.

Findings from States

ANDHRA PRADESH

- ◆ ASHA support system is in place at the ground level which also functions as a grievance redressal mechanism for ASHAs.
- ◆ ASHA Days are held at the PHC level throughout the State on every first Tuesday of the month. ASHA nodal officers or coordinators meet at the district level on every Thursday for review.
- ◆ All ASHAs are trained upto 5th module. Module 6 and 7 training for Home based newborn care has started in 11 districts.
- ◆ Training of ASHAs in promoting “Menstrual Hygiene Programme” is also initiated in the state.
- ◆ ASHAs are involved in promoting ANC, institutional deliveries, family planning, DOTS and organizing VHNDs.
- ◆ Average take home amount per month per ASHA is Rs. 600. Delay in payments was found in Warangal as the claims of incentives are sent to the district head-quarters for verification.
- ◆ All the ASHAs have drug kits, but regular replenishment is an issue.
- ◆ The attrition rate of ASHAs is nearly 800 per annum. Main reasons for drop outs are seasonal labour, economic and personal reasons.



ASSAM

- ◆ ASHA Programme is supported at State level by State ASHA mentoring Group, State ASHA Resource Centre, and three master trainers and at District level by district ASHA nodal officer, district community mobilizers and assistant district community mobilizers.
- ◆ As of September 2011, 2743 ASHA facilitators (1 per 10 ASHAs) were recruited to provide support to ASHAs at the field level.
- ◆ ASHA are effective in mobilizing the community for ANC registration and in ensuring institutional deliveries. Though ASHAs escort women for delivery, they do not conduct post natal visits regularly.
- ◆ ASHAs are highly motivated, active and conversant with RCH programme and other responsibilities assigned to them except for new initiatives under disease control programmes.
- ◆ The average take home amount per month per ASHA was Rs. 1500. Payments are done through e-transfer to the bank account on or before 10th of every month against the claimed amount after verifications.
- ◆ *Attrition rate is nearly 2% in the state.*

BIHAR

- ◆ The state has all the requisite support systems in place although, the State ASHA Resource Centre (SARC) has only team leader and one consultant. District and block community mobilizers are in place and ASHA facilitator selection is underway.
- ◆ In October 2011, the state signed a tripartite MOU with four state level organizations for state training sites where ASHA trainers can be trained. The state has also identified 18 district training organizations to undertake the training of the ASHA.
- ◆ ASHAs have not received any training inputs for over 18 months now.
- ◆ The ASHA, the ANM and AWW appear to enjoy good rapport.
- ◆ Though escort to the institution was seen quite commonly for promotion of institution delivery, escort by ASHAs in cases of sick newborns, children or post partum mothers is not reported.
- ◆ ASHA is not equipped with the skills to undertake social mobilization and/or service provision.
 - ❖ ASHAs also reported that they are not able to reach marginalized households because of distance, and socio cultural barriers.
- ◆ Database of ASHA was being maintained at block levels, bank accounts have been opened, for most, and payments are beginning to be streamlined.
- ◆ Drug kits were given once to the ASHAs but were not replenished thereafter.
- ◆ Some ASHA demanded more training and skills. *Only a few ASHA asked if they would be regularized in government jobs.*
- ◆ The VHSC have been formed and funds transferred, but ASHAs are not part of the picture.



CHHATTISGARH

- ◆ There is a strong support structure in place and a mature programme. It is the only state in which the voluntary character of the programme is highly visible.
- ◆ Mitanins are currently undergoing the 16th round of training. In addition to training in several topics of Modules 6 and 7, the Mitanin have received training in national disease control programme and RSBY, HBNC, and legal rights.
- ◆ Mitanins are clear about their roles, knowledgeable and skilled in a set of basic community level counseling and care practices including appropriate drug dispensing.
- ◆ There is a divergence between the routine reporting structure (which follows the supervisory structure) and the incentive payments, which are made mostly at the block level. This is partly due to the fact that the Medical Officers have been withdrawn from PHCs to the block and PHCs are staffed by RMAs¹ who do not have the sanctioned payment authority. This results in delays. The average take home amount per Mitanin is about Rs. 200 per month given low population coverage.
- ◆ The district NRHM staff did not have detailed tracking of performance and payments made to the Mitanins, which was available with the Mitanin supervisors.
- ◆ There are delays in resupply of Mitanin Drug Kit.
- ◆ Attrition rates are low, upto 4% overall, and primarily due to election to panchayats, moving into other careers such as ANM or AWW.

GUJARAT

- ◆ The state does not have a support structure in place and the programme is managed by the regular staff at state, district and block levels.
- ◆ All the ASHAs are trained upto 5th module and currently training in 6th module is under process.
- ◆ Social marketing of contraceptives program has been launched in the district and ASHAs have started distributing condoms in the community. Incentives are being paid timely through A/C Payee cheques to ASHAs.
- ◆ 29055 ASHAs in the state have been given drug kits. Knowledge on appropriate use was mixed.
- ◆ Records were maintained meticulously by ASHAs which included ASHA Diary, Malaria, family survey, attendance register and eligible couple register.
- ◆ 402 ASHAs have dropped out from the total selected. The main reasons for their dropping out are; family problems, social problems, personal reasons and marriage.

HARYANA

- ◆ While the overall selection of ASHA is 94%, in Mewat district, only 60% of the required ASHA were in place, despite the relaxation of In Mewat district the qualification criteria for ASHA has been relaxed to 5th class pass to get more candidates due to non availability of 8th class pass candidates.

¹ As a state policy, the Chhattisgarh government has started deploying RMAs (Rural Medical Assistants, completing the 3-year Rural Medical Science course) at the PHCs and some identified SHCs while concentrating the Medical Officers at the block and district level. As observed by the 5th CRM teams, it was no doubt strengthening the CHCs, but causing some administrative and financial problems at the sector (PHC) level as the RMAs do not have DDO powers. Also, the ANMs are more experienced (and “senior”) to the RMAs. As a result the RMAs are almost kept out of the RCH functions (as per practice, not as per design).

- ◆ ASHAs are paid an incentive of Rs. 300 for escorting women for institutional delivery.
- ◆ Anganwadi Worker and Lady Panch (i.e. Head of VHSC/VLC) are the designated joint Account Holders of VHSC. To ensure better utilization of NRHM funds, ANM is also being made the joint Account Holder in 2011–12.

HIMACHAL PRADESH

- ◆ The state has no ASHA Programme. Community mobilization and the work done by ASHA are now being allotted to the Anganwadi worker, since the population covered by an AWC is about as low as 300 to 400 which does not merit the introduction of an ASHA, but admits of space to enlarge the AWW functions to include more substantial health prevention and promotion roles.
- ◆ Training of trainers for a consolidated Module 5, 6 & 7 is ongoing.

JHARKHAND

- ◆ The ASHA (Sahiyya) is supported by Village Health Committee Sahiyya Resource Centre (VHSRC) at the Sahiyyas are supported by a Sahiyya Sathi (1 per 15 Sahiyyas). There are no intermediate support structures.
- ◆ There is a Block Training Team (BTT) consisting of 4 BTTs per block and State Training Team (STT) consisting of 2 STTs at state level.
- ◆ Most Sahiyyas have been trained in Module 5B. However, not all were found to be active.
- ◆ Sahiyyas are involved mainly in JSY, RI, FP, Malaria, DOTS and referral of malnutrition children to MTC/MTEC. Some Sahiyyas have been provided with OCPs and condoms for distribution at the community level under social marketing project, although they have not been trained in contraceptive counselling.
- ◆ At the community level many Sahhiyas have earned goodwill and have been a source of help and strength to the expected mothers.
- ◆ On an average incentive received by active Sahiyya was about Rs. 2000 per month. However, many of them reported that they are not getting their incentive on time.
- ◆ State has created a Sahhiya Help Desk at the district hospitals to redress the grievances of the Sahhiyas, this appeared to be very effective at DH, Deogarh.
- ◆ Sahiyya kits have been partially distributed and not replenished till date.
- ◆ Rewards and recognition system for Sahiyya has been initiated in the district.
- ◆ Attrition is mostly on account of Sahiyyas being elected as PRI members.

KARNATAKA

- ◆ State and district level ASHA Resource Centres (ARC) have been established. A State ASHA Program Officer looks after the program at the state level. At the district and block levels support is through existing structures.
- ◆ ASHA Mentors appointed at the District and Block Levels are responsible for review of the program during monthly review meetings as well as to provide support and guidance to ASHAs during field visits.
- ◆ All ASHAs have been trained up to the 5th Module. The State has 15 State Trainers for Module 6 & 7 and ASHAs training in Home Based Newborn Care is underway in selected districts.
- ◆ The health workers at each level of facility work in close harmony with the ASHAs.

- ◆ ASHAs have contributed to the major healthcare delivery achievements including increasing ANC, Institutional Deliveries, Breast Feeding Practices and Immunization Coverage.
- ◆ “Integrated Incentive Package” for ASHAs has been notified and 25 line items have been listed. ASHA payments are made on a monthly basis. By 21st/22nd of every month the payment due is disbursed through cheques. The average monthly take-home amount is around Rs. 600 to 1000.
- ◆ All ASHAs have drug kits which are being refilled at the PHCs during Monthly Meetings.
- ◆ Attrition rate of 3% is attributed to a mis-match in expectations, delayed payments & inadequate support from the health system.
- ◆ ASHA Grievance Redressal Mechanism needs strengthening.



ODISHA

- ◆ The state has expanded the number of ASHAs in remote and inaccessible areas, (designated V3 and V4) resulting in one ASHA per habitation covering in some cases, 100 population with additional incentive provision of 25% to 50% of their total incentive in V3 and V4 areas respectively.
- ◆ The criteria of educational qualifications (8th pass) has been relaxed in the difficult areas, and the state has taken care to ensure that between half and two thirds of ASHA in the V3 and V4 areas are from the scheduled tribes.
- ◆ Nearly 98% of ASHA have been trained in Module 5. Training of Module 6 and 7 in 18 high focus districts for 22,030 ASHAs in 734 batches has begun. Kits and material are being procured. ASHAs have also been trained in First Aid, collection of blood slides for malaria, and management of fixed treatment depots for flood affected areas.
- ◆ Payments to the ASHA are streamlined, with the tenth day of every month declared as ASHA incentive payment day that are made through e transfers.
- ◆ Grievance redressal is part of the monthly of sector meeting and district ASHA Diwas.
- ◆ Drug Kits are provided to all ASHAs. Drug kit User manual and incentive to use the drug kit is also provided to facilitate the use of drug kit. An annual award system is in place.
- ◆ ASHAs have been provided with the ASHA diary, bicycle water bottle, umbrella, torchlight and uniform.
- ◆ ASHA Gruhas are operational in 110 health institutions presently and are managed by ASHAs in rotation.
- ◆ Dropout rate of ASHAs is very low i.e, 1%. The major reasons for dropping out from the programme is either selection of ASHAs as AWWs or because of personal reasons.

RAJASTHAN

- ◆ The ASHA support structure at state, district and block is in place. At the PHC level there is a Health supervisor in lieu of the ASHA facilitator.
- ◆ The pace of training of ASHAs is slow, although Module 5 training is underway and training in Module 6 is to be initiated soon.
- ◆ The state has also established a system of performance indicators to determine functionality and effectiveness of ASHAs.
- ◆ Their key roles included accompanying women for deliveries at the facility, immunization, and community mobilization for ANC, PNC, Family planning and childhood illnesses. Home visits for post partum and Newborn care are not taking place currently.
- ◆ The ICDS pays the ASHA a fixed amount of Rs. 1000 per month and the total carry home incentive varies between Rs. 1350 to Rs. 1500. Incentives for JSY are not as paid as per the JSY guidelines, with the result that the ASHAs do not often provide the escort function.
- ◆ The lack of communication aids results in an inability of the ASHA to provide accurate and complete information during counseling and health education meetings.
- ◆ One of the major challenges in desert districts such as Barmer is access. Hamlet based ASHAs should be considered, if critical functions such as home visits are to be conducted.
- ◆ The attrition rate of ASHAs in the districts visited reported as 2% to 3%.

SIKKIM

- ◆ ASHA facilitators, Block Community Mobilisers, (BCM), and District Community Mobilisers, (DCM) are in place. The State ASHA Resource Centre is yet to be established.
- ◆ All ASHAs have completed training in Modules 6 and 7.
- ◆ ASHAs are highly motivated and are proactive in most spheres including detection of high risk pregnancies, newborn care, managing basic ailments and referral support. They are actively involved in a range of interventions and have systematic workplans that include joint visits with the multipurpose worker to the homes of the chronically ill, including those who require insulin injections,
- ◆ Geographical access is a barrier to reaching communities in rural areas, with some ASHAs having to travel three to four hours to reach a beneficiary.
- ◆ The average take home incentive amount from JSY is low. It ranges from Rs. 600 – Rs. 1800; and in the Northern District it was Rs. 250 – Rs. 350 per month. The state government provides a monthly fixed honorarium of Rs. 3000 per month, payable quarterly, in cash.
- ◆ The drug kits are periodically filled in most areas.
- ◆ The ASHA ghur's are in place and are being used by ASHAs.
- ◆ ASHA Diwas is regularly conducted.
- ◆ There is a working Grievance redressal system in place.
- ◆ Community monitoring is being planned. Members have been selected up to PHC level and ASHA is also a member in the committee.
- ◆ There has been no drop out from the programme post selection and training.

UTTAR PRADESH

- ◆ State ASHA mentoring group has been constituted and is functional. The support system is active at district and block levels. At the state there is one nodal officer with a team of three consultants deputed from NHSRC for support.
- ◆ Module 5 training is underway. In addition ASHAs in 17 districts have been trained in a state specific package entitled "Comprehensive Child Support Programme". The state has recently decided that this package needs to be more skill based and will soon initiate training of state trainers in a modified package of Modules 6 and 7.
- ◆ The tasks on which the ASHAs are focused are mobilization for VHND, motivation and escort under JSY, and in pulse polio.
- ◆ The role of ASHAs in VHSC is very limited.
- ◆ Average take home amount per month per ASHA ranges from 1500–2500, and is mostly through electronic transfers, but there are widespread reports of delayed payments.
- ◆ There was a one time supply of drug kits which have not been replenished since 2009.
- ◆ Grievance redressal mechanism for ASHAs is in place in every district under ACO.
- ◆ No arrangements were available for night stay in the health facilities for ASHAs are in place.
- ◆ An attrition rate of 4% was reported. Main reasons for attrition are shifting their work profile from ASHA to ANM or AWW and Teachers etc.

UTTARAKHAND

- ◆ The support structure at state and district has been outsourced to NGOs who manage the training and support functions. ASHA Facilitators (1 per 18–20 ASHAs) and Community Mobilisers at district and block are in place.
- ◆ About 84% of ASHA have been trained in Module 5, with ASHAs training in Module 6 and 7 being underway. Other training includes topics such as first aid, RSBY, ARSH and Homeopathy.
- ◆ Major activities appear to be mobilization for childhood immunization, JSY, with escort function for JSY, and family planning. ASHAs are not involved in post natal care or disease control activities.
- ◆ Payments to ASHAs are by bearer cheque and appear to be regular. Drug kits were available with all the ASHAs.
- ◆ There are no provisions for ASHAs to stay at the health facilities.
- ◆ Attrition is on account of selection as Anganwadi workers.



Recommendations

- ◆ There is a need for sustained advocacy to explain the characterization of the ASHA. It is the particular combination of roles- as facilitator of services, as a person working for health rights and as a community level care provider- that makes for effectiveness and sustainability. Over-emphasis on any one of these dimensions and failure to recognize the others make for a sub-critical programme that leads to lesser coverage, functionality or effectiveness.
- ◆ There is need for building capacities in the support structures that have been built up already. Other states that have not built up the support structures need to start this up immediately. Similarly community based training sites and training teams which have been initiated in most states as part of training for module 6 and 7 need to be institutionalized.
- ◆ Regular monitoring and support to ASHA functioning is important at the local level to replace non functional ASHAs and at the block level to provide additional support and resources where the challenges are more. The use of functionality indicators and the process of gathering this are key to this change and needs to be rapidly introduced. Another aspect of this is creation of an ASHA database at all levels to track and replace drop-outs as also to facilitate certification and career options for those who require it.
- ◆ Ensure achievement of the minimum skill sets required for an ASHA as defined by modules 5, 6 and 7 within the coming year, with some process of certification of ASHAs who have achieved the prescribed skills.
- ◆ Improve mechanisms of performance based timely payments and urgently put in place the payments for newborn visits.
- ◆ Reiterate once more the need for regular replenishment of drug kits- especially life saving first line drugs of ORS and Zinc, Cotrimoxazole, Chloroquine and equivalent, as well as drugs for management of anemia.
- ◆ Functioning of the Village Health and Sanitation Committees are to be revitalized with the ASHA playing a central role.
- ◆ Creating facilities for the ASHA to stay-in during facility visits is likely to improve access of the community to health facilities.
- ◆ The administrative willingness for long-term planning for the ASHA programme is essential for most of the above reforms. Too much of the ASHA planning has a mindset that views her as an ad hoc passing phase. The other problem in administrative will is the failure to understand the diversity of expectations of stakeholders and the ASHAs themselves from the programme. As we complete the seventh year of the ASHA programme, and the programme gets a five year mandate which would take it to its 12th year by 2017, such a long term 'operational' plan would be an urgent necessity.
- ◆ Long term planning requires planners to provide space for those ASHAs who are happy to remain local volunteers indefinitely with the performance based incentives acting as social recognition. At the same time, those ASHAs who aspire for regular employment and incomes, must be enabled to enter into training programmes for becoming ANMs, nurses, ASHA facilitators, anganwadi workers etc. Options for voluntary ASHAs to opt out voluntarily and be replaced by next generation volunteers after ten years may also be encouraged. Certification of ASHAs for having acquired minimum skills and opportunities for them to upgrade skills would be an important component of this plan. Over a much longer time framework an ASHA who provides a much wider level of community care and health care facilitation, which includes all of non communicable diseases, geriatric care, and palliative care etc. is likely to emerge- and this would not be excessive from whatever international experience teaches of human resource requirements for the health sector.

"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 and achieve reduction of child and maternal deaths as well as population stabilization, gender and demographic balance."



Reproductive & Child Health

Reproductive & Child Health

Main Observations

- ◆ All states have shown increasing trends in institutional deliveries from 2005 to 2011. The increase ranges from 2.6% in Andhra Pradesh to 21% in Assam, 25 % in Haryana-33% in Karnataka-47% in Chhattisgarh and 50% in Bihar.
- ◆ The emergency obstetrics care in terms of handling complicated deliveries by C-Section is still poor in most of the districts visited. In most high focus districts the only FRU is in the district hospital and even that remains a challenge in many districts. In the 30 districts visited, there were 78 hospitals where C-sections were currently available - but of these 58 are from eight districts. These are Warangal and Guntur- of Andhra Pradesh 19 each, Rajkot-4, and Dahod-2 in Gujarat, Chamrajnagar and Bijapur of Karnataka-5 each and Goa-2 each. It is likely that the two districts of Andhra are quoting designated FRUs, most of which are not functional as FRUs. The remaining 22 districts had 20 FRUs and of these 5 had none. Of the 30 districts, 19 had blood banks and 11 had none. Reasons for non functional FRU- in terms of C-sections happening, was always due to non availability of one of the required specialists skills.
- ◆ Safe abortion services are a big gap as most of the states have no facility beyond DH (or some private sector hospital) that provides abortions including Andhra Pradesh, Bihar, Chhattisgarh, Haryana, Jharkhand, Odisha, Uttarakhand. Few states that report facilities available below DH are Karnataka, Goa and Uttar Pradesh. This gap is attributed mostly to lack of MTP trainings.
- ◆ The met need for sick neonates in terms of availability of SNCUs in districts have gone up since last CRM with 16 FRUs in the 30 districts visited. The two districts of Andhra accounted between them for 5 SNCUs, and the rest of 11 were one per districts. Thus 17 districts had no SNCU. States where both districts had no SNCU were Bihar, Chattisgarh, Uttarakhand and Uttar Pradesh.
- ◆ Newborn corners are much more widely established across most states. The large gap between newborn corners and SNCUs is still continuing due to non availability of F-MNCI trained staff in 24x7 facility and functional FRU other than district hospital in almost all states. Few states that have NBSUs (newborn stabilisation units) in place are Goa, Gujarat (14) Jharkhand (1), Odisha (25).
- ◆ Achievements in Family planning methods adoption by clients in state have shown a varied experience. While most of the states reflect positive achievements over both for limiting and spacing method, a few of the districts showed a fall or stagnant trends over these years. NSV performance decreased in Assam by 2%, in Mewat by 14% in tubectomy, and 50% in IUDs), and in Sikkim. In Odisha progress is slow. The decline in family planning in these districts are related to lack of shortage of trained doctors, leading to a lack of regular fixed day services.
- ◆ JSSK scheme has been officially started in all states other than Bihar and Sikkim. Except for the drop back facility most other aspects of care in Andhra Pradesh, Goa and Gujarat are available on a cashless basis. However, though user fees are reduced or removed, out of pocket expenditure persists in Himachal Pradesh, Jharkhand, Odisha, Uttarakhand, Uttar Pradesh. Women are incurring out of pocket expenditure mostly on travel to and back from institution, on diagnostics and drugs in these states.
- ◆ Delay of months in JSY payments due to various reasons has been a major finding of the CRM across most states. Reasons vary. In Assam it was the non availability of cheque book facility in Dhubri, in Bihar-Kishanganj and Goa women had to go to the block to collect payments, and in Haryana, Rajasthan, Uttar Pradesh flow of funds was the constraint.
- ◆ Maternal Death Audit is reported as ongoing from Gujarat, Goa, Haryana, Himachal, Odisha, Sikkim. Death reporting is improving over a period. However 6 of the states visited had not yet introduced audits.

Findings from the States

ANDHRA PRADESH

- ◆ **Maternal Health:** MMR has decreased by 20 points between 2005 to 2008 (154 SRS 2004–06; 134 SRS 2007–2009). There are 800 PHCs (out of total 1624) and 247 (out of total 281) CHCs functioning as 24x7 facilities and 156 facilities functioning as FRUs. 90.5% institutional deliveries and 18% C-Sections at state level. Performance of FRUs in Warangal poor despite availability of adequate number of specialists. The reasons of poor performance of public sector can be attributed to poor quality of ANC. MOs and ASHAs are creating good demand for services however, linkages between service delivery and demand generation need improvement. Anemia rates high, and paper method of haemoglobin estimation at sub-centres and CHC is unreliable.
- ◆ **JSSK:** Health officials not oriented on JSSK. Facilities not prepared to roll out the programme in very near future. User fees are still being charged for laboratory services.
- ◆ **JSY:** APVVP centres do not provide JSY benefit to the women delivering in their CHCs, AHs and DHs. Delayed JSY benefit payment by upto 2–5 months was observed in some cases.
- ◆ **Safe abortion services:** Available in 1 or 2 facilities. No trainings in Medical Termination of Pregnancy organized since 2005 till date.
- ◆ **Child Health:** IMR (57 SRS 2005 – 46 SRS 2010): 11 points drop in IMR of state; 44 SNCUs in Andhra, NBSU-156, NBCC-1372.
- ◆ **SNCU:** Functioning at Medical College hospitals in both districts.
- ◆ **Newborn corners:** Newborn Care Corners not identified and set-up in most of the places where deliveries were taking place.
- ◆ **Immunization:** Immunization coverage is nearly 100%. Disposal of AD syringes and needles after use remains a problem; they are disposed by burning/dumping outside the village. BCG doses were not given before discharge and were given only on fixed days for immunization at the sub-centres.
- ◆ **Family Planning:** Guntur district had projected its target as TFR of 1.3 far below replacement level. Similar targets have been handed down up to sub centre level, obsession with sterilization targets continues. EC pills were also not found in the facilities visited.



ASSAM

- ◆ MMR in Assam has decreased from 480 (SRS 2004–06) to 381 (AHS-2010–11) A drop of 99 points for state. In Nagaon-367 (AHS-2011); Dhubri-366 (AHS-2011) it is less than state average. State has 24 x 7 facilities-494 and FRU-62 (24-DH). There has been 21% increase in institutional delivery since 2008–2009 in the state.
- ◆ **ANC:** In Dhubri-ANC increased by 5% in 2010–2011 as compared to 2009–10. 3 ANC check-ups have increased by 34% in 2010–2011 as compared to 2009–10. Dhubri records high home delivery both because ANM don't stay at SC and infrastructure lacks basic amenities (60% don't have water supply). Nagaon FRUs managing only few emergencies. The management protocols used in labour rooms of training facilities in Nagaon also gives different.
- ◆ **JSSK** launched on September 2011 in state.
- ◆ **JSY:** 20 times increase since 2005 but Dhubri reports backlogs of JSY payments at many centres due to non-availability of cheque books. In addition, bank refusal to open zero balance accounts for the JSY beneficiaries leads to non-encashment of many issued cheques as was seen in one of the facilities where 40/72 cheques issued this year remained pending.
- ◆ **Safe Abortion Services:** MTPs using MVA technique were being done at some facilities. Child Health IMR- (68-SRS 2005 and 58-SRS 2010) Drop of 10 points. Dhubri 72-AHS 2010; Nogaon 66-AHS 2010 SNCU-8 and 404 NBCC present in state.
- ◆ **Neonatal Health:** No decline in neonatal mortality rate since 2005. The early neonatal mortality has gone up from 25 in 2005 to 29 in 2009. Data on 96 early neonatal deaths at Nagaon Civil Hospital indicates that 45.8% deaths were due to birth asphyxia and 4 of 96 babies died of hypothermia. Phototherapy units and radiant warmer were found at most facilities where deliveries occur.
- ◆ **SNCU:** SNCU at Nagaon is now operational and was admitting newborns for treatment, General drugs were available while antibiotics were in very short supply. The SNCU at Dhubri district hospital is well equipped and has become functional only a week ago. All drugs supplies were adequately available.
- ◆ **NBCC:** Functional but skill of staff needs upgradation.
- ◆ **Child Health:** Low Osmolality Oral Rehydration Solution (ORS) and cotrimoxazole tablet and Vitamin A was available at majority of facilities visited; dispersible zinc tablets were also available at a few facilities. At FRUs and DH there is gross use of irrational drugs including multiple antibiotics for management of childhood diarrhoea. Skills for managing diarrheal and Pneumonia were uniformly poor in all categories of personnel.
- ◆ **Immunization:** Riverine areas cold chain point needs to be established. The current ad-hoc practice of supplying vaccines not sustainable. The effect of erratic vaccination was well evident with partial vaccination of children as per immunization cards available with the villagers in these areas.
- ◆ **Family Planning:** TFR 2.6 Male participation in sterilization has been quite good and needs to be highlighted. However this too seems to be declining from 17.32% in 2009–10 to 15.3% in 2010–11. Availability of contraceptives is quite good; however the access to services is poor. Since the fixed-day/fixed-place approach is nonexistent, only sterilization camps are relied on for providing services. The frequency of the camps is also quite infrequent.
- ◆ **Maternal Death Review:** Very weak area at district level. In most cases, the cause of maternal death was mentioned as anemia when the real cause of death as reviewed by CRM team was due to hypoglycemic shock due to mismanaged or untreated hemorrhage.

1. BLOOD SUGAR	Rs. 50.00
2. ESR (Hb) BLOOD UREA	Rs. 70.00
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8. VITAMIN D3 TEST	Rs. 60.00
9. SERUM Hb, A ₂	Rs. 150.00

BIHAR

- ◆ **Maternal Health:** (312-SRS 2004–06 - 305 AHS 2010–11) only a 7 point fall in MMR. Kishanganj under Purnia division-377 (AHS 2010–11) Begusarai - Munger Division 295 (AHS 2010–11). In state 480 PHCs provide 24x7 services. 55 (30 DH, 19 SDH and 6 CHC) are working as FRUs.
- ◆ **ANC:** In Kishanganj: Full ANC only 29% at DLHS-3. Institutional delivery Increased from 2.37 lakh in 2005–2006 to 13.83 lakh in 2010–11 (out of 2412981 expected pregnancies) it is 57% achievement of the expected pregnancy in the state. In Kishanganj, it rose to around 37% in 2009–10. Still 60% of deliveries occur at home. The probable reason for high home deliveries being that APHCs and sub-centres are mostly not able to provide institutional delivery. Women are staying around 24 hours post delivery. PHCs, with new infrastructure are still stretched out to accommodate women. Food is provided but room for stay for family members and ASHA workers not ensured.
- ◆ **JSSK** not yet implemented in state.
- ◆ **JSY:** There seemed to be a near uniform delays in JSY payments, usually of around 1-2 months.
- ◆ **Safe Abortion Services:** In state 143 private accredited centres for provision of family planning centres but none accredited to provide safe delivery or safe abortion services. For MTP training, of a target of 240 MOs last year, (212 + 49 MOs trained). In districts visited private medical college, Janani PPP clinic, only providing MTP. The acceptors of sterilization or IUD were provided MTPs.
- ◆ **Maternal death review:** This is currently not being done.
- ◆ **Child Health:** IMR 61-SRS 2005-48 SRS 2010. A total drop of 13 points. Kishanganj-61 (AHS 2010), Begusarai-46 (AHS 2010).
- ◆ **Neonatal Health:** State as a whole has 9 SNCUs, 452 NBCCs in state.
- ◆ **Essential newborn care/safe newborn corners:** PHCs have recently been provided with some newborn care equipment, including baby warmers and phototherapy units, though it was not clear whether these were being used. Staffs have been trained at the Sadar district hospital. APHCs and sub-centres have no newborn corner.
- ◆ **Child Health:** In state F-IMNCI, of a target of 77 doctors in 10–11, about 44 were trained. This year of a target of 36, only eight have been trained. In training ANM in IMNCI however, the coverage has been better in 09–10 the state trained 427 out of 940, but in 10–11, 863 of 940 were trained.
- ◆ **Full immunization** increased from 11.6 % (NFHS-2) to 49% in CES 2009.
- ◆ **Family planning services:** Male sterilization increased from 428 in 2006 to 10367 in 2011. Female sterilization 67% increase since 2006 in the state. IUCD training is focused on ANMs with 577 being trained so far. Anecdotal evidence from Kishnaganj demonstrates that IUCD as a method of contraception is gaining acceptance. It is often the lack of space or training that limits the provision of this service at the HSC level, thus putting this method of choice out of the reach of women. PHCs were providing fixed day services for tubectomy. There is also a growing acceptance of IUD, ANMs referring women for IUD services at the PHC. Emergency contraception pills were available in sub-centres, although knowledge was weak (i.e. when to take EC). Uptake of methods such as injectable contraceptives (Provided by Janani) was low.



CHHATTISGARH

- ◆ **Maternal Health:** MMR-335 (SRS 2004–06) 275-(AHS 2010). A drop of 60 points. Functional FRU-26, 24x7-203 (119 PHCs and 84 CHC).
- ◆ **ANC:** Improved antenatal registration, check-ups, and referrals; fixed day strategy to fill HR gaps was appreciated by communities.
- ◆ **Institutional Delivery:** There is increase in institutional deliveries - 44.6% since 2005 in state. Stay for 48 hrs, and diet provisions were available at CHC level (Kanker). In *Kawardha* around 60% of reported deliveries are home deliveries. Over last 5-6 years institutional deliveries increased from around 20–25% to 40-45% (of reported deliveries). Facilities for normal deliveries largely satisfactory; RMAs are filling critical gaps of MOs. Partographs being used at Sub Health Centres where ANM is SBA trained. Only one size of Ambu bag and mask was available in most facilities. Follow-up of anemia, especially severe anemia, sickle cell anemia is not being done – only referred but not tracked. *Janani Shishu Suraksha Karyakram (JSSK)* is being implemented in the State. JSSK entitlements have been displayed in the wall posters of the District Hospital and other facilities in the two districts visited. District nodal officers have not been nominated and grievance redressal mechanism has not been set up Health care providers are well aware of this programme but community needs more awareness about the entitlements. Referral transport mechanism is weak so demand is less. 171 private facilities have been accredited in the State.
- ◆ **JSY:** Payments of JSY are being made through cheques at the facilities although with a time lag of 15–20 days between delivery and receipt of cash incentive in some facilities.
- ◆ **Child Health:** IMR decreased from 63 (SRS 2005) 51 (SRS 2010). Total drop of 12 points. Kanker 62 (AHS 2010) *Kawardha* 50 (AHS 2010). SNCU-1.
- ◆ **Newborn Health:** Newborn care corners are being established at every facility. Radiant warmers are not present in every facility and 200 watt bulbs are being used in Newborn care corners, post natal follow up of mother and child is not being done. Care of low birth weight babies, recorded newborn weight is almost rounded off. Immunization at birth had varied practices- some being immunized at the facility where as some being immunized at the Sub- centre concerned.
- ◆ **Family planning:** TFR is 3.0 (SRS 2009). 108 private facilities for Family planning services have been accredited in the State. In Family planning practices, the trend is increasing, but while interacting with the PWs during VH&NDs, the followings were highlighted by the pregnant women. Women are less aware of IUCD Cu T 380 with 10 years life. Majority of the women are on OCPs. There is Poor documentation/ records on family planning services across the facilities. Records on Post operative complication of FP are not maintained.
- ◆ **Maternal and Infant deaths Review:** Systems for review of Maternal and Infant deaths have been brought into action and State and district MDR committees have been constituted.



- ◆ **Maternal Health: ANC:** ANC services are mainly being provided by MOs at SC and by Gynecologists at PHC on fixed day basis. ANC by ANMs and SN is confined to only TT and IFA distribution. MCP card and ANC card in the facilities are issued at the time of registration and maintained throughout the antenatal period. Also, MCP card is linked with birth registration.
- ◆ **Institutional Delivery:** Most of the deliveries are being conducted by the Goa Medical College including normal deliveries and C-Sections which can be conducted at CHCs and district hospitals. Some cases of C-Sections were referred to GMC by Mapusa DH where 7 gynecologists are in place. 48 hours stay after delivery is being practiced in the state in some communities the stay is being prolonged up to a week due to cultural reason.
- ◆ **Child Health:** IMR 16 (SRS 2005) 10 (SRS 2010). Drop of 6 points. 2 SNCUs in state.
- ◆ **Newborn Health:** At District Hospitals and Goa Medical College, newborn care was found satisfactory. All delivery points are equipped with newborn corner but at some of the facilities it is not well organized like arrangement of emergency tray.
- ◆ **JSY Payments:** JSY payment to mother are being made at their PHC irrespective of place of delivery. Because of this arrangement of payment from PHC there is delay in the JSY payments. JSY entitlement is not a reason for increase in the institutional delivery in the state since the persons in BPL are also accessing the private facilities.
- ◆ **JSSK:** JSSK will be launched formally after assuring the drop back transportation services. All the patients including pregnant women are getting free diagnostics, diet, drugs, and OPD & IPD services. Also, pregnant women are picked up from the home to the facilities without any charges by EMRI or other hospital ambulances.
- ◆ **Maternal and Infant Death Review:** Process of Maternal and Infant Death Review is in place. Also, maternal deaths are being analyzed. In addition, all deaths in the facility (DH & GMC) are reviewed once a month. Data for infant deaths has been analyzed which shows high prevalence of prematurity and anaemia.
- ◆ **Adolescent Health:** Fixed day adolescent health services are significantly underutilized probably due to lack of IEC and sensitization to stakeholders. Menstrual hygiene programme is not yet operationalized.



GUJARAT

- ◆ MMR (160-(SRS 2004–06)148 (SRS 2007–09).12 point drop since 2005.
- ◆ **Maternal Health:** As per the HMIS, in 2010–11 86.7% total deliveries have been reported against the expected number and approximately 14% were unreported out of total deliveries reported 89.6% where institutional deliveries. The same was reflected in the districts visited. In spite of registration at the Mamta Diwas often beneficiaries access care late during labour (at times in late 2nd stage). Many of them do not receive full component of ANC care due to migration. CY are handling complicated cases although C-Section rates are not high (10–20%). In Dahod, there is only 1 CeMOC trained doctor and no LSAS trained doctor in the district. CeMOC trained doctors are not utilized as required. Out of 327 regular and 29 contractual ANMs only 23 are trained in SBA. Chiranjeevi Yojana facilities were found to be overcrowded due to high case load and the infrastructure being grossly inadequate, the patients were found sitting outside wards. Chiranjeevi Yojana and Bal Sakha doctors have forged partnerships for ownership of same premise.
- ◆ **JSSK** is advertised in all public sector facilities and all mandated services are being provided including diet and referral transport. In Dahod 23 facilities are designated as JSSK services. Chiranjeevi Yojana is a proxy for public sector, but there is no provision for drop back home to the mother and newborn.
- ◆ **Child Health:** IMR 54(SRS 2005) 44 SRS (2010). There are 31 SNCUs, 14 NBSUs and 296 NBCCs in the state. However, there was no SNCU in the district Dahod. The DH, Dahod has an NBSU and only one 1 Pediatrician assisted by one MO trained in 1 month capsule on Newborn care. Whereas DH, Rajkot has a six bedded SNCU and 2 neonatal corners. The sick Newborns admitted in the NBSU in DH, Dahod were inhouse deliveries, sick Newborns referred from elsewhere or from the community were mostly referred to Baroda Medical College Hospital.
- ◆ **NBC:** Equipments were available but relocation of equipment needs to be done from underutilized facilities.
- ◆ **Family Planning:** TFR:2.5 Sterilization cases-18% cases in Dahod and 15% cases in Rajkot are all female sterilization and no NSVs. IUDs-32% in Dahod & 42% in Rajkot. Spacing methods are better accepted by most of the communities (STs & OBCs) as compared to sterilization. Post partum sterilization is not accepted. Social Marketing Scheme has been launched in the district, condoms, OCPs and ECPs supplies reached the district. Training/Orientation about the programme has been completed for the district & block health officials and ASHAs as well. ASHAs are accepting payments of Re.1 only if the client volunteers as they feel that it affects their reputation adversely. In reality contraceptives are being distributed free.
- ◆ **Maternal Death Audit:** Although Gujarat has been doing verbal autopsy for some years the process of MDR has not been institutionalized in Dahod. The DH does not have Facility Based Maternal Death Review Committee and is merely reporting numbers to the district with no analysis. One area of concern is the high percentage of the deaths that are reported as “others”. Severe anemia is a significant cause of Maternal death besides PPH. Orientation of field functionaries on MDR needs to be done.
- ◆ **Infant Death Audits:** District Dahod has reported increase in infant deaths from 171 in 201–11 to 670 in 2011 upto October 2011. The process of infant death review is not institutionalized yet. Neonatal deaths are being reported from private facilities and community. Neonatal deaths in the community are possibly due to early discharge from the Chiranjeevi facilities.



HARYANA

- ◆ **MMR-156** (SRS 2005) and 153 (SRS 2007–09). Drop of 3 points.
- ◆ **Maternal Health:** FRU-33; 24x7-400; MCHI-507 (functional) State trend shows that institutional deliveries have increased from 49% to 73.88% and the rise has been substantially in government facilities. Total number of pregnant women transported by ETS of the total patients transported shows continuous increase since 2009–12 In district Hissar institutional delivery has increased from 40.51% from 2005 to 82.69% in 2011. The formulation of micro-birth plans and the compulsory 48 hour stay in the facility after delivery were not happening. In Mewat 3 PHCs are functional as 24x7 PHC. No C-Section available in facilities. Diet available only in DH. ASHAs being insufficient number in district and many not accompanying women to hospital. Home visits for PNC are not happening.
- ◆ **JSSK** implemented in both districts, women who delivered were given fruit, milk and biscuits. The state provides free generic drugs to pregnant women and neonates. 102 referral transport is free for most patients including pregnant women, which offer referral to higher centres and drop back home services for pregnant women. Out of pocket spending incurred on USG (approx Rs. 300–450/500 as USG facility not available in CHCs), and non-availability of the lab technicians in the afternoon leads to high out of pocket expenditure on lab test.
- ◆ **JSY Payments** in Hissar District are happening rather regularly, by bearer check, within a week or two post-delivery, however, the process is very cumbersome for a mere Rs 500 or 600. In district Mewat, the beneficiaries were paid JSY incentive by cheque after getting the required documents.
- ◆ **Safe Abortion Services:** No provision of safe abortion services across the district due to non-availability of OBG/LMO. MOs have been trained in MTP but these trained medical officers hesitate to perform MTP due to lack of confidence. There is a practice of referring cases that require MTP to adjoining districts.
- ◆ **Child Health:** IMR- 60 (SRS 2005) and 48 (SRS 2010). Drop 12 points. SNCU 10 District 2010–11 (Mewat-1, Hissar-1); in process in 11 districts; 66 Level-II Stabilizing Units are setup Data of Mewat shows that 137 newborns out of 563 admissions since Sep. 2010 (LAMA-49, Referred-48, deaths 40) which means 28% newborns outcomes are not known and may be adding to mortality. The unit has a dedicated team of two pediatricians and 7 staff nurses who are providing quality care to the admitted newborn.
- ◆ **Newborn Stabilization Unit (NBSU):** No functional Newborn Stabilization Unit (NBSU) was observed. However, Newborn care corners are functional in all delivery points visited. The main constrain in making NBSU functional is shortage of manpower (MO trained in FIMNCI).
- ◆ **Family Planning:** TFR:2.5 (SRS 2009) State achievements have actually gone up compared to last year in period as per data of April to Sep. of 2010–11 and 2011–2012. Sterilization achievements as compared to ELA has increased from 65.1 to 65.4 (April-Sep 2010–11 to 2011–2012); IUD 79.3% to 81%; CC 53.3 to 64.8%. District Mewat actually shows fall in limiting and spacing method over years from 2007 to 2011. Tubectomy by 14% Total sterilization by 20%. IUD by 50%, CC user decreased by 63%, OP users by 65%. The TFR of the district is 4.6 highest in the state Family Planning counselors in place at District Hospital Mewat. Operation theatre at district hospital is being used for providing family planning surgeries. Social Marketing of contraceptives by ASHA (Pilot project) has yet not started due to negative publicity by media.
- ◆ **Maternal and Infant Death Audit:** This is established in Hissar but yet to start up in Mewat.

HIMACHAL PRADESH

- ◆ **MMR:** Not available
- ◆ **Maternal Health:** There are 51 FRUs, 17 Blood banks and 2 blood storage unit in Himachal Pradesh. There are 95 facilities 24*7 facilities in the state. Out of 2071 HSC in Himachal Pradesh, only 3 are delivery points.
- ◆ **Institutional Deliveries:** Home deliveries remain high (50% by CES 2009). Reason being: Lack of assured transport, less than one in ten pregnant women avail of the EMRI - which is either too far away or "timed out." There are no local tie ups and the nearest confident point of delivery is too far and too costly. There is a high degree of delivery "on the way" and the EMRI paramedic conducting more deliveries than most ANMs. EMRI records show many call cancellation or not fructifying- because by the time they reached the woman had already delivered. There is no change in health seeking behavior in the road construction labour migrant and system has failed to reach them. Farm migrants face severe financial barrier to access.
- ◆ The 24*7 facilities are well chosen, but not serving purpose due to HR constraints and lack of referrals and pick ups by EMRI. Referrals due to limited skills and confidence, is common. Thus institutional delivery is dependent only on the sub-divisional hospital and district hospital and the private sector nursing home. District Kinnaur has no functional FRU. Only the private hospital (Jaypee Hospital) performs emergency obstetric care and even this is based on "unbanked blood transfusions". There is one blood storage facility in CHC Sangla, which is not functional as no trained Lab technician is there. There are five PHCs which were to be upgraded to 24*7 PHCs are doing a modest number of uncomplicated deliveries. There are two nurses in place in these facilities performing only normal deliveries. Most referrals are to the Jaypee hospital or Rampur - including large number of normal deliveries - where they pay over Rs. 5000 for the normal delivery package. District Hamirpur has a functional FRU at the district hospital. This has also got a blood bank in place. There are five CHCs which perform the role of 24*7 PHCs including managing some types of complications.
- ◆ **JSSK:** The JSSK scheme has been implemented as the August 15, 2010, after the launch of Matri Sewa Yojana (MSY). Whereas JSSK assures free care till one month after birth, this scheme extends it to one year after birth. Providers are aware of the scheme, but have not made the difference between withdrawing user fees and reducing out of pocket expenditures. High expenditure on drugs, referral transport and even on diagnostics Diet fortunately was provided free. The average expenditure was over Rs. 1200 per woman.
- ◆ **Child Health:** IMR 49 (SRS 2005) and 40 (SRS 2010). 9 points drop since 2005. 1 SNCU in the state. There are functional newborn corners in all facilities conducting deliveries.
- ◆ **Family Planning:** TFR:1.9: In district Kinnaur, it was found that camps for sterilization services planning are held once in a year. So the people in the district have to wait for a long time to get it done, and there is the problem of getting pregnant while waiting for the sterilization services.
- ◆ **Maternal Death Review:** The maternal death review system put in place. However the system needs to pick up deaths at the periphery.



- ◆ **Maternal Health: MMR:** 312 (SRS 2004–06)- 261 (AHS 2010). A drop of 51 points. FRU 20 facilities. 24 x 7 PHCs 23, CHC+SDH 176). ANC registration of the estimated pregnancies was about 80% in last year and has been achieved up to 41% in the current year (till Sept. 2011) which indicates that the achievement rate has not improved significantly.
- ◆ **Institutional deliveries** from 1.59 lakh in 2010–11 to 1.68 lakh in 2011–12 (Oct. 2011). The post partum stay of more than 48 hrs in the hospital has not shown improvement in this year also which is 9.9% of the total institutional deliveries till Sept. (last year-16.8%). C-section in the current year where an increase from 1.34% to 3.76% has been recorded till Sept. In Deoghar one blood bank at District Hospital. There is no blood storage facility at CHC/FRUs. There has been no EMOC and CeMOC training for the MOs. The average number of C-Section done in the DH is less than 3 per month. It was observed that some of Sahiyyas are directly referring obstetric cases to Private facilities for C-Sections ANMs doing deliveries have undergone SBA training; however the SN had not received SBA training. There was no emergency drug tray available in the labour room.
- ◆ **Safe Abortion:** Safe abortion services are nonexistent in the district.
- ◆ **Child Health:** IMR 50 (SRS 2005) 42 (SRS 2010). Drop of 8 points. Giridh: 36 (AHS 2010) Deoghar: 40 (AHS 2010).
- ◆ **Newborn Health: SNCU:** The tertiary care services for neonates absent in the state. At present there are only 1 NBSU and 2 SNCU in the state. Even the Newborn corners are rarely seen. In Deoghar most of the health facilities in the district are lacking in terms of Newborn Care Corners. There is no SNCU facility at the DH also. The protocol on Newborn resuscitation was not displayed at the facilities. There has been problem in procurement of Radiant Warmers. Phototherapy units were not functioning in most of the facilities. NSSK training has not been carried out at the District level. IMNCI training has been conducted for MOs and ANMs.
- ◆ **Child Health:** ORS and IFA are available at the facilities while Zinc tablets were not available. Chloroquine was exhausted. Laboratory functioning reasonably but the tests are limited to Hb and urine only besides Malaria (per day 40 slides including periphery) and TB exclusively.
- ◆ **Immunization:** The ILRs and Deep freezers are functioning well in all the facilities visited by the team. Temperature is maintained and regularly monitored by MO. Two backup generators are present in the facilities. Vaccinations are available as per prescription. Phototherapy unit is not functioning.
- ◆ **JSSK:** Although the state has launched the JSSK in all 24 districts, Out of pocket expenditures on drugs are still evident. The response to the Mamta Vahan which has been introduced as part of JSSK is good and institutional delivery is already showing a remarkable increase. The Mamta Vahan Call Centre has been established at the District Hospital and reported that 80% of the calls have been translated into free transportation of pregnant women to the health facility in Deoghar. A complaint box at the facility and a toll free complaint number for grievance redressal is in place for improving service delivery. Lab tests are free in both the districts but there are very few pregnant women investigated
- ◆ **Family Planning:** Across the facilities visited it was found that the approach towards the family planning services is seasonal and target oriented activity. There has been reduction in the number of NSV, tubectomy conducted in the district. There is poor distribution of OCPs and condoms by ANMs. IUD insertions are significantly low at all the facilities in the district.
- ◆ **MDR (Maternal Death Review)** Committee has been set up in the district.

KARNATAKA

- ◆ **MMR:** 213 (SRS 2004–06) 178 (SRS 2007–09). Drop of 35 points. FRU 149; 24x7 facilities 988.
- ◆ **Maternal Health:** Institutional delivery has increased from 60% in 2005-06 to 93.3% in 2011. Thayi Bhagya Yojana is other than JSY accreditation of public and private institution with incentives for personnel's and beneficiary, Madilu a kit for mother with 19 items and extended Thayi Bhagya (cash assistance to BPL/SC/ST for delivery in private institution). Prasooti Arike (state initiative for nutrition and medical care). 839 private facilities accredited for JSY.
- ◆ **JSSK** all component implemented, except dropback diet available till PHC.
- ◆ **Safe Abortion:** Available in FRUs both MVA and D&E. MTP registers maintained well.
- ◆ **Maternal Death Review:** FBMDR and CBMDR started. 42% of deaths still not captured by the process. Incentive for first informer may boost this.
- ◆ **Child Health:** IMR-50 (SRS 2005)-38 (SRS 2010). Drop by 12 points. SNCU-33, NBSU-177, NBCC-762.
- ◆ **SNCU:** In Bijapur SNCU has adequate case load but manpower in terms of single pediatricians and some male staff nurse are not adequate. Infant death Review has started in 30 districts.
- ◆ **Immunization** 107%, full immunization is low in urban slum than rural area.
- ◆ **Family Planning:** TFR:2 (SRS 2009) The unmet need has risen in DLHS 3 from 15.1 to 15.8. Sterilization (37%) and IUD performance (21%) has declined. Post sterilization complications, failure, deaths high. Male sterilization just 1% hence trained doctor remain unutilized. Young clients less than 30 yrs of age choosing tubectomy though they should be counselled for IUDs. Private sector contribution low. Traditional tubectomies commonly performed than minilap. ANM still not aware of no touch technique in IUDs.



- ◆ **Maternal health: MMR:** 303 (SRS-2004–06) 277 (AHS 2010). 26 points drop. Rayagada 311-Southern Division (AHS 2010) Bargarh 253-Northern Division (AHS 2010). 81 FRUs but only 63 have blood storage facilities. 24x7 facilities 261.
- ◆ **ANC:** Pregnant women registered for ANC increased (from 86.0% to 87.0%) 2009–10 to 2010–11.
- ◆ **Institutional Delivery:** Percentage of institutional deliveries against estimated deliveries has increased from 53.0% to 60.0% 2009–10 to 2010–11. Women discharged at least 48 hrs after delivery at public institutions also declined (from 36.9% to 25.6%). District Rayagada one FRU is functional; only 4% of total deliveries in DHH and 1% of total deliveries in the district are c-sections. Many delivery points do not have running water or attached toilet. 10 Maternity Waiting Home made functional in V4 areas. Rayagada LSAS trained doctor at DH has assisted 1000 c-sections in span of 2 years. 307 Janani Expresses + 421 ambulances providing referral transport in state but Rayagada it was not very functional due to geographical conditions.
- ◆ **JSSK implementation** 1328 MCH centre's are already in place and are conducting deliveries without user fees. There is however, persistent out of pocket expenditure for delivery and for drugs in newborn care.
- ◆ **JSY:** Though the absolute number of JSY beneficiaries for institutional deliveries has increased from 174112 in 2010–11 to 175134 in the first six months of current year of 2011–12, ASHAs who were paid the incentive has come down from 89201 to 75072 in the same period. The state needs to look into the reasons for the same.
- ◆ **Child Health:** IMR-75 (SRS 2005) 61 (SRS 2010). Drop of 14 points. Rayagada-65 (AHS 2010) Bargarh-66 (AHS 2010). 16 SNCUs, 25 NBSUs, 452 Newborn corners established across the state. Newborn Health: SNCU at Rayagada 12 bedded is well functional but just with one pediatrician 4 SNs who are trained in FBNC. 50% patients are outborn i.e. is in other health facility. State has reported nearly 67.4% live births (2.90 lakh) as against the estimated live births (4.30 lakh) in the first half of 2011–12. Proportion of newborns breastfed within one hour has increased from 62.2% in first 6 months of 2010–11 to 85.7% in 2011–12. In the same period, the number of newborns weighed at birth has increased from 66.0% to 83.0% in the current year. Pediatricians were present at DHH/CHC Muniguda and they reported high LBW and asphyxia cases. High proportion of macerated still birth and birth asphyxia are being reported (Rayagada-registers) which indicates good reporting in DH but poor ANC not being able to identify it in time. IMNCI (Integrated Management of Neonatal and Childhood Illnesses) implemented in 20 districts training increased to cover 20 out of 30 districts but progress slow with only 58% training completed till date. Exit interview of mother in pediatric wards at District hospital reported high OOP for both transport and drugs. Irrational drug prescriptions recorded in DH pediatrics ward.
- ◆ **Immunization:** Full immunization coverage has increased from 53% (CES 2005) to 59.5% (CES 2009). Full immunization coverage for the first six months in 2011–12 - 70.5%, which is 13.3% less as compared to the same period in 2010–11. Though immunization sessions held have remained the same as compared to last year; the immunization coverage rates have come down which suggest missed opportunities.
- ◆ **Family Planning TFR 2.4 (SRS 2009):** Total Fertility rate stands at 2.4 while the unmet need is estimated to be high. Female sterilization and IUD insertion has gone up only very slowly; male sterilization has also not picked up significantly in FY 2009–10 and 2010–11. SMS based 'C-LMIS' (Logistics and Supply Chain System for Contraceptive Products) software has been developed. Rayagada only two static centres for FP services functional, camp approach is dominant way of service delivery. IUCD training limited to ANMs across 9 facilities only, although there is increase in IUCD insertions over past year, promotion of spacing methods could be improved further.
- ◆ **Maternal Death Review:** Out of the 308 maternal deaths reported, 49% (151) were classified as "Others". This calls for better orientation on the importance of reporting maternal deaths and to investigate the cause in detail.

RAJASTHAN

- ◆ **Maternal Health:** MMR 388 (SRS 2005) 331 (AHS-2010). 57 points drop. Barmer-322 (AHS 2010)-Jodhpur Division Chittaurgarh:364 (AHS 2010)-Udaipur Division. FRUs 172; 24X7 CHCs and PHCs-635.
- ◆ **Institutional Deliveries:** Gradual shift in institutional deliveries from higher institution (DH/SDH and CHC) towards lower institutions (PHC and SC) in Barmer. Sub-centre deliveries increased from 12.26% in 2008–09 which to 27.68% of institutional deliveries in 2010–11. Chittaurgarh, the utilization of the facilities for institutional services is showing an increasing trend in some of the facilities. Barmer, quality of Institutional births at the PHCs and SCs remain very poor probably due to lack the basic infrastructure such as running water, electricity (available only 6 hours in a day), clean toilets, and clean delivery rooms (including linen). Facilities lack a regular waste disposal mechanism after deliveries. Also, there is shortage of Class IV. At PHC Dhanau in Barmer, the labour table was broken and rusted 83 deliveries being conducted in October 2011. In contrast, the facilities in Chittaurgarh district had well – maintained, clean equipment. In Barmer, significant proportion of women found at facilities were staying 48 hours after delivery at CHCs. Though, this was not the case in DH or PHCs or SCs. Most PHCs visited seemed to be providing regular cooked meals, through the State initiated 'kalewa' yojana.
- ◆ **JSSK** was launched in Rajasthan on Sept 12, 2011. Drop back home facility has been made available through the JSSK and patients visited at CHCs (Dhaurimana and Sheo) and 24 X 7 PHCs were utilizing this service.
- ◆ **JSY** payments are being made through checks at the institution of delivery. The check disbursement process was observed to have variable levels of time lag due to some facilities setting specific days in a month for all JSY checks to be disbursed, the probable reason behind doing this was lack of manpower (as seen in one facility).
- ◆ **Child Health:** IMR-68 (SRS 2005), 55 (SRS 2010), Chittaurgarh:62 (AHS 2010), Barmer:72 (AHS 2010).
- ◆ **SNCU:** 15 bedded SNCU was found fully functional at Chittaurgarh whereas in Barmer SNCU with 12 beds is operational but quality of care was found compromised with little attention being paid to infection control and poor maintenance of patient records. SNCU of the Chittaurgarh DH has an average case load of around 200 cases a month, out of which outborn case load is around 32%. Referral rate is around 7%.
- ◆ **Newborn care corners** were not adequately developed. In some facilities the equipments had been bought, but staff was not trained to use or maintain the same.
- ◆ **Immunization:** There was shortage of vaccines particularly BCG, OPV and Measles in the districts. No extra stock being kept at district level in Barmer. In PHC Dhanau, all children were shown vaccinated with BCG and OPV in the reports even when vaccine was not available in the ILR. In Barmer, all blocks are given the same number of doses of a vaccine regardless of population. Cold chain needs to be better maintained.
- ◆ **Family Planning:** The TFR of Rajasthan is 3.3. Family Planning services are being offered at PHCs and CHCs fixed day basis. At all the sub centres ANMs are providing IUCD insertions. The state has also introduced PPIUCD services at the district hospitals, which is another positive initiative in family planning.



- ◆ **Institutional Delivery:** The rate of institutional delivery has increased over a period of time but the challenge is that all ANC registrations (71%) do not end up in institutional delivery (51%). Rate of full immunization for children born in institutions or at home is almost same. Newborns breastfed within 1 hour is 70%, a figure which is close to the ANC registrations. This could be due to the strong community based services and the peripheral level workforce. The rate of complicated pregnancies attended in public health institutions is 11%, of the total institutional deliveries reported (2010 April to March 2011 – HMIS) in the state, 24% has been conducted in a single institution in Gangtok, the STNM hospital, which is not in fact getting any support from NRHM. Among district also the distribution is very skewed, the North district conducting only 30% of estimated deliveries when the state figure is 51%. However, as per the state figures, the institutional deliveries as a percentage of estimated deliveries is 84% for the period April to September 2011, which is an improvement over the last year's figure of 81%. The home non SBA deliveries are only 8% now. State had planned for MCH centres – 'delivery points'; but they have not categorized by levels of care. North Sikkim, there was not a single centre providing MCH level 3 care. Quality of institutional deliveries is good. Toilets attached to labour room were not clean. Mothers do not stay 48 hours in hospital. They leave the next day of delivery. ASHA ghu's are available in the institutions and ASHA's who bring mothers stay there. There is only one private accredited centre for conducting delivery, Sikkim Manipal Institute of Medical Sciences, which according to the HMIS has conducted 1238 deliveries in the last financial year. There are no accredited providers for doing sterilization operations, anesthesia etc.
- ◆ **JSSK** is yet to be rolled out in the state. But most of the components are already available in the state like free drugs, food, inter-facility transfer etc.
- ◆ **JSY payments** are regular and by cash but takes normally a week to get dispensed. There is no backlog. Mothers have to come again to hospital to get the money. In a difficult terrain and when vehicle costs are much higher than in the plains, the JSY money would just compensate the travel cost. Some of the mothers whom we met had spent more money than they received on travel cost alone. There is no cross checking by health officials to check JSY beneficiaries. However, no informal payments were made according to the mothers.
- ◆ **Child Health:** IMR 30 (SRS 2005) 30(SRS 2010).
- ◆ **NBCC:** Newborn corners were in place at delivery points.
- ◆ **Family planning programme:** Use of permanent methods has come down in the recent years. Uses of temporary methods have stagnated over a period of time.
- ◆ **Maternal Death Review:** The officers of the State were given orientation. In the period January to September 2011, ten maternal deaths were reported. Out of this district-wise bifurcation is East 0, West 2, North 1, South 2, and Urban & Manipal institute 5. PPH was the most common cause (4 out of 5 cases) of death in the rural (all districts) and the 5th one had a retained placenta. The causes in Urban were PPH in 2 out of 5, and septic shock, pulmonary embolism and amniotic fluid embolism one each. The review meetings are happening in the districts and facility level committee meetings are in the process of becoming regularized.



UTTARAKHAND

- ◆ **MMR:** 440 (SRS 2004–06) 188 (AHS-2010). Drop of 252 points. Puari Garwhal 190 (AHS-2010) Rudra Prayag 190 (AHS-2010)
- ◆ **Maternal Health:** FRU 27 (12 DH, 10 SDH, 5 CHC) 24x7 facility 95 PHCs. IMR is 19 (AHS-2009) in Rudra Prayag.
- ◆ ANC quality ANMs not satisfactory, no privacy maintained, no bed at sub centre. State has trained dias who are conducting deliveries in far flung villages and also assisting ANMs for deliveries. Delivery points (MCH) are identified by name but not yet operational. 35% unreported deliveries in the state, varying from 86% in Rudra Prayag to 88% in Paudi Garwhal. C-Section Services are available only at District hospitals in both districts (3%).
- ◆ **JSSK:** Provision of blood was free however absence of pathologists in both District Hospitals is hampering the functioning of the blood banks, drug stock was adequate in the facilities. Patients interviewed in the District Hospital Rudraprayag mentioned receiving free drugs. 40% of all cases of EMRI use are pregnant women. Drop back facility to pregnant women and neonates is being provided through a special fleet of vehicles called 'Khusiyon ki Sawari.' Laboratory facilities were available at the DHs and CHCs but not at all PHCs due to lack of Lab technicians. Ultrasound is not available in the DHs. Lab services are free for BPL families and pregnant women. Diet being provided free or state paying for it in all facilities.
- ◆ **JSY payment** on time by cheque to PW, to ASHAs by e-transfer.
- ◆ **Maternal deaths** are not being reported from the community and the reported deaths are not being reviewed.
- ◆ **Safe abortion services** are only available at CHC-Rudra Prayag.
- ◆ **Child Health:** IMR 42 (SRS 2005) 38 (SRS 2010) IMR in PG-43 (AHS 2010); Rudra Prayag 19 (AHS 2010). 1 SNCU in state. Newborn Corners were not available. Post natal follow-up of mother and child is a weak area. Display and use of standard technical protocols was not seen. HBNC kits have been given to ASHAs (Thermometer, blanket, Baby weighing machine, watch, sanitizer and a baby warmer). Immunization coverage has improved over the years. Zero dose Hepatitis- B is available but is not being administered.
- ◆ **Family Planning:** TFR 2.55 (NFHS -3) Lap sterilization is the preferred method. Services are provided mainly through camps due to scarcity of surgeons. No records of camp performance. There has been an increase in NSV cases. ASHAs are promoting Family Planning services through counselling and motivating for sterilization. Family Planning performance has been much below the ELA since last two years. MOs trained in Lap sterilizations are not performing due to GOIs order. Emphasis on Postpartum Family Planning is low despite increase in institutional deliveries. IUD insertion is mainly done by ANMs at level of Sub centre but rate of removal is high. No trainings in Family Planning (PP-IUCD).



UTTAR PRADESH

- ◆ **Maternal Health:** MMR: 440 (SRS 2004–06) 345 (AHS 2010). 95 points drop in MMR. Badaun 437 (AHS 2010) Barailey Division, Jalon 231 (AHS 2010) Jhasi Division. FRU-162, 24x7 facilities-848.
- ◆ **Institutional deliveries:** 22 delivery points performing 50% (45000/110000) of estimated deliveries at institutional in Badaun. Jalaun 70 delivery points performing 43% (23000/53,000) of estimated deliveries at institutions in 2010–11. Majority of the ANMs/Nurses conducting delivery were not trained. No necessary equipment's and drugs to handle complicated deliveries were available at facilities. State has 1-2% C-Section rate. Badaun, total 1500 cases of C-Section reported from District Hospital (annual load of 600 cases) and three other private hospitals. Jalaun only 550 C-Section were performed including private sector. Even in District Women's Hospital in Jalaun has no Anesthetist.
- ◆ **JSY Payments:** due to lack of funds, payments were delayed across the State for the past 1 month.
- ◆ **JSSK** has been recently launched in the State across all 72 districts and operationalized in 165 FRUs. No evidence of the scheme being operational in the Badaun. Jalaun, District Women's Hospital free breakfast and post-delivery home drop off through the facility ambulance had been initiated. JSSK entitlements have also been prominently displayed at the facility.
- ◆ **Safe Abortion Services:** 767 facilities (DH+FRUs) safe abortion services were available. Dilatation & Curettage still remains the preferred method of MTP in state due to lack of MVA trained medical providers.
- ◆ **Child Health:** IMR 73 (SRS 2005) 61 (SRS 2010). 12 point drop. IMR Badaun 91 (AHS 2010) Jalon 65 (AHS 2010). SNCU-7, NBSU-107, NBCC-759.
- ◆ **Newborn Health:** State needs to plan for SNCU. Newborn care corners non functional due to radiant warmers being unavailable or under repair. Bag and mask was available but usage negligible. Substantial number of intrauterine death/still birth reported in the maternity register, probable cause being excessive and irrational use of oxytocin in private sector as reported by staff in FRUs. Infant death audit is yet to start.
- ◆ **Immunization:** Although AEFI committee has been formed, not a single AEFI case has been reported so far. The team noted that temperature log books were poorly maintained even though thermometers were available. The State needs to also plan for RI session in hard to reach areas in order to catch up with all India figures as regards full immunization.
- ◆ **Family planning:** TFR 3.7 Oral Contraceptive Pills and Condoms were available in sub centres but many CHCs and PHCS had an absolute stock out. IUD insertions were being done by trained ANMs at sub centres but many CHCs and PHCs had stock out of IUD. No fixed day approach for provision of these services. Contraceptive delivery scheme by ASHAs has been taken up by the State. Shortage of doctors trained in mini-lap and NSV techniques leads to persistent camp based approach.



Recommendations

- ◆ Persist with careful prioritisation of facilities for providing facility based good quality and full range of RCH services as appropriate to that level of care. The prioritisation should be such that emergency services are available within one hour of any primary care facility and that there is one primary care facility within 30 minutes travel time of any habitation.
- ◆ Both primary care in terms of outreach services and the outpatient clinic, and higher level of secondary care in terms of the district hospital have developed in the period of the NRHM. The in-between level as prescribed for CHC/block PHC in terms of basic emergency obstetric care and newborn stabilisation units have not started in almost any state and this gap needs to be addressed in the coming years. All 24X7 facilities should be developed to be able to deliver this level of care.
- ◆ In states with persistent high fertility, the gaps are mainly in the supply side and they would need to be addressed through creating a larger pool of service providers who are trained in mini-lap and NSV. There is a need to persist with the goal of fixed day services and to examine district plans to see how they propose to achieve this.
- ◆ There is a need for much more attention to spacing methods, especially like long term IUCD. IUCD insertion on fixed days by ANMs (under supervision of LHV for new ANMs/Staff nurses) has to be encouraged.
- ◆ Availability of MTP by MVA technique and medical abortions has to be ensured at least at fixed points where minilaps are planned to be provided. Thus integration of MVA training and minilap training and basic emergency obstetric care training is essential.
- ◆ Findings of MDR and Infant death audits have to be essentially used in closing health systems gaps and gaps in skills and service provision.
- ◆ Control and management of communicable diseases like malaria, TB and HIV/AIDS directly related to maternal mortality, needs integration with RCH service delivery.
- ◆ There is a need for centrally supported and facilitated thrust at capacity development in the high focus districts within the high focus states. These districts do not have the internal human resources or institutional capacity to make the transition and without such external assistance would take too long to develop it.
- ◆ AYUSH doctors, as required, need to be given SBA, RCH and IMNCI training by providing an enabling framework and utilize their services in meeting unmet needs. This will help pooling of trained manpower for better outreach of child and maternal health services.

“The PRIs and a large range of community based organizations like Self Help Groups, School, water, health Nutrition & Sanitation Committees, Manila Samakhya Groups, Zila Saksharta Samitis provide an opportunity for seeking local levels accountability in the delivery of social sector programmes. NRHM provides for School Health Check-ups and School Health Education to be worked out in consultation with the States.”



Preventive and Promotive Health Services-Nutrition and Inter-Sectoral Convergence

Preventive and Promotive Health Services-Nutrition and Inter-Sectoral Convergence

Progress Under NRHM

Some aspects of preventive and promotive care as delivered by ASHAs and outreach services have been discussed earlier.

The other institutional structure that has been developed to address this is the village health sanitation and nutrition committee. Progress in the formation of this is given in the table below.

State	VHSNCs Formed ²	Revenue Villages
Andhra Pradesh	21916	26613
Assam	26312	26312
Bihar	7978	45098
Chhattisgarh	18706	19642
Goa	308	359
Gujarat	17954	17330
Haryana	6280	6955
Himachal Pradesh	3243	17595
Jharkhand	32643	30012
Karnataka	24208	27481
Odisha	45471	47529
Rajasthan	43437	44672
Sikkim	641	452
Uttarakhand	15431	16826
Uttar Pradesh	51914	106000

The functioning of these committees is discussed below. Inter-sectoral convergence with ICDS on care of the pre-school child and with school education dept. for care of the children in the school going age are also discussed below.

Main Observations

1. ICDS functioning and coordination, was varied across the states visited. Growth Monitoring was adequate in facilities seen in Bihar, Odisha and Himachal Pradesh, though this did not necessarily lead to an improvement in nutritional status. Take Home Ration was being distributed in Andhra Pradesh, Gujarat, Bihar, Odisha, Himachal Pradesh to children below the age of less than 3 years, lactating and pregnant mothers. However in Jharkhand the numbers to whom it is distributed is very limited. In Uttarakhand it is not available (this is a similar finding to last year CRM report). Anganwadi centres were acting as sites of immunisation and village health and nutrition days across all states.

² As reported in Update on ASHA Program July 2011.

2. Facility based Nutritional Rehabilitation Centres were seen in Bihar (2), Chhattisgarh (2), Gujarat (2), Jharkhand (2), Rajasthan. The functionality is variable across states for example Bihar takes in a group of 40 children at a time thus the rest have to wait for their turn, in Gujarat it is equipped, managed and had full caseload. On the other hand in Rajasthan huge infrastructure is under-utilised.
3. The good functionality of NRCs is dependent on their linkages with field level-both identification, referral and service guarantee available to parents. States like Gujarat-Community based nutrition program (Bal Gram Parivar Yojana), Jharkhand (NGOs working with community on malnutrition issues) and Bihar are examples which demonstrate that where good linkages at community level exist, facility based services are better utilized. On the other hand states like, Uttar Pradesh and Rajasthan still have to develop good linkages from community to facility and service delivery quality and guarantee for NRCs to function well.
4. Special Initiatives on addressing social determinants and nutrition activities by non governmental players' involvement in states are Andhra Pradesh (Zila Mahila Samakhya and Self Help Group), Bihar (NGO managing NRC well in Kishan Ganj), Gujarat Community based nutrition program (Bal gram parivar Yojana yet to be started), Jharkhand (NGOs working with community on malnutrition issues), Odisha – Gram kalia Samitis supported by CARE India.
5. Special initiatives for inter-sectoral convergence reported from states include a mass Raksha Bandhan Program in Andhra Pradesh, Monthly Convergence meeting being called in by Chief secretary every month in Goa, Indira Bal Swasthya Yojana in Haryana, and integrated district planning to control epidemics in pilot districts of Odisha.
6. Convergence between field staff of ICDS and Health that is AWW, ANM and ASHA were found to be synergistic and effective in Andhra Pradesh, Odisha and Sikkim.
7. Functionality of VHSNCs: It ranges across states, from those who have acquired monitoring roles - Andhra Pradesh, and one's who address social determinants- Sikkim, Odisha and Karnataka to some that are still in rudimentary phase of development- Bihar, Jharkhand and Uttar Pradesh. Some states are still evolving, like in Assam they are dedicated to providing curative services in village. Goa and Odisha on other hand have undertaken cleanliness drive to control vector borne diseases.
8. School Health Programs are at different stages of development across states. Uttarakhand and Assam provide for NGO involvement. Goa and Karnataka have a dedicated team that is screening and referring cases and health facilities. On the other hand in states like Uttar Pradesh and Rajasthan even screening is not probably happening. States like Andhra Pradesh, Himachal Pradesh, Odisha and Sikkim are in phase of screening and referring for some disease but may need to do more in terms of treatment, follow up and prevention. Dental and eye care seem to be the missing link which many states have to still cater to.



State Findings

ANDHRA PRADESH

- ◆ **Nutritional supplementation:** (Take-home Rations) was given to less than 3 years old children & pregnant and lactating women. Involvement of ASHA, LHV & male supervisors, VHNDs were being monitored by VHSNC members and MO-IC. There is good inter-sectoral linkage with ICDS. Hot cooked meals are provided to eligible children and pregnant mothers at AWCs.
- ◆ **Addressing social determinants:** Zilla Mahila Samakhyas and self help groups in Guntur District: There are nearly 1000 such groups at the village levels. They conduct monthly meetings with the villagers and discuss about health, sanitation, nutrition and hygiene with among other issues of poverty, education and employment. The Anganwadi Worker and the ASHA of the village are also members of the SHG and this helps in better synergy between them.
- ◆ Activities like Mass Raksha Bandhan are also used as a platform for integrating various departments. On such events distribution of pensions, ration cards, sanctioning of houses are announced. Simultaneously, issues related to women and children including health also get discussed.
- ◆ **VHSNC:** VHSNC funds are being utilized particularly for sanitation purposes.
- ◆ **School Health:** It is running successfully through a dedicated team of health staff in all the Govt and Govt-aided schools up to high school level. Medical checkups twice in a year, referrals to higher centres, dental component are some of the main components. However, special referral cards are not being maintained in the districts visited.

ASSAM

Vitamin A, IFA is regularly being dispensed by ANMs at sub-centres. ASHAs follow up patients to encourage compliance.

- ◆ **Iodine deficiency:** Regular survey for goitre and salt testing is being done in all districts. There is a correlation between districts, which report low salt content and proportion of people in a district with goitre. The proportion of people with goitre has reduced over time.
- ◆ **Nutrition rehabilitation:** Three Nutrition Rehabilitation Centres have been established at Kharupetia, Udalguri and Gosalgaoon in the current year. One more centre is being planned at Chirang for this year. A total of 74 patients were admitted 53 discharged and 30 followed up.
- ◆ **Linkage with ICDS:** There are links between VHN Days and ICDS with Vitamin A and IFA supplementation.
- ◆ **VHSNC and social determinants of health:** Most of the VHSNC decisions and procurement is related to equipment and improvement of curative facilities at the village level. There was no evidence that the social determinants of health were being addressed. No coordination between the NRHM programmes and those from other departments of the Government.
- ◆ **School health:** There is evidence of some NGO involvement in school health. Linkage exists between Sarva Shiksha Abhiyan and school eye checkups. Teachers in all schools in Nagaon have been trained to identify children with refractive errors. All children are screened annually and 1690 were referred for confirmation of diagnosis. Spectacles were provided by Sarva Shiksha Abhiyan. HIV/AIDS is being discussed as part of health education for high schools. The Nagaon district has started IEC/BCC activities related to nutrition,

hygiene, water and sanitation for schools with an emphasis on institutions serving minorities. The district has started collaboration with an NGO, VKI North East Apex Body, a wing of The Art of Living, to teach yoga to high school students. A total of 18167 students, from 25 schools in Nagaon district, have benefited from Yoga classes. The second phase of the program plans to extend this training to 12089 students in another 25 schools.

BIHAR

- ◆ **Early initiation of Breast Feeding:** Mamtas indicate that they ensure initiation of breast feeding. There are no systems in place for planning and executing home visits by AWWs.
- ◆ **Supplementary feeding program of ICDS:** Supplies for supplementary feeding program were found at all AWCs visited. Cooking and feeding of children (3–6 years) were observed on both the working days. Conflict among community members due to norms of capping on number of beneficiaries to be covered was reported in all AWCs visited in Kishanganj.
- ◆ **Coverage of population:** There has been a recent delimitation of their areas, and they were concerned that this leaves out a substantial number of households. This was evident from the fact that there were a number of households and few habitations not reflected in the survey register of AWWs. Except for pulse polio and routine immunization sessions (by ANMs only) services don't appear to reach all women and children.
- ◆ **Identification and management of severely malnourished:** In Kishanganj, only one out of six AWWs visited reported having two different weighing scales in working condition (Badapaka mana of Mirajpur sub-centre in Pothia block).
- ◆ **NRC** was functional in the district hospital in Kishanganj. 40 children were receiving services. NGO is managing the NRC satisfactorily. While evidence of linkage with AWCs was found in one of the AWC visited, there is a programming disconnect between the batch-wise admissions at the NRC and management of severely malnourished children. Number of admissions of children has been capped at 40 per month.
- ◆ **Functional coordination** between the ANM, ASHA and the AWWs at the community level present. Coordination between the managerial staff of NRHM and ICDS missing link. This may be the case with the PHED too. No salt testing kits found at the VHSND visited.
- ◆ **VHSNC:** Health staff up to block level were aware of renaming. Due to recent PRI elections there is a turn over of PRI members involved in VHSNCs and most of them were not aware of its existence. For implementation of the state initiative of Nayi peedi Swasth Guarantee Scheme there are coordinated plans with the education department. Non-receipt of incentives by community for construction of individual sanitary latrines, wall writing about TSC was seen.
- ◆ **School Health Programme:** The school health programme has been closed from 31 March 2011. In its place a new scheme – the Nayee Pidhi Swasthya Guarantee Karyakram – to provide health screening of all children from 0–14 years and of adolescent girls from 14 to 18 years. The team visited a school where children did have health cards under the scheme. However, the cards were not filled out properly and many girls had been given the wrong card.



CHHATTISGARH

- ◆ **Micronutrients:** IFA supplementation for children remains neglected. Skills enhancement of workers, RMAs/ doctors for effective counselling; and Hb testing for ANMs, laboratory technicians needs to be done. MCTS should consider tracking a full set of core nutrition indicators upto 2 years.
- ◆ **Vitamin A supplementation:** There is improved coverage of vit A supplementation, regular periodic de-worming. Selected indicators have been integrated into MCTS. Good availability of ORS and Zinc at village level.
- ◆ **Early initiation' of breastfeeding:** There is good promotion of 'early initiation' and exclusive breast feeding for six months at facility and outreach levels.
- ◆ **Macro nutrition:** Assessment of nutritional status of children coming to OPD/IPD, identification and management of undernourished children, referral of severely underweight is not being done. NRCs present but referral network to be strengthened; Closer coordination with ICDS at all levels still to be established; incentives to mothers motivates them to stay for complete duration. Follow-up protocols yet to be established. Screening and appropriate management needs to be emphasized; RMAs may be trained in this regard.
- ◆ **VHSNCs** – clarity of role and capacity building required.
- ◆ Coordination with Total Sanitation Campaign with involvement of VHSNCs and PRIs.
- ◆ **School Health:** School health programme is in partnership with the education department in the state and districts. Partnership with ICDS is however remained weak even when MDM is in place in all government schools. A set of four booklets to sensitize teachers and to facilitate health communication is in place. School visit and cross reference to these materials however revealed that these materials were not available at the school.

GUJARAT

- ◆ **Child Development Nutrition Centre (CDNC):** State has an actively functioning State Nutrition Cell. Child Development Nutrition Centre (CDNC) at CHCs and District Hospitals. Health & Nutrition Day (MAMTA Abhiyan). There are 60 CDNCs functional across the state, children admitted for 10 days. Children are given nutrition rich food under guidance of nutritionist. Mothers counseled, children are given IFA, De worming tablet, Multi Vitamins. Follow up visits after 15th day, 30th day, 45th day and 60th day from discharge date. In both the districts well equipped CDNCs were present. Dahod, CDNC at CHC Jhalod had 10 beds with 9 beds occupied with children. Effective linkages have been established in the district between the ICDS and Health care system. Eg. Follow up of CDNC treated children by AWW and growth monitoring.
- ◆ **Community Based Nutrition Support** called as the Bal Gram Parivar Yojana is planned to be undertaken in the state to address malnutrition. The program will be owned, run and actively supported by the community. A community based approach based on the principle of Positive Deviance and Demonstrative Feeding.
- ◆ **VHSNC:** Untied fund given to the VHSNCs is utilised to undertake various activities in the village. VHSNCs in Dahod have mainly used their fund for purchasing furniture, rugs/mats, etc. for their AWC, to take up cleanliness activities in their village etc. Village health plans involving the VHSCs have not been made.
- ◆ **Preventive & Promotive health services including Nutrition and Inter- Sectoral convergence:** The state has an actively functioning State Nutrition Cell. The Nutrition Programs ongoing in the state are as follows: 60 Child Development Nutrition Centre (CDNC) at CHCs and District Hospitals, Health & Nutrition Day (MAMTA Abhiyan), Iodine Deficiency Disorder Control Program (IDDCP), Vitamin "A" regular and Bi-annual Round, Adolescent Girls Anaemia Control Program (AGACP) & Mamta Taruni.

- ◆ In both the districts well equipped CDNCs were visited. Human resource at the CDNCs - Nutrition supervisor, Nutrition assistant, cook cum helper and Ayah were all in position particularly in Dahod.
- ◆ The linkages between the CDNC and the community are well developed and provided by the AWW.
- ◆ **Financial Management:** HR for accounting is adequate all levels. Few vacancies remain at peripheral levels. Books well maintained and e-banking in place. Multiple sources of funds and different levels of reporting make proper monitoring difficult. Shortfall of Rs. 146 crore is contribution that state had to make (30%) over last five years. Financial monitoring weaker. Appointment of auditors for facilities needs to comply with GoI guidelines. Delays in JSY payment. Utilization of untied funds is good, but high underutilization of DH RKS funds at Rajkot. Accumulated interest of Rs. 22.68 crore should be utilized and IT returns for society needs to be filed.

GOA

- ◆ **National Iodine Deficiency Disorders Control Programme:** As per the survey of 2004, goitre prevalence rate in the state was 7.5%. As per the survey conducted in 2010, 80% of the rural population is consuming iodized salt.
- ◆ **Village Health, Sanitation and Nutrition Committee:** VHSNCs have been formed and few are active. The members have been oriented. Most VHSNCs have undertaken cleanliness drives in their areas, this was done to combat the issue of vector borne diseases. VHSNC funds have not been utilized for nutrition or referral transport of women as is the case in other States. The VHSNC operates under the joint account of Sarpanch and the ANM. VHSNCs require reorientation to ensure that all VHSNCs are made functional.
- ◆ **Inter-sectoral Convergence:** Mechanisms for monthly meetings with the Chief secretary are in place. These meetings are attended by representatives of other departments such as WCD. Also certain systems such as the WCD submitting a list of malnourished children to health department for follow up on a monthly basis are in practice. This facilitates convergence. However system for formal meetings of the State Health Mission is not in place.
- ◆ **School Health:** School Health Programme is providing comprehensive care where eye checkup, dental checkup are done periodically. The state is implementing school health programme with the team of medical officers of Ayush/ allopathic and Ophthalmic Asst. to examine school children in which they are examined for vision defects, ENT and nutritional diseases. The programme also undertakes de-worming of the children. The state provides free spectacles to the children who are having vision defects.



HIMACHAL PRADESH

- ◆ **Nutrition:** All the anganwadi centres visited were functional. There was take home rations given to the children, but full attendance was not seen. There are 20% underweight children. It was noted that though under weight children were attending the anganwadi and even getting rations, the trend was for them to remain in the same status over time and not normalise even at the time of exit from the anganwadi. At the places visited the school mid day meal programmes found functioning very well – both in quantity and quality of food given.
- ◆ **Drinking water and sanitation:** There is also a very vigorous programme to introduce a sanitary latrine in every household and this programme is doing well even in remote habitations. Despite problems of terrain the state claims to have provided a safe water source in every habitation. The problem may be primarily with hill springs, which in popular perception is safe, but in fact is very vulnerable to feco-oral contamination. There is a high incidence of diarrhoea associated with use of these. Tested methods of making spring water safe from biological contamination- needs to be implemented in every habitation which is using this water source.
- ◆ **School Health Programme:** *Mukhyamantri Vidyarthi Swasthya Karayakaram:* Includes check up/screening, Medication and advice for de-worming, anemia and other health issues, counselling session with parents, Lectures, Health Talks and counselling session with boys and girls (Class 9 to Class 12), AYUSH doctors and medicines involved in the program. For the financial year 2010–11 the state had examined 29% of the students- about 2.89 lakh students, and of these 14% had a referral. Hamirpur, Rs. 11.5 lakh of the 30 lakh received and examined 55,197 school children from all the 775 schools in the district in a series of 272 cluster camps. The percentage of referrals was 6.8. Medical team for cluster camp health check- up had been constituted this year, but due to the crowding at the cluster camp, there is a loss of quality. There were no checklists to guide those screening and simple biometrics like height and weight of the children was also not being recorded. There are also no systems to ensure follow up. Records maintenance is weak, and record cannot be passed on to the next class.
- ◆ **VHSNCs:** State has 20118 revenue villages but VHSNCs have been constituted at Panchayat level. There are 3243 VHSNCs - as there are 3243 GPs. So far 3, 27,376 VHNDs held in the state. They have lack of clarity on how to leverage this more effectively for action. In Himachal the GPs are very small in themselves and villages even smaller and fragmented. A meaningful plan of action and institutionalization needs a critical size - and hence the GP level decision has its strength. Funds go to water and sanitation initiatives and to some referral transport needs and for improvements in anganwadi or sub-centre level facilities.

HARYANA

Inter-sectoral Convergence: Indira Bal Swasthya Yojna (IBSY) launched on 26th Jan 2010 in convergence with Health, SSA, WCD and Social Justice & Empowerment. The scheme was implemented in a phased manner with focus on identification and management of disease, deficiency and disability. Under IBSY 2010–11 in the state: Schools/Anganwadi Covered 32493, Total Children Covered 3065974. Anemic (45%); Ht/Wt for age below mean value (3%); Suspected Vitamin – A Deficiency-(.2%);No. of suspected T.B. Cases 1030. In Mewat IEC/BCC activities with regard to preventive & promotive health is done through Sakshar Mahila Samiti (SMS) in the form of 26 fortnightly programs per year. This program as reported by district authorities was not found very popular. Recently they have started IEC/BCC through ‘Mewat Radio’ which is gaining good popularity.

- ◆ Salt testing for Iodine is in practice.
- ◆ VHSNCs are functioning.

JHARKHAND

- ◆ The distribution of 'Take Home Ration' (THR) has been staggered in last few months. Supplementary Nutrition is not provided at any AWCs visited since September- October 2011. Adolescent Girls were given IFA tablets to be consumed *one per week*.
- ◆ **Nutrition Rehabilitation Centres:** The state has increased the number of NRCs known as Malnutrition Treatment centres from 58 in 2010–11 to 65 in 2011–12. Every district hospital has got one. Number of children admitted in MTCs was very few. No NGOs were involved in tackling malnutrition in Giridih. MTC in Giridih district is functioning well. Staff had required knowledge, understanding and skill for rehabilitation of severely undernourished children. Some AWWs were aware of MTCs and refer severely underweight children. Less number of cases avail follow-up services of MTCs. Keeping this in view, the state has launched financial incentive scheme to promote post follow-up.
- ◆ **Vitamin-A Supplementation:** Massive campaign in the months of February and September for supplementation.
- ◆ **NIDDCP:** State laboratory for NIDDCP had not been established. Five persons for State laboratory were recruited but did not join/continued due to lack of availability of funds. Salt testing kits were not available and were not in use in VHND. All Civil Surgeons in the state were trained in February 2010 on salt testing. Sahiyas were trained and were to be supplied 10 salt testing kits but did not get as expiry date for these kits was January 2011. PRI members were not actively participating in NRHM programme.
- ◆ **Village Health Nutrition & Sanitation** nomenclature of Village Health Nutrition Sanitation Committee (VHSNC) to be universally implemented. Committees requires better involvement of PRI members.
- ◆ **School Health Program** not yet established in Deoghar.

KARNATAKA

- ◆ Facilities maintaining data on breast feeding.
- ◆ **NRCs** location has to be reviewed as DH is too far from community to access and stay for long time and follow up.
- ◆ Karnataka Govt. has launched *Karnataka Comprehensive Nutrition Mission* to address nutritional needs of pregnant and lactating women, 6–36 months old children and adolescent girls. Pilot to be launched through NGOs at Bellary Rural, Sheikaripura, and Gubbi Taluks. Excellent convergence with NACP.
- ◆ Inter-sectoral convergence at field level staff of ICDS and Health that is ASHA, ANM and AWW good.
- ◆ **VHSNC:** Some of the activities include: Provision of Slippers for every Pregnant Women, Cleaning of the Village, Cleaning of Water Tank, Procurement of Bleaching Powder, Transportation of sick patients, ASHAs uniform. VHSNC members have recorded incidents where VHSC members have collected donation for this purpose. They attend VHNDs whenever possible to motivate the participants to increase utilization of government health facilities for mother & childcare and for their illnesses as well.

The Panchayat president mentioned that the fund available with Gram Panchayat (Rs. 3000) was insufficient for latrine construction in the villages.

School Health Programme: 'Suvama Arogya Chaitanya': Annual school health checkup is being under taken and children detected with health problems are referred to PHCs, CHCs or Taluka hospitals/DH. Those requiring specialised tertiary treatment are referred to speciality and super-specialty hospitals. Almost 93% of school children are being covered under this scheme.

ODISHA

- ◆ *Pushtikar Diwas*, joint micro planning at district and block level (for immunisation, health checkups and referrals) are found to be effective in bringing functionaries of two departments together in addressing common issues. 2,28,641 Malnourished (different grades) Children (screened and counseled) treated through *Pushtikar Diwas* from 2009–10 to 2011–12. The biggest challenge is that state has 3 NRCs and hence even if children are detected, they cannot go for rehabilitation if required.
- ◆ **NRCs:** Only 3 NRCs but none in the districts visited.
- ◆ **VHSNCs:** Capacity building of the *Gaon Kalyan Samittis* (VHSNCs), through ongoing technical support from CARE India and which is being piloted at Rayagada district. GKS level Conventions (Block & District). Mapping out of Block wise Low/Lowest performing GKS. Block specific plan & Activity mapping to improve effectiveness of GKS. VHSC (13,000 GKS) involved in LLN distribution. E-transfer of funds is in place up to GKS level.
- ◆ **Inter-sectoral Convergence** Also, use of the new joint mother and child protection (MCP) card, regular meetings of VHSNC (GKS) with participation of health personnel (LHV/ANM/ASHA) on the planned dates have fostered stronger convergence between health, ICDS and PRI. Key factors observed which have played significant role in bringing better convergence between health and ICDS are: Strong, committed and a pro-active leadership at the district level by the District Magistrate, the Chief District Medical Officer (CDMO), and the District Programme Management Unit (DPMU) under NRHM. Clarity on goals, needs and problems among the district and block NRHM teams. Excellent field level coordination between frontline functionaries of ICDS and health particularly between AWWs and ASHAs; Demand for better quality health and nutrition services from the community through community mobilization efforts like Gaon Kalyan Samitties (GKS); and Support from NGOs and development partners (DFID/UNICEF/CARE India).
- ◆ **School Health:** 1806 tribal residential schools included under Intensive School Health Programme & 57972 schools included under Extensive School Health Programme. In district Rayagada: 129 schools are categories under the programme. 127 school teachers (designated as School Health Coordinators). The SHC are trained on the programme. An amount of Rs. 10,000 per school as untied fund have been placed. All the HWs, HSs, AYUSH Doctors and BPOs are trained under the programme.

RAJASTHAN

- ◆ **School health:** Schools claimed that they were given IFA tablets regularly along with the de-worming medicines, but the records do not prove that. Schools informed that the nurses from health centres come and administer the medicines. On checking whether medicines were provided by the Health Centres it was found that they had not provided any medicine except where de-worming medicine was given to 8 students for complaining of stomach ache. There is confusion between the Health Department and Education Department in the State regarding administration of micronutrients. Education Department is of the view that micronutrients like IFA tablets are not to be administered to boys but only to girls. Even six monthly dose of de-worming tablets are not being given regularly to the school children. Only when children complain of stomachache, these tablets are administered. The Health Centres are least concerned about the school children. They examine the school children only on a reference from the school and they are given ordinary treatment. The only thing, which is done regularly, is a visit to the school by the nearest Health Centre at the beginning of the academic session to take measurement of height and weight of the children and physical examination of eyes, teeth and throat. To decide whether a child is anemic only cursory glance through eyes and nails are done.



- ◆ **Midday meal initiative** being run by Nandi Foundation through a centralized Kitchen and is functioning well. However, on further inquiry it was found that IFA tablets have not been given to boys of the school. Upon enquiring from Primary Health Centre Bhadsoda why micro nutrients have not been served at the boys school, the team was informed that micro nutrients are sent but they are thrown away by the children. The District Education Officer, Chittorgarh and the Director, Midday Meal, Government of Rajasthan were of the opinion that IFA tablets are not to be given to the boys. As a result both physical and mental growth of the boys were stunted.
- ◆ **VHSNC:** VHSNCs untied fund being credited in sub-centres account which hampers the smooth flow of decentralization. Funds for all VHSNCs under a Gram Panchayat are being operated through a single account. Substantial amount of advances (Rs. 89.35 lakh) were lying up to 31.10.11 with sub-centres and VHSNCs associated to untied fund due to lack of understanding and coordination between ANM and Sarpanch.

SIKKIM

- ◆ Good inter-sectoral convergence between the Health Department and ICDS. During ANC visits, pregnant women are being provided iron supplementation. Vitamin A prophylaxis in children is being undertaken by providing Vit A doses upto 5 years of age.
- ◆ **NIDDCP:** The sale of non-iodized salt is banned in the State of Sikkim Positions are filled and state iodine monitoring laboratory has been established in the state capital. ASHA's have been provided salt testing kits and they are using these for testing of dietary salt. District IDD survey is being done at regular intervals.

- ◆ **VHSNC:** The VHSNC's are holding meetings at regular intervals discussing issues related to food, water and sanitation. Documentation in the form of proceedings and countersigned by the committee members, follow up of the decisions taken in these meetings is also being done. District health action plan available on the same is also available. There are no Nutrition Rehabilitation Centres in the state.
- ◆ **School health programme** is going on fine as visible by reviewing visit schedules, and the beneficiaries by time period. Last year 88% of the school children were covered under the programme. Dentists are also conducting outreach services but they had a grievance that they do not get travelling allowances for the services but those who go in MMUs get it.

UTTARAKHAND

- ◆ Anganwadi centres visited were functional but take home ration for pregnant and lactating mothers and children was not available since last 6 months.
- ◆ No Nutritional rehabilitation centres were seen in both of the districts as the malnutrition in the state is low.
- ◆ Vitamin A and IFA/Zn were not available in districts visited.
- ◆ **Village Health and Sanitation Committees** yet to be renamed as VHSNC. Lack of focus on nutrition during the VHNDs. VHSNCs are mostly focused on cleaning of drainages, sprinkling of bleaching powder, bush and grass cutting etc. and no activities related to food/water/education are being done. Palkis have been purchased by VHSNCs untied funds.



- ◆ Convergence of ICDS with health department seemed to be weak. Convergence with other departments including VHSNCs is not happening.
- ◆ **School Health Programme:** A strong school health programme seen in the districts carried out in collaboration with education department. In Paudi district there are total 2095 Primary and Senior Secondary Schools out of which 520 schools are covered till October 2011. In Rudra Prayag, out of 411 schools-217 primary schools have been visited so far. Two dedicated teams consisting of two AYUSH doctors, 1 pharmacist, 1 community mobiliser to screen- disability, deficiency and disease, are responsible for providing services. They have been given kit of medicine for general ailments. School Health Cards have been made to identify the SHP children. Children referred under SHP are given preference in DH. Due to excessive skin disorders – training has been given on identifying leprosy cases in children. There is an innovative strategy where the State plans to use Iodine salt testing kits on the salt brought from home by the school children. There is a need to add a Dentist in the SHP to check dental health and for prescription of allopathic medicines for common ailments. Plan to monitor BMI and obesity by these teams is also in place.

UTTAR PRADESH

- ◆ **NRCs:** Malnourishment among women, children and adolescent girls was quite high in the districts. The paediatrician stated they have been receiving cases of severely malnourished children. However, no Nutritional Rehabilitation Centre (NRC) has been established in either Badaun or Jalaun. Though it was sanctioned for Badaun, it is yet to be established. The State has also not enlisted the support of NGOs to tackle malnutrition of women, adolescent girls or children. Nevertheless, it was noted that mothers are educated about importance of breast feeding, homemade food, lentils, milk etc.
- ◆ **Inter – Department convergence was visible at district level:** The inter – department convergence down below the district level from block level especially at the Village Health & Sanitation Committee, was lacking.
- ◆ **VHSNCs:** VHSC at village level are relatively weak interaction with Gram Panchayat Sarpanch revealed that funds under VHSC have not been received so far. It was also noted that the VHSCs were not giving priority to sanitation in the village and its surroundings. The CRM team observed during village visits that sanitation levels were quite poor and it was found that lanes and roads were lined with human and animal waste.
- ◆ **School Health:** The School Health Programme (SHP) in Uttar Pradesh covers only about one third of primary schools in State. A nodal officer at the State level was seen to be overburdened with other responsibilities. In Jalaun district the team visited a Navodaya Vidyala School funded by the Central Government, which was running a School Health Programme on its own initiative without the support of the State Government. However, in Badaun, the team visited a Government Primary School where it was seen the programme has become dysfunctional since 2009–10.

Recommendations

- ◆ NRCs are starting up in district hospitals as part of facility based care but it can optimally function only if community feels demand for it. This demand generation can possibly be done through community themselves approaching facility (if they are so aware) or it can be facilitated process. Examples from states show that, NGOs, CBOs or SHGs along with active participation of community can be a driving force not only in bringing the beneficiary to facility but also for post discharge follow up. But this linkage is still not possible without support of community (VHSNC), ASHA and AWW.
- ◆ The continuum of care is important not only for pregnancy but also for nutrition. Hence clarity of roles on who is responsible for child less than 2 years (ASHA supported by VHSNC) and beyond 2 years the AWW takes over this role. Beyond 6 years the school takes over the responsibility. Also from home to anganwadi centre to facility based care and back through the same route- a continuum of care needs to be established.
- ◆ The role of VHSNC has to be in addressing social determinants and example from state do explains that community does rise to occasion, the need is capacity building –which does not mean lectures for PRI members but actually take them through a process and make them realize the root cause of problems like poor sanitation for vector borne disease (Goa). This process needs to involve the whole village so that they also realize their role and support the VHSNC members.
- ◆ School health has to involve education on social determinants (moral science and civic lessons) with health messages messages and relevance of traditional local foods and health practices. Identification of diseases and their treatment by either sending composite team of doctors including AYUSH practitioners or through MHUS in their schools. Ailments beyond dental extraction and hearing aids etc can be easily treated at sub-centre (where deliveries do not happen) once disease is identified and prescription formulated. This can be a quarterly process. The follow up is possible by pharmacist/MPW/ANM.
- ◆ Midday meals have to be linked to nutritional rehabilitation process as a follow up for grade II,III and IV malnourished once identified.
- ◆ Growth monitoring is the basis of any of these recommendations to take up and produce any outcomes and VHSNCs need to be made accountable for growth monitoring during VHNDs.

“The vision of the Eleventh Five Year Plan is to end the multifaceted exclusions and discriminations faced by women and children; to ensure that every woman and child in the country is able to develop her full potential and share the benefits of economic growth and prosperity. The Eleventh Plan addresses these problems by looking at gender as a cross-cutting theme. It will recognize women’s agency and the need for women’s empowerment. At the same time it will ensure the survival, protection, and all-round development of children of all ages, communities and economic groups.”



Gender Issues and PCPNDT

Gender Issues and PCPNDT

Progress Under NRHM

In this section we look at the progress made in addressing the problem of a declining child sex ratio- a major concern of our times. We also look at mainstreaming gender concerns across all aspects of health care. We also consider some aspects of the adolescent health programme. There is no baseline measure for these aspects with respect to the NRHM - though one could look at sex ratios in the 2001 census and compare with 2011, as well as differential infant and child mortality in the 0 to 4 age group from SRS data.

Main Observations

- ◆ NRHM interventions whether in human resources, infrastructure, quality, community processes have all contributed to improved access and quality of services for women, as seen in the proportionate increase of female inpatient admissions in all states. The NRHM has also led to a major increase of employment for women especially in the most remote and underprivileged areas.
- ◆ In implementation of PCPNDT, State Supervisory Boards have been constituted in all states. States have also established PCPNDT cells to oversee the constitution of the Appropriate Authority and Advisory Committees at district levels. Formation of such committees at district levels has taken place in Andhra Pradesh, Goa, Gujarat, Sikkim and Uttar Pradesh- but it has not yet been established in all districts of the other states visited. States such as Bihar, Odisha, Karnataka, Jharkhand, report the establishment of a special cell or programme management unit to oversee activities related to PCPNDT. In the others it is being managed through designated nodal officers.
- ◆ The PCPNDT act is being implemented in letter and spirit with all four components: registration of ultrasound facilities, submission of completed Form F, regular regular review meetings and IEC taking place in Goa, Gujarat, Karnataka, Uttarakhand and Sikkim. Only Goa reports the tracking of second trimester abortions. In other states only registration of ultrasound clinics has been reported with other elements being either incomplete or missing. Even this is incomplete in Bihar. The failure to analyse form F is a major and most unfortunate gap for without this, there is not much use of all other aspects. Emphasis on monitoring private mobile ultrasound clinics or even their restriction should be considered.
- ◆ In addition to the decline in sex ratio at birth, there is an excess female mortality in the 0 to 4 age group which is contributing in a major way to the declining child sex ratio. Few states appear to be cognizant of this dimension of adverse child sex ratio and there are no programmatic devices to address this aspect. Such a differential could be as high as 17 per 1000 in states like rajasthan and haryana. In Assam, Haryana, Himachal, Gujarat and Uttar Pradesh, the state has schemes to incentivise limiting the family size even if there are only girl children.



- ◆ On the issue of gender sensitive services such as provision of privacy in outpatient and inpatients services, and separate toilets for women, all states have a long way to go, with non high focus states faring as poorly as the high focus states. However where there is a will, change is possible. So Kishenganj in Bihar, which has so many handicaps in other areas- does one of the best in privacy. Karnataka also attracted favourable comment on this parameter. Vishaka guidelines to redress issues of sexual harrasment are in place only in Goa. Only Himachal amongst the states visited has undertaken any sensitization or training of providers in gender issues and violence. In some districts sections of women were found to be excluded from basic services due to social or financial barriers. There is however no conscious planning or affirmative action taken based on such identification to ensure that these excluded women are also able to access quality services.
- ◆ Adolescent health programmes under NRHM relate to addressing adolescent anemia and provision of reproductive and sexual health counselling and access to services, and menstrual hygiene promotion. Adolescent anemia programmes were operational in Gujarat, Jharkhand, Odisha and UP – all being the once per week IFA model pushed by WHO. The impact of this is not assessed- but it can certainly do no harm. The adolesent clinic has been set up in these four states and Haryana and Himachal- but attendance is a problem. The observation was that community centred programmes would have a better chance of outputs as compared to the clinic based approach.
- ◆ Menstrual Hygiene programme training for ASHA is ongoing in all states except Bihar and Assam. Supplies of sanitary napkins have not reached any of the districts visited- but that was perhaps because none of these were amongst the pilot districts.

Findings from the States

ANDHRA PRADESH

- ◆ Authorities at State, District and sub-district levels have been notified under the PC & PNDDT Act.
- ◆ State has 41 mobile clinics registered under the Act.
- ◆ Some irregularities in maintenance of F-forms and delay in filing of charge sheets were found in Guntur district.
- ◆ IEC/BCC like display of messages regarding PC- PNDDT were good at all facilities.
- ◆ Facilities need to be more gender sensitive in terms of privacy, availability of separate toilets for women and implementation of Vishakha guidelines. Some of the facilities displayed names of women undergone tubal ligation violating the privacy of the beneficiaries.
- ◆ No special programme for addressing adolescent anemia has been launched in the state. However, convergence between ARSH and NACP is planned to provide Adolescent Health Services in tribal PHCs/CHCs.
- ◆ Training of ASHAs in promoting “Menstrual Hygiene Programme” has been initiated in the state.

ASSAM

- ◆ PC & PNDDT Act has been implemented across the state since 2004. District and sub-district level Advisory Committees are functional in several districts but not all.
- ◆ Regular meetings and submission of reports to Central Government on a quarterly basis. District Appropriate authorities are functional in all districts.
- ◆ At present there are eight Government and Private Ultrasound centres in Dhubri and 20 in Nagaon. However functional Ultra-sound facilities are available only at District Hospitals.

- ◆ Seven ultrasound machines were seized in Kamrup district and five in Barpeta District during the year 2011. However in Dhubri and Nagaon districts there has been no case of seizing and prosecution till now.
- ◆ Separate ward and toilets for women were not available at many CHC and PHCs.
- ◆ State has launched the Majoni Scheme which focuses on the newborn girl for safeguarding her educational, health and nutritional rights.
- ◆ DHS (FW) has proposed for constitution and functioning of State inspection and monitoring Committee to the state Government.

BIHAR

- ◆ PC & PNDT Department/cell has been constituted at state level to supervise constitution and meetings of the advisory committees at district level.
- ◆ In Kishanganj district, the PCPNDT Committee has been constituted and the nodal officer appointed but in Begusarai district this is yet to happen. Block level workshops to implement PCPNDT are also being conducted in Kishanganj.
- ◆ The state has 1090 USG centres in the public sector, of which PCPNDT is not being implemented in 48 facilities. There is no state level data on private sector clinics at state level.
- ◆ Kishanganj has 12 registered USG centres while none of the 47 USG machines functional in Begusarai (including one under PPP in Sadar hospital) are registered. Registration of one USG centre was recently cancelled in Kishanganj for non compliance.
- ◆ Form F is not being filled at any facility in Begusarai and Kishanganj.
- ◆ IEC activities such as radio spots have been implemented across the state.
- ◆ The posting of Mamta in the labour wards, increased attention to issues of privacy and comfort in the female wards, albeit with a focus on the maternity section all indicate improvement in providing gender sensitive services. Gender sensitization of programme officers and service providers is urgently needed.
- ◆ The state has not yet established ARSH clinics or outreach interventions for adolescents.
- ◆ Bihar has ten districts under the Menstrual Hygiene scheme but the state has not yet undertaken training of ASHA. However district planning is underway to begin the programme.

CHHATTISGARH

- ◆ PC & PNDT act is implemented by Director of Health Services at State level, by Collector at District level, by Block Medical Officer at block level in the state.
- ◆ PCPNDT Advisory committee meetings and regular inspection of USG clinics to be done regularly.
- ◆ Currently 462 facilities are providing USG facilities in the State. Of these, 33 facilities are registered in public sector (State Govt.-32 and Central Govt.-01) PCPNDT act has been implemented in all of these facilities.
- ◆ No cases of complaints or prosecutions were reported till date from the state.
- ◆ There is no expenditure of PC& PNDT IEC budget.
- ◆ Facility of separate toilets for women in OPD facilities needs to be provided.
- ◆ Mitanins are trained in Menstrual Hygiene in five district but ARSH programme is yet to be implemented in the state.

GOA

- ◆ State Supervisory Board formed under the PNDT Act and regular meetings held Setting up of District Supervisory boards is under way. An orientation workshop was organized in 2010–11 for members of Advisory Board.
- ◆ District Appropriate Authority for both the districts is functional under the chairmanship of District Magistrate & Collector with representatives as envisaged under the Act. Quarterly progress report sent regularly to ministry.
- ◆ All mobile/portable machines have also been registered under PC-PNDT. There are 11 units in government setup and 129 in Private sector.
- ◆ No complaints and no court cases were reported till date.
- ◆ Filling of Form F is a regular practice. Hard copies are sent to collector of respective districts on regular basis and reviewed in meeting held every month under chairmanship of Collector.
- ◆ All pregnancies are tracked on basis of second trimester whether retained or terminated. If terminated, what were the reasons? Quarterly reports are referred for analysis against no of live births and birth registrations from the chief registrar office.
- ◆ Good IEC at facilities were observed. Sign boards on PC-PNDT were available in all the health facilities visited such as DH, CHCs and PHCs. Posters, hoardings on public transports, advertisements, street shows, letter to all newly married couples are written by department for saying no to sex selection. Active involvement of NGO'S for awareness generation.
- ◆ Vishakha guidelines are met and a redressal mechanism is in place at state level. Committee of three members (i.e medical officer at Directorate, a Sr Pediatrician and a Gynecologist) resolves any complaint of sexual harassment in the state.

GUJARAT

- ◆ Monitoring and inspection of ultrasound Clinics is done by the State Inspection Monitoring Committee at state level, District Appropriate Authority & CDHO at the district level and at block level by Block Appropriate Authority & BHO.
- ◆ Most of the F forms revealed self referrals in Rajkot, Vatsalya Hospital (CY).
- ◆ The display boards and records were found to be as per the Act mandate in Rajkot.
- ◆ Dikari Yojana, BCC/IEC campaign named "Beti Wadhao" ('wadhao' meaning welcome) and advocacy campaigns by involving MLA and MPs has been carried out in the state to promote gender equality.
- ◆ ASHA trainings in Menstrual Hygiene has been completed in Gujarat.
- ◆ ARSH programme, Adolescent Girls Anaemia Control Program (AGACP) & Mamta Taruni are operational in the state.

HARYANA

- ◆ In the district of Mewat, Advisory Committee for PC & PNDT Act has been constituted. Meetings however are infrequent as new registrations and renewals are few.
- ◆ Three out of 11 clinics are not functional due to lack of staff or equipment.
- ◆ Reports and Form F sent by these eight ultrasound clinics are not analyzed. District officials informed that since the sex ratio of Mewat is better than many other districts of Haryana very little attention was given to inspection.

- ◆ There has been no court case since last four years in Mewat. The last case was reported in 2007 and this could be due to low focus on inspection by the authorities.
- ◆ In Hissar district the enforcement of PCPNDT is done through the Civil Surgeon at the District Level. Three persons were prosecuted for violation by providing information about the sex of child in Hissar in 2008.
- ◆ ARSH is operational in entire state and AFHS clinics have been established.
- ◆ Training of ASHAs on Menstrual Hygiene in seven districts is underway.

HIMACHAL PRADESH

- ◆ The state has adopted Measures for enforcement of PC and PNDT act at all levels, with a dedicated cell at state and district level.
- ◆ In Hamirpur, there are 16 Ultrasound clinics, 4 of which are in public facilities and 12 in private facilities. Kinnaur has six ultrasound clinics of which one is private.
- ◆ A few court cases have been filed and conviction in one case was noted in Hamirpur.
- ◆ District & Block Level Workshops were being organized every year for sensitisation of service providers.
- ◆ A highly visible state wide mass media sensitization campaign on the girl child called 'Beti Hai Anmol' was launched in 2009 and a number of IEC/BCC activities have been undertaken under this scheme.
- ◆ The state has adopted a multipronged strategy to through running multiple schemes by different departments. These include 'Balika Smridhi Yojana' by Department of Education, 'Kishori Shakti Yojana' by Department of Women and Child Welfare, which provides meals and IFA tablets to adolescent girls. The SABLA scheme for adolescent girls is being implemented on pilot basis in District Chamba, Kullu, Solan and Kangra to improve nutrition and health status, self development and empowerment.
- ◆ Birth rates are down to 12 per 1000 and the decadal growth rate is just 7%. There were anecdotal reports of infertility and there is a need to know whether there is de-population. Whatever the complex of factors, the resulting situation in gender equity is much better than most places.
- ◆ Gender sensitization trainings of medical officers, nurses and FHWs have also taken place.
- ◆ AFHS clinics have been set up in the districts but there was no evidence of these being used by adolescents.
- ◆ Training of AWWs on Menstrual Hygiene is underway. However the introduction of the Menstrual Hygiene Programme based on production by local self help groups has been hampered on account of the plastic ban in the state of HP.

JHARKHAND

- ◆ State PCPNDT cell is the authority responsible for implementation of Act. Monitoring of the implementation is done by state inspection and monitoring committee.
- ◆ In district Deoghar, there is no evidence of enforcement of the PC&PNDT Act or advocacy against sex determination. District has not put in place any monitoring/inspection protocols for USG clinics. No training workshops have been conducted on the PCPNDT Act.
- ◆ There are 58 registered USG centres in the public sector in the state.



- ◆ The display boards for IEC/BCC do not meet the guidelines of PC&PNDT Act in Deoghar.
- ◆ There is no privacy provided to the pregnant women during ANC examination at some of sub-centres of Deoghar.
- ◆ ARSH Programme as well as adolescent anemia control programme is operational in the state.
- ◆ Menstrual hygiene training for ASHAs has been initiated.

KARNATAKA

- ◆ There is a State level supervisory board under the chairmanship of Minister of Health and Family Welfare, Government of Karnataka and a State level Appropriate Authority headed by Project Director (RCH), DHFWS, Bangalore.
- ◆ A special cell at the Directorate of Health and Family welfare Services is monitored by Appropriate Authority – Deputy Director, Department of Health and Family welfare Services, Bangalore. 529 inspections have been done by the appropriate authorities totaling to 1075 during this year.
- ◆ Advisory Committee has been established in district Chamarajanagar, with District Collector as Chairman and District Health Officer, RCHO, Representative of 6 NGOs and the District Public Prosecutor as members. However, no meeting has been held in 2011.
- ◆ An officer under the charge of the District RCHO is looking after the implementation of the PCPNDT Act in the district.
- ◆ The District Health Office has ensured that all the centres display the form B.
- ◆ Privacy during examination is maintained by use of a screen around examination table. Separate screens for beds in the wards were seen in one PHC.
- ◆ 1255 AFHS clinics have been established and are functional in the state.
- ◆ ASHAs have been trained for Menstrual Hygiene in 9 districts.



ODISHA

- ◆ District Task Force and District Level Advisory Committee have been formed. Independent inspections have been carried out for one clinic in 2010–11 and two in 2011–2012.
- ◆ 601 USG clinics have been registered in the state under the PC & PNDT Act in the state.
- ◆ A total of 19 ultrasound machines have been seized and 17 prosecutions launched against violations of the PC & PNDT Act in the state.
- ◆ Against the quarterly budget of Rs. 3.35 lakh under 'PNDT & Sex Ratio', the State has reported no expenditure as yet.

- ◆ A State gender and equity cell is established at the state level. Odisha State legal Service Authority was constituted for capacity building of officers and stake holders. Workshop held for O & G specialist through FOGSI.
- ◆ Strengthening of Institutional mechanisms is done through child sex ratio mapping, Monitoring of ultrasound clinics, Appropriate action on defaulter clinics and ban of mobile USG machine in the State.
- ◆ The adolescent health programme is operational in 19 districts with 9 district having SABLA as well. The anemia control for adolescent has been started and adolescent 35 adolescent clinics have started against a target of 135.
- ◆ Training of ASHAs in Menstrual hygiene has been initiated.

SIKKIM

- ◆ The State Supervisory Board has been constituted under Section 16 (A) of the PCPNDT Act. In 2010–11 only one meeting has been held by the State supervisory board. An action plan for PCPNDT activities is available at state and district levels.
- ◆ Advisory Committees are functional at State, District and sub-district levels and the reports of the meetings are forwarded to Government of India on a quarterly basis. The District Appropriate Authorities have been notified on 3rd of May 2007. Independent inspections by districts are held once a month.
- ◆ Constitution of State inspection and monitoring committee is under process. State level PCPNDT cell is not separately constituted and the State RCH Cell is working as the State level PCPNDT cell.



- ◆ There are 18 ultrasound machines (9 Government and 9 private) registered in the State including 4 mobile machines in the 4 district MMUs. The East district had 8 registered machines and North district has 2 machines.
- ◆ Details of filled in formats F and H was also available at state headquarters. Analysis of form F and feedback is regularly conducted and the same is quarterly reported to Gol.
- ◆ No search & seizure of ultrasound machines have been done so far.
- ◆ There is also no mechanism for making anonymous e-complaints.

UTTARAKHAND

- ◆ District Appropriate Authorities are in place.
- ◆ USG machines in private and Govt. sector are being monitored closely.
- ◆ Form Fs are filled and analyzed on a regular basis.
- ◆ IEC on PC & PNDDT was also observed to be good.
- ◆ No capacity building on PC & PNDDT done in the state.
- ◆ Menstrual Hygiene programme has been launched in five districts and ASHAs has been trained.
- ◆ ARSH programme was piloted in five districts but no AFHS clinics were observed in the districts visited.
- ◆ During school vacations Adolescent health, menstrual hygiene programmes are also conducted at VHNDs by school health teams.

UTTAR PRADESH

- ◆ PC-PNDDT Committees (Appropriate authority, supervisory, advisory) have been formed at the state and district level and nodal persons identified but meetings are not being held regularly. The periodicity of inspections is irregular and they are conducted in an ad-hoc manner.
- ◆ In Jalaun district, there were 11 registered sonography centres wherein the Badaun district there were 26 registered centres. No sonographies are done at any of the public health facilities in any of the district, due to absence of a radiologist.
- ◆ Though Form F is filled in by facilities, a large proportion of forms are partially filled, with ineligible entries, making it difficult for tracking cases.
- ◆ Multi-stakeholder involvement is currently limited.
- ◆ It was noted that Mobile USG clinics pose a serious hazard to the declining sex ratio and should be tackled by co-ordination between different district and department authorities.
- ◆ There is limited awareness amongst service providers and community members of the provisions of the PC-PNDDT Act. This needs to be addressed with sensitization and prominent display of Act regulations at facilities and IEC material at the community level.
- ◆ ASHAs have been trained on Menstrual Hygiene
- ◆ ARSH programme implementation needs strengthening but Anemia Control programme was underway in the districts visited.
- ◆ Saloni Swasthya Kishori Yojana has been launched in state. The scheme focuses on monitoring of height, weight and eyesight of girls, counseling on hygiene and providing IFA once a week and Albendazole once in six months.

Recommendations

- ◆ All four components of the PCPNDT implementation need to be assured- setting up statutory committees, registration of ultrasound facilities, Completing and Analysing Form F and IEC. The functioning of all private sector mobile ultrasound clinics should be halted immediately.
- ◆ The contribution of excess female mortality in the age group 0–6 years should be studied in each state where it is a problem, and community processes through the ASHA and VHSC should be leveraged to address this.
- ◆ Gender sensitivity in service provision should be made part of quality management protocols and should be certified. This also includes training of service providers, instituting Vishaka guidelines and mandating district level committees to take action on sexual harassment.
- ◆ Adolescent friendly health services need further innovation and development to develop community centred approaches to improve utilization.

“Strengthening Disease Control Programs by integrating them horizontally under the mission, strengthening disease surveillance system at village level, provision of Mobile Medical unit at District level for improved outreach activities and supply of generic drugs.”



National Disease Control Programme

National Disease Control Programme

Progress Made During NRHM

- i. The separate district and state level societies for each of the programmes have been merged into the state and district health society. Funds flow to the joint society accounts and from here they are transferred to the joint account. The States have been allocated additional resources for each of the disease control programmes.
- ii. Large number of contractual posts have been allocated for NVBDCP. However, the states are finding it difficult to fill-in the approved posts.
- iii. ASHAs and to a lesser extent VHSCs are playing important supportive roles in all disease control programmes.
- iv. There have been efforts at sharing the infrastructure and human resource created for each programme with the rest of the mission components.
- v. IDSP units are functional in 619 districts and a total of 2562 personnel have been trained. Reporting on various formats (Form-P, L, and S) has shown steady improvement across the country (80–100%). Epidemiologists are in place in about one thirds of the districts.
- vi. The National AIDS control programme is running well in the states with HIV test centre, a STD clinic and an ICTC centre at district level. Under this programme targeted intervention of high risk groups are done by programme managers and care is provided to positive cases following the necessary protocols.

Key Observations

I National Vector Borne Control Disease Programme

- i. Malaria continues to be a Public Health Problem across all states including State of Sikkim. There has been generally increase in number of Falciparum Malaria in all the CRM states except in Karnataka where there is a decline. This reason may in part be attributable to improved surveillance. Large number of malaria patients are treated and diagnosed in Non-Govt. facilities, which are not included into the malaria incidence reporting.
- ii. Generally, considerable delay in getting the blood smear examination report for malaria has been observed. Out of pocket expenditure is incurred in getting the Malaria diagnosis confirmed early from the out-sourced laboratory in
- iii. 18 Districts of Uttar Pradesh are in the grip of Japanese Encephalitis/Acute Encephalitis Syndrome (AES) Epidemic, which was primarily in Eastern Part of the State, with sporadic case also



being reported from the other parts. A long term strategy/plan for prevention and treatment of the disease need to be developed. In the current year, JE/AES has been reported from Jharkhand (46 cases till October 2011)

- iv. Kala-azar cases have been reported from Bihar, Jharkhand, Sikkim and Himachal- the last of which is an emerging threat.
- v. Dengue was reported as a public health problem in Andhra Pradesh, Uttar Pradesh, Bihar, Karnataka, Goa, Haryana and for the first time as an outbreak in Guwahati. Chikungunya was reported in Goa and Haryana. In other states there is an incidence, but it is low. There is a public health response in each of these states but its adequacy could not be commented upon. Surveillance measures have increased across all states.
- vi. In the State of Himachal Pradesh, Rickettsial infection (scrub typhus) has been reported, which was previously non- existent there. There is a clinical response at the hospital level- but no adequate public health response. Even exact mode of transmission is uncertain.

RNTCP Revised National Tuberculosis Control Programme

Key observations:

- i. Uttar Pradesh has highest burden (21%) of the disease. Total 2.8 lakh cases, 1.7 lakh infectious cases and 15,000 drug resistant cases notified in 2011. There is a deterioration in case detection rates as well as default rates. Jharkhand has improved.
- ii. Despite increases of manpower in most states, there are still shortages, primarily in Lab technicians, MPWs and supervisors in the high focus states of the north and in Gujarat. Maximum shortage has been reported from UP. In Uttar Pradesh, there is deficiency of approx. 300 microscopy centres, and upgradation of laboratories and binocular microscopes is required.
- iii. In Assam, sputum collection centres were found inadequate especially in non public health institutions which were not designated microscopic centres. This problem has been reported from other states also as one of the main contributors to poor case detection rate. High default rate (9%) among smear positive patients was observed in Assam.
- iv. In Odisha, sub-centre wise mapping of cases referred for sputum examination and cases diagnosed as positive have been done and this has helped improve case detection and follow up. Sputum collection centres have been opened in inaccessible areas.

NLEP National Leprosy Elimination Program

Progress made during NRHM

- i. Many states like Assam, Andhra Pradesh and Odisha which have already reached or near the goal of Leprosy elimination are still reporting increasing number of new cases suggesting active transmission of disease. In Andhra Pradesh 14.7% of new cases are in children. UP and Bihar are stagnant. Over 200 blocks in UP having a prevalence over 1 and 2.3 having disability.
- ii. New case detection rate is either declining or constant in Sikkim, Chhattisgarh, Jharkhand, Haryana, Goa, and Gujarat.

- iii. In Goa all deformed patients have undergone reconstructive surgeries with no back log. In Karnataka PoD (Prevention of Deformity) camps are held regularly in rural areas. 74 reconstructive surgeries were performed. ASHAs and Sahiyas are actively involved in IEC, detection, treatment, and distribution of self care kits, MCR shoes and motivating patients for reconstructive surgeries. Distribution of Self care kits and MCR shoes is ongoing in most states. No reconstructive surgeries have been undertaken in Chhattisgarh, and Sikkim.

National Programme for Control of Blindness

- i. Progress of most of the states is satisfactory in terms of cataract surgery, school eye screening and eye banking, except for Chhattisgarh and Odisha which are performing below average in cataract surgeries. In Chhattisgarh and Odisha there is only 37% and 20% achievement in cataract surgeries. Uttar Pradesh does well and has achieved targets in this programme.
- ii. Operative facility in the public sector limited to District hospital in almost all states. In Andhra Pradesh no activity was observed even in the district hospital in Guntur and Warangal district. There is no operational eye OT in district Kawardha of Chhattisgarh. Although, 2 eye surgeons and 3 ophthalmic Asst. are available in the district. Lack of equipment was also a problem in Jharkhand.
- iii. In Assam School Screening Programme is not being implemented adequately in the peripheral institutions. No records for number of spectacles distributed are available.
- iv. There is shortage of trained manpower reported from many states e.g.: In Goa, number of ophthalmic assistance is less than required and in Odisha 17 post of specialists of 58 sanctioned are empty.

Integrated Disease Surveillance Project

- i. The quality of reporting on S Forms and P Forms is inadequate- and in many instances zero reports are only reflective of a failure to report- not of the absence of these common syndromes. Syndromes as a rule are grossly under-reported. Lack of training on IDSP was a problem in many states. Jharkhand team observed this gap for newly appointed AYUSH Doctors and mobile doctors. In one district only 20 health workers out of 450 have been trained.
- ii. Private sector is not reporting the incidence in many states.
- iii. Infrastructural development is satisfactory in terms of building and equipments except in Jharkhand where Data Centre and Training Centres are yet to be established although space has been identified. Gaps related to Human Resources have narrowed but there are still many gaps especially in states of Sikkim, Bihar, Karnataka, and Jharkhand. (Epidemiologists, Microbiologists, District Surveillance officer, IT and accountant).
- iv. Across the states the pattern is of complete non use and non response to disease reports. Often the data goes from facility to district IDSP officer who enters the data and transmits it up with no feedbacks to district, block or facility level officers. The general problem observed with the IDSP is that it sees itself as collecting data for transmission to a national repository- rather than using it for immediate and local public health action.
- v. Laboratory support is slow to develop. Goa has strengthened districts labs for the project. The state has constituted rapid response team consisting of Physician, Microbiologist and Epidemiologists. In Odisha

District & Block Rapid Response Team have investigated all the 16 nos. of Media Alerts (including one media alert from Central Surveillance Unit) & 3 no's of rumours, and submitted the investigation report to the State Surveillance Unit within 48 hours in the Year 2011. The VSAT equipments have not been found functional in Sikkim for the want of satellite signal issues in Sikkim.



National Iodine Deficiency Disorder Control Programme

- i. Most States have one or other elements of the programme in place- banning the sale of non-iodized salt, reporting on goitre, IEC, integration into school health, NIDDCP cell at the state level, distribution and regular testing of salt at VHNDs in place- but few have all elements. Difficult to comment because team have not written about all the components separately.

National AIDS Control Programme

- i. In Goa programme has done well to aware masses with the street plays, good IEC activities and involved VIP in meetings to address the issue. Free bus passes are issued to HIV +ve patients.
- ii. In Himachal Pradesh, 4 days a month are given to the awareness generation campaign, when the Counsellor goes to different villages, mahila mandals and schools.

Non-Communicable Diseases

- i. Goa has started the programme well with innovative technique like diabetic control programme and diabetic registry. There is mobile van run by state with collaboration of private sector to test blood sugar level and HB1AC. The state has a programme to diagnose gestational diabetic by testing blood sugar levels in ANCs during first and third trimesters. There is a mobile van to conduct cancer clinic camps to pick up early cases of breast cancer using mammography and cervical cancer through Pap's smear.
- ii. Gujarat has initiated a Sickie-cell Anaemia Control Program based on public private partnership. The program targets 61.62 lakh tribal population with an expected 10 lakh people with sickle trait and 1 lakh sickle disease patients. Strategies adopted in the program are screening antenatal mothers and their husbands, screening of every Newborne in tribal population by dried card method, Screening of all adolescents.

In conclusion

Disease control programmes seen were largely limited to the major national programmes for control of communicable disease. There were also no programmes for any other communicable diseases. With the above exceptions there are no major programmes for non communicable diseases in any of the districts visited.

Recommendations

1. Efforts at integration need to improve by a) including disease control programmes into district plans at the levels of facility development, outreach services and community processes, b) improved sharing of data across the MIS systems of the different programmes c) flexible financing to facilities so that those hospital handling higher caseloads of these diseases can get more.
2. Preventive measures for disease control need to be based on epidemiological understanding of the diseases. For this both IDSP data, mortality reporting and analysis of hospital based information need to be strengthened. The information from these sources should be used for epidemiological profiling and disease control programmes should reflect it. Disease like hepatitis and typhoid which are being reported are still not part of district plans.
3. The integration with HIV control programme needs to be strengthened to prevent mother to child transmission, with RNTCP and with blood banking and adolescent health programmes and BCC programmes.
4. Human resource planning in the district plans need to take into account the needs of disease control programmes especially at a time when the attention to non communicable diseases is increasing.
5. Where specialist care is required but cannot be organised at sub-district levels- either specialists should be encouraged and supported to visit block hospitals on scheduled days for the referral or patients should be supported through transport and free care to reach the specialists at appointed times. This particularly refers to services like eye surgery, reconstructive surgery etc.
6. Source reduction programmes for vector control need much better entomological and epidemiological support linked to functional VHSCs and district societies. The high degree of vacancy in difficult districts needs to be overcome by recruiting from available nearly qualified persons and then closing knowledge skill gaps through an appropriate distance education strategy.

“In order to provide managerial support, for tracking funds and monitoring activities under the Mission, provision has been made for setting up Programme Management Units at the State/District level. The NRHM also emphasizes the setting up of fully functional Block and District level Health Management systems, as under NRHM 70% of the resources would be utilized at Block and below Block levels and 20% at the district level.”



Program Management

Program Management

Progress Under NRHM

State health societies and district health societies have been established in all states and districts.

Broader based hospital development societies have been established for all district hospitals, CHCs and PHCs.

State and district programme management units have been established in most states and districts. These units have a core staff made of contractual employees with programme, financial and data management skills. Such programme, accounts and data managers are also extending to blocks in most states.

Directorates of health and Mission Programme management units require supporting additional technical capacities for the management of infrastructure, procurement and supplies, community processes, data management, quality assurance, training, and knowledge management and for these various para-statal organisations or at least specialised management cells have sprung up. Some best practices in these are registered societies like TNMSC for procurement, or Punjab health systems development corporation for infrastructure development, or SIHFW, Odisha for training, or ASHA resource centre, Uttarakhand, for resource support to community processes or SHSRC Chhattisgarh for knowledge management. There is no clear pattern of which functions require an autonomous institution and which can be managed by a dedicated team. This depends a lot on governance capacity to provide stewardship to institutional development, the availability of leadership for developing new institutional entities and current leaderships insight into their own limitations and technical needs for supporting reform and managing change.

Main Observations

1. The State Health Society & Mission are established & functioning in all the states visited, but frequency of meetings, documentation of proceedings and active follow up of action taken on recommendations is not uniform. The performance in this area seems better in Gujarat & Karnataka.
2. Infrastructure & logistics of the Program Management Units: was found satisfactory at state and district level in general but needs attention in most of the blocks.
3. Manpower, Vision & functioning of Program Management Units: The shortage of manpower is an issue mostly at block level but orientation of staff about role of organization & providing terms of reference to staff members is lacking in most of the states even at state & district PMU. (Exceptions: Karnataka, Gujarat & Bihar).
4. In many states the retired officers from state health services have been hired in PMUs. In others responsibility of guiding the staff of district PMUs in specific health programs such as monitoring of vector borne diseases, has been assigned to senior officers from Health Directorate leading to integration of working between NRHM Mission office and directorate (example – Himachal, Gujarat).
5. In few states the responsibility of monitoring performance of certain districts has been divided among senior officers from Health Directorate & SPMU for NRHM further improving the accountability & frequency of monitoring. (example – Jharkhand, Bihar, Karnataka) At the same time infrequent monitoring visits, absence of checklists for monitoring, lack of documentation on observations & poor follow up of action taken on recommendations are diluting the outcome of inputs invested for monitoring. (Exceptions: Gujarat & Karnataka)

6. There is acute lack of actively planning and implementing state and district specific strategies to reach out and serve community living in areas difficult to reach and to support the health staff to work and continue in these areas. (Exception - Haryana). Interdepartmental coordination, particularly with AYUSH is weak and mainstreaming of AYUSH component of NRHM is not handled adequately in the planning, implementation and monitoring process.
7. Capacity building, motivation & retention of PMU staff: The lack of experts in Public health, management, civil engineering, information technology and finance in state PMU was also observed in many states (example – Himachal, Chhattisgarh, Jharkhand, Uttarakhand, Assam, Goa, Haryana, Uttar Pradesh), although state representatives agreed that given the challenge of multi dimension needs of NRHM activities and large size of unutilized budget, hiring such experts was necessary. In most of the states mentioned above under example, lack of induction training, absence of TOR, lack of attention on upgrading management/accounting/ICT skills of PMU staff & using most of their time for routine administrative tasks was found the reason for further decreasing their optimal utilization & lack of motivation to continue. The low remunerations and uncertain future of most of the contractual staff in PMUs leading to low motivation & ownership amongst them is a serious concern that needs to be addressed.
8. Development & utilization of institutions providing technical assistance- SHSRCs, SIHFW, TAST: In some states such as Jharkhand & Bihar, these institutes have been provided necessary support and their capacity is being utilized to assist the state and districts for better planning and monitoring. On the other hand in many states either proper attention has not been given for their development or the staff of these institutes is being misused in day to day assistance for implementing the health programs or in routine administrative work.

State Findings

ANDHRA PRADESH

Well established Program Management Structures at State and district levels with good coordination between Health Directorate and PMU. The coordination between the District Medical and Health Office and District Coordinator of Hospital Services (APWVP) is a weak link in overall implementation and monitoring and supervision of programs of NRHM in secondary care hospitals.

The Program Management structures are well established at both state and District level. There were no major vacancies at the DMPUs in the State.

Good coordination between the Health Directorate and the Program Management Unit was seen at Guntur District whereas the case in Warangal is different. In Warangal, the contractual employees of the DPMU are burdened with work of regular employees. The DPMU at Guntur is also better established than that at Warangal district.



The State has recently deputed a senior regular employee of the health department to head the DPMU after training in Public Health Management. This may prove helpful in bringing about better understanding between the District Health Directorate and DPMU. However, the State must caution that this might not necessarily improve dynamics between the regular and contractual employees and a serious dissatisfaction in job may be prevalent among the contractual employees of the DPMU and below.

Community Health and Nutrition Cluster (CHNC) have been established in all the districts of the state. It functions as a block level monitoring and supportive supervision structure. The office of the CHNC is situated at the identified secondary care hospital and a Senior Public Health Officer (SPHO) is in-charge of the CHNC.

The SPHO along with other officers and supervisors of the CHNC undertake thorough monitoring of functioning of the Primary Health Centres, Sub-centres and other public sector hospitals in its area. They also undertake financial monitoring of the various funds released to these hospitals under NRHM.

ASSAM

At the state level, 111 contractual staff are in position such as Programme Managers, consultants and other support staffs recruited in SPMU. In DPMU, 260 contractual staffs were recruited while 1028 staffs were recruited in BPMU.

Program Management structures at District & Block level were found adequate. At some places the program management unit workers are more than needed and at other places a single person is handling accounts of entire PHCs in the area. At the organizational level, coordination of SPMU, NRHM with directorate of H & FW, Guwahati was uncertain. PMU are in place at the Districts and Blocks.

There is acute need to look into the training of Data entry operators at block level for HMIS and MCTS.

It appears that supervision and monitoring by the PMU is weak especially in the backward, hard to reach and the revenue areas. The Monitoring and supervision unit may also take up the supervision of the NDCPs.

BIHAR



Program management units are established at state, regional, district and block levels across the state. Managers and accountants at district and block level were found in place in all the districts and blocks visited during the CRM. However a number of positions of district and block community mobilizer were vacant and only few positions at the ASHA resource centre were filled. Integration of NRHM Mission structure is also there with the Department of Health and Family Welfare at various levels. At the state level contractual and government officers are posted in the SHS for managing different components of NRHM.

While decentralized efforts are being made on a weekly basis to recruit staff for different positions, there is a high turnover among contractual staff posted at difficult block and district situations. Better remuneration packages and perks from other agencies are attracting a number of experienced staff from the NRHM PMUs in district and block level.

While integration of program management units with the functionaries of department of HFW is clearer at block and district levels it appears weak at the state level. As per discussions with state and district level officials of health society, the directorate is mainly involved in managing the administrative affairs like leaves, transfers, deputations etc of the permanent cadre of health staff at all levels.

Many of the contractual staff in state and district PMUs and some block health managers were found to have adequate capacities to handle their responsibilities. It was found that the Program Officers/Health Managers are also sent to the institutions such as NIHFW, IIMR, PHFI for various short duration courses. Accountants at the district and block levels had adequate skills in basic accounting practices.

All of the accountants and most of the managerial staff reported that they have not received any formal training about their work as part of PMU. They all have learnt on the job and through their interactions with seniors and by referring to available literature.

As each district has an assigned nodal officer at the state PMU, a number of coordination issues are addressed in timely manner through the nodal officers. The capacities of state PMU point persons in program content other than their own domain area appear to be limited and this may require alternate arrangements like drawing other program officers for issue specific support.

While the DPMU staff undertakes a number of visits to the blocks and often to the sub-centre and community levels, there is no structured monitoring process adopted. Adapting from the approaches of CRM and JRMs, the state and district PMUs could evolve more ongoing internal monitoring mechanisms that can enhance timely mid course corrections of program implementation.

The state health society is being supported through the NHSRC and the TAST established under Bihar Health Sector Reforms Project supported by DFID resources. Ongoing support from NHSRC is recognized by the state health society. SIHFW provides training support however quality monitoring and follow up continues to be a challenge.

CHHATTISGARH

The PMUs both at the State and at district level are a dynamic team of workers with high potential. The managers seem dedicated, but lack the supervisory skills, which require to be supported by regular health services managers, both at the State level and at the district level. BPMUs are also active although functional only at some places.

The lack of regular appointees for program management is a gap in implementing NRHM in general and the vertical national health programs in particular. BPMUs although functional only at some places, are active and found to be accountable.

The status of regular & contractual staff: The number of contractual staff is 35, out of total 38 technical and program support staff in SPMU. At district & block PMU, all the 117 & 851 staff members are on contract.

Many posts of Block Program Managers are vacant in the districts.

JDS (RKS) meetings are irregular. Utilization of funds by the JDS is not in accordance with the guidelines and JDS are being used for recurring expenditures like salary & paying electricity bills at SHCs.

DPMUs are not conducting mandated monitoring visit. Recording system in both the districts was found to be poor; especially financial/accounting & record keeping.

GOA

In the absence of a dedicated District Program Management Unit, the role of the SPMU in Goa is made even more critical. It is thus essential that the SPMU is a well strengthened institution.

Generally all program staff, the SPM and the SFM directly report to the Director of Health Services who in turn reports to the Chief Secretary (Health). The Chief Secretary is also the Mission Director of NRHM in the State.

Monitoring and field visits by SPMUs need to be focused as most of the staff is busy with administrative work. As of now there is no M & E officer in the State.

Induction of staff under NRHM for program management has not been conducted. The staff has now picked up the components of NRHM on its own. Nevertheless program management staff needs orientation to improve the performance of key deliverables under NRHM such as untied funds/RKS/VHSNC etc. Performance evaluations of contractual staff under NRHM are not conducted.

There is almost nil turn over of other staff employed under the SPMU and the positions have been filled as follows: SPM is Permanent State Govt. Official, SAM, SDM, SFM, Social Scientist, Consultant in Safe Motherhood, Consultant in Communication & Advocacy intervention, Nutrition officers & IEC Officer appointed on contract basis. HMIS, MCTS, Training consultants not yet appointed.

There are no district program managers in the State. However the State may consider appointing one person each to specifically monitor progress in their respective districts.

In the absence of accountants at facility level, some or the other staff such as sanitary inspector or LDC has been trained to handle the accounts of the facility at CHCs and PHCs. This is severely affecting the way accounts are maintained at the institutions. Thus it is essential that Accountants are engaged at facilities to handle NRHM funds.

In general there are no institutes such as SIHFW that are providing technical assistance in the State.

GUJARAT

The Mission Director is responsible for steering the course of the mission in the state along with the support from the Executive and program Committees. The Program Committees are led by Additional Directors who provide technical assistance to the program.

Established Program Management Unit structure is in place at state, regional, district & block levels to support and manage NRHM/RCH-II Program.

The District Program Management Unit (DPMU) is operational in all 26 districts, and majority of positions at the DPMU are filled. Block Program Management Unit (BPMUs) are also well institutionalized in the state.

In Dahod, out of the 7 Block Program Management Units only one Block Finance position is filled. There are 65 positions of PHC Data Operator-cum-Accountant out of which only 4 are vacant.

Managers functioning at various levels like Project Officers/RPC/DPC/AHA are qualified Health/Hospital Management Professionals to ensure their technical capabilities and focus on the program management.

Orientation Training of the NRHM/RCH-II Program has been given to all Managers at the time of recruitment and periodically whenever required. Prepared Terms of Reference for every staff are in place which includes their Qualifications Criteria and Job Responsibilities.

Managerial Support- Program Officers are involved in preparation of DHAP/RHAP/SHAP under NRHM, providing regular managerial support to various programs at different level for better implementation of NRHM/RCH-II program in the state. They are also involved in preparation of monthly progress report, FMR Preparation and analysis of the indicator reports.

Monitoring and Supervisory structure at state, regional and district levels: State Level Mission Director (NRHM) is the overall Supervisory Authority and respective Additional Directors/Program Officers are the Monitoring Authority for the various staff functioning at SPMU under NRHM.

District and Block Health Action Plans are available and are reviewed by the District Development Officer and The CDHO. Quarterly financial and physical progress reports are prepared. Regular meetings of the District Health Society were being held and minutes of meeting and their agendas were also available at the DPMU.

HARYANA

The State of Haryana has NRHM Cell in state capital responsible for overall management of the Program with one NRHM nodal officer from state administrative services and program management staff.

At district level CMO is over all responsible for the program implementation and monitoring with support from district program management team namely manager, accounts assistant and public health specialist. Decentralization of district program management is being practiced i.e. Additional CMO and/deputy CMOs are assigned responsibility of the various programs and reporting to CMO.

District Program management unit supports CMO on day to day basis in planning, implementation and monitoring of the NRHM and other health activities. IDSP, RNTCP, NLEP, NIDDCP, NBCP, NVBDCP programs have their designated nodal officers or independent program staff, supporting districts and Block officers in program management.

District DPU & DPM lack the support & capacity to take up the massive planning and monitoring role. MOs are handling administrative and financial responsibilities also, as observed in districts visited.

There is urgent need of regular program audit and strengthening monitoring as evident from the observations such as:

- ◆ The regular meetings & review of activities and financial status of Village Health & Sanitation Committees & Rogi Kalyan Samitis is lacking leading to large amount of SOEs (statement of expenditure) pending with VHNS & lack of utilization of funds available with RKS.
- ◆ Recording of data about BP & Hemoglobin was observed at number of facilities where BP instrument & Haemoglobinometer were found out of order. This raises doubts about the validity of data being entered and capacity of system to detect high risk ANC.
- ◆ The drug kits for ASHA were reported as not procured since last one year.
- ◆ In Mewat at PHC Nooh the Government residential accommodation for doctors and staff was found "at



risk" for living, still staff was living there due to non availability of rented accommodation. Some staff quarters had been abandoned. This situation was reported to be existing since last 3 years, yet no efforts for repair/new construction had been made reportedly because of non availability of architect to get the estimate prepared for construction. The local PWD staff was reported to be not cooperating for the same.

The SIHFW was found to be actively involved in assessment of load for different trainings and conducting them. SHSRC has only two staff members and needs lot of support in terms of filling up of vacant posts, technical guidance and utilizing the staff in better planning and monitoring instead of routine administrative work.

HIMACHAL PRADESH

There are state health societies and district health societies in position. These are representative and have both a governing body and an executive committee meeting. The GB meets once a year. The state and district health missions as such have no clear existence or meetings.

Under the state and districts there are functional Program Management Units. The state level SPMU (State Program Management Unit) has 20 persons working in it. For technical expertise, 3 consultants and other program managers are appointed.

The DPMU (District Program Management Unit) across 12 districts has 63 staff working with it. The BPMU (Block Program Management Unit) has 69 regular staff positions and 69 support staff. In these levels no contractual staff positions are sanctioned. The SPMU functions from its own office which is adequate to the purpose.

Coordination with the directorates of health seems good and there is ownership of the program from all sides. There are periodic visits made to districts from the directorate. There is however more of an administrative supervision, and there is less effort in understanding public health problems and issues and improving quality of care.

The SIHFW is weak, with only three persons. The major training programs are managed directly from the directorate- and this slows down the roll out. Considering the involvement of AYUSH in national health programs in the state, the training facilities are inadequate at the institute.

The SHSRC has been announced but not strengthened enough to take off. Part of the problem had been the reluctance to induct contractual staff, even for a much higher level technical resource support function. One alternative state had proposed to overcome this administrative reluctance was to bring in government officers who had done a public health course into such a unit and then further train and mentor them in-house with NHSRC support. Himachal does have such a pool of medical officers with public health qualification, but has failed to make use of this.

There is no clear public health oriented team in the districts, and this is clearly hampering progress. Again the state took a decision not to have a management or MPH or MHA qualified contractual district program manager to support the DPMU- and this too is hampering progress.

There is an accountant, a data entry operator and a person for BCC- but no one to assist in planning, management, supervision. The program officers at the district level for main programs are basically clinicians who have considerable clinical load to handle, and therefore little time to spare or orientation towards program management- except perhaps for the MOH.

In the District of Hamirpur, of 5 Blocks, 2 had Block Program Managers (BPM), but both were posted at the District headquarters. Similarly there were five block accountants who also did data entry. There was a district HMIS officer- basically with data entry qualifications and a district accountant. This was the similar situation in Kinnaur.

JHARKHAND

State has a functional Program management unit. There are different program wise cells in state headed by Health directorate person. This seems a good initiative for integration and co-ordination between program management unit and department of Health and Family Welfare at state level.

Training for District data manager and Accounts manager has been recently introduced. There is no training program for Program managers. Infrastructure provided to management unit in visited facilities was poor. Condition is worse at Block level. Co-ordination between various levels of management unit is not present in visited districts.

All the 140 staff members at state, 141 at districts and 388 at block level PMU are on contract. This raises serious issue about integration and continuity of management and monitoring activities.

State has the supervision and monitoring schedule although adherence to this is an issue. State has appointed two persons, one from administrative side and one from management unit for every district for supervision and monitoring.

SHSRC is new in state and still in a phase of stabilization. Performance evaluation of management unit in state is recently done by SHSRC. SHSRC is now involved in data analysis and state health planning.

Giridih

Two posts of account manager are vacant (Block Deori and Rajdhanmar). Integration with administrative structure of health and program management unit is weak in the district. No orientation and training has been provided to the newly appointed district data manager. District does not have any capacity development plan for Block program managers. Block account managers are also working as data managers at block level. There is no provision of post of Block data manager in district. This is affecting the data uploading of MCTS and HMIS. Co-ordination between district and block program management units is weak. There was no supervision and monitoring schedule available at District Management Unit.

Deoghar

The Program management unit is weak as the position of DPM was vacant for past 3 years. The BPMUs are non functional in most of the blocks due to lack of Human Resources. PMU Staff unaware of job responsibilities and accountability. The last meeting of DHS held six months back. No induction training provided to newly recruited PMU staff. The infrastructural support provided to PMU is inappropriate. There is poor coordination between DPMU & BPMU.

KARNATAKA

The State Health Mission, the State Health Society (both Governing Body and Executive Committee), District Health Mission and District Health Society meetings are held regularly. The State has SPMU and DPMUs in place. The State of Karnataka has integrated the personnel of KHSDRP and NRHM and thus has a doubly strengthened DPMU of 6 personnel.

The DPMU is headed by the District Health & Family Welfare Officer and is assisted by the District Project Monitoring Officer (DPMO) who is responsible for implementation of the programs under NRHM and KHSDRP. In addition the DPM, DAM and the other contractual staff work under the DPMO for effective implementation of NRHM programs.

The Block Program Management Unit (BPMU) was established at every Taluka/Block of the State during the year 2009–10. The Taluk Health Officer (THO) who happens to be a doctor under the H&FW services, is the head of this unit and supported by Block Program Manager, Accounts assistants and DEOs.

In addition to the above mentioned regular officers of H&FW services integrated in implementation of NRHM programs, Nodal Officers at the State headquarters are identified for each district and assigned specific work of visiting these Districts every month for monitoring the activities undertaken in their districts against the budget released to each district every quarter. Further the districts too have appointed nodal officers for monitoring their taluks.

The DCs have been given concise checklists to help them review the health programs effectively within a short time. The HR is also being trained in the Organization Development and leadership which is a progressive step. However, there is need to provide adequate infrastructure for BPMUs especially in the Chamrajanagar district.

ODISHA

The State is recruiting fresh graduates and is training them to become managers and placing them with a bond of 3yrs at districts to man the PMUs. 118 Hospital/FRU Managers have been recruited. SPMU & BPMU posts are filled.

In order to provide techno managerial support to program, accounts and data analysis and monitoring for Mission activities; there is a program management unit at block and district levels. DPMs, Accounts Managers, DHIOs for MIS are in place in all DPMUs to facilitate overall management.

In addition to the staff available, all blocks that have initiated MCTS (Mother and Child Tracking System) will have an additional Data Entry Operator/MIS Coordinator and a Community level mobilizer. The managers seem to be dedicated, but lack the supervisory skills, which are required to be supported by the technical knowledge of regular health services officers, both at the State level and at the district level. The gap between the Program Officers (State & district) and the SPMSU/DPMSUs was evident.

SIKKIM

The program management team at State, district and block level is in place. The State Program Manager, Accounts Manager and Finance Consultant are on deputation from the State government and other staff are on contractual basis. State Health Mission meetings are irregular and only 3 meetings have been held since its formation in January 2007.

At the district level District Health Mission is formed and meetings held regularly. DHS meetings were held regularly until last year. In 2011 meetings are irregular. The district team also have a District Public Health Nurse.

Capacity building for district planning was conducted by State officers with support from NERRC. Trainings for Accounts managers, HMIS



and other management trainings are conducted annually. However, the newly recruited staff (due to attrition) is yet to receive trainings.

Coordination of the various programs undertaken through the district and block program management units are held through meetings and supervision & monitoring visits by nodal officers. The supportive supervision uses structured formats and only after the submission of tour report by the officer, the reimbursement of the travel expenses are made by the state.

The state does not have a State Institute of Health and Family Welfare. The state request for an SHSRC was turned down and there is also no other technical support body available within the state.

The district plans and block plans are in place. The plans are in majorly made by a team at each level and the involvement of other staff or members is very limited. Use of HMIS data in planning is very limited.

The State had attempted preparation of Village health action plans in 2007. As of now what are being prepared are the sub-centre plans which are compiled at the block level. The SC plans are actually formats which every sub-centre fills and sends without prioritizing the requirements based on the specific needs of the sub-centre or the villages that it caters to.

UTTARAKHAND

The State Program Management Unit is fully functional with a team of 4 persons -State Program Manager, State Accounts Manager, State Finance Manager and State Data Manager. The SPMU also includes a State HMIS Cell, which includes a Consultant, a State Data Officer and a Fellow, dedicated to MCTS and HMIS. The positive aspect about the SPMU is that most of the staff has been in place over 2 years which has made it a stable body.

At the district level, District Programme Management Units are in place in all 13 districts. The DPMUs include the District Programme Manager, District Accounts Manager and Data Assistants.

In Block Program Management Units out of the 95 blocks in the state, 87 blocks have Block Programme Managers and 93 have Block Level Accountants/Block Accounts Manager. Of late, the Block Accounts Managers have been overburdened with the task of entering data on the MCTS.

All SPMU, DPMU and BPMU staff are on contractual appointment on a yearly contract. Annual performance appraisal is carried out. An increment to the staff ranges from 5–10% and is not on a performance basis.

Smooth coordination seen between the State nodal officers, SPMU and DPMUs.

The DPMUs in both the districts visited did not have a dedicated area for their office and were operating out of the CMOs office in the District Hospitals. Basic logistics (furniture, computers and internet) was available in both districts.

The State Health Systems Resource Centre started in 2007 has seen some attrition lately and currently is working with two Consultants – a monitoring Consultant and a Documentation Assistant. For technical assistance, at the Directorate level, 2 Directors are responsible for providing technical oversight. RCH programme is looked after by an Additional Director, while Disease Control Programmes are under Joint Directors.

NIHFW undertakes training of the DPMU (including BPMU) every year on various aspects of the NRHM. New programs such as JSSK are covered under this training.

UTTAR PRADESH

It was clear to the CRM teams that the AD, JD, CMO, ACOMO, DCMO, Medical Superintendents and IC-MOs all require further training in Management Skills and Public Health. Under the PMUs, the SPM, DPMs and BPMs similarly require support and training in these areas. There are competent institutions in the State that could support this work. Capacity building will result in significant improvements in program management and ultimately service delivery.

The CRM teams found that DPMs are very actively focused on their routine program implementation tasks; however, they are not providing a longer term strategic focus and direction to District activities. In addition to routine management, DPMs should have a strategic and supervisory role; they urgently need additional support and skills in this area. It is recommended that the State supports them in moving from a basic administrative and managerial role, to providing a more strategic function; applying public health knowledge and management skills.

At present, the District Accounts Manager under the DPMU is not utilized effectively. Each national program has a concerned accounts person with whom the PMU accounts manager is required to coordinate. This may be inefficient and time consuming. Options should be explored to streamline these activities.

The CRM teams found that supervisory and monitoring functions from District level, especially by ADs, CMOs, ACOMOs and DCMOs were rather weak. While some monitoring was taking place, mobility allowances had not been received, visits were not routine and also recording was inadequate.

Supervision and monitoring was also weak at the level of Superintendent of the Block CHCs as well as the IC-MO of the PHCs. DPMs were also not sufficiently involved in monitoring and supervision. Where supervision had taken place, facilities were not left with a written action plan which would focus attention and hold staff accountable. The weakness of the RKSs, lack of BPMs, and lack of untied funds further limited the ability of facilities to respond to suggestions, and be held accountable to local communities.

In some Districts, CMOs are holding monthly meetings which provide a forum for sharing best practice and addressing problems. These should be made more routine, formalised and extended to Block level. Minutes of

these meetings should be forwarded to the next senior authority and progress on action points actively monitored. Furthermore, cross District sharing meetings should be initiated to further share good practice and improve coordination between neighboring Districts.

DPMs have a central role in District level planning and have demonstrated considerable skill. However bottom up planning is not taking place with Village Health Action Plans often absent and VHSCs not performing. Additionally BPMs are not in place, further hindering specific need based planning. It is recommended that the State expedites the recruitment of BPMS and provide further support to bottom up need based planning in the Districts.



Recommendations

A re-assessment of the need for State and District Health Missions as separate from the governing board of these societies is required.

Greater effort to ensure that regular meetings of the governing board and executive committee of state and district health societies take place and the minutes are submitted to the next higher level on a regular basis is needed.

Ensure that the Programme Management Units (PMU) at the district and state level have medical officers of requisite seniority, trained in public health and public health management in addition to the contractual staff. This could be part of developing a public health cadre, but even where a policy decision for such a cadre is not made, medical officers could be trained to enable such qualifications. It must be ensured that AYUSH integration related activities are duly planned and projected in the PIP and implemented closely coordinating with the State/District AYUSH authorities in accordance with the roadmap given for mainstreaming of AYUSH.

The Chief Medical Health Officer is one of the most important positions for the NRHM. It would be useful to find ways to ensure good governance criteria in making this appointment. A fair and transparent process and an insistence on public health management qualifications would be a step forward. Similarly a three year experience at the level of this position should be made mandatory for higher state level management positions.

Integration of Directorates with state PMUs and the supporting institutions requires formation of working teams/committees led by Directorate officers with inter-disciplinary staff from these organisations as members.

There should be a career path and a HR policy in place such that those in programme management, data management and financial management positions are able to upgrade their skills and be retained within the health sector. The State should have orientation, capacity building and ongoing training for relevant staff of SPMU, DPMU and BPMU in areas identified through proper needs assessment, with an ability to cater to a high variation in the level of trainees (ranging from new entrants to highly experienced). Considering that most of the contractual PMU staff are well qualified academically, and are computer literate, there is immense scope to provide structured online capacity building courses and distance learning options.

Developing policies for governance and human resources management in para-statal organisations (such as SIHFW, SHSRC, ARC, TNMSC) that provide the additional technical capacity needed for the public health sector is an area of need. Areas where such organisations are needed are infrastructure development, procurement and logistics, community processes support, training and continuing medical education, knowledge and change management, and for data management. Some of these functions could be combined within fewer institutions- but the importance is in ensuring that all such functions have a state level institutional capacity in place.

"NRHM aims at ensuring access to quality healthcare to the people, especially to the rural and underprivileged population. This includes ensuring good quality essential drugs and supplies at all levels, including peripheral health facilities and outreach health workers (including ASHA). This is to be ensured in a transparent and responsive manner."



Procurement System

Procurement System

Progress Under NRHM

The efforts to strengthen procurement systems and improve supply chain management are only now beginning to have some effect.

At the centre, a Central Procurement Agency is being set up and would be operational by March 2012. Currently procurement of vaccines and supplies for various national health programmes are being procured through an Empowered Procurement wing. A national essential drug list is in place and mechanisms for its periodic update are expected.

Many states are moving in the direction of setting up a procurement and logistics system modelled on the Tamil Nadu Medical Services Corporation (TNMSC). Yet if we consider that this was to have been achieved in the first few years of the Mission, the progress overall is disappointing.

Main Observations

- ◆ Drug availability in the public health facilities is reported as improving across all states. The caution is that there are stock-outs and there continues to be a high prevalence of outside prescriptions, both of which point to a supply driven logistics instead of a demand-responsive one. Medical supplies are still following the “supply-push” approach (top-down, normative allocation) and not the “demand-pull” approach (based on actual demand, in line with the actual burden of disease).
- ◆ Inventory management is still unscientific and systems like FIFO, safety-stock, “2-bin” system, ABC analysis, which are widely used in the industry, is still not adopted in the public hospitals and district warehouses. Infrastructure inadequacy is still there, in terms of lack of proper storage facility and drug warehouses.
- ◆ IT based solutions for inventory and supply chain management (like ProMIS) are increasingly being adopted by states. As seen in the 5th CRM, Jharkhand, Odisha, Sikkim and Uttarakhand are in various stages of adopting ProMIS. Other states like Haryana, Karnataka and Rajasthan have developed their own software for inventory and supply chain management.
- ◆ Procurement reforms are focused more on the tendering process, and quality assurance systems are still not so well developed.
- ◆ Preventive maintenance is still absent in most states, leading to substantial machine downtime awaiting engineers from state headquarters or sometimes outside the state. No concept of district/regional maintenance workshops.
- ◆ Many states have started moving towards establishing autonomous central procurement agency at the state level, on the lines of TNMSC. Of the 15 states covered under the 5th CRM, 5 states have a separate corporation/society, like TNMSC (Andhra Pradesh, Bihar, Chhattisgarh, Karnataka and Rajasthan). States like Gujarat and Himachal Pradesh have central procurement agency but not on the lines of TNMSC (i.e. not established as autonomous corporation or society).
- ◆ Many states (Andhra Pradesh, Odisha, and Rajasthan) are taking serious steps to universalize the provision of fair priced essential drugs through experiments like “Jan Aushadhalaya”.

Findings from States

ANDHRA PRADESH

- ◆ Drugs and Equipments are procured centrally at the State by the APHMIDC. Additionally District Headquarters also have powers to procure medicines from the Central Drug Store if required.
- ◆ The State provides flexibility to the facilities to purchase drugs from open market from the Rogi Kalyan Samiti Funds if not available in the Central Drug Store.
- ◆ It was observed that there is purchase of drugs worth a significant sum from the private sector. There is no monitoring of this purchase of drugs directly from the private sector. The purchasing patterns of the facilities could be studied by the Districts and change indenting patterns accordingly to reduce such purchase of drugs.
- ◆ There is only one Jeevan Dhaara store situated at the Government General Hospital attached to the Medical College which provided subsidised medicines to people in Guntur.

ASSAM

- ◆ Centralized procurement at state level on the basis of L1 bidders
- ◆ Basis of need assessment for equipment etc needs improvement. Computerization of ProMIS for logistics is only at central level. ProMIS is not installed at the regional and district drug ware houses though the training on procurement management information system for four districts is already complete in 2010-11.
- ◆ No decentralization to the district and below. Some emergency drugs are procured by health facilities out of RKS fund but generally patients are asked to purchase from outside.

BIHAR

- ◆ The Govt. of Bihar has set up the Bihar Medical Services and Infrastructure Corporation (BMSIC) as a non-profit organization under the Companies Act 1956 and is responsible for procurement of quality drugs, equipments, consumables, services and civil construction for the DoHFW.
- ◆ Govt. of Bihar has drawn up Essential Drug List (EDL) consisting of 33 drugs for OPD and 112 drugs for IPD from the level of addl. PHC upto the District hospital level. Similarly, for medical college hospital, 65 drugs for OPD and 120 drugs for IPD have been notified.
- ◆ Civil Surgeons have been delegated financial powers to incur expenditure upto Rs. 1 lakh for procurement of drugs etc. Medical Officer in charge of the block PHC can procure drugs medicines etc. up to Rs. 15,000.



CHHATTISGARH

- ◆ Chhattisgarh Medical Services Corporation (CGMSC) being set up, recruitment of staff under process, to take up all procurement functions from 2012–13 onwards.
- ◆ The SHS has adopted the “State Bhandar Kraya Niyam” guidelines for procurements of Medicines & Equipments.
- ◆ Essential equipment such as anthropometric rods (non functional), weighing machine, Sahli’s hemoglobinometer, BP apparatus were available in the sub-centres.
- ◆ Poor inventory management resulting in stock-out lasting 2–3 months on an average. Many essential items like ARV, IFA not available from state supplies, being locally procured through JDS.

GOA

- ◆ EDL was not found in any of the health facility visited.
- ◆ Stock-outs were observed in the facilities. There were lack of bronchodilators for nebulization at PHC Sakoli and PHC Aldona, and lack of Glucometer Strips at CHC Valpoi.

GUJARAT

- ◆ CMSO function as a Central Drug Procurement Agency at State level. Established in 1978 under the H&FW, Department of Government of Gujarat.
- ◆ The CMSO is responsible for procurement of 90% of the drugs procured and supplied to very public sector facility. The district store sends the indents for the requirement of the district to the state through E-Procurement system.
- ◆ Field visit indicated that drugs were available, in stock and patients were getting drugs free of charge. While there were no observed stock out of vaccine, there were some complaints about shortage of OPV in Rajkot. The essential drug lists were not displayed prominently in all facilities. Some equipment such as Oxygen concentrator were supplied to facilities without any explicit need from facilities on the same.



HARYANA

- ◆ New Drug Procurement Policy put in place, which weeds out sub standard Pharma Companies.
- ◆ Purchase preference is given to 5 Central PSUs for 102 Essential medicines. State RC finalized at highly competitive rates. DGS&D and ESIC rate contract also declared as approved sources. Competitive rates negotiated for local purchases in emergency.
- ◆ Procurement is mostly centralized at state level and orders are placed by State to Central PSU at Haryana Govt. approved rate contract. If items are not available in RC, next preference is given to ESI Rate contract or DGS & D rate contract whichever is lower. Purchase Committees have been formed at State, District and SKS levels.
- ◆ The State is using locally developed software for records keeping and reporting.

HIMACHAL PRADESH

- ◆ Procurement of drugs including AYUSH medicine and supplies is through the state civil supplies agency, largely done centrally and then supplies made to the facilities. Supplementary procurement of drugs was found being done at all facilities viz. Sub-centre, Primary Health Centre (PHC), Community Health Centre (CHC), Regional Hospital (RH) etc. often using RKS funds. AYUSH medicines are also purchased from centrally sponsored scheme funds directly from the suppliers approved by the Department of AYUSH.
- ◆ The facilities face interruption of supplies and non supply of many categories of drugs making outside prescriptions necessary.
- ◆ Quality assurance mechanisms in drug logistics chain are as yet weak. ProMIS is not in use. Procurement cell exists only at the state level.

JHARKHAND

- ◆ There is no specific procurement unit for NRHM at the State and District level. A purchasing committee at state level looks after procurement under NRHM. The procurement is done as per Jharkhand State purchase rule. For drugs centralized rate fixation with fixing of agency are regular practices.
- ◆ Drugs are procured by district. State provides funds to districts according to their demands and requirement. The needs are assessed on the number and type of cases and caseload, and the existing number of institutions in each block.
- ◆ Present procurement system is not comparable with the transparency, efficiency and drug safety benchmark of TNMSC model. State has a procurement manual.

KARNATAKA

- ◆ Karnataka State Drugs Logistics & Warehousing Society (KDLWS) was established in 2002 which is the single point procurement agency for procuring drugs, chemicals & miscellaneous items for the use in the hospitals in the entire State. KDLWS has 14 district level warehouses.
- ◆ The management of stocks and distribution is automated through the use of electronic Drug Distribution Management System (DDMS). Indenting is done through annual drug indent books, which are compiled by district drug house at the district level.
- ◆ KDLWS has adopted unified end to end e-procurement system maintained by the State E-governance Department for all its procurements worth over Rs. 1 lakh. DDMS links the warehouses to the central office and there is daily data synchronization between the warehouses and the central database.
- ◆ The facilities visited by the CRM teams had all the essential drugs. No stock outs were reported for the drugs supplied. The drug store and dispensing units in FRUs and DH are of transparent glass for public to see the current position of drug availability.

ODISHA

- ◆ "Janaushadi" is in place to reduce out of pocket expenses.
- ◆ There was no stock out at any facility visited, however proper storing facilities were not in place.
- ◆ Under NRHM the State shares the major portion of the drug budget; resulting in a remarkable increase in the budget allocation of the State over last five years.

- ◆ For inventory management Web based application software ProMIS has been functioning since 2010. To Deal with Stock entry, tender evaluation, payment processing, Purchase order etc. procurement of Drugs & consumables standalone application software named DIMS is also in use which takes daily backup by email from Districts and gets updated at SDMU Govt. of Odisha.

RAJASTHAN

- ◆ The State Govt. has constituted Rajasthan Medical Services Corporation Limited (RMSCL) for procurement. Distribution is through Drug Distribution Centres (DDCs).
- ◆ All Health institutions in the state/district are allocated fixed budget for indent of medicines and surgical consumables and additional 20% budget has been kept in case of any shortfall. Health institutions are provided with Passbooks to keep track of expenditure on drugs and consumables. One copy of the passbook remains with the institution and the other copy is kept at the district warehouse.
- ◆ Drug distribution is controlled through a software *e-aushidhi*. All DDWs are connected with central server through the software. The software calculates the cost of drugs/consumables issued to a facility and the cost is entered in the passbook.
- ◆ District hospitals and CHCs make procurements for Life line drug stores (stores operated at the hospitals by the hospital staff from where generic drugs are sold to the patients after adding an amount of 10% on purchase price).
- ◆ It was observed that the drugs and consumables supplied to the health facilities from allocated budget were grossly inadequate leading to shortage of essential items in the hospitals.



SIKKIM

- ◆ In the State there is no Centralized Procurement Agency for procurement of drugs and supplies. Procurement manuals are available and the societies follow the guidelines for procurement.
- ◆ Stock registers are available but a computerized system would improve the drug management process. ProMIS training is completed but implementation of the same is yet to start.
- ◆ Some essential drugs were found unavailable in the Northern district hospital and patients were buying them from the medical store within the hospital premise.

UTTARAKHAND

- ◆ Drugs in the state are procured at two levels – 40% at the state and 60% at the districts.
- ◆ Drug supply was found to be adequate except for IFA, Vit A and Zinc. Essential drugs are adequate & where ever shortages are encountered they are managing through RKS funds.
- ◆ The CMOs have been empowered to do local purchase of stocked out essential drugs. List of generic drugs available were prominently displayed in PG and RP facilities.
- ◆ Equipment was generally available, however, lying unused due to lack of training and manpower.
- ◆ Since the state does not have an AMC policy, once the equipments break down, it is difficult to repair/replace them except for ILR and Deep Freezers. In most of the labour rooms, heaters/warmers were not available.
- ◆ Implementation of Pro-MIS in underway in the state.

UTTAR PRADESH

- ◆ No procurement manual found at State and District level. Badaun district procured the emergency medicine on the basis of local tender.
- ◆ Drug and supplies are procured by Central Medical Stores Division (CMSD), which functions at the office of DG Medical & Health. In 2009, a central purchase committee has been constituted at the office of DGFW, which had been entrusted with the job of procurement of drugs & supplies under the National Health Programmes. Subsequently, the State has constituted District procurement Committees at district level, which has been entrusted with job of procurement of drugs and supplies for all health facilities except for district hospitals.

Recommendations

1. Accelerate the establishment of procurement and logistic systems on the model of TNMSC. The processes that need to be benchmarked with TNMSC include (a) Process of tendering, (b) Pre-qualification of suppliers and black-listing of errant ones, (c) Quality Assurance of suppliers, (d) Monitoring inventory levels at warehouses and facilities, (e) Ensuring three months supplies in every facility and warehouse, and suppliers automatically responsive to changing consumption pattern.
2. Capacity building for staff handling stores and supplies. Have SOPs and guidelines in place for day-to-day processes in line with the best practices of inventory and Supply Chain Management.
3. Expand the scope of ProMIS to make it an effective IT solution for comprehensive inventory and assets management, with interoperability that helps relate it to HMIS.

“The success of decentralization experiment would depend on the strength of the pillars supporting the process. It is imperative that management capacities be built at each level ... and this should include include skills for .. improved collection and maintenance of data and the use of information technologies and management information systems.”

Page 25, para 18, NRHM Framework for Implementation



Use of Information Technologies

Use of Information Technologies

Progress Under NRHM

1. Regular reporting on a unitary health management information system from across all 640 districts of the country have been established.
2. National Web-portal that acts as a central repository of information pertaining to service delivery in the public health sector and reproductive and child health figures have been established.
3. As many as one third of the states have developed and put in place supplementary systems to support information analysis and use at district and sub-district levels.
4. Systems to support HR management, hospital management and use of mobile applications are also growing across states.
5. All states have begun developing systems for supporting follow up of care in pregnancy and immunisation for the infant, in an effort to close gaps in service delivery, improve coverage and accountability.

Main Observations

1. The generation and use of district level data is considerably improved as compared to all earlier CRMs.
2. Infrastructure, manpower and software systems are in place at state and district level, but facing problems in block level. Maintenance of computers and lack of support for data entry & analysis, internet connectivity and power cuts are the constraints that most blocks are facing. Computerisation at levels below the block headquarters is the exception rather than the rule. Amongst the states visited only Karnataka and Gujarat have managed this. Facility level data entry in such a situation has been slow to start up. The national web-portal has also slowed down considerably under the increased load and there are lack of electronic bridges to connect with state systems. Use of facility level information for district action is almost non existent in most states.
3. In most of the states the quality and completeness of data is inadequate. This becomes a reason for managers to not refer this data for planning, monitoring or programme management. As data are not utilized, gaps are not corrected and efforts to improve their quality do not get due attention. This unfortunate vicious cycle between non-use and poor quality needs to be broken.



4. Poor quality and completion relates to a high degree to inadequate design of primary registers, and lack of proper authorisation of officers for timely confirmation of data are other frequent problems that were noted. Lack of availability of the manuals with details of data definitions and collection and reporting rules was another major constraint observed – not only for HMIS but also for IDSP, malaria reporting etc.
5. Facility level data is directly entered into web portal in Assam, Chhattisgarh, Jharkhand, Karnataka and Sikkim. It is entered into state level applications in Bihar, Himachal, Odisha, and Rajasthan. In the first set of states, the problems are of non-compilation of many district reports and non-availability except perhaps Karnataka. In the second set of states, only district consolidated reports go to the web portal, and facility data is difficult to transfer though usable for district and sub-district planning.

In some states (Himachal & Gujarat) Hospital information systems have been developed as a state initiative. This needs to be studied & lessons learnt need to be adopted in national HMIS system, where found feasible and sustainable. However, AYUSH facilities by and large lack computers and HMIS.

In some states data entry initiative using mobile phones by ANMs & peripheral facilities needs to be studied & adopted where found feasible.

Financial Management Reports that used to flow in an integrated manner with HMIS has now stopped flowing.

6. All states are making serious efforts at putting in place a MCTS. The problems of shortage of manpower, infrastructure & maintaining the systems at sub-district level especially in blocks for data entry are felt much more with the maternal and child tracking system- as the volume of data to be entered is much higher. In a situation of human resource and infrastructure constraints emphasis on tracking systems could de-stabilize existing systems. At all states the MCTS data exists completely parallel to the HMIS, in that the aggregate numbers from MCTS are not used as the input for the aggregate numbers seen on HMIS. The exception in this regard is Himachal where the aggregate numbers in use are the same as derived from MCTS.
7. The huge backlog of data to be entered in many districts, leads to a situation where the data entered is not usable for service delivery follow up. There are also many other systemic gaps why the use of data on MCTS is very limited. Mission directors and programme managers are getting feedback from the centre on results of sample phone calls made to beneficiaries- but the feedback does not have the critical levels of information needed for a programme response.

The verification and validation of data entered was attempted by a few CRM teams. Where this is being tried discrepancies have been observed between data captured in ANM registers/forms and entered in MCTS database and also with actual mothers and children tracked in village through their phone numbers.

8. The burden of reporting – time, effort, resources expended- on MCTS is high and the use of this information has to be made proportionate to this. There is also a question of opportunity costs of this time and effort. It is important to ensure that time that should be spent on clinical care and counselling and home visits is not being unduly diverted to data gathering and reporting. The generation of work schedules is meant to assist and ease the work of the service provider- but whether in effect it has done so, remains to be studied.

State Findings

ANDHRA PRADESH

The State has now shifted to data entry from the facility level. Integration of MCTS, HMIS, MDR – TB tracking, School Health Programme all of which are of current importance to the State administration. This is being done using DHIS-2 software, which is being introduced in the State. The State is undertaking orientation training of its staff to use DHIS-2. But institutionalisation is taking time. However, this has caused irregular data entry into the national HMIS portal.

Information on MCTS is uploaded at the district/cluster level, however data uploading is not up to date and the staff requires orientation/training on MCTS. In most of the centres visited, the computer facility was not available and wherever it is available, not put to use. The collected information was not being utilized for tracking and monitoring.

ASSAM

Facility level data uploading has been started in 22 districts. Remaining 5 districts will be covered within next 2 months. In some districts, district data is not compiled and not available.

MCTS System has been implemented in the State.

Computer with Printer and UPS has been provided to all DH, SDCH, CHC and BPHC. Computer set is also provided to PHCs wherever electric connection is available. Computers provided to all levels have been utilized for data entry in Tally ERP 9, HMIS and MCTS. Internet connectivity is available in all District HQ. Internet connectivity has been established in Block PHCs wherever Internet facility is available.

BIHAR

Facility level data is entered into DHIS-2 and district compiled reports are uploaded on to the web site. The state health society with the support of NHSRC, UNFPA and IIHMR has initiated the up gradation of the skills of health staff at various levels to ensure the quality of data recording, analysis, report generation and use of data for decision making. There are systematic efforts at analysis and use of data and the software available supplants this use.

The emoluments of the data entry operator at the PHC level are inclusive of purchase and maintenance of the computer and other hardware. Thus the total income is only about Rs. 4300 per month, which is demotivating.

The quality of maintaining MCH registers varies in the district. In some areas it is incomplete because the data gathered during actual service delivery, most often the VHND is not transferred to the main register.

MCTS is operational in all blocks; but beyond data entry very little action is being taken. Data from programmes such as immunization, IDSP, Finance are not being integrated into the HMIS. The name based tracking system has been initiated and several instructions are issued for this programme. The Kishanganj team observed a mismatch between prescribed format for MCTC and MCH registers available with ANM. The MCH registers are not completed, and the physical verification of the data is not being done although at the PHC level data entry operators had a good understanding of MCTS format.

The state has hired around 50 resource people for validation of data at HSC level. They are also expected to train ANM and data entry operator on accurate reporting and entry of MCTS data. The State has developed a new MCH register for data entry which is customized to the needs of the MCTS. The MCTS is also being reviewed in the monthly meeting of Civil Surgeons at the state level, to ensure pace of data entry and validation of data. The State has appointed nodal officer at all the level to track development of MCTS.

CHHATTISGARH

District Kanker- 204 SC/28 PHC/08 CHC/01 CH/01 DH are reporting in HMIS portal and forward monthly reports to District. District Hospitals and Sub- centres are reporting timely. Only 50% Civil hospitals reporting timely.

Many districts have little idea of what their monthly consolidated data is. No feed back to nodal officer and Block level officers is provided. HMIS data is not being used in District/Block level planning. Regular feedback is not being given to block level officials and supervisors for betterment of HMIS. It was observed in Kawardha that ANMs did not have a duplicate copy of HMIS forms with them and therefore even facilities and supervisors do not have their own data. Data Centre has been established at all blocks and computers are connected via LAN.

Nodal officers for MCTS have been appointed for block and District level. The quality of data filled in MCTS registers needs authentication. (In Kawardha: as per the registers seen, 80% women were not anemic, majority had body weight between 40–50 kgs, and everyone had normal BP, and all babies weighted between 2.5–3.5 kgs.

Around 50% backlog in computerizing the registered women. No plan/strategy for covering the missed out women and children). Feedback is not being provided by district and block levels to ANMs/LHV's.

State has started E-Mahatari (SMS based maternal child tracking system) pilot project has been started in 1 district of the State (Dhamtari) and will be implemented throughout the State upon successful completion of pilot project. Mobile phones have been distributed to ANMs in the district and data is being entered through SMS based system. The team found that data entry procedure is simplified and ANMs are also comfortable to use this system.

GOA

1. HMIS: Facility based data entry is being done at PHC level, where information from all sub-centres is collected and entered by data assistant. Standard registers are not available and records keeping is poor. Data entry in portal is adequate but parallel reporting in the form of manual formats are also in practice. MCP Cards: Mother and Child Protection cards are provided to all pregnant women. The presence of an MCH card has been made mandatory for availing State government scheme for girl child. This has increased ANC registration and has ensured that almost all mothers carry and preserve their MCP cards.
2. Name based women and child tracking is in practice and the national portal is being used by data entry operators. Feedback to improve data is being provided by the DHS but the use of data is confined to their immunization sessions only. Birth planning is not yet in practice. A state level M&E officer under NRHM is involved in managing MCTS & HMIS.

GUJARAT

1. HMIS- In Dahod, at PHC Paanchwada forms and formats of HMIS were traced to the sub-centre level. Form 6 submitted by all the 6 attached sub-centres were found to be complete in all respects. The figures were also verified by ASHAs. Form 7 submitted by PHC was also complete. It was verified with the PHC records and Registers. Many discrepancies were found in the data of District Dahod which is sent to state for uploading on Gol website. Forms received from facilities are manually compiled at district level and uploaded to the web portal.

The problem was found to be in collation, and compilation of data at Block and District Level. Data entry operators receive time to time different contrary instructions from state causing confusion. Wherever they have any doubt, they put a 0.

2. Data reported through the HIMS is timely and to a large extent accurate. Incentives to improve reporting of vital events through the civil registration system increase the accuracy of CRS data. Need to triangulate data with data generated from E-Mamta system as well as use of this data to improve program performance is there.
3. **Hospital Management Information System:** This has been operationalized in 6 medical colleges and 24 district hospitals. The District hospital, Rajkot has this system and was being utilized by the hospital authorities for more effective management of the hospital services. Data operators were used for data entry at different service location at the hospital. An MIS Manager has been hired to manage the overall system including problem with hardware and software. The team was informed that the remuneration of the staff has recently been increased, which is the welcome step to retain such skill within the sector.
4. **E-Mamta:** is a well established system in the state It is a system to track beneficiaries (Mother and children) to ensure services are provided and reduce dropouts. All facilities visited had an operational E-Mamta system for the primary health care level and generated work plans for the ANM/FHW to perform their weekly duties. While full coverage is not yet achieved. This is a significant step to track and provide MCH services to beneficiaries. There is a need to evaluate the benefits of this system in relation to the work involved so as to learn lessons for scaling it up.

When the team made efforts to trace JSY beneficiaries, it was not possible to link it with the E-Mamta data at PHC Gumta and PHC Khirsara. Due to large scale migration in Dahod the tracking of all the pregnant women and newborn is not possible.



HARYANA

1. HMIS Reporting formats and operational manuals available up-to sub-centre level. Regular Capacity building of teams in data usage for monitoring and planning. Core team notified for State & District level implementation. Computers are available up to PHC level.

In many districts aggregation is done manually at district level and then uploaded on to web-portal. Both HMIS and IDSP Portal are slow and have cumbersome online data entry. Limited analysis is conducted.

2. **MCTS:** Nodal officers at all level (Upto PHC) are being notified; State and District e-Mission teams are being constituted. There are 2205 sub-centres, and 420 PHCs and 105 CHCs reporting from 111 data entry points. Over 222 persons have been trained.

In the district visited there are gaps- 6 data entry operators available against 13 posts at CHC/PHC (Mewat); MCTS data uploading has started for pregnant women; but not yet for children. sub-district entries created by DPMU; Work plan generation has been started. Huge backlog of data entry as data entry is confined to CHCs.

HIMACHAL PRADESH

In HMIS system facility level data is entered, but its utilization as of now is much poorer. Though district aggregated data can be uploaded into the national web-portal there is no electronic bridge as yet for entering the data from the facilities. AYUSH contribution in the health data is not reflected separately.

As un-reported deliveries were checked, it was found that these are really indicative of either reporting gaps or populations getting left out.

One significant innovation is the hospital information system- which is in at interim stage of development. Built on the open MRS platform, computerization of registration, billing, and laboratory investigation has proceeded well. However maintenance of case records is slow to pick up and the interfaces with the district HMIS has to be strengthened.

Once this is developed the state plans to replicate this to every hospital- and since there are no license fees and in-house capacity is being built, this scaling up can happen at minimal costs- the only costs being that of capacity building.

The mother and child tracking system is being implemented with considerable seriousness and effort. However the advantages of the system in helping providers to recognize gaps in service delivery or in managers to supervise the providers better are not being realized.

There is also much duplication of work. The names are retained at block level and only aggregate numbers are entered into the system. The names that are entered into the portal with phone numbers get tested by calls from a centre in Delhi. A feedback on this is sent to the state mission director, but the information is not possible to act upon.

JHARKHAND

1. In Jharkhand, the state has gone in for facility level reporting. However, shortage of data entry operator, poor internet connectivity and troubles in logging due presumably to server problem are working as bottlenecks.

Between April to September 2011: ANC registration against expected pregnancies is 13%. Reported deliveries against expected deliveries are 4.9%. The institutional deliveries are 2.3% against estimated deliveries & 47.2% against reported deliveries. Premature transition to facility level reporting has been a problem.

2. MCTS is operationalized but is struggling due to huge increase in work load and lack of staff. In most blocks, block account manager is doing MCTS entry into such PHC. Jharkhand state started MCTS application with a new name E JANANI, and a good team has been put in place. The entry team is always facing MCTS application error at the time of entry. Much of the entry is overdue and there is little to no use of the data. So far a total of 223528 mothers and 192022 children have been entered.

KARNATAKA

HMIS: Data entry is done at PHC level (PHCs and SCs). Facility based reporting being done from many facilities but a few CHCs are left. Training of officers and staff is in progress. PHC officers and staff are trained by State officials through video conferencing. The SC staff is trained at taluka level by District and Taluka officers.

HMIS data is being analyzed and plans are made on the basis of HMIS data. Regular feedback is given to district authorities on HMIS data.

Health resource management system (HRMS), software has been developed indigenously for online data entry of human resources. The State has requested Gol to make provisions in HMIS for capturing data from private facilities (For the time being Karnataka has created notional facilities).

MCTS: The State is using SMS- based systems for real time updating of the MCTS data. So far 5,95,889 pregnant women and 1,21,250 newborns have been registered. Till recently the uploading of registration data was being done at taluk level but now facilities too have started uploading data. As it is a recent step, many facilities do not have computer operators and many need to be oriented.

The registration of newborns is lagging as more deliveries are at CHC, TLH and DH where data entry is yet to take off fully. The facilities are identifying person for data entry and getting him/her trained.

ODISHA

1. HMIS: The state HMIS system is being used for facility level data entry and there is regular analysis and use of data. Block level and facility level disaggregated analysis is being put to use.
Certain data (e.g. Body weight at birth below 1.8 kg, use of oxytocics, blood units, anti-hypertensive's, etc in management of complicated pregnancies, etc.) are not being generated at facilities, which is a training issue.
2. MCTS: This system is supported by NIC and running in the state since April, 2011.
3. e-Blood Bank: e-Blood Bank system is a web based blood bank application for tracking and tracing system of blood collections, Issue & disposals, including inventory management. The application facilitates automation to the entire work process of a blood bank.
Currently e-Blood Bank has been implemented in two major blood banks of Odisha, i.e. in Capital Hospital, Bhubaneswar and CRC BB, Cuttack.
4. e-Swasthya Nirman: is a web-enabled system, developed to track and trace the physical and financial progress of all construction activities undertaken by NRHM at State, district and block level. This online application integrates all activities of construction unit such as forecasting, tender processing, work execution, monitoring of financial utilization, user tracking, allotments etc.

5. Drug Testing and Data Management System: This Application automated the day-to-day work processes of State Drugs Testing and Research Laboratory (SDT&RL). The Service of the System will be extended to citizens, who desire to submit their samples at SDT&RL and get report online.
6. MHU Tracking: A GPS based tracking system has been developed and implemented at Raygada District on pilot basis. Currently, the system has been piloted at Raygada District. It helps in real-time tracking of the MHU with local route map, speed and mileage, unauthorized travels/deviations, warning system to the MHU operator, control panel for the administrator.
7. E-Attendance: The attendance of the staffs of all DHHs and Medical colleges are being captured through time based attendance system (Bio-metric device), installed at all locations. It's going to be linked with payment of salary/compensations.
8. HRMIS: The Human Resource Management Information System, initiated in February 2010 captures all information of persons working under the contract of the project. It also gives GIS facility for employee tracking. All Employees data is being updated each quarter and the data is being used for HR management and Planning.
9. Mission Connect: Under this scheme, selected field level service providers have been provided with CUG post paid SIM cards for better communication and service among employees of H & FW departments. The related cost is being managed from the untied fund of the sub-centres.

It helps in better communication and service delivery, Strengthening MIS and reporting tools, develop interaction between user groups, prompt information sharing during epidemic & other emergencies.

RAJASTHAN

HIS system in the state uses its own software for facility level analysis and use of information. Aggregated district data is uploaded on to national web portal.



Presently, Rajasthan state has its own Pregnancy, Child Tracking & Health Management online System (PCTS). On the PCTS the data entry is being done by name based tracking of pregnant women and children as per the GoI guidelines. PCTS is facility based data reporting system. Monthly data up to sub-centre level is being entered at block and some PHCs.

The delay of few months in initial entry and huge gap in subsequent updates has been observed in MCTS. Therefore, timely tracking for dropouts is not seen. The system is generating SMS for beneficiaries as well as for respective ANMs for due events, but effectiveness of the system is yet to be seen.

The system for service tracking needs rapid entry to ensure timely reminder.

SIKKIM

Adequate manpower is available in the State, district and Block level for collection compilation and transmission of data. All the Primary Health Centres have Computers and internet facilities. The staff working in Primary Health Centres and other places were well trained.

The infrastructure for the facility level online data entry has been created. But due to poor internet and telephone connectivity the system could not function. Hence, there was no data uploaded in to the HMIS system for the past one year.

All the centres visited, had printed registers. The registers have been filled in clearly with complete information. The reporting formats were complete.

State is not using the data generated by the HMIS software. The state is relying on the old system in place to collect the data. The data collected by that system have been used for reviews and other purposes such as documentation. The major reason cited was they were not able to upload the data and there is no current data available in the HMIS for Sikkim. Moreover they had recently uploaded 6 month data as bulk upload which is also not available in the HMIS server.

The Mother and Child tracking is done through the MCTS register. All the particulars have been recorded in a printed register and they are being regularly updated. As encountered with other data transmission the Mother and Child tracking system was not made online. Hence it will be difficult to assess the level of coverage and generation of reports at the state level.

UTTAR PRADESH

Computer with printer and broadband connection up to the block level, and data entry operator up to block and district level have been made available. The post of data entry operator was however found to be vacant in some of the facilities visited by the team. Data uploading on JSY and HMIS portal was satisfactory. There is a need to institutionalize systems for validating the data and minimizing the time lag of more than a month for uploading of HMIS data.

Many fields of reports were lying blank or filled as 'NA' and therefore quality of data needs to be improved. In some instances it was noted that denominator was missing. It was also noted that analysis and use of data was very limited.

Mother and Child Tracking System (MCTS)

The team observed that Maternal and Child Tracking System is in its very early stage of implementation. State needs to organize the orientation and training sessions at all levels and provide support for effective implementation of the MCTS. State may like to have a provision of usage fee for ASHA in order to motivate her to implement the SMS alert system.



Maternal & Child Tracking System: MCTS operationalized and 73000 mothers and 44000 children have been registered in last two years. The state needs to focus on analysis and use of the MCTS data at the district and block levels. A more intensive and continuous capacity building programme on MCTS needs to be planned for the BPMs. Frequent load shedding and poor internet connectivity is a major problem.

Health Management Information System: Facility level data entry is being undertaken.

Use of HMIS data needs to be improved at the district levels. Analysis of the data and its use needs to be emphasized by the CMOs.

Recommendations

1. There should be a rapid shift of effort to use of information and related data quality issues.
2. There should be greater attention of the Centre to setting up of data policy, data quality standards, and standards of inter-operability with more autonomy to states to feed their own data and to include AYUSH data.
3. HMIS data should be analyzed at all levels and should be used for planning and decision making. Root Cause Analysis should be done for any deterioration in indicators and time bound action plan should be formulated to take action. The focus needs to be on “hands-on” training for HMIS from district to block levels on priority.
4. Speed of the central server needs to be increased. Access to back generated reports to be given to states (at least for administrative log-in). Query builder needs to be provided so that states can generate any reports in any combination. Readymade dashboard to be provided in MCTS portal for help in analysis.
5. Considering huge amount of data that need to be entered under MCTS along with huge cost and time of manpower related with it, it may be worth testing this more extensively in few selected districts across the country and solving most of the constraints. Then based on this experience detailed specific strategies/solutions for country wide application or groups of states with similar problems can be worked out. The districts where MCTS has been rolled out comparatively with more success can provide secrets of success.
6. There should be a clear base paper on MCTS that spells out:
 - a. How MCTS will work to improve maternal survival.
 - b. What are HR requirements.
 - c. How much time service provider like ANMs are expected to provide to this work and what benefits service providers would get.
 - d. Software requirements and level of computerization.
 - e. Integration with other systems.

"NRHM is a vehicle to finance health systems strengthening in the states. It is an umbrella programme integrating all different funds flow mechanisms of various national programs under one common channel. The Financial Management under NRHM is designed to ensure adequate and smooth funds flow through society route at all levels with efficiency and transparency."



Financial Management

Financial Management

Progress Under NRHM

NRHM releases by components from 2005–06 to 2010–11 (Rs. in crore)

S.N.	Programme	2005-06		2006-07		2007-08	
		Release	Exp.	Release	Exp.	Release	Exp.
1	RCH-II	898.84	253.66	1351.70	885.19	1715.94	1879.22
2	Additionalities under NRHM	962.13	40.76	2053.71	430.91	3132.74	1526.85
3	Routine Immunization	150.68	37.79	73.93	87.53	126.78	120.03
4	P.P.I.	312.97	307.42	451.76	417.89	421.59	352.96
5	Infrastructure Maintenance	1545.62	2012.69	1195.26	2026.43	2317.28	2353.10
6. National Disease Control Programmes							
a	I.D.S.P.	32.66	5.80	8.60	26.49	20.88	24.80
b	N.I.D.D.C.P.	1.32	1.25	0.97	1.01	3.49	2.18
c	N.L.E.P.*	17.12	31.62	30.03	32.57	22.65	22.82
d	N.P.C.B.*	86.82	79.76	102.81	100.27	153.09	133.39
e	N.V.B.D.C.P.*	243.94	243.94	289.45	289.42	341.80	341.81
f	R.N.T.C.P.*	181.65	189.47	216.08	220.98	252.63	252.91
Grand Total		4433.75	3204.17	5774.30	4518.68	8508.87	7010.07

Note: * Denotes inclusive of kind grants.

Expenditure for the F.Ys 2009-10, 2010-11 & 2011-12 (upto 30.09.2011) are provisional

Release for F.Y. 2011-12 is upto 25.12.2011

The above Releases relate to central Govt. grants & do not include state share contribution.

The NRHM funds have been released to states through the state health societies as four components- RCH flexi-pool, Mission flexi-pool, Immunization (including Pulse Polio) and the National Disease Control Programmes. Under RCH flexi-pool the total amount released to states in these six years was Rs. 14,488 crore and under Mission flexi-pool the total amounts released was Rs. 16,265 crore. For Immunisation and Pulse Polio, a sum of Rs. 2,728 crore has been released. In these six years, for disease control, the amount released was Rs. 4,667 crore. In addition through the treasury route, Rs. 14,250 crore was released for infrastructure maintenance.

Rate of expansion of financing did not keep pace with expectations. The annual expenditure in 2010–11 was to reach Rs. 55,000 crore. The NRHM Framework for Implementation estimated an expenditure of Rs. 175,000 crore over seven years. But in fact we have reached only Rs. 50,000 crore or less than one thirds of this projected amount. Even including the 2011–12 expenditures we would achieve about Rs. 75,000 crore only. In many areas,



NRHM releases by components from 2005–06 to 2010–11 (Rs. in crore)

2008-09		2009-10		2010-11		(05-06 to 10-11)	(05-06 to 10-11)
Release	Exp.	Release	Exp.	Release	Exp.	Total Release	Total Expenditure
2955.83	2928.80	3327.91	3124.69	3443.80	3715.93	13694.03	12787.49
2597.44	3256.08	3365.65	4777.37	4153.60	5932.89	16265.27	15964.86
114.58	148.36	150.03	176.74	178.20	224.12	794.20	794.57
618.02	461.55	593.46	452.61	369.88	429.58	2767.68	2422.01
2527.16	2965.29	3139.28	3845.70	3764.57	4850.19	14489.16	18053.41
National Disease Control Programmes							
7.01	17.78	23.05	25.68	32.26	31.55	124.47	132.10
5.40	3.53	2.11	3.75	4.83	3.97	18.12	15.69
35.53	29.46	30.95	34.97	31.70	33.64	167.96	185.07
230.08	223.21	235.55	188.20	184.07	220.79	992.43	945.62
272.90	272.33	311.16	300.30	380.51	338.28	1839.75	1786.09
261.15	258.71	291.03	286.04	327.70	335.31	1530.23	1543.42
9625.09	10565.10	11470.18	13216.05	12871.11	16116.25	52683.29	54630.33

for example the ASHA programme, we find the same pattern- the total expenditure across five years is equal to the projected expenditure across two to three years. Physical achievement in comparison to expectations may also have the same ratio. All of this has to be seen together.

Main Observations

- ◆ Expenditures have picked up across states, especially under Mission flexi-pool, showing a greater understanding of systems reforms and translating the reform agenda to specific actions as per local need and capacity.
- ◆ Integration of various programs under NRHM and financial decentralization, have helped in targeting the local problems (especially related to shortage of consumables, minor repair, mobility support, etc.) in terms of adequacy and timeliness in a comprehensive manner.
- ◆ States have, more or less, put in place the financial professionals at state, district, block, and (in some states) at the PHC level. This has greatly helped the absorption of funds and tracking expenditure in details.
- ◆ States have adopted e-transfer of funds, speeding up funds flow. Along with adoption of Tally ERP-9 software, it is revolutionizing the way program finance is being managed on such a large scale as in NRHM.
- ◆ Compliance with statutory audits have established that in spite of off-budget (society) route, such flexible funds are transparent and accountable, thus countering the criticism from some quarters against off-budget transactions.

- ◆ Huge amounts of funds blocked as advances under civil works and in VHSC and RKS accounts. In such a scenario, the lowest performing unit (health facility or block) holds the entire system to its pace and in the process, blocks funds flow the good performing units (as funds flow is hindered in the absence of UCs from all units).
- ◆ There is increased workload among peripheral workers regarding book keeping and making vouchers, along with increased load of program activities. This is creating problems in expenditure tracking and timely submission of UCs. At the block level many accountants double as data entry operators or programme managers which is becoming difficult in view of huge increase in burden of data entry work.
- ◆ Due to inadequate coordination in many instances it is not clear to whom the funds under mainstreaming of AYUSH component are to be released resulting failure or delay in the implementation of planned activities.
- ◆ The accounts and finance staff, especially at the district and block levels) are mainly fresh graduates with very little experience and knowledge of health systems and public health issues. But all training of such had focused only on Tally ERP-9 software. They also need to be oriented to the peculiarities of public systems and the health sector.

Findings from the States

ASSAM

- ◆ Electronic transfer is going smoothly in the State. A pilot project is going to implement in Kamrup District for E banking. It is proposed to complete rollout E-Banking at State Health Society by January 2012.
- ◆ Tally is installed properly but not maintained by finance personnel on regular basis due to lack of response by Tally Solutions in some places. Most of the places Tally ERP 9 was implemented and used regularly. The financial personnel are not aware of generating report like Bank Reconciliation Statement, which they are preparing manually now.
- ◆ Auditing procedures are to be improved. They had concurrent audit which is done on quarterly basis and statutory audit procedures. FMR, SOE, SFP, etc. related internal controlling documents are being used to see the funds position. There were no physical audit of Assets, but it should be implemented. Stock audit is also not yet done.
- ◆ Regular updation of HMIS was not done because there were some difference between the formats given by the Ministry and HMIS, such as under NRHM Additionalities the Point no. B3 shows Annual Maintenance Grant in Ministry format and according to the HMIS format the B3 shows Hospital Strengthening. Thus the format must be uniform of Ministry and the HMIS. So, HMIS updation is not regular.
- ◆ They did not maintain the records in an organized way. The vouchers and supporting bills were being kept in loose bunches which is not according to the Financial Guidelines. The timeliness of the reports is average and State and District authorities try to prepare and provide the reports in time.
- ◆ The model accounting hand books are not yet received by some District/sub-district because of lack of supply. So, it is the barrier to make the books of accounts uniform.
- ◆ Procurement Manuals have been framed and are in under process of approval. Procurement is being made as per procurement guidelines.
- ◆ The activities carried out from State Contribution commensurate with NRHM activities.
- ◆ Cheque scarcity is there but if they try to coordinate with the banks, they will provide the cheques bundles. The cheques were printed by the finance personnel by the help of computer. This step may help to decrease manpower and promote efficient working.

BIHAR

- ◆ There is 100% Usage of customized version of Tally ERP-9 software upto District, PHC and Block level. All 533 PHCs/Blocks under 38 Districts duly covered under Tally ERP-9. Smooth Electronic transfer of funds upto PHC level, which saves a lot of time. SOE's are upto date till 31st October, 2011. All JSY Records and Photographs of beneficiaries maintained properly. Cash Book, Stock Register, Cheque issuing Register, Cheque Book, receiving Register and Advance Register are maintained upto date and properly. Internal Auditors team constituted comprising 4 officials.
- ◆ Only 8 districts out of 38 have uploaded the financial monitoring report on the HMIS Portal. As per report Internet is quite slow due to which uploading at NRHM Web Portal becomes time consuming. Concurrent Audit has not improved the internal control system as Bank accounts are not being reconciled on regular basis. The intervening period for Reconciliation varies from 3 months to 8 months. Further there is no periodic reconciliation of advances and age-wise analysis of advances.
- ◆ The state has issued detailed guidelines on delegation of financial and administrative powers based on Gol guidelines to all districts on 15-12-2009 which are being followed at district and state level.
- ◆ RPMU has already been authorized to conduct training to improve capacity building on regular basis of all the DAM and Block Accountants. Tally Training has already been conducted twice upto PHC level as regards Accounts training all the RPMU's have already been instructed for orientation of the Accounts personnel, funds have been provided for 2011-12 besides funds being allocated for exposure visit of finance personnel is in process.
- ◆ There is inordinate delay in submission of SOE from Sub centre and VHSC to PHC which results in higher unadjusted advance reporting and low funds utilization. No funds have been released to VHSCs during current year. The main reason for delay in funds release to VHSCs is non-submission of utilization Certificates since 2009. State needs to issue instructions to districts for quick settlement of outstanding advances to VHSCs before release of funds.
- ◆ The financial integration of NDCPs with state health Societies has been achieved and a single statutory auditor is being appointed by the State to carry out statutory audit of State Health Society and NDCPs and a consolidated FMR is sent covering expenditure details of all NDCPs.
- ◆ To bring out the uniformity in the Books of Accounts, Model Accounting Handbooks (Software) has already been made available to districts with the instruction to make available to all the PHC's. Printing of Hard Copy of Model Accounting Handbooks is in process and will be made available by the end of December 2011. Model Accounting Handbooks published by the Ministry have been circulated upto district level but not available at sub-district levels. State should distribute Accounting Handbooks translated into vernacular language to sub-district accounting staff for easy understanding and frequent usage.

CHHATTISGARH

- ◆ The state of Chhattisgarh has been showing a very erratic trend since the beginning of NRHM, as far as funds utilisation under NRHM is concerned. The total NRHM funds utilisation (including the flexipools and disease control programs) were consistently more than 100% of the releases in the initial three years, which fell to 65% in 2008-09, increased to 91% in 2009-10 and again fell marginally to 87% in 2010-11.
- ◆ The erratic trend of expenditure under NRHM in Chhattisgarh becomes more pronounced when we look at the RCH and Mission flexi-pools separately. Under RCH flexi-pool, Chhattisgarh started with 93% expenditure (of releases) in the very first year, which fell marginally to around 80% in 2006-07, then suddenly increased to almost double the release in 2007-08, then stabilising around 80% in the two subsequent years and

climbing to almost 90% in 2010–11. In contrast, under the Mission flexi-pool, the state started with a low rate of expenditure (of the releases) of less than 20% in the first, which suddenly shot up to 66% in 2006–07, then kept falling to 20% and less in the two subsequent years, followed by a spurt of around 60% in 2009–10 and almost 100% of releases spent in 2010–11.

- ◆ The ERP 9 is used only by four districts (Janjgir, Durg, Dantewada, Raipur). It is planned to cover all 18 districts by end of Dec. 2011. The state is not working towards any other software for Accounting. In Kanker District it was observed that the Tally ERP-9 software had expired on last year at district and block levels. In Kawardha, Tally was installed only at the DHS level.
- ◆ The integration of vertical programs is yet to fully completed, but the process had begun.
- ◆ Longstanding Advances mainly seen in the JDS/RKS Grants, AMG, Untied funds, VHSCs and Infrastructure (Constructions) activities. The CRM team observed that these are mainly due to the staff at lower level facilities and VHSC being unaware of how to spend the money and book the expenditure. Regarding constructions, it was observed that the funds are given to other agencies (like PWD) and these it becomes difficult to obtain UCs from such agencies. Also, the shortage of accounts personnel in the CHC, PHC causes problems in obtaining UCs from the periphery.
- ◆ Almost 46% of annual budget blocked in civil works (28%), VHSNC (6%) and JDS (10%) accounts as “advance outstanding”, causing problems in funds flow.

HARYANA

- ◆ Funds transfer from State to Districts is done through electronic channels (RTGS) and funds are transferred on the same day. From District to CHC also funds are transferred electronically in District Hisar but funds from CHC to PHC and sub-centres are transferred through cheques, which takes about 15–20 days time in clearing.
- ◆ Tally ERP 9.0 customized version has been installed and implemented in all Districts and State office and running successfully. State is planning to install Tally software on all CHCs within the current financial year. All DAMs have been trained in Tally and training of Account Assistants is in currently in progress. The response of TSPL has been good in trouble shooting of problems. All accounts personnel have to appear in a test on Tally accounting conducted by State Head Quarter failing which their contract are not renewed.
- ◆ The state has issued detailed guidelines on delegation of financial and administrative powers based on Gol guidelines to all districts on 15-12-2009 which are being followed at district and state level.
- ◆ Training of all DAM in Tally ERP 9.0 customized version has been completed and training of Accounts Assistants posted in districts and CHCs is currently in progress and likely to be completed within current financial year. State has signed an MoU with Institute of Public Auditors of India (IPAI) to visit all districts and conduct on the spot training of district accounts staff and to ensure that all necessary books of accounts are maintained and updated regularly.
- ◆ There is inordinate delay in submission of SoE from sub-centre and VHSC to PHC which results in higher unadjusted advance reporting and low funds utilization. Due to high unadjusted advances of Rs. 32.03 crore with districts as on 30-09-2011, the funds release of AMG, UTF and RKS grants was withheld to many PHC and sub-centres. The funds release to PHC and Sub centre takes upto 45 days due to sanction procedures and unsettled advances. No funds have been released to VHSCs during current year. The main reason for delay in funds release to VHSCs is non-submission of utilization Certificates for last three years by VHSCs. State needs to issue instructions to districts for quick settlement of outstanding advances to VHSCs before release of funds.
- ◆ As on 30-09-2011, the total outstanding advances to the implementing agencies were of Rs. 105.97 crore out of which Rs. 31.68 crore were under RCH, Rs. 38.64 crore were under Mission Flexipool and

Rs. 31.99 crore under other Programs. This is due to delayed release of funds by the state to districts and non-submission of SOE by the implementing agencies. To avoid delays, State has now started Flexipool method instead of activity-wise release of funds. State is also required to submit reply to the management letter and the audit para on long standing overdue advances as pointed out in the statutory audit report for 2010–11.

- ◆ State has preferred to rename RKS as SKS (Swasthya Kalyan Samiti). There are 487 registered SKS in the State out of which 39 SKS were in district Hissar. As per the user charges report compiled by the State, funds of Rs. 34.45 crore were available under this head in the State out of which an expenditure of Rs. 7.44 crore was reported upto Sept. 2011. The SKSs were periodically depositing income from user charges into separate bank accounts but were not utilizing it. SKS need to deposit income from user charges into bank account on daily basis. The community participation was found to be low in the monthly meetings of SKS. State is advised to issue revised guidelines to SKS for effective funds utilization in view of revised instructions issued by the Ministry in 2010–11.

HIMACHAL PRADESH

- ◆ On the whole the accounts management and financial management is satisfactory. Adequate staff have been deployed at state and district and block levels and utilisation certificates and auditing are on the whole regular. One important positive development is the recruitment and deployment of block level accounts managers. These contractual managers not only maintain block accounts, they also visit the PHCs in their block and help the PHCs maintain accounts. This has no doubt contributed to much better expenditures at this level.
- ◆ There is however a problem that the same block accounts manager is also asked to undertake block level data entry work. But with the increased load of pregnancy tracking and facility based reporting, the work becomes too much and both accounting and data entry suffers.
- ◆ The Untied Funds and Annual Maintenance Grant have not been received by any of the facilities in the District for the year 2011–12. These funds when released should be treated as advance and should only be booked after provision of the FMR/SOEs and Utilization Certificates from the facilities- a financial rule that needs to be adhered to.
- ◆ The Janani Suraksha Yojana (JSY) beneficiaries were found not being paid at the facility where the delivery has taken place. Instead, cash is made available to the Health Worker (HW) referring the case to the higher facility like CHC or DH. This is causing delay in reaching of the benefit. Where the cash is paid at the time of delivery at the facility – the problems are much less. Check payment is not insisted on- since banks are far and difficult to access.
- ◆ Regular training of finance and accounts staff needs to be undertaken by utilizing the E-training modules and the Model Accounting Handbooks. This would bring uniformity in accounting. There is transfer of funds between districts which is not desirable.
- ◆ In terms of financial management, the main issue is the amount of advances lying with the HPPWD for civil works. But other than for this problem with civil works utilisation of funds is better. As the expenditure on civil works gets booked the picture

on absorption of funds improves. One problem is that the state gets many plan areas approved by the centre and then it gets turned down at the state level- especially in manpower. This leads to sanctioned funds not getting spent. This is clearly to be avoided- and the sanction of the state government should be taken before putting it up to the central government.

JHARKHAND

- ◆ Electronic fund transfer from state to district, but through cheques from districts to block/health facilities. Tally ERP.9 is installed at state and some districts.
- ◆ No training measures have been adopted by the state to improve capacity building of finance personnel of the state. However, training on Tally ERP.9 has been given to the District Account Manager (DAM) at state level in the month of October, 2011.
- ◆ Utilization Certificates of Rs. 46.53 crore under RCH Flexipool and Rs. 89.20 crore under Mission Flexipool is pending for the amount sanctioned during 2010-11. State has informed that the collection of UCs from the district shall be speed up.
- ◆ There is low utilization of funds on some activities like family planning, ARSH, referral transport and routine immunization (RI). Reason for the low utilization is that number of health facilities are in remote areas.

ODISHA

- ◆ E-transfer of funds is in place up to GKS level. The main account is with ICICI Bank and programme accounts at district and block level are with SBI.
- ◆ Induction training completed, however on-going capacity building training has yet to be provided to the District Accounts Manager, Block Accountant and Data Assistant.
- ◆ Unspent Balance under EAG is still pending with the State.
- ◆ The State Programme Management Unit, District Hospital, District Health Society, Bargarh and CHC, Dava, accounts are being maintained through Tally soft ware other than the Authorized Version. This has at places resulted in the data crashing resulting in books being maintained manually.
- ◆ Funds are not being received timely at sub-district Hospital, Padampur and PHC (New), Paikmal. Funds were received only on 19-08-2011 and 27-09-2011 respectively. It appears that the delay is at the district level.

SIKKIM

- ◆ The electronic funds transfer system via. RTGS is in place to transfer funds from the State Health Society to District Health Society.
- ◆ Tally ERP 9 software has been procured and installed in all 24 PHCs, District Hospital and State Headquarter. The firm provided two days training to the Accounts Staff. However, the short training imparted was not sufficient. Therefore, the State Health Society has decided to organize a 15 days training during the month of December, 2011. Technical support from Tally Solutions Pvt. Ltd. will be available during the training.
- ◆ The FMG data is compiled at the district level and is entered into the HMIS portal. No time lag is observed in the filing of SOE and FMG and with the receipt & disbursement of funds. State's contribution to the kitty needs improvement.
- ◆ User charges collected from facilities are not used for facility improvement but are deposited to the State exchequer. RKS funds are not reaching the institutions on time. Other untied funds are disbursed on time and their utilization is properly documented.

UTTARAKHAND

- ◆ State has not reported the physical progress of any program and the expenditure of the NDCPs in the FMR.
- ◆ Fund transfer to VHSC Account under Untied Fund is treated as expenditure.
- ◆ Tally ERP 9 software is uploaded at the district and a two day training had been imparted to the District Accounts Manager/Block Accounts Manager but the software is not being used yet at district or block level.
- ◆ Statutory audits of the District Health Society for Financial Year 2010–11 has been completed, but the audit reports are yet to be received by the district.
- ◆ Concurrent Auditor has been renewed for the financial year 2011–12. No audit reports have been submitted to the DHS till date.
- ◆ Training to the financial personnel are being conducted but are not adequate, TALLY ERP-9 training is given by the state DAM & BLA but no data entry is being made till date during this financial year.
- ◆ At District level, districts are not maintaining the trial balance, advance register, journal register, budget receipt and control register, fixed asset register and BRS is not in the prescribed format. At block level cash book, cheque issue register, journal register, BRS for any month is not being maintained properly.
- ◆ Disbursements of funds from district level to the block level are made without considering the opening advances as on 1st April.
- ◆ Disbursements of Untied Fund to VHSC are not made directly to the account of VHSC, as from block level funds are being transferred to Block Development Officer's Account and with instructions to transfer the same to VHSC Account.
- ◆ Districts have not transferred the Annual Maintenance grant to the CHC, PHC till date.
- ◆ There is no integration between the NDCPs staff and DHS because the financial report does not include the NDCPs expenditures and is sent separately.
- ◆ Advance register are not maintained so it is not possible to find out the Long Outstanding advance at district level.
- ◆ There are no committed liabilities reported by the district to SPMU but district has made the expenditure pertaining to the previous year under NGO and MNGO of Rs. 4,93,406.00, NSV Training of Rs. 10,916.00.
- ◆ RKS funds have been released to all facilities. All facilities except the District Hospital have utilized over 50% funds so far. Utilisation of untied funds is also over 50%.

UTTAR PRADESH

- ◆ The total approved budget of the State for financial year 2011–12 Under NRHM is Rs. 2462.62 crore against which the expenditure has incurred by the State up to Sep 2011 is Rs. 850.38 crore equivalent to 35% of approved PIP. The State has only 20.57% expenditure under RCH flexible pool against the approved SPIP of Rs. 1073.75 crore and only 18% expenditure reported under Mission Flexible pool against the approved SPIP of Rs. 645.45 crore. The reasons of low utilization of funds are pending payment of JSY beneficiaries, ASHA incentives and advances outstanding at various agencies.
- ◆ There is huge manpower shortage in the State. Out of 71 districts 22 positions of District Accounts Manager are vacant and vacant position of Block accountant in 823 blocks needs to be filled the vacant post. One post of Sr. Finance Manager, 2 post of Manager Finance, 2 post of accountants and 2 posts of internal auditor are vacant at State level.

- ◆ State has implemented the concurrent audit system in 2009–10 and 2010–11. Concurrent audit has not been conducted for the 2011–12. Appointment of Concurrent audit is under process from State level. State is going to appoint 9 auditors from State level for all 72 District Health Society.
- ◆ Electronic funds transfer system is being used in the State up to CHC/PHC level. Activities wise funds transferred under NRHM to District Health Society. Timely funds are not transferred from the State Health society to District Health society for implementation of RCH and NRHM activities. JSY and ASHA incentive is pending for payment at District Hospital and CHC/PHC level. District Accounts Managers are not properly monitor the release of funds and outstanding advances.
- ◆ Training to accounts personnel is not provided at District level and State level. CHC/PHC accountants are not provided Accounts training for maintainly the books of accounts on double entry system.
- ◆ Tally software ERP9 procured and training has been conducted up to district level. Tally software is working properly at State and District level. Print out of tally ERP9 accounts are not seen at District level. Approved SPIP has not uploaded in software at District Health Society level.

Recommendations

1. Cross training of technical/public health staff in basics of financial management and orientation of finance staff in health issues, to develop better coordination in achieving physical and financial progress. The regular government staff (especially accounts and finance personnel) also needs to be oriented to the special nature of NRHM and its special accounting needs.
2. Expenditure units (health facilities, blocks and districts) that have more needs (larger population, caseload) and greater capacity (reflected in terms of low outstanding balances) should get more funds. This needs to be accompanied by building the capacity of other non-performing and under-performing units. Such an arrangement would be possible if there is a shift away from strictly “norm based” financing to “differential financing” within broader norms (parameters with a defined range rather than strict and definite parameters).
3. In future, the overall NRHM funds may be divided into two separate streams of Revenue and Capital accounts (similar to treasury route), wherein releases of funds for items in capital account (civil work, procurement, etc.) may flow separately over an extended time-frame (more than a year). This will ensure funds for routine activities like JSY, VHND, ASHA, salary of contractual staff, etc. are not held up due to non-submission of UCs on items with larger expenditure cycle (like civil works and procurement).
4. Increase focus on supporting peripheral institutions (RKS and VHSC) in reconciling their funds position. This might be done by (a) more accounting staff at the block level, and (b) increasing the scope and resource support for Concurrent Audit to cover a larger sample of peripheral institutions.
5. Absorption of funds is a function of two aspects - (a) the choice/mix of programmes and activities that are taken up for financing, and (b) the financial management. A critical appraisal of the last 5 CRMs show that if (i) the accounting staff and related structure is put in place, (ii) there is differential financing, as different from norm or quota based financing, and (iii) there is a separation of capital and revenue funds (items with large expenditure cycle like civil works separated from routine and fast flowing items like salaries, JSY payments, etc.) - the financial management is no longer a limiting factor. Some attention has been given to the first (staff), but the other two needs to be addressed.

“District Health Action Plan (DHAP) is the main guiding document and instrument for planning, inter-sectoral convergence, implementation and monitoring of activities under NRHM which is formulated through a participatory and bottom up planning process and it should be as far as practicable the aggregation and consolidation of the village and health block plan responsive to health care needs of local community.”



Decentralized Health Action Plan

Decentralized Health Action Plan

Progress Under NRHM

	Year: 2006	Year: 2011
No. of VHSNC established	NA	483496 (i.e. 76% of total villages) (RHS, 2010)
Total No. of villages	6,40,000 (as per 2001 census)	6,38,000 (as per 2011 census)

Main Observations

- ◆ District Health Action Plans are made for most districts but their quality is varied. In many states, the quality has been reported as poor. Involvement of non-state actors and stakeholders limited in preparing for DHAP and their participation varies across districts. Use of HMIS district reports in the planning process is improving in many states- but there is little available information and its use in intra-district differences.
- ◆ Block health action plans as separate documents have not emerged though most district plans are aggregate of block plans. There is no plan to address intra-block differences in health and social status through specific activities or programmes.
- ◆ Majority of districts visited had functional VHSCs. Often ANM/AWW is the co-signatory and are functional in all states. These are sited of convergent action and discussed there. The village health plan is not yet institutionalised anywhere – and there are no clear models or clarity in its role and utility.
- ◆ There is increase utilization of untied funds for VHSCs and RKS. The involvement of PRI in health planning process and in the function of VHSNC and RKS is limited.
- ◆ Of the 15 states visited the only state with Community monitoring was in Karnataka and starting up in Bihar.

Findings from States

ANDHRA PRADESH

- ◆ District Plans are made but their quality is poor. Situation analysis and participatory planning is missing with all targets and activities for districts being assigned by the State.
- ◆ Community participation through VHSNCs is largely taking place. Funds are available with these committees and are being utilized for sanitation (purchase of bleaching powder).
- ◆ ASHAs are creating demand for Maternal, Child Health and Family Planning services.

ASSAM

- ◆ DHAP is available for each district in the state though there is no existence of separate block health plan. District Plans included grants to NGOs on health education and BCC programmes in schools. Special focus on school programmes in Madarasas. PPP programme in a tea estate for the workers is also supported.
- ◆ PRI participation in VHSCs is good and funds for the same are utilised. RKS funds are also well utilised.
- ◆ There is no community monitoring mechanism and it is yet to be initiated.

BIHAR

- ◆ The DHAP and BHAP are well prepared and available.
- ◆ Plans are not implemented due to budgets not matching what was asked for- especially in infrastructure. Technical assistance is also poor and administrative support is weak.
- ◆ Though there are joint accounts for the untied fund of HSC and fund for VHSNC at panchayat level; there is poor utilization of funds. RKS fund has not been utilized due to lack of clarity on the guidelines.
- ◆ NRHM has recently been included into the District Vigilance and Monitoring Committee.
- ◆ The state has identified a nodal agency (the Population Foundation for India) for community monitoring in eight districts.

CHHATTISGARH

- ◆ District health plans are made but focus is often only on the budget sheet.
- ◆ State has plans for reaching the unreached, backward and difficult to reach areas through a decentralized service provision package initiated by Field NGOs active in the RCH sector in the district. 14 PHCs are planned to be contracted to an NGO for running in difficult areas.
- ◆ Had a good community monitoring programme earlier, but this has been given up.

GOA

- ◆ There are no district plans made. There is no district administration or district programme management unit and facilities are linked directly to state office. Only facilities project their demand directly to the DHS which get incorporated into the PIPs.
- ◆ VHSNCs have been formed in the State as per norms of which a few of VHSNCs are active and the members have been oriented by the SPM in meetings held at the sub-centres informally. A positive initiative by VHSNCs is that most VHSNCs have undertaken cleanliness drives in their areas. The ANMs and extension educators in the State were made responsible for persuading the VHSNCs to take up the drives with an aim to combat the issue of vector borne diseases in the State which is a best practice.
- ◆ The functioning of RKS is weak in most places, wherever constituted.
- ◆ District Vigilance and Monitoring Committee has been constituted. There is high public pressure to perform and there is in built system for community monitoring.

GUJARAT

- ◆ District health Plans are made in all districts- but funds flow does not match this. There is no platform for participation of various stakeholders in the planning process of the block and districts health plan.
- ◆ Village Health Plans with the involvement of VHSC is non-existent though 17433 Village Health Sanitation and Nutrition Committees have been formed in the state and joint accounts are in place. The untied fund given to the VHSNCs is utilized to undertake various activities in the village.



HARYANA

- ◆ District health plans were made, but these were not examined for quality and are not in use.
- ◆ Village Health Sanitation Committee (NRHM) and Village Level Committee (VLC) have been merged in the State. 6280 VHSC/VLCs formed for 6955 revenue villages. Out of Rs. 628.00 lakh sanctioned there is a 86.14% utilized in 2010–11. There was no periodic review of activities and expenses required for VHSC and RKS.
- ◆ There is no community monitoring programme attempted.

HIMACHAL PRADESH

- ◆ The districts have been regular in making district plans and plans seen were of good quality.
- ◆ Allocations do not go according to plans and this cause considerable disappointment to those who have been involved in very elaborate and careful planning. Funds have not been provided in line with district plans as installments. Rather funds are given as per budget line items. The typical example is non utilization of funds for co-location of AYUSH facilities in nine CHCs in Kinnaur and Hamirpur districts.
- ◆ The use of HMIS data for planning has improved considerably. There is not much clarity on how to use facility level reporting. IDSP data is not used for district planning.
- ◆ There is no community monitoring programme in place in the state.

JHARKHAND

- ◆ Districts have been regular in making health plans. However allocations do not go according to plans.
- ◆ There are VHSNC with bank accounts, but it is not found functional. VHSNC does not consist of PRI members since it was formed prior to panchayat election in the state. Fund utilization is not transparent to the PRIs. Many Sahhiyas, however, reported that the money is spent on purchasing insecticides; repair of hand pipe etc. but the issue of utilization of untied fund is never discussed and reported at the VHSC and this has caused resentment.
- ◆ At the HSC level as well, there is no involvement of PRIs. The bank account at Sub-centre level is jointly operated by ANM and Aganwadi Worker and there was better utilization of untied funds although the timeliness of fund received is a matter of concern.
- ◆ RKS/Hospital Management Committees were existent though it is not properly active. The planning and supervision of NRHM activities at the local level has been very weak.
- ◆ A good practice of Jansamvad was started to redress the grievances of all concerned and general public, but not on a sustainable basis.
- ◆ There is no community monitoring.



KARNATAKA

- ◆ The District Health Action Plan is prepared in consultation with all the block/taluk officers. Requirements of all the facilities of the district were collected and it made the basis for DHAP.
- ◆ Financial allocation from the State is made on the basis of the DHAPs.
- ◆ Block health plans are in fact budgets of the block and not plan per se.
- ◆ VHSCs have been formed in 25,200 revenue villages out of 27481 inhabited villages. Joint accounts opened with Panchayat member and ASHA as co-signatories. Untied funds of Rs. 10, 000 released through e-banking. ANM drawing the whole untied fund of Rs. 10,000 at one go. VHSCs have not got the full confidence of community though there are complaints of inadequate transparency and capacity to spend.
- ◆ Community Monitoring is functioning well.

ODISHA

- ◆ The decentralized institutional mechanism of ZSS (District Swasthya Samithi/Zilla Swasthya Samithi), BSS (Block Swasthya Samithi) and GKS (Gram Kalyan Samithi) are functioning under NRHM and are actively contributing to the decentralized local health action plan. District plans are regularly made and adequate.
- ◆ CARE, an international NGO, is supporting the sensitization of community persons on health issues and also reviewing GKS in a number of villages. Such NGO support to VHSCs is a good model and could be scaled up in other districts.
- ◆ The facility-level RKS are active, in some cases making very effective use of the resources available to them. Although some facilities had "suggestion boxes," there is little evidence that a grievance redressal system is effectively functioning.
- ◆ There is no community monitoring programme in the state.

RAJASTHAN

- ◆ District plans are in place. Block plans for RCH are incorporated in them.
- ◆ Realignment of DHAPs to sanctioned funds is not carried out.
- ◆ VHSCs formed in all villages – but at G P level accounts and control.
- ◆ Money is being deducted from untied funds for some centralised district expenses related to training and health communication expenses.

SIKKIM

- ◆ The district plans and block plans are in place and are of good quality.
- ◆ The plans are majorly made by a team at each level and the involvement of other staff or members is very limited. Use of HMIS data in planning is very limited.
- ◆ The State had attempted preparation of Village health action plans in 2007. Currently what are being prepared are the sub-centre plans which are compiled at the block level. The SC plans are actually formats which every sub-centre fills and sends without prioritizing the requirements based on the specific needs of the sub-centre or the villages that it caters to.
- ◆ VHSNC are functioning (641 units) and funds are available on time. The involvement of PRI is good.
- ◆ The Community monitoring is yet to take off. The district level Vigilance and Monitoring Committees are also not formed.

UTTAR PRADESH

- ◆ District health plans were available for each district, however these did not seem to be developed using inclusive or participatory processes. Fund flows are not according to plan.
- ◆ Though VHSC are constituted but their functions are relatively weak. The community at large was unaware of the existence of the VHSC and regular meetings did not seem to be held and how decisions on fund utilization were made was unclear. The membership of the VHSC was also not broad based to include community and civil society representatives and those of marginalized groups.

UTTARAKHAND

- ◆ District Plans are in place. Block plans need to be integrated into district plans. District HMIS data is used but facility level data, needs to be analyzed and utilized for planning.
- ◆ Each village has nearly 3 to 4 Gram Panchayats and joint accounts are in place and the signatories are Gram Pradhan and Gram Sevak Adhikari, whereas ANMs have been left out of this process.
- ◆ VHSC meetings need to be held regularly. The VHSC members participation in VHNDs is weak. The VHSCs need to involve ASHAs and ANMs in the decision making processes pertaining to the plans for village level activities as well as planning for the use of untied funds.
- ◆ Village health plans are not being made.
- ◆ No community monitoring programme in place.

Recommendations

1. The district plans as proposed by the District Health Society (DHS) and as modified by sanctioned funds must become a public document owned by the DHS. The district health plan must remain the actual guide for program management and review. HMIS and IDSP data need to be analyzed and utilized for planning at all levels.
2. The process of planning must involve consultation with different stakeholders and understanding of the health situation as gleaned from village health planning exercises. A platform should be developed for inclusive, meaningful and proactive participation of stakeholders, non- State actors and community representatives in the planning process of block and district health action plans.
3. Active involvement of PRI members in the functions of VHSNC should be ensured by district and state authorities. PRI members must be involved in preparation of health plans and planning and management of Rogi Kalyan Samitis (RKS). Capacity building and orientation of members of VHSNC, PRI and RKS is the need of the hour.
4. VHSNC and village plans should focus on social determinants and preventive action and access to care of marginalized sections in states.
5. District Vigilance and Monitoring Committee needs to be constituted in most states.
6. Community monitoring by VHSNCs, Community Based Organizations, supplemented by NGOs is a model that has shown positive results in states where it has been tested. This needs to be persisted with.

“The NRHM mandated mainstreaming of AYUSH and revitalizing Local Health Traditions by co-locating AYUSH doctors at the Public Health facilities. The prior aim of this strategy was to provide choice of treatment to the patients as well as to use the AYUSH personnel in implementing the National Health Programmes. The IPHS standards provides for AYUSH specialists at the DH and CHC as well as MOs with AYUSH pharmacists at all levels. NRHM intended to train community and outreach workers also in AYUSH and establish herbal gardens in the premises of sub-centre and PHC.”

AYUSH



AYUSH

Progress of AYUSH at the National Level

S. No.	States under 5 TH CRM	Health facilities in the State				No. of AYUSH doctors sanctioned	No. of AYUSH Doctors In position			No. of AYUSH paramedics		
		DH [^]	CHC	PHC	AYUSH Hosp/Disp.		Regular	Contractual	Gap	Sanctioned	In position Reg/Contr	Gap
1	Andhra Pradesh	15	281	1624	NA	NA	NA	712		NA	1500	
2	Assam*	25	108	856	4/445	NA	NA			NA	0	
3	Bihar				NA	1694	1135	1384/1305?		NA	0	
4	Chhattisgarh*	17	148	741	NA	1092	759	325	8	NA		
5	Goa	2	5	19	NA	NA	11	NA		NA	0	
6	Gujarat	24	318	1152	NA	919	0	886	33	NA	0	
7	Haryana	21	107	441	0/504	729	442	155	124	762	460/161	141
8	Himachal Pradesh*	12	73	449	1159	NA	1159**	49		NA	NA	
9	Jharkhand	21	188	330	NA	NA	NA	50		NA	NA	
10	Karnataka	19	326	2193	NA	NA	NA	563		NA	NA	
11	Odisha*	32	377	1228	11/1227	1476	NA	1263	203	NA	NA	
12	Rajasthan	34	368	1504			1743	1014			401	
13	Sikkim	4	2	24	1/2	NA	NA	NA		NA	NA	
14	Uttar Pradesh*	135	602	2676	NA	NA	NA	NA		NA	NA	
15	Uttarakhand				NA	NA	NA	210		NA	NA	

[^] Does not include Medical College Hospitals serving as DH in many States.

* Out of the 15 States under CRM, these 5 state teams included senior AYUSH officials as well for the visits. No. of regular AYUSH doctors and paramedics in position needs to be checked.

** As estimated from the report mentioning that each stand alone facility had at least one AYUSH MO.

As summarized in the table above it can be seen that the sanctioned number of posts for AYUSH doctors was not available in most States and largely the doctors are contractual except in H.P. and Chhattisgarh where substantial number of regular posts exist as well (also Odisha?). The availability of AYUSH paramedics however is a major gap seen across all States except Haryana and A.P. However comparing with the total no. of health facilities in the States the sanctioned posts for co-located AYUSH doctors and AYUSH paramedics do not comply with the IPHS norms made under NRHM, neither are any population norm followed by any of the States for sanctioning such posts leading to unclarity in defining AYUSH service delivery which is presently confined to No. of OPD cases treated only with no further details.

Main Observations

- ◆ AYUSH doctors are present and providing services in all states. In all states stand alone AYUSH facilities exist and contribute to national health programmes.
- ◆ Colocation has taken place in most states- and to that extent, the choice of treatment to the public is achieved. There is good utilization of AYUSH services in colocated facilities, especially where drugs are available.
- ◆ Contribution of AYUSH Doctors in National Health Programmes including RCH especially in the States where MOs availability in rural and remote areas is difficult is strength to be utilized in proper way by the States. Contribution of AYUSH Doctors in School Health Programmes was noticed in many States.
- ◆ Availability of AYUSH doctors for recruitment has been utilised to fill up medical officer vacancies across a large number of states, especially in the most high focus of districts.
- ◆ Better role clarity of AYUSH doctors is a major constraint, for both i.e. those who are doing own systems' practice or mainly doing cross practice (Prescribing Allopathic medicines) in the States where no legal compliance is existent. Inadequate capacity building efforts for strengthening own system's practice as well as for implementing NHPs including RCH, no specific training centres for doing so.
- ◆ No Population norms for AYUSH services in most states. Poor administrative co-ordination and salary disparity for even those working in remote areas. Inadequate support staff i.e. AYUSH paramedic availability or sanctions found in almost all States.
- ◆ Contribution by AYUSH doctors is unnoticed and not reported in the Information systems. No coordinated efforts by the Central and State Dept of AYUSH or H & FW on data collection and reporting of AYUSH service delivery in detail except the yearly OPD numbers.
- ◆ In spite of District & other AYUSH hospitals in place, specialist cadre of AYUSH not created in many states (except in Himachal, where it needs to be properly structured), graduate and postgraduate doctors are doing the same work.
- ◆ AYUSH Drug supply inadequate in most of the States under CRM.



Findings from the State

ANDHRA PRADESH

- ◆ Convergence and coordination with AYUSH is lacking at all levels.
- ◆ There is shortage of AYUSH drugs and AYUSH equipment at AYUSH facilities visited.
- ◆ There is a good network of AYUSH co-located facilities in both the visited districts.
- ◆ AYUSH doctors were not being used as a substitute to allopathic doctors. This was conducive to preserve the nature of their practice and provide choice to the patients.

- ◆ However, many of these AYUSH practitioners have not been provided with equipments relevant to the practice.
- ◆ AYUSH doctors have also not been receiving salaries regularly. Gross shortage of drugs was found at many facilities.
- ◆ The AYUSH is being implemented and managed by a separate Commisionerate. Convergence with this Commisionerate is not sufficient to ensure smooth functioning and coordination between health department and AYUSH at district level and below.



ASSAM

- ◆ In the districts under review some of the facilities were run through AYUSH doctors only since there are more AYUSH doctors than the sanctioned posts (out of total 22 sanctioned posts; there are 52 AYUSH doctors of which 30 are contractual employees).
- ◆ AYUSH doctors have been deployed in the rural and remote area and are providing health services and some of them even conduct deliveries. However, they are not practicing their own system of medicine and AYUSH drugs are not adequately available.
- ◆ None of the facilities reported availability AYUSH Pharmacists.
- ◆ No specific IEC programme conducted on mainstreaming and strengths of AYUSH systems.
- ◆ One of the districts in review has started collaboration with an NGO, VKI a wing of The Art of Living, to teach yoga to high school students. A total of 18167 students, from 25 schools in have benefited from Yoga classes. The second phase of the program plans to extend this training to 12089 students in another 25 schools. Yoga classes have also been taken for prisoners in the local prisons.

BIHAR

- ◆ 80% of all AYUSH positions are filled and are posted in the APHCs, and in the sub-centres.
- ◆ AYUSH doctors have been oriented to NRHM, and trained in IMNCI, HMIS, and family planning.
- ◆ The AYUSH practitioners are using Allopathic drugs in some instances, because of non availability of AYUSH drugs although the state has recently put in place a contract to HLL Life care to provide AYUSH drugs in the facilities.
- ◆ 399 Facilities have been provided with AYSH drugs.
- ◆ In Begusarai, Ayurvedic and Homeopathic drugs were available.

CHHATTISGARH

- ◆ Chhattisgarh is one of the few herbal states in India. The AYUSH health care set up in Chhattisgarh employs large cadre of AYUSH Physicians. The health services provided by AYUSH network largely focused on primary health care. The sector has a marginal presence in secondary and tertiary health care.

- ◆ AYUSH doctors play critical role in the delivery of essential health care services in some of the most difficult tribal areas where allopathic services are unavailable. AYUSH dispensaries are co-located in mainstream health facilities which also provide maternal and child health services. These physicians may be trained on “Essential Maternal Health and Child Survival” for further strengthening their skills on Maternal & Child Health.
- ◆ Training of approximately 60,000 Mitnin on AYUSH module “Jad buti lae kar lae illaj” as a means of propagation and utilization of herbal combinations for common ailments has been completed which helped in widening of Ayurved Gram Services to the villages.

GOA

- ◆ AYUSH doctors were well placed. Mostly Homeopathy doctors are placed at CHC and PHC level.
- ◆ They have a separate unit well operating and are not working in place of General duty medical offices.
- ◆ Community of Goa as observed is quite particular about the pathy they want to be treated by.
- ◆ The state is implementing school health programme with the team of medical officers of Ayush/allopathic and Ophthalmic Asst. to examine school children in which they are examined for vision defects, ENT and Nutritional diseases and deworming.

GUJARAT

- ◆ Due to shortage of MBBS doctors some PHCs are run managed by AYUSH doctors who are conducting normal deliveries at the PHCs even if not SBA trained.
- ◆ AYUSH doctors are managing the National Health Programmes extremely well. Knowledge of the programmes, surveillance activities, education/awareness provided to the community is admirable and records were well maintained.
- ◆ AYUSH doctors were found to be managing PHCs independently; they are not co-located with Allopathic doctors. They are utilized as substitutes for Allopathic doctors rather than promoting AYUSH and providing people with alternative Indigenous system of medicine.

HARYANA

- ◆ Co-location of AYUSH facilities in place.
- ◆ AYUSH Doctors are member of SKS/DHFWS.
- ◆ Running School Health & Immunization Programme.
- ◆ Doing Promotion of early breast feeding.
- ◆ Participation in Anemia control and Polio eradication.
- ◆ Patients referred to allopathic system of medicine.
- ◆ No. of OPD in AYUSH in 2010–11 was 1633548 in 2011–12 no. of OPD is 908689 till Sept. 2011.
- ◆ 163 facilities have been co-located out of which 142 are funded by NRHM.
- ◆ 504 stand alone AYUSH facilities.

HIMACHAL PRADESH

- ◆ The facility per head of population is about the best in the nation as the State has total 1159 AYUSH institutions, most of which are Ayurvedic institutions and almost every institute has one AYUSH Medical officer.
- ◆ 60 lakh AYUSH out patients last year.
- ◆ District Ayurveda Offices are placed in all the 12 districts of the state.
- ◆ Only 463 AYUSH units are running in Government buildings, remaining 696 units are housed either in rented buildings or in rent-free/donated buildings.
- ◆ Inclusion of Ayurveda Director in State Health Society, State Health Mission and AYUSH services in the HMIS is important. of AYUSH officers in Rogi Kalyan Samitis.
- ◆ There is also significant convergence between Health and Ayurveda departments in implementing national health programs. 661 Ayurveda centres are notified by the State Government for National Health Programs. DOT Centres under National Tuberculosis Control Program are provided in AYUSH units with related training to the staff.
- ◆ AYUSH doctors are also involved in implementing school health program and anemia free initiative across the state.
- ◆ The co-location programme has not taken off much in Kinnaur and Hamirpur but standalone facilities were found well functioning.
- ◆ Also one-month hands on training regarding strengths & potential of AYUSH, emergency care, national health programs, general administration, medico-legal aspects, GFRs etc. is being imparted in batches to the contractually appointed AYUSH doctors at Government Ayurveda College, Paprola.

JHARKHAND

- ◆ Co-location in the study districts had not taken place.
- ◆ Against 42 and 12 posts sanctioned for AYUSH only 3 were filled in both the districts.
- ◆ Karnataka: PHC Average 60–80 OPD per day and Ayush facilities are provided by doctor with Ayurvedic medicines.
- ◆ Provisional diagnosis was not written on the prescription of the patient.
- ◆ One of the PHC was under the Karuna Trust PPP Model where Medical officer not trained in National programmes who was an Ayush doctor posted by Karuna Trust.
- ◆ Ayush doctor prescribing Allopathic medicines.
- ◆ As per MOU, MBBS doctor is supposed to be posted by Karuna Trust but Ayush doctor is posted in this PHC @20,000/salary which is the salary of an MBBS doctor. All the expenditure is being reimbursed from NRHM.
- ◆ FRUs does not have AYUSH Services.



ODISHA

- ◆ Main streaming of AYUSH is good. The State has increased its strength of AYUSH personnel.
- ◆ AYUSH doctors have been added to the health workforce. In 2005, there were no sanctioned positions for them; presently 1123 AYUSH doctors are in place as against 1819 sanctioned positions. It is to be noted that most of these doctors are in regular positions. Only 278 out of 3575 doctors across the state are contractual.
- ◆ 646 AYUSH doctors are being trained for early detection and prompt treatment under NVDCP malaria.
- ◆ Involvement of AYUSH in Planning in Dist, Block level etc.
- ◆ Co-location & Involvement in all National Prog.
- ◆ Essential AYUSH drugs being provided.
- ◆ AYUSH doctors are utilizing the laboratory facilities of PHCs/CHCs.
- ◆ Separate OPD for consultation.
- ◆ Training of AYUSH doctors: 97% trained in SBA, 58% in IMNCI 94% in RI 89% induction training.
- ◆ 24 New PHC's and the Ambulance services are being managed by AYUSH Physicians.
- ◆ The Ayurvedic Physicians are SAB trained for conducting normal deliveries.
- ◆ Supply of AYUSH drugs inadequate.
- ◆ No AYUSH Pharmacist and paramedical staff available.



SIKKIM

- ◆ The AYUSH branch that is available in Sikkim mostly belongs to the type AMCHI, which has its origin in Tibetan Medicine.
- ◆ There are 5 AYUSH co-located facilities which are supported by NRHM.
- ◆ AYUSH doctors were working in the institutions visited (DH) and medicines were also available.
- ◆ A good number of OP cases (10311) last year were found in records.
- ◆ There are no AYUSH doctors working as general duty medical officers.
- ◆ Fund transfer to AYUSH not taking place at district level (North).

UTTAR PRADESH

- ◆ SBA training which was planned for female AYUSH doctors who are undertaking delivery in PHCs and CHCs, has not been started so far.
- ◆ The team was informed by Labour room nurse at CHC Datagunj and doctor (AYUSH practitioner) at Jagat PHC in Badaun District that they had used episiotomy occasionally, when perineal tear was anticipated. However, none of the locations had episiotomy tray or instruments to undertake the procedure.

- ◆ It was noted that Medical Officers under AYUSH stream of medicine have been provided in several CHCs and PHCs.
- ◆ However, the AYUSH doctors were not practicing AYUSH stream of medicine. Instead they were found to be running OPD under modern medicine, providing antenatal care and conducting deliveries, assisting the Medical Superintendent/IC Medical Officer in administrative matters and even running IEC campaigns.
- ◆ Thus, the very purpose of mainstreaming AYUSH under NRHM is defeated.

Recommendations

1. There is a need to persist with co-location and add two more features- better drug supply to co-located AYUSH facilities and insistence on co-located practitioners providing AYUSH remedies and not switching over to allopathic drugs, unless they are part of a national program for which they have been trained. The process of co-location of AYUSH in primary health network needs to be completed in 12th Five-Year Plan.
2. Inculcate systematic, planned use of AYUSH staff in all national programs with special emphasis on preventive and promotive components and public health education.
3. Adequate training and certification in skills for AYUSH practitioners who are asked to play role of MBBS medical officers due to lack of availability of the later.
4. Create specialist cadre of AYUSH doctors for enhancing the access to specialised AYUSH clinical services.
5. Incorporation of AYUSH service data into HMIS and build MIS for AYUSH services.



Overall Outcomes of NRHM

Overall Outcomes of NRHM

One can assess overall health outcomes in terms of three indicators - IMR, MMR and TFR.

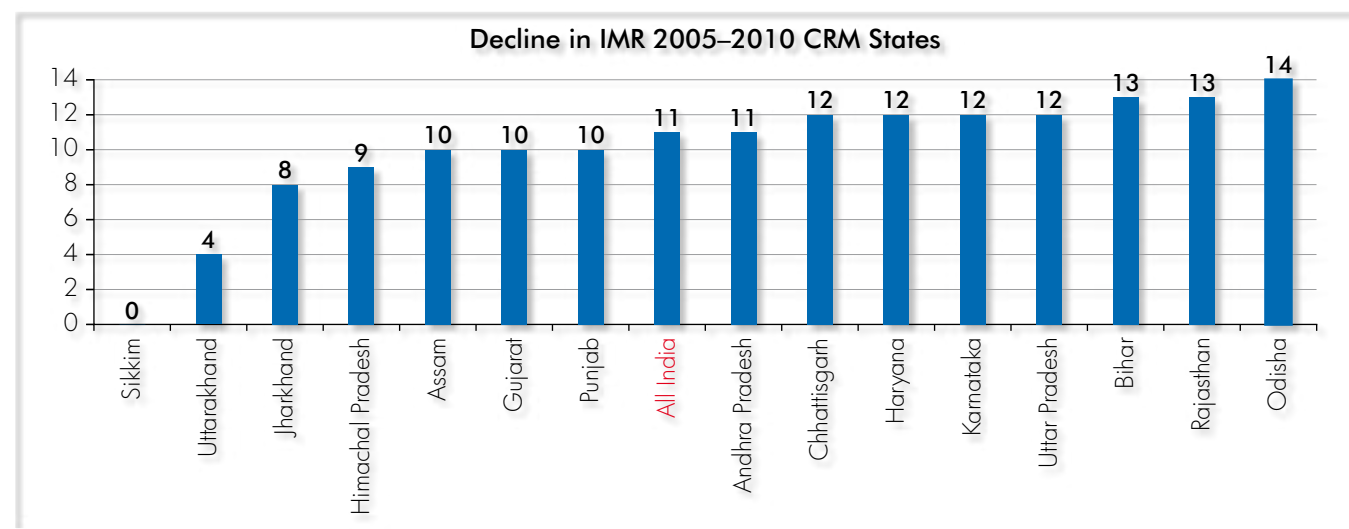
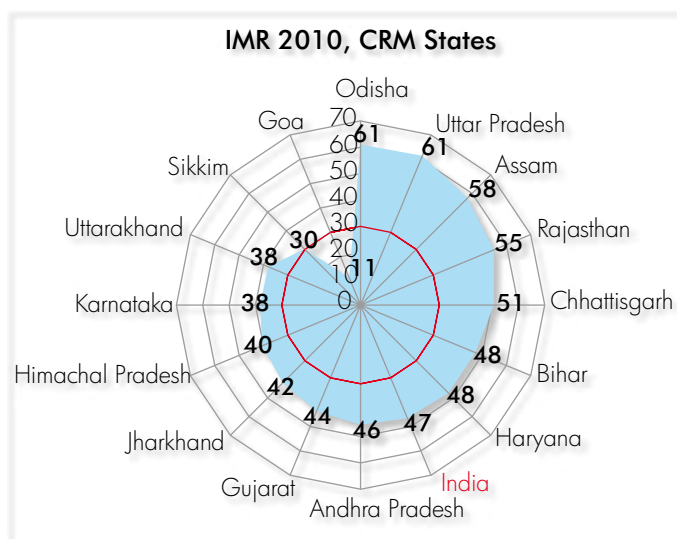
In addition one can assess NRHM in terms of key outputs- namely the strengthening of community process and the extent of movement towards providing universal access to health care services.

One needed to have also assessed outcomes for disease control programmes - but at this stage except some vector borne diseases most reliable and recent data pertain only to service deliver and pregnancy targets. Disease control outcomes needs to be discussed separately.

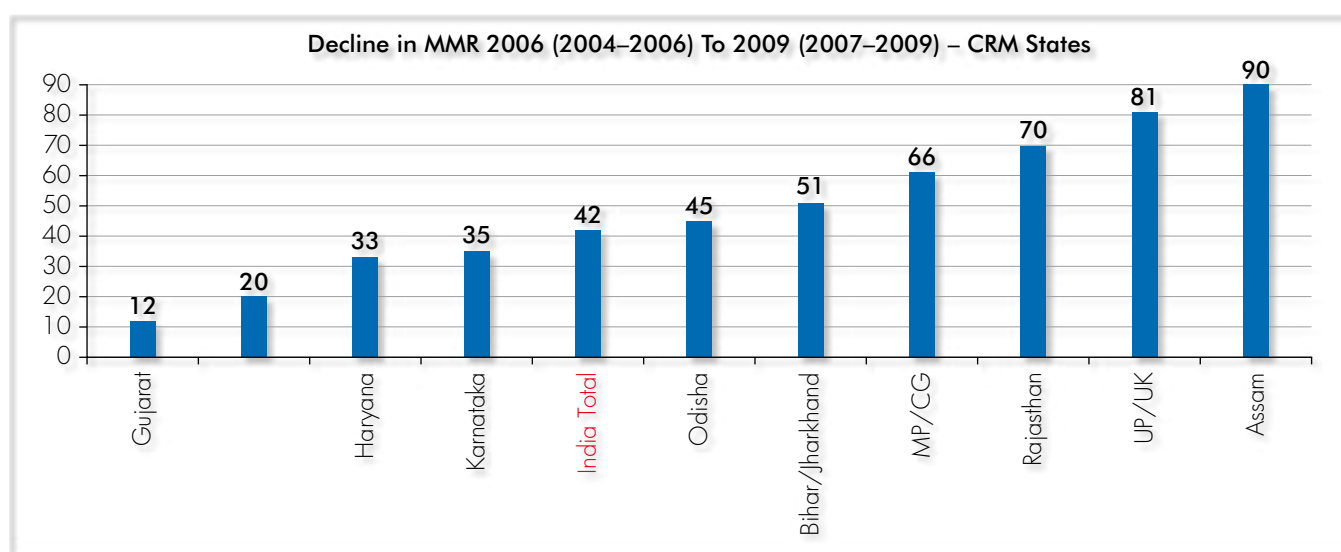
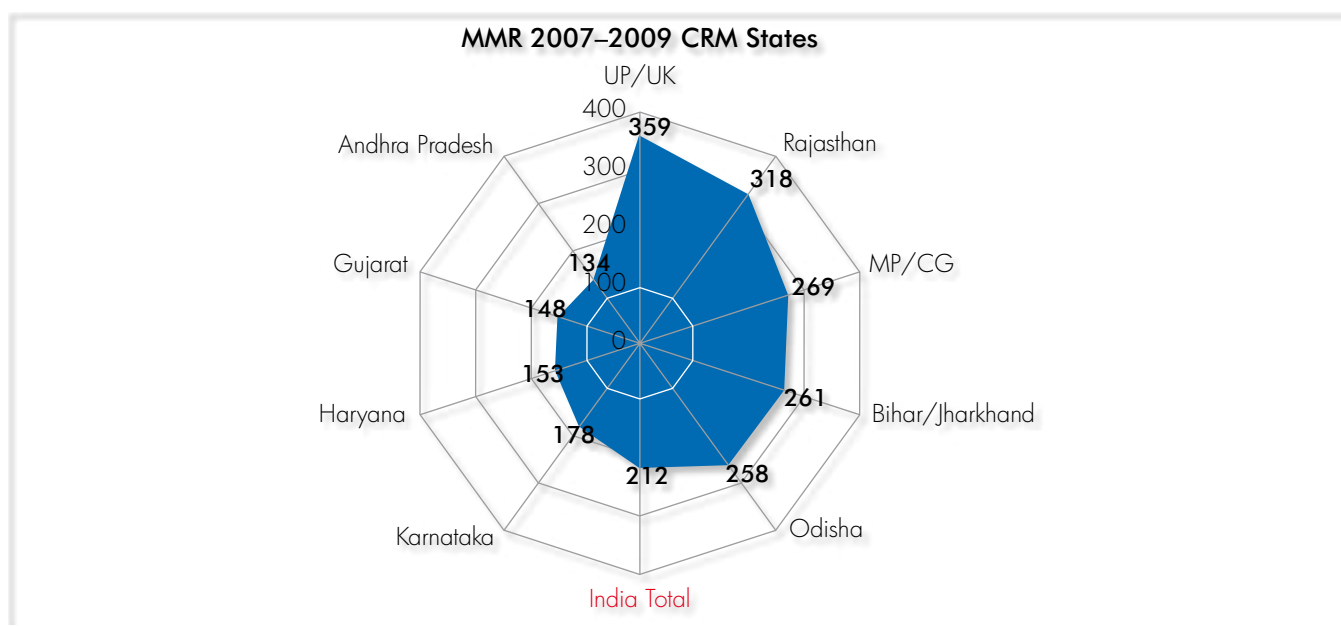
In terms of infant mortality the achievements as of 2010 are given in the figure below:

The All India IMR has come down to 47 per 1000 live births. Looking at the target of reducing IMR to 30 per 1000 live births by year 2012, the states of Kerala, Tamil Nadu & Maharashtra have already achieved the target. The states of West Bengal, Punjab & Karnataka are positioned to reach this goal and their current rate of improvement. The remaining states need to put in considerably larger effort to achieve the national target of 30 and some states have clearly a long way to go.

The positive news is that states having highest load of IMR - Madhya Pradesh, Odisha, Uttar Pradesh, Assam, Rajasthan & Chhattisgarh have shown the maximum decrease of 14 to 10 points from year 2005 to 2010. At an average decrease of 12 points per year it comes to 2 points fall per year. If these states achieve the fall of IMR by 3 points per year, a fall of 15 points in next 5 years should be possible.



One note of concern is that many small states specially in the North-East have shown stagnation or increase in IMR – though these are on relatively better baseline. There is insufficient understanding of why these states have worsened, despite reasonable performance on many other NRHM parameters and this needs to be investigated further.



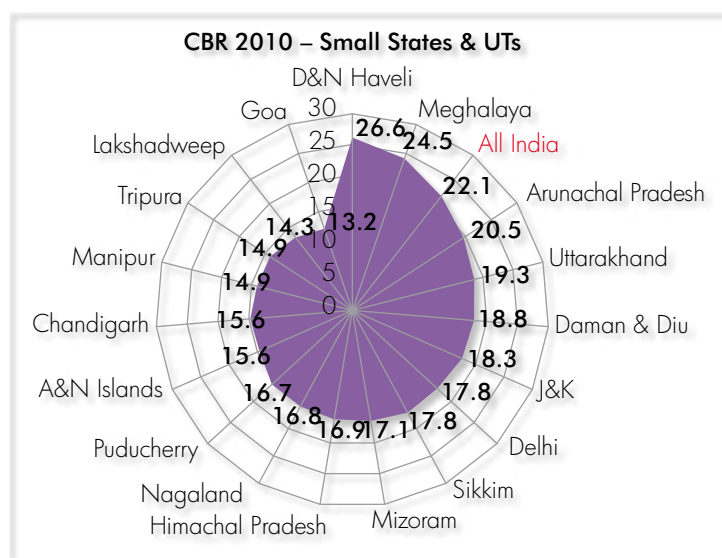
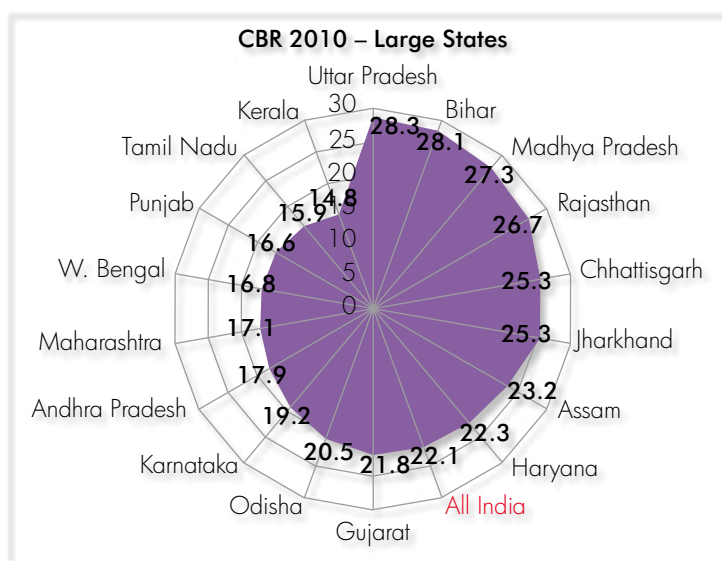
At all India level the MMR has come down to 212 per 100,000 live births. Looking at the target of reducing MMR to 100 per 100,000 live births by year 2012, the states of Kerala, Tamil Nadu & Maharashtra have already achieved the target. The states of Andhra Pradesh, West Bengal, Gujarat, Haryana, Punjab & Karnataka need to achieve reduction of 34 to 78 points to reach at the target. The remaining states need to put in considerably larger effort to achieve the national target of 100.

The states having highest figures of MMR from 390 to 258 – Assam, Uttar Pradesh, Uttarakhand, Rajasthan, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand & Odisha have shown decrease of 90 to 45 points from year 2005 to 2010. This comes to an average decrease of 7 points fall per year. If these states try to achieve the fall of MMR by 10 points per year, a fall of 50 points in next 5 years may be possible, but that does not seem to be good enough looking at challenge of decreasing MMR by 290 to 158 points in 9 poor performing states. What would be needed in these states is an infusion of human resources, and managerial skills from outside the state and focussed on the poor performing districts if we want to make it happen.

Of the large states, eight of the Non- High Focus states (Tamil Nadu, Kerala, Andhra Pradesh, West Bengal, Punjab, Andhra Pradesh, Maharashtra & Karnataka) and one high focus state- Orissa, CBR is less than the National figure of 22.1. Except Orissa and Gujarat, all these states have also achieved the replacement fertility rate of 2.1.

Rest of the large states which include seven high focus states and one non high focus state – Haryana have CBR above the National figure. However, the rate of decline of CBR is the highest (range –1.8–2–3) in this group except for the state of Jharkhand which has a decline of 1.5 points.

Among the smaller states, all states except Meghalaya and UT of Dadar and Nager Haveli have CBR less than the National figure of 22.1. But in terms of TFR, only Goa, Himachal, Delhi & Sikkim have achieved the target of 2.1 (as per NFHS 06) while J&K, Tripura & Uttarakhand need to achieve reduction of 0.1 to 0.5 points to reach the target. The decline in CBR since 2005 is less than 1 point in Delhi, Meghalaya, J&K, Daman & Diu, Andaman and Nicobar Islands while there has been a slight increase of 0.2–0.5 points in CBR of Manipur, Nagaland and Puducherry.



Outputs

In terms of key outputs approximately one third to half of facilities that were planned have achieved 24x7 status facilities have done so and one fourth of those who were to become first referral units have become so. The problems and gaps in facility development and RCH and disease control services have been discussed in earlier sections. The other major gap that the CRM draws attention to relate to developing services for other communicable diseases (those not on the national programme list) and the entire spectrum of non communicable diseases- including dental services and mental health, geriatric care etc. The vision of NRHM was explicit in requiring its inclusion into the district plan, even if it were to be financed from other financial heads. However as rolled out the NRHM is largely been a RCH plan and non communicable disease programmes have grown independent to district plan. But just like facility development for RCH for developing universal quality, a similar form of facility prioritisation should linked to cater to all other programmes for 24x7 and first referral care.

In terms of community processes and innovations in management and in financing earlier sections have outlined the progress made under NRHM.

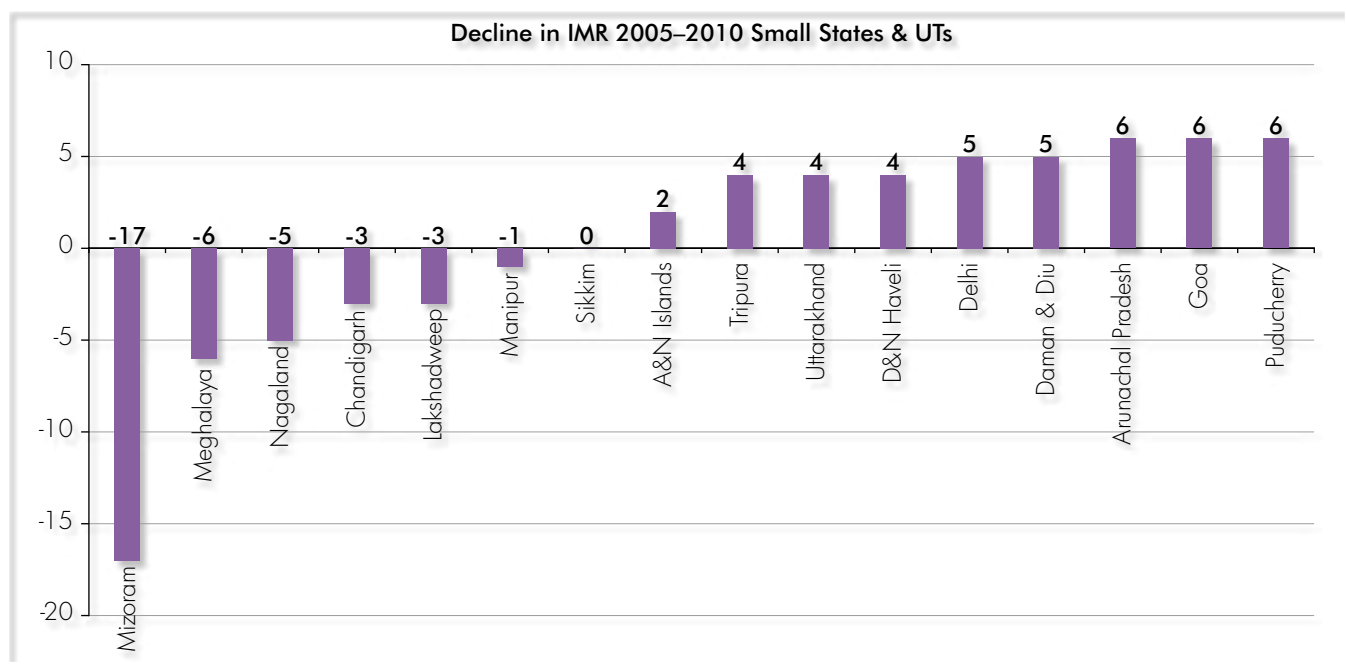
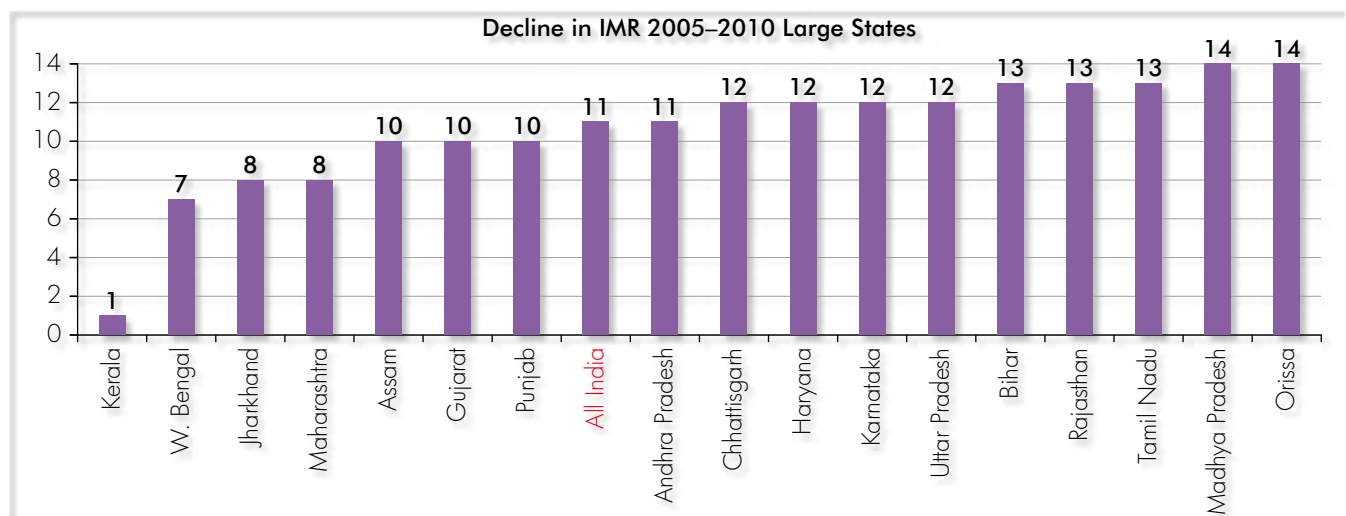
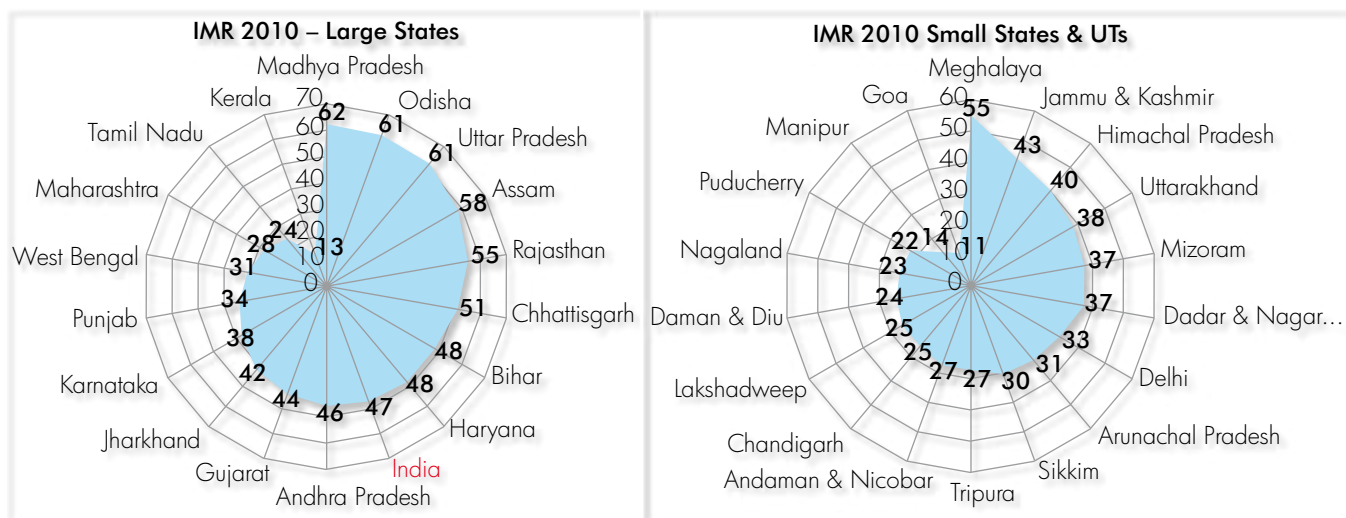
Recommendations

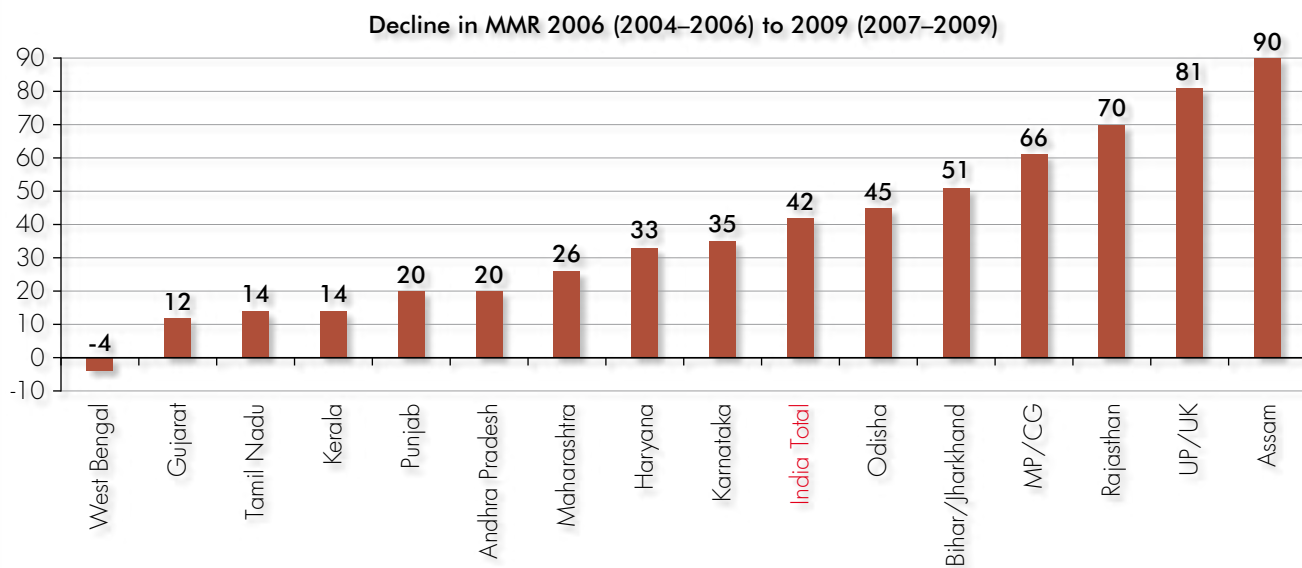
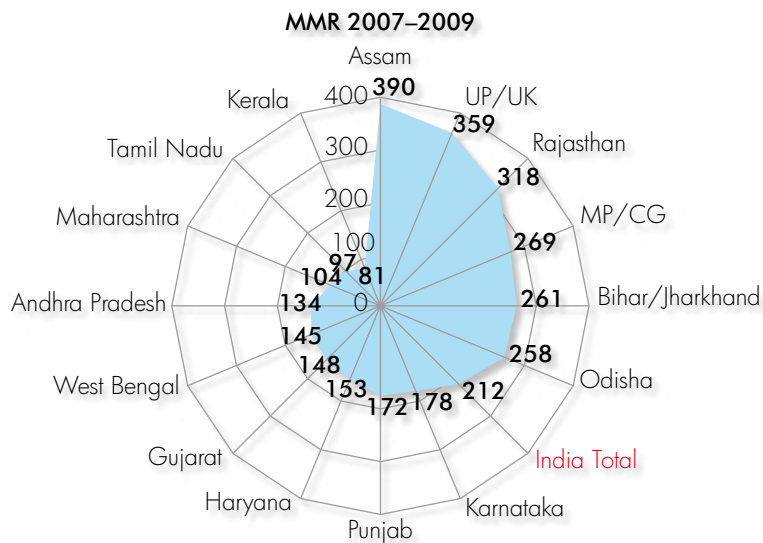
There is a need for bringing in technical and managerial resources from the rest of India to the high focus districts of the eight states who lag behind Uttar Pradesh, Bihar, Jharkhand, Chhattisgarh, Madhya Pradesh, Rajasthan, Assam and Meghalaya. These resources should be used to build up training and knowledge institutions within these districts, so that when they are withdrawn, the programmes would sustain based on the buildup of internal capacity. The first four of these would in that order be more requiring of such an infusion of resources than others. A special purpose vehicle or national programme management unit may be placed in charge of such a transfer of resources. The other states in high focus group like Odisha and Uttarakhand may also require such increased resource transfers to high focus districts, but potentially they could find these resources from within the state.

The other main strategy is that for all posts except specialists local recruitment for training/educational programmes with incentives for working in these districts are most likely to solve the constraints of skilled service providers. For specialists a scale up of the family medicine programme – such that every medical officer available to work here is potentially trained into a basic specialist- and then retained here through a package of incentives and workforce measures is likely to yield results.

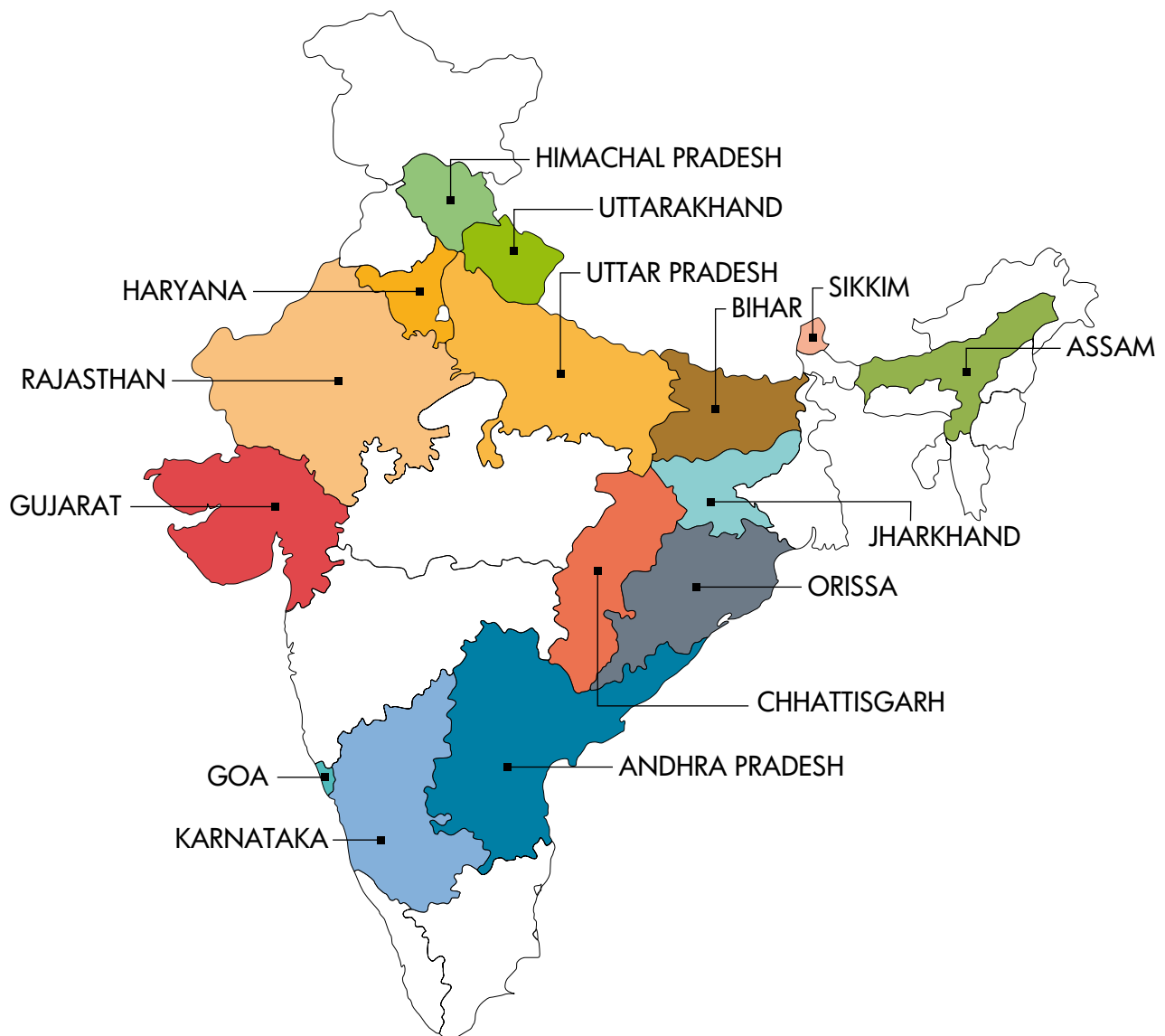
The private sector presence in these districts is minimal but as such as there are usually mission hospitals and the like play very important role- and one must consider a PPP approach that can harness them- at least for limited goals like emergency obstetric care, safe abortion and sterilisation services. A national programme management unit could facilitate this.

The other major recommendation which applies to all other areas is to develop a model of horizontally integrated district planning which incorporates the control of communicable and non communicable diseases. This would be the major part of the thrust towards universal health care. The NRHM has by far remained RCH-centric, which was understandable given the urgency of achieving RCH goals. But in all states, except for these eight, though RCH concerns are still important- the time has come to develop facility development strategies that go beyond RCH.

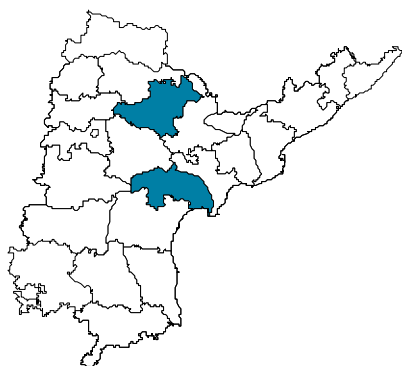




States of India Visited By 5th CRM Teams



State-Wise Key Findings



DISTRICTS/INSTITUTIONS VISITED

GUNTUR

Medical College hospital - Government General Hospital Guntur (NICU); DH Tenali; AH Sattenapalli, AH Narsaraopet; CHC Vemuru, CHC Macherla, CHC Venukonda; PHC Sangam Jagarlamudi, PHC Kolluru, PHC Nudurpadu, PHC Savlapuram; SC Angalakuduru, SC Donepauli, SC Nagulavarum, SC Phirangipuram, SC Karnamanchi, SCCuandala Padu; AWCs- Angalakuduru, SC hamlet at Angalakuduru, Koppunuru (VHND) Karamudu; Villages Kothapalli (104 services), SC Hamlet (Angalakuduru-SC).

WARANGAL

GMH, Hanmakonda, CKM Hospital; AH Mahabubabad; CHCs Ghanpur (Stn), Thorru, Wardhannapet, Parkal; PHCs Nellikudur, Regonda, Shyampet, Raiparthy(W); HSCs Matedu, Kotancha, Bhageerathpet, Mailaram, Pathipaka; Villages Matedu, Mailaram and ANMTC & nursing school, Warangal.

THE REVIEW TEAM

- ◆ Dr. P.K. Prabhakar, Deputy Commissioner, Child Health, MoHFW. (Team Leader)
- ◆ Dr. M.S. Mathur, Sr. Regional Director, MoHFW
- ◆ Ms. Sujata Sharma, Director, Planning Commission
- ◆ Dr. Kalpana Baruah, Joint Director (NVBDCP), MoHFW
- ◆ Sh. V.P. Singh, DS (MS), MoHFW
- ◆ Dr. Dinesh Agarwal, National Programme Officer (RH), UNPFA
- ◆ Dr. P. Padmanaban, Advisor, NHSRC
- ◆ Prof. T. Mathiyazaghan, Prof. & Head, Deptt. of Communication, NIHFV
- ◆ Dr. H. Sudershan, Karuna Trust
- ◆ Ms Padmavati, AD (NRHM-II)
- ◆ Mr. Anil Garg, Consultant FMG
- ◆ Dr. Rachana Parikh, Consultant (NRHM), MoHFW
- ◆ Mr. Vipin Garg, Consultant Reproductive and Child Health, MoHFW

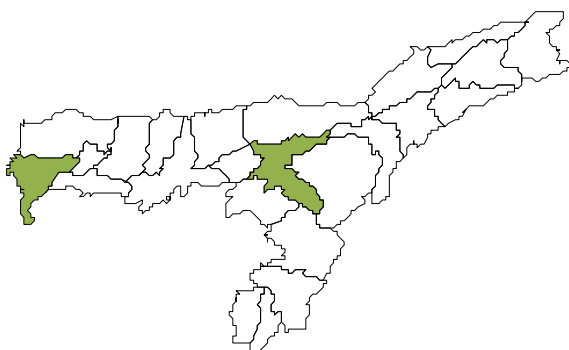
POSITIVES

- ◆ State has achieved TFR of 1.9, which is exceeding the national target of 2.1. More than 90% of all the deliveries are institutional and immunization coverage is 97%.
- ◆ The state has achieved NRHM targets for reduction of malaria and dengue mortality and case detection rate and cure rate for tuberculosis.
- ◆ Infrastructure is good in most facilities at CHC level and above. Focus on closing infrastructure gap at CHC and areas hospitals.
- ◆ Availability of equipments in labor rooms and operation theatres was good.
- ◆ No major shortage of drugs at any level.
- ◆ EMRI is an effective emergency referral mechanism.
- ◆ Training Infrastructure seems adequate in the state (including private institutions).
- ◆ Out of pocket expenditure among the pregnant women was almost nil in the public health facilities.
- ◆ Citizen's charter was displayed at most of the institutions.
- ◆ VHNDs are being carried out regularly.
- ◆ Fixed Day Health Services (104) are providing outreach medical services at village level.
- ◆ PMUs have been established and are functioning with good coordination with health departments at both state and district levels.
- ◆ Good convergence between Reproductive Health and HIV/PPTCT.
- ◆ ASHAs are effective in demand generation for MCH services and family planning.



AREAS OF IMPROVEMENT

- ◆ Delay in completion of infrastructure projects needs to be checked. Regular monitoring of progress of the projects could be initiated. All health Facilities must be provided with barrier free access for disabled and infirm/old people.
- ◆ Quality of training needs to be ensured including in all private training institutions. Multi-skilling, MTP, IUDs trainings need to be restarted.
- ◆ Performance of CHC, FRUs and 24 x 7 PHCs can be further optimized. Strengthening of strategically identified CHCs could be done. This would reduce congestion at secondary and tertiary level facilities.
- ◆ Laboratory services need to be strengthened, particularly in the CHCs, AHS and DHs.
- ◆ Better convergence with AYUSH should be done.
- ◆ Protocols, guidelines, training and facilities for segregation, storage, monitoring and disposal of waste need to be introduced and implemented. Protocols for ensuring asepsis in labor rooms and OTs needs to be introduced.
- ◆ Protocols of Newborn care need to be implemented. New Born Care Corners (NBCC), NB Stabilisation Units (NBSU) and Special Newborn Care Units (SNCU) need to be established in concurrence with the national guidelines.
- ◆ Adolescent anaemia control programme needs to be introduced and safe abortion services need to be provided and made easily accessible.
- ◆ Sub-district TFR goals need to be removed and spacing methods needs to be encouraged.
- ◆ Irregularities related to Form F needs to be prosecuted appropriately.
- ◆ Guidelines issued by GOI in December, 2006 on Delegation of Financial & Administrative Powers need to be implemented. Adequate training of all the staff handling accounts needs to be done.
- ◆ District Health Action Plans must be made by bottom up planning.
- ◆ HMIS, MCTS, IT systems and data flow require considerable improvement from peripheral level to district level onwards.



DISTRICTS/INSTITUTIONS VISITED

DHUBRI

Chapor CHC/FRU, South Salmora CHC (Tumni), Mankachar CHC, South Salmora BPHC, Ghaziakandi BPHC, Satsingmari SD Civil Hospital, Bilasipara SHC, Folimari SHC, Boladmora SHC, Fekamari SHC, Rakhalpat SHC, Jaskal SHC, Lakhiganj SD, Golakganj BPHC, Kachokhona SD, Satrasal MPHC, Halkura BPHC/CHC, boat clinic.

NAGAON

Block PHC Dhing, CHC Hojai, BPHC Jakhalabandha, Doboka, Udmari MPHC, Kuwaritol MPHC, Riverine PHC Khundalimari, khairamari SHC, South Radha Nagar SHC, Borjuri SHC, Block PHC Jugijan, Simonabasti 24x7 PHC, Kathiatoli PHC, Sagamotea, Udmari AWC.

THE REVIEW TEAM

- ◆ Dr. Rakesh Kumar, Director (NCD), MoHFW
- ◆ Dr. V.K. Raina, JD (NVBDCP), MoHFW
- ◆ Dr. Partha Jyoti Gogoi, RD, RoHFW
- ◆ Dr. V.K. Manchanda, Consultant (RCH), World Bank
- ◆ Dr. Pradeep Khasnobis, CMO (IDSP), MoHFW
- ◆ Dr. A. Raghu, Assistant Advisor (AYUSH), MoHFW

- ◆ Dr. J.K. Das, Dean of Studies, NIHF
- ◆ Dr. Suchitra Lisam, Sr. Consultant, NHSRC
- ◆ Dr. K.S. Jacob, Professor of Psychiatry, CMC
- ◆ Dr. Bhriku Kapuria, Consultant (UIP), WHO
- ◆ Dr. Abhishek Gupta, Consultant, MoHFW
- ◆ Dr. Puneet Jain, Consultant, MoHFW

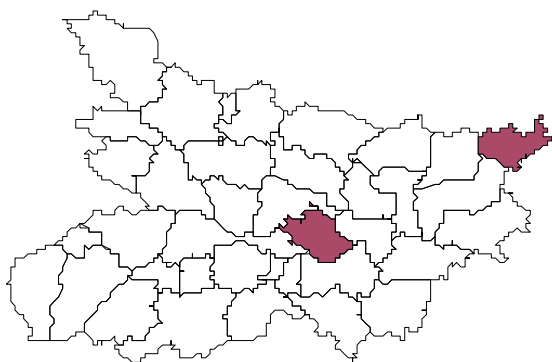


POSITIVES

- ◆ There has been increase in the number of health facilities. PHCs increased from 647 to 856 and the number of DH and medical colleges has increased from 21 and 3 to 24 and 5 in the last five years. Similarly, the GNM training centers has increased from 15 to 20.
- ◆ The state has rolled out the three years rural health course, "Diploma in Medicine and Rural Health Care" (DMRHC) so as to ensure that skilled manpower is available in rural areas. As of September 2011, 19 Rural Health Practitioners (RHP) were deployed in health sub-centers in remote and rural areas of Dhubri district out of 261 RHPs deployed in the state.
- ◆ The state conducts recruitment drives for appointment of large number of contractual employees under NRHM. Enforcement of the compulsory government service bond has ensured their availability in public health.
- ◆ The state has MIS for human resource, which is used for management of transfer and posting primarily.
- ◆ The state could reach out to the unreached and marginalized population in riverine areas through boat clinics for providing universal primary health care services.
- ◆ ASHAs are highly motivated and converse with RCH programme and other responsibilities assigned to them except for new initiatives under disease control programmes. Though 91–95% had received training for Modules 1 through 5, training for modules 6 and 7 is yet to start.
- ◆ Adequate availability of cold chain equipment and its functioning at every level.
- ◆ Significant improvement in the implementation of NVBDCP strategy, with ABER increasing from 8.09% in 2007 to 14% in 2011 and malaria incidence reduced by 58% and deaths reduced from 152 reported in 2007 to 30 (80%) during 2011.
- ◆ 26312 VHSNCs functional with operational joint accounts and better fund utilization with numbers of VHND held showed significant increase in quality over the last 5 years.

AREAS OF IMPROVEMENT

- ◆ High IMR, NMR and MMR remain matters of concern and require further improvements in both facility based care and community level care.
- ◆ More rapid roll out of modules 6 and 7 is essential to put home based newborn care in place.
- ◆ Sub-centers with 2 ANMs in difficult and inaccessible areas may be upgraded for institutional delivery after training of ANMs in SBA and by providing required infrastructure. Problems of water, electricity and residential accommodation for staff at such sub-centers should be taken up as the priority.
- ◆ Improve quality of training, develop a standardized training plan and calendar for various cadre/ categories of staffs with regular facility-wise training needs assessment.
- ◆ Need for constitution of a Quality Assurance Committee in district hospital and higher facilities since it was observed that quality of health service delivery is a major weakness in the district as a whole. Orientation of health management on need for biological waste management needs immediate attention.
- ◆ Improve maternal and infant death reviews and reporting.
- ◆ Need to intensify counselling and service delivery in family planning – especially for spacing.
- ◆ Reduce out of pocket expenditure on drugs and supplies at the public hospital.
- ◆ Put a proper monitoring plan with clear work allocation to senior officers and frequent field visits to be undertaken for corrective actions and advise for improvement. Community monitoring also needs to be started.
- ◆ Urgent need to put an efficient and transparent procurement and logistic system for drugs, supplies and equipment in place, with some space for RKS based local purchase of emergency drugs as a supplementary measure.
- ◆ VHSNC need to revitalize through proactive participation and involvement of PRIs in overall development of all determinants of health.
- ◆ Should integrate and coordinate the many different government schemes to improve the lives of people and to empower them and provide social justice.



DISTRICTS/INSTITUTIONS VISITED

BEGUSARAI

DH Begusarai, SDH Balia, RH Manjhaul, PHC Bakhari, PHC Naokothi, PHC Barauni, PHC Teghra, APHC Banwaripur, APHC Sokhra, APHC Simaria, APHC Phulwaris, Mohanpur HSC, HSC Maheshwara, HSC Chandrapur, HSC Atarwa, HSC Baramuri, HSC Kasavarain, HSC Barbigi, HSC Bagatpur, Anganwadi Centre Chanhakat Mohanpur.

KISHNAGANJ

DH Kishanganj, M.G. (Private) Medical College, ANM Training Centre, Surya Clinic (Nursing Home accredited for Family Planning, MTP and JSY), Block PHC Terhagachh, BPHC Pothia, BPHC Bahadurganj, HSC Gamarhia, HSC Maheshbathna, HSC Jhala, HSC Chhatargachh, Mirzapur, HSC Mahadev Dighi, HSC Bargarhiya, AWC Bargarhiya, AWC Khajurwadi, AWC Bada Paka Mana, AWC Gamarhia, AWC Jhala, AWC Maheshbathna.

THE REVIEW TEAM

- ◆ Mr. Deep Shekhar, Director, Procurement; MoHFW, Gol, New Delhi. (Team Leader)
- ◆ Dr. B.K. Tiwari, Advisor Nutrition, MoHFW, Gol, New Delhi
- ◆ Dr. S.I. Amir, Senior Regional Advisor; Regional Office For Health & Family Welfare, (Bihar & Jharkhand), Govt. of India, Patna
- ◆ Dr. Rajani Ved, Advisor, Community Processes; NHSRC, New Delhi
- ◆ Dr. Sher Singh Kashyotiya, Assistant Director (Public Health); NVBDCP, DGHS, Delhi
- ◆ Mr. Billy Stewart, Senior Advisor, Department for International Development, New Delhi
- ◆ Mr. Sunil Babu, Consultant, Bill & Melinda Gates Foundation, New Delhi
- ◆ Ms. Usha Kiran, Deputy Director, Bill & Melinda Gates Foundation, New Delhi
- ◆ Dr. P.C. Bhatnagar, Programme Director, Voluntary Health Association of India, New Delhi
- ◆ Mr. Ajit Singh, State Facilitator, NHSRC
- ◆ Dr. Sarita Sinha, Consultant NRHM, Planning & Policy, MoHFW, New Delhi
- ◆ Ms. Medha Gandhi, Consultant, ARSH, MoHFW, New Delhi
- ◆ Mr. Ravi Sawlani, Consultant Finance; MoHFW, New Delhi

POSITIVES

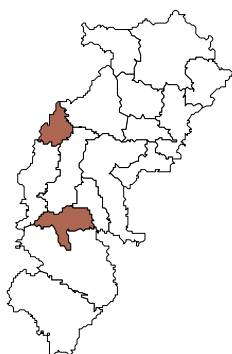
- ◆ Continued increase in out-patient and in patient loads managed by health facilities. Consistent increase in number of institutional deliveries at block PHCs.
- ◆ Total numbers of functional facilities increased from 10631 to 20049 and of these 11694 are functioning with minimum staff and service packages as indicated in IPHS.
- ◆ Significant efforts were being made by the state to increase human resources deployment in the health sector. Measures taken to fill vacant positions include proposals of creating new medical and nursing colleges, expanding seats for nursing students, intensifying efforts in ANMTCs to train ANMs. Also innovations in recruitment process-include walk-in interviews, online applications, campus placement interviews, recruitment drives for medical officers during their internship and incentives.
- ◆ State is setting up State Infrastructure Corporation, and using funds from multiple sources (MDSP, Sam Vikas Yojana) to enable construction of facilities. Work is in progress to upgrade 201 BPHCs into CHCs and 14 CHC-level facilities are being upgraded to Sub Division Hospital level.
- ◆ Nursing Skill labs for rapid improvements in skills of nurse and ANMs for care during pregnancy at birth and immediate postpartum and newborn care is a promising innovation, currently in the process of being scaled up.
- ◆ AYUSH doctors posted at additional PHCs are trained in IMNCI, HMIS etc. have been oriented in NRHM and have been co-located in facilities.
- ◆ Formation of grievance redressal cells are being initiated.
- ◆ Innovative selection and deployment of NGOs as additional capacity for training ASHAs at state and district level. Good working relationships between ANMs, AWWs and ASHAs.



AREAS OF IMPROVEMENT

- ◆ High parity women adopting terminal methods calls for greater attention to spacing between pregnancies. State needs to seriously consider innovative ways to promote post-partum contraception.
- ◆ Ensure more rapid and clearly prioritised closure of infrastructure gaps.
- ◆ There is an urgent need to improve availability of BEmOC and CEmOC at facilities especially with high volume of deliveries.
- ◆ Facility based sick child care needs major effort for acceleration. NRCs also need to be established.
- ◆ State needs to focus on getting doctors and nurses to work in difficult areas. Residential quarters within the hospital/HSC compound need to be constructed.
- ◆ To operationalise procurement and logistics system at the earliest.
- ◆ Free referral transport for all pregnant women for first and subsequent referrals needs to be ensured.
- ◆ Record keeping at block PHCs needs to be strengthened. Complicated deliveries and referral registers should be maintained.
- ◆ Additional capacities from NGOs and outside the state should be recruited for increasing pace of skill based training for service providers. In addition, there is a need to strengthen the monitoring and supervision for ASHAs.
- ◆ Training, drug kit refills and introduction of incentives for home based newborn care needs to be expedited.
- ◆ Current delay of 1 to 2 months in JSY payments should be eliminated and payments at time of admission in institution should be ensured.





DISTRICTS/INSTITUTIONS VISITED

KANKER

District Hospital (Kanker), CHCs (Narharpur, Antgarh, Bhanupratappur, Dhanelikhanhar), PHCs (Sarona, Korar), SHCs (Dawarkhar, Mussurputta, Kurishtikur, Kanharपुर), AWC (Picchekatta), and Villages (Adarpara, Baardeori).

KAWARDHA (KABEERDHAM)

District Hospital (Kawardha), CHCs (S.Lohara, Pandaria, Bodla), PHCs (Bhimbhori, Pondi, Dullapur, Kukdoor, Chilfi, Pori), SHCs (Dhaniyakhurd, Chilfi, Oriyakalan, Visheshra, Singhampuri), AWC (Visheshra, Dhaniyakhurd, Chilfi, Behsinjhor, Pipartola), Ayurvedic Dispensaries (Suriapura, Chilfi), AYUSH gram (Dullapur), School (Govt. Primary Schools at Chilfi, Bisesera), Private Hospital (Goraj Children Hospital, Kawardha).

THE REVIEW TEAM

- ◆ Mr. Bishwajeet Das, Director, MoHFW, (Team Leader)
- ◆ Dr. R.S Sharma, Joint Director, NVBDCP
- ◆ Dr. Manoj Nesari, Joint Advisor, AYUSH
- ◆ Dr. Prema Ramachandran, Director, NFI
- ◆ Mr. Gautam Chakraborty, Advisor-Healthcare Financing, NHSRC
- ◆ Ms. Ashi Kohli Kathuria, Sr. Nutrition Specialist, World Bank
- ◆ Ms. Ekta Saroha, Strategic info & Policy, USAID
- ◆ Dr. B.S. Deewan, Consultant (NIHFW)
- ◆ Dr. Hemant Sharma, Consultant, NRHM
- ◆ Mr. Mani Mohan Manna, NRHM (FMG)
- ◆ Dr. S.V. Gitte, RD Office (MoHFW), Raipur, Chhattisgarh
- ◆ Dr. Subha Sankar Das, Consultant (School Health), RCH Division, MoHFW

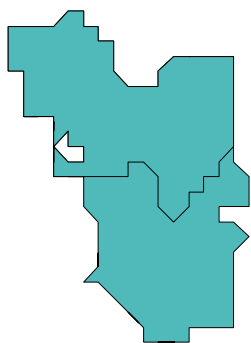


POSITIVES

- ◆ Increase in OPD and IPD over the last 6 years, but the increase is not consistent.
- ◆ Good child sex ratio.
- ◆ Upgradation of health facilities in terms of infrastructure development with satisfactory. Cleanliness was observed to be reasonably good.
- ◆ Essential minor equipment such as height measurements, weighing machine, Sahli's hemoglobinometer (with reagents), BP apparatus which are needed for ANC were available in the Sub Centers.
- ◆ Cold chain equipments like deep freezer and ILR in functional condition in PHCs.
- ◆ Innovative measures for attracting and retaining doctors- decentralized, three year trained Rural Medical Assistants (RMAs) and the Chhattisgarh Rural Medical Corps (CRMC) with special incentive packages are all showing positive results.
- ◆ Significant increase in ANM and MPW training schools, especially in the private sector.
- ◆ Functional Mitanins with very low dropout rates. Mitanin trainings showing good progress.
- ◆ Mitanin support structure in place and supervised through SHSRC. All Mitanins provided life insurance cover for their husbands and scholarships for their children studying in class 9–12th.
- ◆ JSSK implementation begun with abolition of all user charges and provision of free medicines.
- ◆ RDKs for malaria available and being utilized.
- ◆ Chhattisgarh Medical Services Corporation (CGMSC) being set up, recruitment of staff under process, to take up all procurement functions from 2012–13 onwards. Till then Jeevandeep Samitis (RKS) are filling gaps in medicines availability through local procurement – almost 40% of JDS expenditure is on drugs. Drug storage condition is good.
- ◆ District Planning takes place and district budgets sanctioned are communicated at the beginning of the financial year.
- ◆ AYUSH Gram a good model for promoting AYUSH at the community level.

AREAS OF IMPROVEMENT

- ◆ Delays in civil works. Poor quality of construction in health facilities. Deficiency of residential accommodation of staff.
- ◆ Fixed-day services at PHCs initiated, with doctors on visit from CHCs, especially for sterilization and specialist care.
- ◆ Training centers (ANMTC) in the government and private institutions functioning sub-optimally mainly due to lack of trained faculty.
- ◆ Huge backlog in training (achievement against PIP ranges from 3% to 33%).
- ◆ Poor utilization of District Hospital observed in both the districts- due to lack of specialists and nurses and limited range of services.
- ◆ The AYUSH facilities and services for Geriatric health Care and other life style diseases need to be strengthened.
- ◆ More than 50% of deliveries are home deliveries, although institutional deliveries have doubled - from 20–25% to 40–45% - in last 5 years.
- ◆ All MCH facilities are functioning as level-1 or level-2. No facility functioning as level-3 or FRU level in both the districts.
- ◆ PCPNDT is on low priority, given the prevalent good child sex ratio. Officials involved in PCPNDT not fully confident on how to initiate cases against non-compliance.
- ◆ Shortage of program management staff, especially at the block level, resulting into huge backlog in UCs from the peripheral institutions. Also, low remuneration of program management staff (as compared to MGNREGA, SSA) causing discontent and turnover of staff at district and block levels.
- ◆ Many essential items like ARV, IFA not available from state supplies, being locally procured through JDS.
- ◆ HMIS data no longer being analysed at district level, nor being used for preparing PIPs as there are no tools or support for such analysis.
- ◆ Almost 46% of annual budget blocked in civil works (28%), VHSNC (6%) and JDS (10%) accounts as "advance outstanding", causing problems in funds flow.
- ◆ Sub-optimal infrastructure of AYUSH facilities.



DISTRICTS/INSTITUTIONS VISITED

NORTH DISTRICT

District Hospital Mapusa, CHC Valpoi, CHC Pernem, PHC Sanquelim, PHC Alodona, PHC Candolim, PHC Betki, SC Harvalim, SC Bastora, SC Sangolda, AWC Bardez, AWC Ponda.

SOUTH DISTRICT

District Hospital Hospicio Madgaon, CHC Curchorem, CHC Curacuram, PHC Balli, PHC Ioutolim, SC Raia, SC Verna.

THE REVIEW TEAM

- ◆ Ms. Preeti Pant, Director – NRHM – 3, MoHFW, Govt. of India, New Delhi. (Team Leader)
- ◆ Dr. D.D. Malekar, RD Office, Govt. of India, Pune
- ◆ Dr. Aboli Gore, Maternal Health Officer, UNICEF, New Delhi
- ◆ Ms. Anamika Saxena, Consultant, Training, MoHFW, Govt. of India, New Delhi
- ◆ Dr. Dinesh Jagtap, Consultant – Public Health Planning, NHSRC, New Delhi
- ◆ Mr. Prabhash Jha, Finance Management Group - NRHM, MoHFW, Govt. of India, New Delhi
- ◆ Ms. Salima Bhatia, Consultant, NRHM-1, MoHFW, Govt. of India, New Delhi

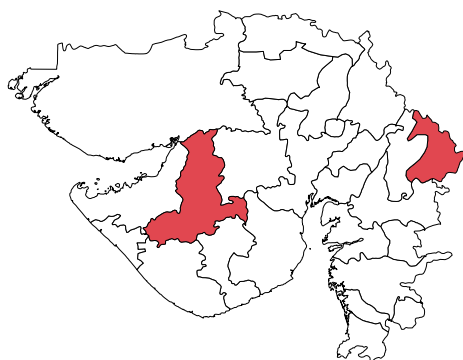


POSITIVES

- ◆ Fully functional one tertiary care and two secondary care Hospitals to cater to 14 lakh population.
- ◆ PRI involvement to monitor the health system is helping which is up to a large degree satisfying the need of community monitoring.
- ◆ State has many initiatives towards addressing emerging needs of non-communicable diseases where diabetes, cancer, neonatal screening for metabolic disorders are significant.
- ◆ The State needs to go in for quality certification of hospitals and also put in place hospital managers to assist the head of the hospital in managing the hospital. It should strive to ensure adherence to quality assurance standards in the provision of health care at all levels of service delivery.
- ◆ Completely FREE Services including diagnostics and drugs to those who come to the government facilities – ‘Ensuring affordability and removing barriers to access’. Out of pocket expenditures are minimal and there was no evidence of informal payments.
- ◆ Availability of assured referral transport to cater to emergencies. For neonatal emergencies specialized neonatal ambulances have been introduced since a month.
- ◆ State has to immediately start drop back services for operationalizing JSSK. JSSK entitlements should be urgently displayed at all facilities.
- ◆ State has many initiatives towards addressing emerging needs of non-communicable diseases which include: Diabetes Screening and Registry, Mobile Mammography Vans, Cancer Registry, Hypertension screening, Screening for Infant Metabolic Disorders, Tobacco Control Initiatives, Mental Health – De-addiction.
- ◆ Goa is considered among top states in terms of completeness of data entry for the Mother and Child Tracking System.
- ◆ Absence of a State level training institute. Thus training infrastructure and capacity to achieve training load should be developed.
- ◆ State has to strengthen RNTCP programme to meet the national targets. There is a need to study and find out the reason for low annual case detection rate of TB.

AREAS OF IMPROVEMENT

- ◆ Doctors with DGO (diploma in Gynae & Obstetrics) qualification should be empowered to deal with the complications and C-sections where they may go for a refresher training to build their confidence.
- ◆ Health Package is needed that clearly defines the entitlement of every citizen about the services that each of the primary and secondary level facility is going to provide in the State.
- ◆ State has to strengthen RNTCP programme to meet the national targets.
- ◆ HR policy for contractual staff along with performance review method to be developed.
- ◆ Quality Assurance Committees need to expand their mandate to cover full range of service delivery.
- ◆ State needs to start district and block level action to have a decentralized planning under NRHM.
- ◆ State has to immediately start the referral transportation for PW particularly to ensure drop back services.
- ◆ State needs to improve further quality of services. Patient friendly services at the hospital need to be strengthened.
- ◆ NRHM funds need to be disbursed on time to all the facilities.
- ◆ Protocol for conducting labor including use of partograph to be ensured.
- ◆ There is a need to study and find out the reason for low annualized case detection rate of TB.
- ◆ To detect glaucoma cases Ophthalmic Assistants may be trained to perform tonometry.
- ◆ State needs to update and disseminate essential drug list (EDL) to all health providers.
- ◆ District Health Societies need to maintain all account registers including advance register to be reconciled periodically.
- ◆ Procurement manual/guidelines need to be prepared by the state for all NRHM societies.
- ◆ To ensure functional VHSNCs a reorientation is required.
- ◆ Absence of a State level training institute. Thus training infrastructure and capacity to achieve training load should be developed.



DISTRICTS/INSTITUTIONS VISITED

RAJKOT

District Hospital, Padam kunvarba Hospital, Morbi Sub District Hospital, Raj Shobag Satsang Mandal, Saila CHC, Surendra nagar PPP Model, CHC Limkheda, PHC Rajpar, PHC Khankhreach, 24 x 7 PHC Gomta, Thorala Sub Center, Makansar Sub Center, Ambardi SC, Vadmajari SC, Vatsalya Hospital, Shri Ram Hospital Trust Hospital, Goyal Hospital.

DAHOD

District Hospital, State Hospital, Devgarh Baria, CHC Jhalod (designated FRU), PHC Bordi Khurd, PHC Panchvada, PHC Bandibar, Sub Health Centre Dungarpur, Sub Health Centre Thanda, SHC Agara, Santok Bai Maternity and Children Hospital Dahod, Neil Maternity Home, Limkheda the last two are Chiranjeevi Yojana facilities.

THE REVIEW TEAM

- ◆ Mrs. Anuradha Vemuri, Director, MoHFW (Team Leader)
- ◆ Dr. Manisha Malhotra, AC-MH, MoHFW
- ◆ Dr. P.D. Chavda, Regional Director Health and Family Welfare, Ahmadabad
- ◆ Dr. Prabha Arora, JD, NVBDCP
- ◆ Dr. Parminder Gautam, Senior Consultant, NHSRC

- ◆ Dr. Vikaram Rajan, Senior Health Expert, World Bank
- ◆ Vd. Smita Bajpai, Coordinator, RRC-CHETNA
- ◆ Mr. K. Kaushal, FMG, MoHFW
- ◆ Dr. Mahaveer Golecha, PHFI
- ◆ Dr. Arpana Kullu, Consultant NRHM

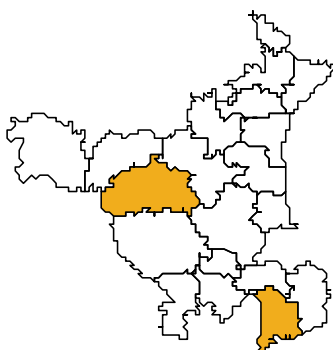


POSITIVES

- ◆ Project Implementation Unit for infrastructure has helped in completion of projects on time.
- ◆ Serious quality accreditation programme for health facilities, under a state quality assurance cell, working with different options and approaches - Work ongoing in 89 facilities.
- ◆ AYUSH doctors are making important contributions to National Health Programmes and their knowledge, surveillance activities, education/awareness provided to the community is admirable and records were well maintained.
- ◆ Good progress in NSSK and IMNCI training with post training follow up for IMNCI is being conducted by SIHFW.
- ◆ Innovative initiatives have been taken for bridging HR gaps-e.g. enhancing retirement age to 65 years for doctors and nurses, contractual appointment of specialists and MOs, outsourcing paramedical staff, walk in interview every Monday/Tuesday for MOs/Specialists.
- ◆ Supply of Drugs and Disposables adequate at all facilities visited and essential drug list was available.
- ◆ Citizen charters with service guarantee was displayed in Gujarati at all facilities visited.
- ◆ "Mamta Diwas" is being conducted with full range of activities and active involvement of all field functionaries, AWW, ASHA and FHW, and with necessary equipment and supplies.
- ◆ There are in total 88 MMUs with GPS systems installed in the state out of which 32 are for tribal areas in the state, providing outpatient care.
- ◆ EMRI – emergency response systems- Currently available throughout Gujarat through the toll free number 108 and 526 ambulances. Includes both Basic and Advanced Life Support Ambulances.
- ◆ State has launched a sickle-cell Anemia Control Program- with extensive public private partnerships to reach 61.62 lakhs tribal population of whom 10 lakhs people are expected to be having sickle trait and 1-lakh sickle disease.

AREAS OF IMPROVEMENT

- ◆ There is a need to focus more investment, and more human resource and more managerial skills in the high focus districts of the state. Increased recorded infant deaths in the high focus district of Dahod and overall stagnant high infant mortality in the state needs to be addressed.
- ◆ There is a need for special incentives and remuneration package to attract and retain specialists, medical officers or nurses in tribal and remote areas.
- ◆ Quality of services in Chiranjeevi facilities needs to be ensured- with focus on women staying on for at least 48 hours after child birth. Efforts needed to eliminate out of pocket expenses in Chiranjeevi and Balsakha schemes.
- ◆ Strengthening FRUs (163 designated) in public sector need to be operationalized. This requires improvement in training of doctors in LSAS and CeMONC.
- ◆ AYUSH doctors to be encouraged to practice their respective systems rather than encouraging only their role as substitutes for MBBS doctors.
- ◆ Training in bio-medical waste management for all cadre of staff.
- ◆ Maternal Death and Infant Death Review to be institutionalized and done with higher degree of analysis. It should be insisted upon even in Chiranjeevi Yojana facilities.
- ◆ Timely payments for JSY and Sterilization from the facilities need to be ensured.
- ◆ Though a pioneer in maternal and child tracking, state needs to ensure timely uploading of data so that outputs in terms of work plans for health workers.
- ◆ State may take corrective actions to settle the pending advances and keep NRHM funds separate from non NRHM funds.



DISTRICTS/INSTITUTIONS VISITED

HISSAR

State Health Society, Panchkula, Haryana, District Health Society, Civil Hospital, District Medicine Store, Civil Hospital, Sub District Hospital, Adampur, CHC, Mangali, Barwal,, Seeswal, PHC, Ladwa, Chuli Bagaria, Sub Centre, Bagana, Bahbalpur, Seeswal.

MEWAT

District Hospital-Mandikhera, CHC-Nuh, PHC-Nuh, Tauru, Sub Centre-Bhadas, Delivery Point-Nautki, Outreach Session-Dabla, Focus Group Discussion-Nautki and Pada.

THE REVIEW TEAM

- ◆ Sh. Sanjeev Chadha, Director PMSSY, MOHFW, Gol, (Team Leader)
- ◆ Dr. Aruna Jain, AD (NVBDCP), Gol
- ◆ Dr. R.K. Pal, Advisor (NHSRC)
- ◆ Mrs. Kimberly Allen, ARSH Expert (UNICEF)
- ◆ Dr. Ankur Yadav, NIHFV
- ◆ Dr. Syed Shahid Abbas, PHFI
- ◆ Ms. Neha Agarwal Consultant (MoHFW), Gol
- ◆ Dr. Sunita Paliwal, Consultant (MoHFW), Gol
- ◆ Mr. Utpal Kapoor, Consultant (MoHFW), Gol



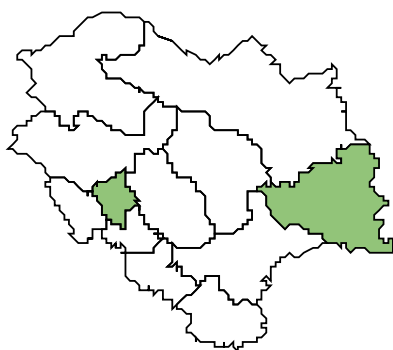
POSITIVES

- ◆ Difficult area allowance is being given to Doctors posted in Mewat district and Hathin block of Palwal district (Rs. 25,000 per month for Specialist, Rs. 10,000 per month for other Doctors).
- ◆ Effective steps being taken for mainstreaming and utilization of AYUSH manpower: AYUSH Doctors are member of SKS/DHFWS. They are participating in school health & immunization programme, promotion of early breast feeding, anemia control & Polio eradication.
- ◆ For effective IEC/BCC, Mewat FM1 90.4 launched on 29 Sep.2011. It is functioning at Nuh CHC with a transmission limit of 20 KMs covering around 60% of the district. The Radio operates in local Mewat language 3 hrs in morning and 3 hrs in evening.
- ◆ 26 vehicles are hired on each Wednesday and 19 on Friday to drop paramedical staff and vaccine for Immunization and ANC session in inaccessible/difficult to reach villages. This initiative has been started since Sept 2010.
- ◆ Under Jachcha-Bachcha Scheme in the state to ensure post-natal care, incentive to ANMs at the Sub-Centers & to Staff Nurses at PHCs & CHCs are paid after a minimum 3 deliveries per Staff Nurse/ANM per month.

AREAS OF IMPROVEMENT

- ◆ Existing role & expertise of DPM needs to be expanded and number of relevant experts to be added.
- ◆ As being implemented in Mewat for blocks having poor access, weekly provision of hiring vehicles for team of ANMs & supervising MOs need to be initiated & continued in relevant blocks of other districts also, where similar problems exist.
- ◆ Regular supervision of functional status along with checking the calibration of equipments & efforts to develop a system for their prompt repair are crucial & require urgent attention.
- ◆ The tendency to record false data in absence of functioning equipment needs to be curbed.
- ◆ Timely reimbursement of incentives to keep ASHA motivated, preparation of training plan to enhance their skills & local purchase of drug kit without waiting indefinitely for state procurement to start.
- ◆ Strengthening regular Supportive supervision of over all program is required on urgent basis.





DISTRICTS/INSTITUTIONS VISITED

KINNAUR

DHs, Rekong Peo, SDHs Theog and Rampur, Jaypee Hospital (Pvt.), District Ayurvedic Hospital, Rekong Peo, Ayurvedic hospital Rampur, CHC Bhavanagar and Pooh, PHCs Spillo, Gyabung, Ribba, Kalpa, Ayurvedic Dispensary, Nako, SCs Bari, Ponda, Rispa, SC and AWC Malling, AWC Nako and Kache.

HAMIRPUR

District Hospital, Hamirpur, Civil Hospital Tauni Devi, MPW Training School, CHC Bhoranj & Nadaun, Sub Centers Chabutra, Kharwar, Lohakhar (block Tauni devi) & Janiyari.

THE REVIEW TEAM

- ◆ Dr. Sila Deb, Assistant Commissioner (Child Health-II), MoHFW, Gol. (Team Leader)
- ◆ Dr. Abhishek, Regional Director, Gol, Shimla
- ◆ Dr. Dinesh Katoch, Joint Advisor, Dept. of AYUSH, MoHFW
- ◆ Ms. Neidono Angami, Member Mission steering Group, Civil Society
- ◆ Dr. T. Sundararaman Executive Director, NHSRC, NIHFW Campus, New Delhi
- ◆ Dr. Suprna S Pachauri, Ministry of HRD, Shastri Bhawan, New Delhi
- ◆ Dr. Preeti Kumar, Public Health Foundation of India, New Delhi
- ◆ Dr. Sheila Ward, Public Health Expert, European Union
- ◆ Dr. Umesh Chandra Sahoo, Senior consultant NIHFW, New Delhi
- ◆ Mr. Aman Kumar Ram, Consultant, FMG, MoHFW,
- ◆ Dr. Nitasha M Kaur, Consultant (NRHM-I), Consultant (NRHM-IV),
- ◆ Ms. Shraddha Masih, Consultant (NRHM-IV), MoHFW, New Delhi

POSITIVES

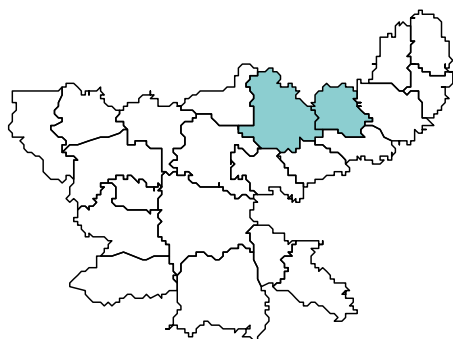
- ◆ Achieved national goals in TFR.
- ◆ Adequate infrastructure of very good quality with requisite density as needed for hilly areas.
- ◆ Every hamlet has access to primary health care and there RMPs private practice by government doctors. Health care delivery in the state is predominantly by public sector with an almost 2.4 OPD visits per capita.
- ◆ Good functional AYUSH facilities with adequate supply of medicines, 1159 AYUSH units in the state attended to about 60 lakh patients in a year.
- ◆ AYUSH doctors are involved in DOTs, anemia control and school health programs.
- ◆ Well-designed incentive package and expansion in medical education helps fill up medical officers vacancy even in inaccessible areas. Over 95% of the 456 PHCs in the state are functioning with Medical Officers.
- ◆ Health facilities including sub-centers in Kinnaur district was well stocked with essential drugs and supplies as a result of higher per capita spend on drugs and supply based on essential drug lists rather than drug kits. But in Hamirpur, scarcity of drugs and stock outs was a problem.
- ◆ Innovative programmes like the Anemia programme and Beti Anmol Hai have a wide reach and welcome.
- ◆ Innovative, open source based participatory developed, Hospital Information system has much potential as decision making support to both clinical care and hospital administration and could be scaled up.



Maling Village has the world's highest altitude situated Sub-Centre

AREAS OF IMPROVEMENT

- ◆ MMR and IMR remains high and indicates areas with persisting lack of access to quality services.
- ◆ Acute shortage of ANMs and nurses and paramedics could be overcome by expediting regular recruitment, and decentralizing contractual appointments to district level. Creation of nursing positions also urgently required.
- ◆ Public health orientation of nurses and doctors in peripheral facilities so as to go beyond clinical outpatient care to improving population health status. Multi-skilling of health workers in peripheral facilities needed for efficient use of available staff to provide a larger range of clinical services.
- ◆ Responsive and transparent procurement and supply chain management system based on the TNSMC model.
- ◆ Need to reach out to the migrant labor in apple farms and in construction work, recognize and overcome exclusion and ensure access to free health services.
- ◆ There should be a coherent and actionable public health plan to address the emerging threats from leishmaniasis and scrub typhus.
- ◆ Need to strengthen mainstreaming of AYUSH to make a greater choice of systems of care available in the PHC, CHC and district hospitals.
- ◆ The EMRI system needs to be supplemented with tie ups with local transport service providers.
- ◆ Greater attention is required towards strengthening measures for reducing out-of-pocket expenditures and user fees in public hospitals.
- ◆ The implementation of RSBY scheme needs to be strengthened to ensure that beneficiaries received cashless service, that poor are not excluded on a number of technical grounds and programme gaps, and that reimbursements from insurer to facility are timely.
- ◆ Filling up vacant posts of AYUSH doctors & paramedics and to house AYUSH dispensaries in own government buildings need to be taken up on priority.
- ◆ Specialist cadre of AYUSH need to be properly structured for appropriate use at Regional and District Ayurveda hospitals.



DISTRICTS/INSTITUTIONS VISITED

DEOGHAR

Sadar Hospital Deoghar, ANMTC, Deoghar, Block PHC Palojori, Block PHC Madhupur, Block PHC Karon, Block PHC Mohanpur, Block PHC Sarwan, Block PHC Sarath, PHC Madhupur, Budhai PHC, HSC Kushamaha, HSC Lakhoria, HSC Buscopia, HSC Chulhia, HSC, Malahar, HSC Bedia, AWC Lahore, AWC Buscopia, AWC Malahar, AWC Kherwas.

GIRIDIH

Sadar Hospital Giridih, ANMTC Giridih, Block CHC Pirtand, Block CHC Bagodhar, Block CHC Bengabad, Block CHC Jamua, Block CHC Birni, Block CHC Tesri, Block CHC Gandey, Block CHC Deori, PHC Barmasia, PHC Palganj, PHC Sariya, HSC Khiuri, HSC Lokai, HSC Chandori, HSC Chatro, HSC Nagar Keswari, HSC Bakshidih, HSC Chitradih, HSC Ojhadih, HSC Behradih, HSC Chitki Khagariya, AWC Gapai-II, AWC Ghatadih, AWC Basariya, AWC Chitadih-II, AWC Rukutand, AWC Mohandih, AWC Bandhawad, AWC Bharti Chalkari, Village Kala Pathar, Village Amnari, Village Jamua, Village Loki, Village Gapai-II, Village Chitadih-II, Village Bharti Chalkari.

THE REVIEW TEAM

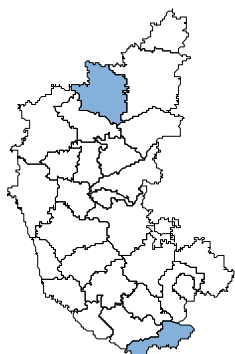
- ◆ Dr. Navneet Kumar Dhamija - Deputy Commissioner (Immunization), MoHFW, Govt. of India. (Team Leader)
- ◆ Dr. G.S. Sonal - Addl. Director-NVBDCP & HOD Malaria Division, MoHFW, Govt. of India
- ◆ Mr. Suryamani Mishra- DD(Health), NIPCCD, Ministry of WCD, Government of India
- ◆ Dr. J.N. Sahay - Advisor - NHSRC
- ◆ Ms.Shailaja Chandra - Civil Society Member,Former Secretary to Government of India
- ◆ Prof. R.B. Bhagat- Professor and HOD, Deptt of Migration and Urban Studies.IIPS,Mumbai
- ◆ Ms. Nirmala Mishra - Program Manager,Public Health Foundation of India
- ◆ Dr. Sangeeta Kaul - Care and Treatment, USAID, American Embassy
- ◆ Dr. Pradeep Tandan - Consultant NRHM, MoHFW
- ◆ Dr. Shahab Ali Siddiqui – Consultant, NRHM, MoHFW
- ◆ Dr. Shibu Vijayan- Consultant – RNTCP, MoHFW
- ◆ Mr. Dharmendra Kumar - Consultant Finance, NRHM, MoHF
- ◆ Dr. Purna Chandra Dash- Expert in Health Economics & Research Methods, European Union

POSITIVES

- ◆ There is 120% increase in ANM Schools from last CRM (4th). 12 new private institutions have come into existence amounting to total 22 ANM schools in the state.
- ◆ More sub-centers are performing well and conducting deliveries as well with support of local community and Sahhiyas.
- ◆ There is substantial increment and up gradation in health infrastructure. From 12 to 21 district hospitals, 194 new CHCs/SDHs and 136 new PHCs.
- ◆ 'Skill Labs' at Giridih district, help the ANMs and Nursing staffs to update their knowledge, acquire skills and enhance confidence.
- ◆ Response from the public for the maternity referral transport scheme, Mamta Vahanis encouraging.
- ◆ The essential Drug list was available at most of the facilities visited and drug availability position has improved. In the PHC/CHC there was a display board depicting the medicines.
- ◆ Patient related information and citizen charters were visible at the district hospital level. Giridih District hospital has a formal close loop complaint management system in place.
- ◆ All aspects of the cold chain management shown improvement and this is reflected in have improve by immunization.
- ◆ ANMs coordinate well with ASHA/Sahiyya and AWW. There is good interdepartmental convergence for the VHNDs and immunization. As a good practice we found that the state has created a Sahhiya Help Desk at the district hospitals to redress the grievances of the Sahhiyas.
- ◆ Malnutrition Treatment centers for severe malnutrition, increased from 58 in 2010–11 to 65 in 2011–12.
- ◆ Malaria surveillance has improved with Annual Blood Examination Rate (ABER) going up from 7.12 in 2006 to 10.51 in 2010, mainly due to use of Rapid Diagnostic Test (RDT) and better programme management unit.

AREAS OF IMPROVEMENT

- ◆ Construction activities need to be better streamlined with quicker completion, better quality, faster handing over to users and involvement of local health officials at every stage. Need to prioritise residence facilities in remote areas & HSC in infrastructure were deliveries are happening.
- ◆ Need for functional Quality Assurance Committee and Quality Management System at the Public Health Facilities. Adherence to Biomedical waste Management, as per protocol is required.
- ◆ District Hospitals visited needs major infrastructural inputs in terms of SNCU, dedicated OBG operation theatre and newborn resuscitation facilities at OT to provide Comprehensive Emergency Obstetric and Newborn care. Emergency services are not available separately during OPD hours. The OTs in district hospitals are on Ground Floor while labour rooms, wards, post-op wards are on first floor with no lifts or RAMPs. Patients are physically lifted by 4–5 people (generally relatives etc.) and this important aspect needs immediate attention.
- ◆ Need to address human resource gaps and skills development issues.
- ◆ The emergency services across the state register a very minimal presence. Emergency Trauma centers at the district head quarters is needed.
- ◆ The available diagnostic services in the facilities have provision for limited number of tests.
- ◆ PRI Participation and awareness in RKS and VHSNCs is variable. Utilization of RKS funds, untied fund is about 50% and meetings are not held regularly.
- ◆ Need to emphasize on providing in-patient services. The bed occupancy across the facilities in the district is 25 to 50 %. Predominantly the beds are occupied by delivery cases.
- ◆ In most of the facilities little emphasis is given on Family Planning methods. There has been reduction in the number of NSV & tubectomy conducted in the district. There is poor distribution of OCPs and condoms by ANMs. IUD insertions are significantly low at all facilities in the districts.
- ◆ Poor drug kits refilling is hindering the good work of Sahiyyas.
- ◆ State has inadequate anti-malarial stocks. There is also shortage of RDT and ACT. States needs procurement supply side system in place.
- ◆ Reporting of HMIS data is lagging behind in the entire state due to HR crunch exacerbated due to MCTS workload.



DISTRICTS/INSTITUTIONS VISITED

BIJAPUR

DH Bijapur; Taluka General hospitals Sindagi, Basavana Bagewadi; PHC – Honaganahally, PHC Kolhar, PHC – KANNUR, PHC Vandal, PHC (24 x 7) Thamba; HSC Madhbhavi, Tidagundi, Balluthy; MMU Chikkallapur; ANMTC Bijapur.

CHAMARAJANAGAR

DH Chamarajanagar; CHC Santhamaralli, CHC Gundlepet Block Hospital; PHC Gumballi, PHC Gonachi, Chilakavade, Palya, Sathyagala, Hangla, Harve, Gundelpet Block; SC Yergamballi, Santhamaralli, Mariala, Nanjadevanpura; AWC: Nanjadevanpura.

THE REVIEW TEAM

- ◆ Dr. S.K. Sikdar Dy. Commissioner, FP Family Planning Division, MoHFW. (Team Leader)
- ◆ Dr. C. Anbazhagan Sr. Regional Director- Karnataka, MoHFW
- ◆ Dr. Dilip Singh, Advisor NHSRC
- ◆ Mr. K.V. Hamza, DNIP Care
- ◆ Dr. K. Ravi Kumar CMO (SAG), RO, Bangalore, MoHFW
- ◆ Ms. Mona Gupta Technical and Management Support, MSG Strategic Consulting Pvt. Ltd.
- ◆ Dr. Megha Khobragade, Asst. Director Integrated Diseases Surveillance Programme
- ◆ Dr. Pratima Mitra Sr consultant NIHFV
- ◆ Dr. Raghuvanshi State Programme Officer, UNFPA
- ◆ Mr. Sanjiv Rathore Finance Assistant FMG
- ◆ Mr. Vaibhao Ambhore, Consultant (NRHM-I), MoHFW



POSITIVES

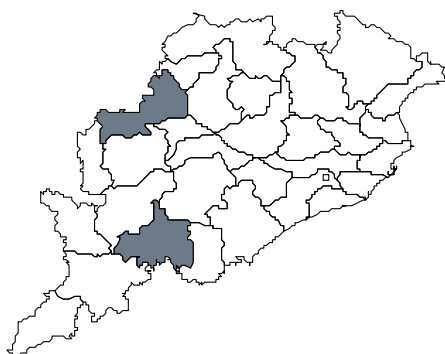
- ◆ Major gains made in some key health indicators - TFR target surpassed and MMR and IMR have shown steep declines. TB, malaria and leprosy control programmes doing well.
- ◆ Architectural corrections in health systems in last 2 years exemplary- establishment of Karnataka State Drug Listing and Warehousing Society (KSDLWS); regulation of transfers and postings by a legislative Act; registration of all private practitioners etc. and SMS-based mother and child tracking; web-enabled financial tracking system. More Acts and regulations to streamline health systems functioning and ensure transparency in the pipeline.
- ◆ Adequate number of facilities at all levels, in compliance with national guidelines and most facilities provide a good range of RCH services as expected for that level. In addition 839 private hospitals accredited for JSY.
- ◆ Incentives are being provided to all staff posted in remote/difficult areas.
- ◆ Quality Assurance Committees have been formed at state and in all districts, and quality of services was found to be satisfactory at visited sites.
- ◆ 517 ambulances as part of EMRI and 176 as part of Janini Suraksha Yojana provide emergency referral transport services.
- ◆ JSSK programme working in all aspects except free drop-back home.
- ◆ Availability of experienced senior officials as well as energetic young KHSDRP-NRHM officers at the state, district and taluk level. Many examples of personal excellence.
- ◆ Excellent convergence between NACP-3 and NRHM.



AREAS OF IMPROVEMENT

- ◆ Maternal mortality is the highest amongst southern states and correlates with high unreported deliveries (32% of estimated deliveries) and relatively low institutional delivery on DLHS-III, needs further focus- especially in high focus districts.
- ◆ SNCUs and facility based care for sick newborns and children needs to improve. Nutrition rehabilitation centers may also be needed.
- ◆ Immunization coverage needs to be increased. In all RCH services, coverage of BPL population in urban areas needs greater focus.
- ◆ Unmet needs for family planning have increased slightly between DLHS-2 and DLHS-3 and is a cause for concern, despite overall targets having been achieved.
- ◆ MMUs could be utilized better and the range of services provided by these MMUs can be expanded for better health outcomes.
- ◆ Actual availability of 24x7 EmOC services especially at night is an issue. Some FRUs are conducting elective c-sections and not really providing the Emergency Obstetric Care as mandated. The complicated cases at night are being referred to DH which has the same complement of staff and equipment as an FRU for EmOC.
- ◆ High risk cases (e.g. severe anaemia, high BP etc.) are being screened but follow up of such cases is an issue.
- ◆ Though many sub-centres continue conducting good number of deliveries, Sub Centre deliveries are not considered institutional delivery in Karnataka.





DISTRICTS/INSTITUTIONS VISITED

BARGARH

District Hospital - Bargarh, SDH-Padampur, CHC – Attabira, Dava, Agalpur, Barpalli, Suhela PHC (N)-Satalama, Kumelsingha, Ghess, Khadobal, Paikamal, Jharbandh SHC – Kusumpuri, Satalama, Jhara, Jaring, Iarambha, Janapara & Amthi VHND - Amamunda, Kumelsingha AWC – Amamunda Others - ASHA Gruha-Padampur, ASHA Training (AJKA) Paikamal, MHU Paikamal, Shanti Nursing Home, Meeting with Sarpanch & Bar Association (Life Line) members.

RAYAGADA

District Hospital-Rayagada, SDH Gunupur, CHC – Ramanaguda, Muniguda PHC-Kolnara SHC–Therubali, Gogopadu AWC, GKS, VHND – Relipadar, Jhara, Guakona ASHA Training Centre – Muniguda GKS Convention - Rayagada Others – Maternity Waiting Home, District Drug Store, District Vaccine Store.

THE REVIEW TEAM

- ◆ Dr. B. Kishore, Dy Commissioner, MoHFW, Gol. (Team Leader)
- ◆ Dr. A.K. Sathpathy, Sr. Regional Director, Odisha, MoHFW, Gol
- ◆ Sh. Manoj Pant, Director, Ministry of Health & Family Welfare, Gol
- ◆ Dr. S.K.Sahu, Advisor, AYUSH, Ministry of Health & Family Welfare, Gol
- ◆ Dr. S.K Adhikari, Assistant Director, (M & E and Training), ICDS Programme, MOWCD, Gol
- ◆ Mr. Patrick Mullen, Programme Specialist, World Bank
- ◆ Dr. Anuradha Jain, Sr. Consultant NHSRC, MoHFW, Gol
- ◆ Dr. Ashoke Roy, Advisor, Public Health, Regional Resource Centre- N.E. States, MoHFW, Gol
- ◆ Dr. Deepti Agarwal, Consultant, Assured Service Delivery, RCH, MoHFW, Gol
- ◆ Dr. Surojit Chatterji, Project Director, Health for Urban Poor Project (HUP), Population Foundation of India (PFI), Lucknow, Uttar Pradesh
- ◆ Ms. Hena Chakrabarty, Consultant, Planning & Policy Division, NRHM, MoHFW, Gol
- ◆ Sh. T.D. Prasanta Rao, S.O. NRHM, Finance, MoHFW Gol

POSITIVES

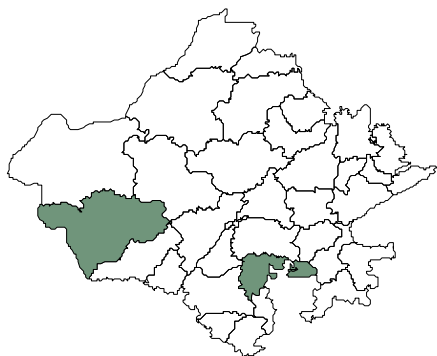
- ◆ MMR dropped from 303 (SRS, 2005–06) to 258 (SRS, 2007–09) – a decline of 45 points.
- ◆ FRUs increased from 20 to 81 with 63 having blood bank/blood storage facilities.
- ◆ 10 Maternity Waiting Homes made functional – this is a systems innovation in hard to reach areas.
- ◆ Construction process decentralized with the establishment of engineering wing and integrated with infrastructure planning and monitoring process.
- ◆ A State Human Resource Management Unit and Nursing Management Support Unit have been established. A data base of health personnel is in process.
- ◆ 792 of 1225 doctors recruited last year are through OPSC recruitment process.
- ◆ Fixed day payments and grievance redressal, drug kit replenishment for ASHA every month, ASHA “Gruha” and e- transfer of their incentive has facilitated better functioning of ASHAs.
- ◆ Gradation of Gram Kalyan Samiti and capacity building efforts to improve its performance is a good model of community involvement in addressing social determinants of health.
- ◆ District level convergent planning and epidemic control measures to prevent cholera epidemic was a good model observed.
- ◆ Prevalence rate of leprosy has increased from 0.85 to 1.17 per 10,000 due to better detection and treatment completion rate (99.4%) has also improved due to involvement of ASHAs.



AREAS OF IMPROVEMENT

- ◆ IMR has decreased from 75 (SRS 2006) to 61 (SRS 2010)-14 points - average decline of 3.8 points every year. This rate of decrease needs to be enhanced.
- ◆ Neonatal deaths are going unrecognized at facilities. Peri-natal death enquiry system to be put in place to address large number of neonatal deaths.
- ◆ Civil works seem to take inordinate time. Build, Operate and Transfer (BOLT) mechanisms could be explored for civil works in the state. Infrastructure planning as appropriate to technical requirement is the need of the hour.
- ◆ Monitoring and supportive supervision needs strengthening at the State and district level on a regular basis.
- ◆ Biomedical waste management needs strengthening in state.
- ◆ Poor synchronization between conceptualization of Pushtikar Diwas and whole state having just 3 NRCs is an area requiring improvement.
- ◆ Multi skill training of Medical Officers specially for LSAS, EMOC and F-IMNCI and MTP will help state to improve its range of services for RCH.
- ◆ Multi skilling of lab Technicians and improvement in range of lab services will further boost case loads.
- ◆ Performance of NPCB is an area of concern due to lack of appropriate Human Resource (ophthalmologists) and infrastructure (operation theatres).





DISTRICTS/INSTITUTIONS VISITED

BARMER

District Hospital, District Drug Warehouse Barmer CHC, Kalyanpur, CHC, Dhorimanna, CHC, Sheo, PHC, Dhanau, PHC, Sata, PHC, Bhakasar, Sub – Center SHC Mukne Ka Tala, Sub Centre, Mangta, Sub Centre, Alamsar, Sub Centre, Majiwala.

CHITTAURGARH

District Hospital, Chittaurgarh, Nimbahera SDH, CHC Badisadri, Mandophia CHC, Rawatbhata CHC, PHC Nikumbh Boraw, PHC Bhadsoda, PHC Ghosunda, PHC Sowania, SC Lasrawan, SC Badolia SC.

THE REVIEW TEAM

- ◆ Ms. Rita Chatterjee Joint Secretary, Ministry of Human Resource Development. (Team Leader)
- ◆ Dr. Sajjan Singh Yadav Director NRHM – I, II Ministry of Health & Family Welfare
- ◆ Dr. Sanjeev Gupta Additional Director, NVBDCP, Ministry of Health & Family Welfare
- ◆ Dr. A.C. Baishya Director RRC -NE, NHSRC
- ◆ Dr. V. Shekhawat Regional Director, Rajasthan, Ministry of Health & Family Welfare
- ◆ Sh. A.K. Deori US (EPW), Ministry of Health & Family Welfare
- ◆ Mr. Vijay Paulraj Project Management Specialist, Family Planning –USAID
- ◆ Dr. S.K. Mondal Senior Manager, Population Foundation of India
- ◆ Mr. Rahul Govila Finance Assistant, FMG NRHM, Ministry of Health & Family Welfare
- ◆ Ms. Asmita Jyoti Singh Consultant – NRHM, Ministry of Health & Family Welfare
- ◆ Ms. Rajashree Panicker Consultant, Public Health Foundation of India
- ◆ Dr. Sonali Rawal Consultant – NRHM, Ministry of Health & Family Welfare

POSITIVES

- ◆ Adequate health infrastructure and sufficient equipment were available in both districts.
- ◆ State has provided flexibility to districts and facilities to come up with the innovative ways of fund raising. From many sources funds are being used

for creation of health infrastructure in the State like BADP, donation by the community/trust/business houses, corporate, donor funds.

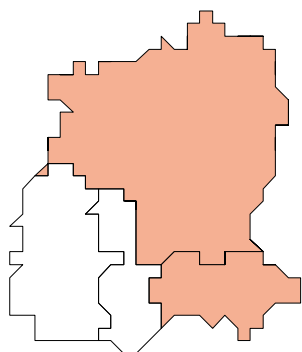
- ◆ Contractual recruitment has been the main strategy to meet the immediate demand of the human resources in the State. At present, 18593 contractual staff has been recruited at different levels out of the

total 20,335 sanctioned posts in Rajasthan. For better programme management and strengthening of health infrastructure, around 500 management professionals, 1100 Accounts professionals and 600 IT/Computer professionals have also been appointed on contract under NRHM.

- ◆ State has tried to meet the critical gaps of the MOs at the various levels of the facilities by recruiting AYUSH doctors. As of now, 2757 AYUSH Doctors are posted under Ayurveda Department and 1014 AYUSH Doctors are posted at PHCs, CHCs and DHs under NRHM.
- ◆ Special appointments of doctors have been made for rural and remote area and state has incentivized the posting of these doctors in inaccessible areas of the state.
- ◆ Gradual shift in institutional deliveries from DH/SDH and CHC towards PHC and SC has been noted. In district Barmer, Sub-Centers were handling 12.26 % of institutional deliveries in 2008–09 which increased to 27.68 % of institutional deliveries in 2010–11.
- ◆ SNCUs in both districts were found fully functional.
- ◆ 108 service for referral transport has been made operational in the State.
- ◆ State has 43000 ASHAs involved in mobilization and service provision under ICDS program with the Anganwadi workers. Due to ASHA's expanded role they are called as ASHA Sahyogini in Rajasthan. ASHAs are given a fixed incentive of RS. 1,000 per month from the ICDS for their work.
- ◆ The State initiated 'kalewa' yojana and most of PHCs visited by team were providing regular cooked meals.
- ◆ Dedicated PCPNDT Cell has been established at State and District level. A total of 4494 inspections, 196 suspension and cancellation, 298 Seal and Seizures of the health facilities have been done and 192 Complaints and 22 FIR have been filed in the court by the appropriate Authorities. Department has started auditing of form-F as a separate activity in all 34 districts through District PCPNDT Co-ordinators. 342 NGOs will be involved in the Inspections & Public Awareness activities to prevent Female Foeticide.
- ◆ The State Govt. has constituted Rajasthan Medical Services Corporation Limited (RMSCCL) for procurement and free distribution of medicines to all patients visiting Govt. facilities.

AREAS OF IMPROVEMENT

- ◆ Coordination between the infrastructure wing and health department needs to be strengthened at all levels to minimize the infrastructure gap.
- ◆ Effective use of the untied funds should be considered as most of the facilities visited by the team were poorly maintained and the untied funds are poorly utilized.
- ◆ There is need to plan the alternative mechanism to ensure the proper electric supply specially at the facilities where the cold chain is maintained.
- ◆ To catch up with acute shortage of specialists and medical officers, state should adopt rational deployment of the Human Resources for the optimal utilization. It is essential that state pays special attention towards retention of skilled professionals.
- ◆ The training needs of the health carders to be assessed and implemented effectively.
- ◆ Multi-skilling of existing staff must be prioritized in the State to mitigate the scarcity of specialists and doctors.
- ◆ Grievance redressal mechanism needs to be strengthened at every level and with proper information about higher appellate body.
- ◆ Awareness about 108 services among people to be promoted and call centre strengthened for effective operation of the referral transport.
- ◆ Quality Assurance committee needs to be strengthened.
- ◆ State may consider multi skilling as one of the strategies, as there is a critical shortage of the doctors in state for conducting NSV.
- ◆ Although state is trying to establish its drug supply chain, but that clearly needs training and supervision in maintaining drug warehouses.



DISTRICTS/INSTITUTIONS VISITED

NORTH DISTRICT

District Hospital Mangan, Phodong PHC, Passingdong PHC, Dikchu PHC, Phensong PHSC, Ting Bong PHSC, Singhtam PHSC.

EAST DISTRICT

District Hospital Singhtam, Rhenock CHC, Rangpo PHC, Pakyong PHC, Rongli PHC, Assam Lingzey PHSC, Changey Senti PHSC, Rorathang PHSC, North Regu PHSC.

THE REVIEW TEAM

- ◆ Dr. P.K. Nayak, DC (Training), MoHFW, New Delhi
- ◆ Sh. P.K. Abdul Kareem, Additional Economic Adviser, MoHFW, New Delhi
- ◆ Sh. Amba Dutt Bawari, US (NRHM-I), MoHFW, New Delhi
- ◆ Dr. Jagdeesan, UNICEF, New Delhi
- ◆ Sh. Prasanth K.S, Consultant, NHSRC, New Delhi
- ◆ Dr. Pradeep Malhotra, Regional Directorate of H&FW, Kolkatta
- ◆ Dr. Anubhav Srivastava, Consultant, NRHM, New Delhi
- ◆ Dr. Jayant Pratap Singh, Consultant, NRHM, New Delhi

POSITIVES

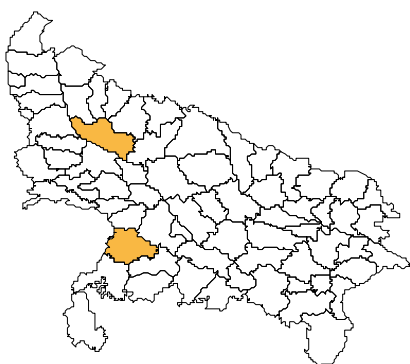
- ◆ Since April 2005, 9 newer institutions were built up, 2 CHCs, 2 PHCs and 5 SCs. All the buildings have been handed over, occupied and used by the Health and Human Services Department.
- ◆ The bed population ratio has improved from 530 to 390, in the mission period. The annual OPD has also increased from 194384 (2005–06)

to 381021 (2010–11). The IPD also showed an upward trend, from 27502 to 45703. The institutional deliveries in the state has shown a steady increase (HMIS) from 2430 (2008–09) to 3813 (2009–10) to 6648 (2010–11). Correspondingly the home deliveries have decreased from 2588 (2008–09) to 1972 (2009–10) to 1483 (2010–11). AYUSH OP cases have been good (10311) last year.

- ◆ All 4 districts have one MMU each which is functioning very well. In 2010–11, 44872 patients were examined in the MMU camps. This seems very much suited for population staying in difficult terrains.
- ◆ Doctors (other than specialists) are in place in the state as per the IPHS requirements; issue is with the distribution (skewed to the most developed areas of the state, the capital city and East Sikkim). There are 57 PHSCs with Second ANM and 138 PHSCs with MPW (male) as well.
- ◆ No informal payments were made by the mothers. They also did not spend money on drugs or consumables. They also received food from the hospital. Service guarantees and citizens charter was displayed in all institutions. All registers and records were printed and filled in. Records on RKS funds spending on patients amenities were available. Signages were also adequately put-up. Separate toilets were also available for women in all facilities. Canteen facility was available in district hospitals. A grievance redressal system is also in place. All the centres had printed registers.
- ◆ 96% of Planned Outreach immunization sessions have been held, and 94% of planned VHNDs have been held.
- ◆ ASHA selection has been completed by July 2010. All ASHAs have completed training up to 6th & 7th module. The system of giving honorarium by the state government (3000/month, payable quarterly) to ASHAs in Sikkim has been helping them and the system to address the drop outs.
- ◆ State has started the Maternal Death Review and reporting formats are filled and sent to government of India.
- ◆ The State Supervisory Board, Advisory Committees and District Appropriate Authorities have been notified in the state under the PCPNDT.
- ◆ The fund utilization rate was good, once it picked up, except for the year 2010–11. The overall fund utilization (from 2007) was 74% for RCH, 92% for NRHM and 95% for UIP.

AREAS OF IMPROVEMENT

- ◆ Gap in quarter requirement as per IPHS was only marginally addressed (e.g. nurses quarters requirement in district hospitals is 308 and only 4 was added during mission period).
- ◆ The State needs to come up with a Comprehensive Human Resources Strategy. The State has relied much on the contractual staff to fill up the positions in the difficult areas (e.g. North district). When one gap gets filled, at some other place, new gap is created.
- ◆ An assurance of level 3 care in every district, is essential to ensure the district manages its own population. Decentralization of the service delivery points is very essential. (STNM hospital at Gangtok, which does not receive any support from NRHM, conducts 24% of all deliveries reported from Sikkim).
- ◆ Among the 4 districts the North district is the most difficult geographically. It is important that the district should have very good emergency transport system and district hospital should be developed as a Specialized Emergency Centre with functional OT, blood bank and ICU to manage emergency cases.
- ◆ Internet and telephone connectivity is a challenge affecting many services including HMIS. The state may address this issue as a priority.
- ◆ When institutions are upgraded (PHC to CHC for instance), IPHS standards need to be followed. The state could also take up some quality accreditation programme.
- ◆ State must lay stress in ensuring;
 - ❖ Safe abortion services are initiated in the district hospitals.
 - ❖ JSY dispensation has to be fast and before the mother discharges from the hospital.
 - ❖ Improved utilization of ambulances in the hospitals.
 - ❖ Centralized Procurement Agency for procurement of drugs and supplies.
- ◆ Centre may also consider having a separate set of criteria for determining difficult, most difficult and inaccessible areas in the Sikkim and the other North Eastern states.



DISTRICTS/INSTITUTIONS VISITED

BADAUN

District Male Hospital, Badaun Urban, District Female Hospital, Badaun urban, Ujhani CHC (FRU), Bilis CHC, Bisouli CHC, Wazirganj CHC, Shaswan CHC, Dataganj CHC, Saidpur PHC, Mion PHC, Usawa PHC, Khitaura APHC, Bhetaghosia APHC, Paroli APHC, Sisora SC, Biharipur SC, Gautra VHND, Narpat Ramsi Patti VHND, Myori VHND, Khera Bujurg Jagat VHND, Nowshera Government Primary school.

JALAUN

District Male Hospital, Orai, District Female Hospital, Orai, Jalaun CHC, Konch CHC, Kalpi CHC, Bawai (Mahewa) PHC, Rampura PHC, PHC Pindari Konch ASC/VHND, Jagamanpur APHC, Mai APHC, Niyamatpur ASC, Churki SC, Navodaya Vidhyalya, Orai, Government Primary School. Mahiyakhash village, Chiriya Jalaun, Government primary school.

THE REVIEW TEAM

- ◆ Dr. Suresh K Mohammad, Director –RCH, MoHFW (Team Leader)
- ◆ Ms. Shashi Kiran Baijal, Director Planning Commission
- ◆ Dr. S.K. Choudhary, Sr. Regional Director (H&FW), Lucknow
- ◆ Dr. K.S. Gill, Joint Director, NVBDCP, MoFHW
- ◆ Dr. Jalis Subhani, Assistant Adv-UNANI, AYUSH Department, GoI
- ◆ Dr. Avinash Kanchar, Programme Officer, HIV-TB, NACO
- ◆ Sh. Sanjiv Kumar Gupta, Finance Controller, MoHFW
- ◆ Dr. Amit Shah, Clinical Specialist, NIPI
- ◆ Dr. Ben Rolfe, External consultant (Governance specialist), European Union.
- ◆ Dr. J.N. Srivastava, Senior Consultant, NHSRC
- ◆ Mr. Sanjay Pandey, Health Specialist, UNICEF, Lucknow
- ◆ Dr. Manpreet Singh Khurmi, Consultant –RCH, MoHFW
- ◆ Dr. Rakesh Rajpurohit, Consultant, NRHM, MoHFW
- ◆ Dr. Ritu Aggarwal, Consultant Medical, NIHFW

POSITIVES

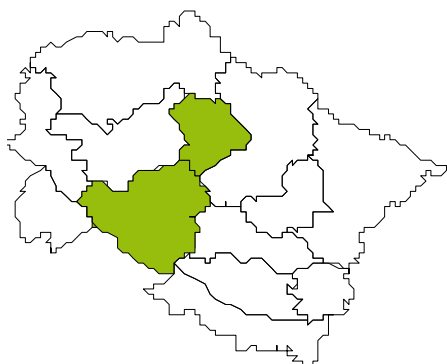
- ◆ Under JSY, payments are being made at the time of discharge from the health facility or within 2–3 days of the delivery and the information is uploaded on the web. Payments are through checks or e-transfers.
- ◆ There has been remarkable progress achieved under JSY scheme and in improving institutional delivery in the State which can be largely attributed to ASHAs who were doing commendable work.
- ◆ ASHAs form a vibrant and responsive link in Health delivery system. In the district, ASHA – SAMMELAN have been held periodically and they are a system of formal review and recognition of ASHA's work. A significant number of ASHAs have been trained on new initiatives of the Govt such as Home based newborn care, menstrual hygiene programme, etc. About 50,000 ASHAs are trained and conducting home visits under HBNC programme.
- ◆ Saloni Swasth Kishori Yojana is being implemented in the State, under which, school-based outreach services are provided, which includes distribution of Iron Folic Acid (IFA), de-worming and General check-up.
- ◆ Significant outreach activities are being undertaken by health sub-centers, which is providing a foundation for further expansion and broadening of scope.
- ◆ IDSP in the State is working with State surveillance officers at State level with the district surveillance units at the district level. The State unit collects information from all the districts on P and L formats which are compiled regularly and sent weekly to NCDC, New Delhi.



AREAS OF IMPROVEMENT

- ◆ High IMR, MMR and TFR due to persistent poor access to services.
- ◆ In order to improve access to institutional delivery for all pregnant women, more delivery points/facilities need to be identified and made functional.
- ◆ Quality of RCH care and range of RCH services need to be improved even access to contraceptives services needs to increase.
- ◆ New PHCs which have been constructed in the past 3–4 years need to be operationalized fully, in terms of construction of connecting road, electricity connection, sewage connection and deployment of adequate manpower.
- ◆ Priority to construction of residential quarters, and ASHA waiting rooms.
- ◆ AMCs leading to better maintenance and timely repair of life saving equipment.
- ◆ Plan for developing facility based sick newborn and sick child care needs to be put in place along with strengthening home based care.
- ◆ Need for an innovative HR policy to address the severe human resource crises, which cannot be bridged by normal recruitment procedures.
- ◆ Citizens Charter to be displayed prominently in every health facility.
- ◆ Biomedical waste management needs improvement.
- ◆ Timely appointment of Statutory Auditor and concurrent audit for timely submission of audit reports, better maintenance of books of account, using a double entry system and closer monitoring of fund flow at all levels is required.





DISTRICTS/INSTITUTIONS VISITED

PAURI GARHWAL

Male Hospital Paudi DH, Female Hospital Paudi DH, Combined Hospital SDH Kotdwar, Dugadda Block, Pabau CHC, Thalisen CHC, Patisain PHC, Khirsu PCH, Jaiharikhal PHC, State Allopathic Dispensary Sabdharkal, Sabdharkal SC, Kathuli SC, Patisain SC, ANMTC Khirsu block, Anganwadi Centre Bhandeli Village, Thalisen block, VHND Bhandeli Village, ASHA resource centre/MNGO Dugadda Block, Mobile Health unit.

RUDRAPRAYAG

DH Rudraprayag, CHC Augustyamuni, PHC Ukhimath, SC Kalimath, ANMTC Ranipokhri Dehradun, Resource centre/MNGO Ukhimath, VHND Naula village, Anganwadi centre Naula village, EMRI centre Dehradun.

THE REVIEW TEAM

- ◆ Dr. Anjana Saxena, Deputy Commissioner (MH), MoHFW, Govt. of India, New Delhi. (Team Leader)
- ◆ Mr. V P Rana, Deputy Secretary (CHS), MoHFW, Govt. of India, New Delhi
- ◆ Mr. K.K. Bansal, Deputy Director (Stats), MoHFW, Govt. of India, New Delhi
- ◆ Ms. Divya Shree, Consultant (NRHM)
- ◆ Dr. V K Anand, Health Specialist, UNICEF, New Delhi
- ◆ Dr. Geom Abraham, Programme Coordinator, Christian Medical Association of India, New Delhi.
- ◆ Ms. Jhimly Baruah, Consultant, PHP, NHSRC, NIHFW Campus, New Delhi
- ◆ Dr. Rajeev Aggarwal, Consultant (MH), MoHFW, Govt. of India, New Delhi
- ◆ Dr. Ravinder Kaur, Consultant (MH), MoHFW, Govt. of India, New Delhi
- ◆ Mr. Sumantha Kar, Consultant (FMG), MoHFW, Govt. of India, New Delhi

POSITIVES

- ◆ Good increase in case loads managed by public health system- about 0.6 OPD visits per capita currently.
- ◆ Health facilities visited had good infrastructure most of it added through NRHM funds. Facilities were well maintained and clean. Basic amenities -water/electricity with back up was available at most of health facilities.
- ◆ Referral transport facility in the form of EMRI available and accessible to all. Inter-facility transfers done through facility level ambulances. Drop back system introduced through a fleet of vehicles 'Khusiyon ki Sawari.'
- ◆ School health programme performing well in collaboration with Education dept; 5250 schools covered so far. Good system of follow up through school health cards and referral to DH. During school vacations-Adolescent health, menstrual hygiene at VHNDs.
- ◆ AYUSH system functioning well, co-location seen at the CHCs level. Adequate availability of AYUSH drugs.
- ◆ Strong linkages with local NGOs which are active as MNGOs and also functioning as ASHA Resource Centres in the districts.



AREAS OF IMPROVEMENT

- ◆ Maternal mortality rates and TFR are still high and need further attention. Increase in institutional delivery has been modest and much below national average.
- ◆ There should be a dedicated team at the state level for monitoring and supervision of infrastructure related works, with a fixed time line for completing the works. Integrate Quality Management System into the facility development plans.
- ◆ State needs to ensure rational deployment of multiskilled doctors in keeping with the case load and level of the facilities.
- ◆ Need to deploy a strategy for attracting and retaining doctors in rural areas- which includes rotational postings and incentives for difficult areas, and home regional preferences. Most contractual MOs are concentrated in the Dehradun (40), Nainital (30), Almora (14), Haridwar (13) regions.
- ◆ There is a large number of under utilized paramedical staff like Health supervisors and pharmacists who need to be multi-skilled and be provided with revised TORs to ensure their full utilization.
- ◆ There is need to put in place full time Technical/ Programme Officers in the districts along with contractual programme managers to support the CMHOs in the technical areas and in supervision of facilities and programmes.
- ◆ Need to expedite skill based trainings with prioritization of ANM and SNs in the functioning delivery points. The SIHFW should be made functional urgently.
- ◆ Facility level care for sick children was not in place in the facilities. NBCCs, NBSUs, SNCUs need to be planned and made functional at all facilities on priority.
- ◆ In spite of operationalisation of MCTS a high number of deliveries are going unreported; this necessitates proper analysis and use of the aggregated information flow on HMIS at the district and block levels for public health action.

“The district plan must articulate a road map for providing assured universal preventive, promotive, curative and rehabilitative care needed for a population within the district itself with only very few disease conditions requiring highly specialized care outside the districts. The financing of facilities within the districts must match the varying case loads and range of services being provided. It should act as a lever to ensure that every facility provides an externally certified minimum acceptable quality of care. Areas/districts which are more marginalized, or have greater problems of access, should receive a greater investment of human and financial resources.”

*Para 9.36, Approach to the
Twelfth Five Year Plan
Government of India*



National Rural Health Mission
Ministry of Health & Family Welfare
Government of India
Nirman Bhawan, New Delhi

