NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

6th COMMON REVIEW MISSION REPORT

2012

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Cover Photo: An old family member is be taken to health centre in Churachandpur, Manipur, facilitated by an ASHA.

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

Message

I am happy to learn that efforts put in by NRHM for bringing health closer to people and enhancement of services has led to steady improvements in the health status and health service delivery in the country. This report of Sixth Common Review Mission has brought out both the improvement and the gaps in service delivery. I note that flexible financing under the Mission has also fostered several innovations across the country.

I read with some satisfaction that availability of infrastructure and health human resources in the remote areas has increased substantially and the areas that are difficult to reach are being reached through mobile medical units.

In the second phase of NHRM we look forward to consolidating the efforts made so far and make universal primary health care a reality for the people. JSSK has shown us the way in expanding free services by providing free delivery and newborn care including drugs, diagnostics and transport. Our focus is going to be on strengthening and expanding accessibility of free public health care services for both communicable and non- communicable diseases and for emergency and trauma care.

States should take note of the observations and recommendations of this report and I am sure that this will further the improvement process. This annual review process has become an assessment of our performance and a source of guidance for future. I thank all the experts who were part of this exercise for their valuable inputs.

(Ghulam Nabi Azad)

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GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NIRMAN BHAVAN, NEW DELHI - 110108

Message

This year is an important milestone for the National Rural Health Mission- this being the first year of 12th Five Year Plan. Expectations from the Mission have greatly increased. The 12th Plan promises a three fold hike in allocation for health as compared to the 11th Plan. Further, the National Urban Health Mission (NUHM) is also proposed to be launched with focus on addressing primary health care needs of urban poor. Thus, The 12th Plan period period provides a great opportunity to the States to accelerate progress towards improving health outcomes and quality health care for entire population by adopting appropriate strategies and addressing critical gaps in governance using the Common Review Mission (CRM) findings.

The Common Review Missions have served as an important mechanism for monitoring the progress of the programmes and in taking timely corrective actions. The findings of the Mission point to various shortcomings that we take note of. The recommendations from this review mission have emphasized the need for increased availability of drugs and diagnostics, planned development of infrastructure, HR policy reforms, skill development of available human resources, enhancing quality of health care delivery, strengthening community support and accountability mechanisms and increased convergence with the related departments. I am sure that States will incorporate these suggestions into State Implementation. Plans for the coming year.

On behalf of the National Rural Health Mission, I convey my thanks and appreciation to all the team members who travelled to 15 States and prepared this report thus offering a learning experience for us all. The observations provided in this report will help us take the mission forward in the context of the Twelfth Five Year Plan. I would also thank all those who have worked tirelessly for the success of the National Rural Health Mission.

28/12/2012

(P.K. Pradhan)

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

Message

The Rural Health Mission in its first phase has laid the foundation for re-vitalisation of primary health care in the nation. The last seven years have seen a renewed commitment to strengthen public health systems at all levels - from the sub center to the tertiary care facility. Not all of this is directly under the Mission. The remarkable increase in nursing, paramedical and medical institutions in the public sector and even the private sector in the last seven years is not a direct objective of the Mission. However the Mission's policy articulations and its readiness to match this by investing in strengthening public health facilities and building partnerships with the private sector has created a conducive environment that has contributed to this increase. The additions of over a lakh to the public health workforce, reversing a trend where almost no additions had taken place over the previous year had been fundamental to such a change. Similarly the Mission has made a major contribution to strengthening health care infrastructure at all levels - from the sub-center to district hospital. Other major areas have been an emphasis on community processes to strengthen the demand side, making all health care services for pregnant women and newborns completely free of costs, and a push towards governance reforms.

I am happy to read from this report that there is a marked increase in the out–patients, admissions, institutional delivery and major surgeries across the country in the public health institutions. There has been also considerable increase in the range and quality of services being provided. In particular, district hospitals and block level PHCs have been strengthened and are delivering a wide range of services. Cold chain gaps in immunization are more or less completely attended to and delivery of immunization services has been streamlined. I also note that the Mission has confirmed to dramatic increase in emergency transport services and in facility based care for the sick child.

However, I also note that there are many areas where the progress has been unacceptably inadequate- especially in some of the states which face the greatest challenges. It is clear that we will need to pay much greater central attention – both in the from of monitoring and support to these areas of poor progress. We also need to develop a much better and inclusive strategy for capacity building where we leverage partnerships with medical colleges and schools of public health and health NGOs for achieving the institutional capacity that is required at state and district levels.

I wish to assure all stakeholders and participants in this process, that the Mission takes the follow up to the CRM very seriously and rigorously. The state specific reports are shared with each state, and it is expected that states provide a response and a follow up action commitment. Based on this the national leadership for the Mission also draws up a schedule to monitor such follow up action – and more important direct support to those areas - geographic and thematic – where support is most needed.

I thank all the participants of Mission for the time and effort they have put in, and invite them to remain partners in the process of follow up and implementation of the recommendations.

Gupta

(Anuradha Gupta)

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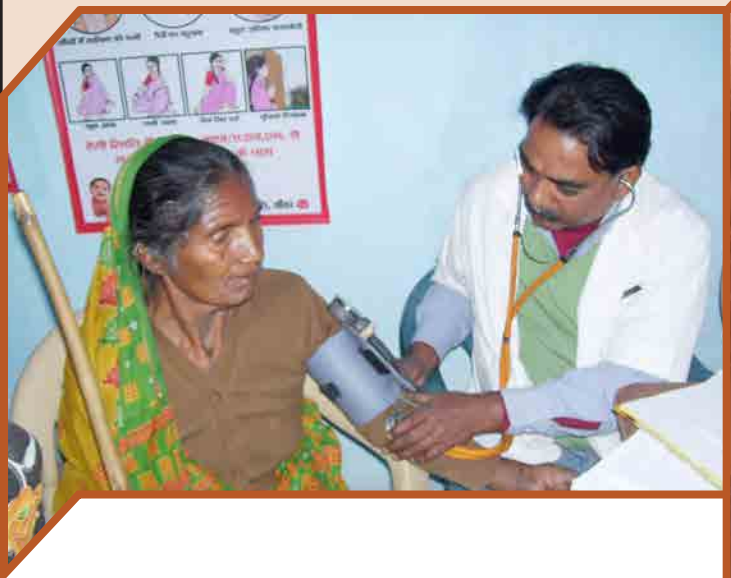
ABBREVIATIONS

AGCA	Advisory Group on Community Action
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ANMTC	Auxiliary Nurse Midwife Training Centre
APHC	Additional Primary Health Centre
API	Annual Parasite Index
ARC	ASHA Resource Centre
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric & Neonatal Care
BMO	Block Medical Officer
BMWM	Bio-Medical Waste Management
BPHC	Block PHC
BPM	Block Programme Manager
BPMU	Block Programme Management Unit
BPL	Below Poverty Line
CBOs	Community Based Organizations
CEmONC	Comprehensive Emergency Obstetric & Neonatal Care
CHC	Community Health Centre
CMO	Chief Medical Officer
CMOH	Chief Medical Officer Health
CRM	Common Review Mission
CT Scan	Computed Tomography Scan
DH	District Hospital
DHAP	District Health Action Plan
DLHS	District Level Household Survey
DOTS	Direct Observation Therapy - Short-course
DPM	District Programme Manager
DPMU	District Programme Manager Unit
DTC	District Training Centre
DWCD	Department Women & Child Development
EDL	Essential Drug List
EmONC	Emergency Obstetric & Neonatal Care
EMRI	Emergency Management and Research Institute
FMG	Financial Management Group
FP	Family Planning
FRU	First Referral Unit
GNM	General Nursing Midwife
HMIS	Health Management Information System
HMRI	Health Management & Research Institute
HR	Human Resource
HRD	Human Resource Development
HSC	Health Sub-centre
ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centre
IDSP	Integrated Disease Surveillance Project
IEC	Information Education Communication
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPD	In Patient Department
IPHS	Indian Public Health Standards
ISO	International Organization for Standardization
IUCD	Intra-uterine Contraceptive Device
JE	Japanese Encephalitis
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
LLIN	Long Lasting Insecticide Treated Nets
LR	Labour Room
LSAS	Life Saving Anaesthetic Skills
LT	Laboratory Technician
MB	Multi-bacillary cases
MCTS	Mother and Child Tracking System
MDR	Multi-drug Resistant (TB)
MIS	Management Information System
MHW	Male Health Worker
MMR	Maternal Mortality Ratio
MMU	Mobile Medical Unit
MO	Medical Officer
MoHFW	Ministry of Health & Family Welfare
MOIC	Medical Officer In-charge
MoU	Memorandum of Understanding
MPW	Multi-purpose Worker
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NGO	Non-Government Organisation
NHSRC	National Health Systems Resource Centre
NICU	Neonatal Intensive Care Unit
NIHFW	National Institute of Health & Family Welfare
NIPI	Norway India Partnership Initiative
NPCB	National Programme for Control of Blindness
NLEP	National Leprosy Eradication Programme
NRC	Nutritional Rehabilitation Centre
NRHM	National Rural Health Mission
NSSK	Navjat Shishu Suraksha Karyakram
NSV	Non-scalpel Vasectomy
NVBDCP	National Vector Borne Disease Control Programme
OPD	Out Patient Department
PCPNDT	Pre-Conception and Pre Natal Diagnostic Techniques (Prohibition of Sex-selection) Act - 1994
PHC	Primary Health Centre
PHN	Public Health Nurse
PIP	Programme Implementation Plan
PMU	Programme Management Unit
PPP	Public Private Partnership
PRI	Panchayati Raj Institution
PWD	Public Works Department
RCH	Reproductive and Child Health
RDK	Rapid Diagnostic Kit
RHFWTC	Regional Health & Family Welfare Training Centre
RHP	Rural Health Practitioner
RKS	Rogi Kalyan Samiti
RMA	Rural Medical Assistant
RNTCP	Revised National Tuberculosis Control Programme
RSBY	Rashtriya Swasthya Bima Yojana
SBA	Skilled Birth Attendant
SDH	Sub Divisional Hospital
SHC	Sub Health Centre
SHSRC	State Health Systems Resource Centre
SIHFW	State Institute of Health and Family Welfare
SNCU	Sick Newborn Care Unit
SPMU	State Programme Management Unit
STG	Standard Treatment Guideline
TB	Tuberculosis
TNMSC	Tamil Nadu Medical Services Corporation Limited
VHND	Village Health and Nutrition Day
VHSNC	Village Health and Sanitation and Nutrition Committee

EXECUTIVE SUMMARY



EXECUTIVE SUMMARY

The Sixth Common Review Mission was organised from the 2nd to the 9th of November 2012 in fifteen states. The broad objective of the CRM was to review progress of the NRHM against expected outcomes and outputs defined in annual plans, with reference to the overall goals of the Mission. Seven of the states belonged to High Focus category; Bihar, Chhattisgarh, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand, Uttar Pradesh; three were from the North Eastern States - Assam, Manipur, Tripura and five were the Non High focus states of Delhi, Kerala, Punjab, TamilNadu and West Bengal.

A total of 171 resource persons constituted the 15 state teams. Of these, 43 were government officials, 42 were public health experts from academic institutions or technical support units, 17 were from civil society, 18 representatives of development partners, and 51 were consultants working in the Ministry. There was significant participation of officials from the Planning Commission and other Ministries in this CRM. After national, state and district briefings, each state team visited a sample of district and sub-district hospitals, CHCs and PHCs and sub-centers and villages in two purposively selected districts in each state.

Progress of NRHM was reviewed on ten broad parameters, each with ten components. This 10x10 matrix, or 100 process and output elements, captures essential dimensions of state government action and accountability for the necessary outcomes.

Key Findings

- Across all terms of reference while the common finding is of considerable progress, there are shortfalls in achieving key objectives. These shortfalls are due to the historical legacy of a weak health system reflected in low baselines, and existing institutional constraints that have likely hampered more rapid progress.
- There has been accelerated progress in achievement of key health outcomes-notably in child survival and population stabilisation. In maternal mortality too, there has been substantial reduction, although the lack of data after 2009 limits speculation on accelerating rates of decline.
- So far as increased utilisation of health services is concerned, there is considerable increase in outpatient attendance and in-patient admissions. However, in-patient increases are not widespread and fewer than one fifth of the facilities cater to a disproportionate part of the increased case-loads, and in-patient increases are seen in facilities at district levels and higher. As a consequence of this overcrowding, quality

of care is compromised.

- The package of health care services offered in non high focus states has expanded and includes a wider range of communicable and non communicable diseases. In the high focus states the emphasis is almost exclusively on Reproductive and Child Care Services, with a focus on midwifery services.
- There is significant progress in the creation of new facilities and infrastructure at sub-centers, CHC and DH levels, but not for PHCs whose numbers have stagnated or declined. All facilities above sub-center level now function from a government building. However some of them are located within a facility that conforms to IPHS standards of a lower category, with many PHCs and CHCs functioning from sub-center and PHC buildings respectively.
- Availability of drugs has increased at all levels, but gaps are observed at sub-center and ASHA levels. Interrupted and inappropriate supplies consequent on poor logistics continue to be a problem. Improved availability of diagnostics is seen at the block PHC, CHC and district hospital.
- The success of the JSSK, albeit limited to pregnancy and newborn care, has challenged the assumptions that justified user fees.
- JSSK has also helped foster the perception of health care as an entitlement within the public system. Further, it has also enabled a goalpost shift from mere withdrawal of user fees to active elimination of out of pocket expenditure. While Out of Pocket expenditures have declined, they still average about Rs 500 for an institutional delivery, being higher where surgeries or more complex diagnostics are involved. Provider and managerial perceptions are slow to change, and this is reflected in the continuing practice of outside prescriptions, which are the main source of out of pocket expenditures. The absence of policy articulation on free drugs and diagnostics at the state level, contributes to slow and uneven progress.
- Public Private Partnerships (PPP) have been tried in many forms. One form of PPP that has unquestionably worked well across states, is the dial 108 emergency response services. The outsourcing of maintenance services and Bio-Waste Management, especially waste disposal also appear to be successful. Early attempts at outsourcing for diagnostics and facility management attempted in Bihar and other states, have either not survived or demonstrated success as yet. It is difficult to determine whether the cause is poor contract design or mismatch with existing systems or whether the problem is inherent to our context. Accreditation for JSY has a reasonable outcome with a number of smaller nursing homes in more backward areas participating, but partnerships for critical gap filling in areas such as cashless emergency obstetric care are not attempted seriously.
- Interface between Rashtriya Swasthya Bima Yojana (RSBY) and NRHM is reported from a few states. There is no sharing of data on RSBY funded caseloads or disease categories in any state. Many of the poor admitted in DHs are not covered by RSBY, and those that are, report substantial out of pocket expenditures.
- Reimbursements by RSBY to the hospitals are not complete or timely. Denial of claims occurs on technical grounds (eg. non working of smart card readers) or on social patterns (family of five could exclude the younger girl child or the elderly etc). It must be highlighted that no RSBY patient had any idea of what was charged to their card and what sum remains.
- There is considerable increase in attention to quality of care across all states, but also considerable fragmentation. Some elements of quality, clean toilets, patient amenities, clinical protocols, grievance redressal, signages, and biowaste management show progress in all facilities visited, but others are neglected. Infection control was a problem in all states except Tamil Nadu. Lack of privacy for women

patients and insensitive providers were still problematic in many states. Quality Assurance Committees exist, but their functioning and value addition is uncertain. There is no "measurement" of quality improvement, except in a few instances where more comprehensive quality management systems were set-up.

- Service provider vacancies have decreased due to innovations in recruitment, task-shifting and packages for attracting and retaining skilled providers. However these have yet to make a dent on specialist vacancies, where the situation remains grim and unrelenting, or on nurse vacancies in those states where the generation of this cadre is sub-critical. The other problems are lack of parity on work allocation and remuneration between contractual and regular staff, and the insensitivity to other needs of contractual staff.
- The lack of sensitive and enlightened workforce management policies for contractual staff is even more apparent when it comes to non clinical managerial staff including staff of programme management units, data entry and account staff, and staff of government training and technical support institutions. This leads to a revolving door effect, with constant, high attrition and inadequate replacement resulting in poor quality and performance.
- Training programmes are stagnating due to lack of institutional capacity for training. Most trainings rely on ad hoc arrangements with poor institutional linkages and are not sustained. Fragmentation of training on skills for service providers is a problem.
- In all high focus states, emergency obstetric care or fixed day family planning services and even MTPs below the district hospital level remains a challenge.
- All states report improvements in immunisation, with no reports on gaps in cold chain, for the first time since CRMs began. Vaccine logistics too have improved. The first four CRMs reported little progress in facility or home based newborn and sick child care. The 5th CRM showed initiation of this work, and the 6th CRM records substantial increases on this front in most states. However some states, notably Chhattisgarh, are still to initiate facility based care and others – notably Delhi have yet to start home based newborn care.
- Another major positive development is that all states visited except Tripura and Manipur now have one or more systems of publicly financed emergency response and patient transport systems in place, with a high degree of functionality. While much remains to be done to improve efficiency and outcomes and stabilise contracting processes; this is clearly India's great success story of PPP, and of the clear commitment to move towards a cashless universal health care regime.
- Horizontal integration of disease control programmes continues to improve, especially at district and state levels, and amongst peripheral workers and community levels. Integration at the level of data management and use, however, is weak. The IDSP suffers from critical shortages of skilled professionals required for the programme, more so in remote areas.
- There is commendable improvement in indoor residual spraying and distribution of bednets in the malaria programme, but gaps in supply of drugs and RDK kits to peripheral workers and the lack of locale specific action for very high endemic pockets remain.
- There are short-falls in case detection for TB and slow and incomplete roll out of MDR-TB control measures.
- For blindness control, the good progress on cataract surgery now needs to cover rural and remote areas. Coverage of the refractive errors correction programme in schools also needs to be scaled up.
- The last mile in leprosy and kala-azar is proving difficult-and we must question when and where

vertical programme structures give way to an integrated effort, what is the minimum action and support required in areas where the programme is in surveillance mode, and where intensification for elimination is required.

- The ASHA programme remains the component where reports from across states are uniformly positive, as regards her functionality and enthusiastic participation. Both role clarity and coordination with other peripheral workers show improvement. However reports also note that where there is no additional technical capacity deployed, progress in training is slow and uncertain. Mechanisms of payment, drug logistics, supportive supervision and performance assessment remain a challenge in states which have failed to invest in a well-trained support structure. Odisha is a best practice example on payment, Bihar on the development of training sites, Assam and Chhattisgarh on welfare measures and recognition, and Bihar and Chhattisgarh on basic education up-gradation.
- Action on social determinants has made some headway where village health and sanitation committees are functional and have the capacity and leadership – usually from the ASHA. PRI participation at village and local facility level has improved. The district and block panchayat however have yet to emerge in leadership roles. There are best practices noted from different states on coordination for improved nutrition, school health programmes, civil registration of births and deaths with potential for scaling up in other states.
- Although state and district health societies show improved functioning and demonstrate better coordination with Directorates, the capacity of the state programme management units in many states is sub-critical, related to managing the contractual staff and building capacity.
- Progress on building dedicated organisational structures for procurement and logistics and infrastructure development is painfully slow. Where they have been formed, they are yet to become functional. Nonetheless, there is forward movement on one front or another, albeit fragmented, to improve logistics and streamline infrastructure development.
- States are slow in building institutional capacity for knowledge management, be it for strengthening State Institutes of Health and Family Welfare, Regional and District training institutions, or the establishment of effective State Health Systems Resource Centers. States remain dependent on ad hoc, time bound externally funded project arrangements for technical support. Partnerships with medical colleges and schools of public health and other academic and research bodies or with health NGOs are also weak.
- Financial flows have increased and so has absorption of funds. Against a projected allocation of Rs. 175,000 crore over seven years to achieve the NRHM objectives; about Rs. 71,963 crores were actually released and over 98 % absorbed. An important contributory factor is the improved accounting system and a large newly created force of accounting staff. Poorly trained staff and weak supportive mechanisms need attention, to correct the small but numerous errors that appear to be plaguing the process in most states. Concurrent audit is in place in many, but not all states.
- Greivance redressal mechanisms are slow to start up, and only two or three states have functional grievence redressal for peripheral employees and another two or three for public grievances linked to assured services and entitlements. Accountability mechanisms such as separation of Governing Bodies from the Executive Committees, with the former ensuring the accountability of the latter are weak. Therefore Rogi Kalyan Samitis and District and State Health Societies are able to play the role of coordinated implementation, but not accountability. Community Monitoring processes are sporadic and poorly sustained and are reported from only three states.
- All states are now complying with stipulations on

state share; though many states face problems in clearing the backlog of contributions in the early NRHM years.

- The increase in public expenditure on health care consequent to NRHM and the stimulus to public health sector growth led to an increase in public share of total expenditure on health from 19.1% in 2005 to 30.3% in 2009, with further increases likely. Though this portends well for enhancing the social protection function of the public health care facility, funds allocated and absorbed are only one third of the envisaged allocation. Not surprisingly health outcomes and programme outputs are also in the same range. The systemic reasons for poor absorption of funds are largely related to long time cycles for infrastructure development and the problems of normative allocation of untied funds. Despite this, fund absorption, when considered over a five year period is close to 98%. This correlation between outcomes and investment suggests that while improved efficiency is required, the central problem still remains lack of government investment in public health systems.

Recommendations

Ensuring Access and Quality of Facility Based Services

- The District Health Action Plan must be revived as the operational basis and road map for achieving NRHM goals in the 12th Plan period, which would become synonymous with the goal of universal health care. The district plan must spell out the service package to be delivered by each facility within a stipulated time period.
- Services for RCH and Communicable diseases would remain the priority for the immediate period for high focus states. All states need to initiate work on Non Communicable Disease services with the non high focus states making it a priority.
- District plans should specify public facilities where emergency and trauma services would be made available to match the growing presence of Dial 108 pattern of emergency response services. Prioritisation for infrastructure development and for deploying additional human resources must relate to the plan.
- New facilities should be proposed where access to existing facilities is sub-optimal due to geographic considerations, with reference to "time to travel", or because of high caseloads and overcrowding in tertiary and secondary care facilities. In all other contexts, the focus should be on adding more beds and human resource to existing facilities. Residential facilities for staff where rental accommodation is not available must be prioritized.
- A clear policy for the supply of free drugs, diagnostics and diet in public hospitals must be articulated by each state, and the measurable objective must shift from reduction of user fees to reduction of all out of pocket expenditure. Besides financial inputs, the CRM recommends sensitisation of providers, rational drug use and use of standard treatment guidelines, protocols and formularies, better logistics, and responsive allocation of untied funds - preferably renamed as "operational costs".
- Display of information on free entitlements and services available must be ensured in strategic areas such as entrance of facilities, wards, labour rooms and SNCUs.
- A responsive and transparent Grievance Redressal system meeting minimum process standards to be defined by states and put in place in every facility.
- States need to put in place a strategy to address issues of quality assurance and improvement, beyond fragmented approaches to selected dimensions of quality. Such a strategy should include defining quality standards, processes of measurement, establishing quality management systems and a system of un-biased certification. A quality system should address at the least clinical protocols and medical audit, cleanliness and hygiene, safe drinking water, patient

amenities, privacy, security and bio medical waste management.

- Ensure separate wards for male and female patients, and provision of separate beds with curtains in injection rooms. Security needs to be strengthened across facilities, and payment of security staff must be increased up to the daily wage norms.
- Infection control needs immediate attention in all four dimensions – infrastructure design, infection control practices, sterile supplies and specific technical monitoring.
- At the district level, supportive supervision through periodic review and supervisory visits should lead to improvement of quality of care in all facilities. Quality Assurance Committees could be sensitised and revamped to monitor facility level range and quality of services.

Strengthening Outreach Services

- There should be a clear policy articulation that mandates a move towards an adequately staffed sub-center acting as the first port of entry into the district health care system. In most contexts, this means at least two female and one male worker- supported by ASHAs. Whether the sub-centre would be a site of institutional delivery, have a mid- level care provider, have one or both female workers playing a role in disease control, and exact work distribution between sub center staff are context specific decisions to be made by states. Standard treatment guidelines and the training programmes for this cadre should be based on the service package and redefined roles.
- The package of services to be delivered by the MMU and its role (whether equivalent to the outreach services of the sub-centre or the referral support of the PHC or both) needs to be defined in each context. The frequency, periodicity, human resource deployed and quality of services need to improve, and the impact of MMU services on the underserved should be assessed for appropriate design modifications.

Human Resources for Health

- States need to develop a comprehensive human resource policy with a clear plan of action to meet public health workforce requirements and ensure performance. A policy cell or committee with representatives from the Directorate, SHSRCs and SPMUs should be created to facilitate this.
- States must commit to sustaining an expanded, well trained and supported public workforce made possible through NRHM funding.
- Establish and strengthen the HRH cell for all contractual staff (since regular staff are generally dealt with the establishment division of the Directorate) to manage workforce requirements of contractual staff – recruitments, payments, training, career progression and grievance redressal.
- Strategies for attraction and retention of skilled workforce in rural and remote areas should go beyond limited incentivization, and could include well planned non-financial incentives, positive work force environment, rational transfer policies, grievance redressal systems and in service training. Long term measures such as creation of educational reforms to enable selection and training of local candidates for existing and new professional categories (Rural medical assistants, nurse practitioners, family medicine practitioners) as appropriate to the area. The delivery of financial incentives needs to be increased with streamlined implementation..
- Ensure parity in remuneration between contractual and regular employees for a similar service role at public health facilities and design recruitment policies such that contractual staff are regularised, and invest in skill development.
- To close the specialist gaps, states should improve existing options and explore newer options such as scaling up family medicine programmes.
- Human Resource Management Information Systems should allow for decision making and relate human resource deployment to service delivery outcomes.

Reproductive and Child Health

- "Delivery points"-should ensure not just midwifery services, but the entire range of RCH services as appropriate to that level, with a focus on services for MTP, family planning and care for the newborn and sick child.
- Where the population served is small, and geographical or other barriers to other sites of care exist, facilities with smaller case loads should get inputs prioritized for delivery points.
- Quality of clinical care for RCH depends on three dimensions that need immediate action: better training to carefully prioritized service providers, better logistics to ensure uninterrupted drug supplies, and good quality supportive supervision.
- Nutrition Rehabilitation Centers require support for effective operationalization especially in states of high need, and the quality of forward and backward linkages including children with severe acute malnutrition and follow up on discharge needs urgent improvement.
- Buttress the JSSK's achievements by sensitizing service providers and mid level managers to the concept of health care entitlements and reduce all out of pocket expenditures in the public health sector.
- Build on the success story of referral transport, with the development of quality standards, monitoring and evaluation frameworks and good contracting processes to ensure quality services and involve a number of providers. Complementarity between the 108, the 102 and the local tie-ups would be key to closing the gaps in assured referral transport and efficiency of its provision.
- The key challenge in family planning is to have a well focused, especially designed package for the four large high focus states. In all states the frontier is now further promotion of Non scalpel vasectomy (NSV), use of spacing methods and counseling.
- States that have not been able to establish facility based care for the sick newborn must be linked to technical partners to help build the capacity at a faster pace, and strengthen the referral link between home based and facility based newborn care.
- The establishment of L3 facilities or FRUs providing comprehensive EmONC with blood transfusion facilities should be strengthened in a focused manner by prioritizing districts where they are completely unavailable followed by those where they are below threshold levels, and actively promoting partnerships with private providers where available.

Disease Control Programmes

- The IDSP programme needs re-orientation to emphasize immediate and appropriate district and facility level public health response to disease outbreaks and use of IDSP information for local planning.
- The HR strategy for IDSP in states to generate, recruit, retain and support microbiologists, epidemiologists, entomologists, and data Managers, needs the Center to play a greater facilitatory role.
- Timely supply of antimalarials and RDK in the hands of peripheral workers-ASHA, MPW and ANM and locale specific intensive operations in areas with very high API are essential to reduce malaria deaths. Regular reporting of fever related deaths among younger age groups would help identify and respond to high malaria morbidity and mortality.
- Case detection and establishment of MDR-TB detection and treatment facilities must be improved.
- Areas for action in the blindness control programme are improvements in convergence with school health programmes and increased rural outreach.
- For leprosy control the need is to persist, remain alert for new cases, improve follow up of migrants

and expand sites for reconstructive services in tertiary care hospitals.

- Integration of NCD programmes with other district programmes is an agenda that must begin now. It involves developing indicators, standard treatment protocols for each cadre of workers, improving logistics for drugs, diagnostics and supplies, work allocation between sub-centers workers, promoting community level care and integration with AYUSH and school health programmes.

ASHA Programme

- States should complete ASHA selection in all vulnerable areas even if it means reducing the population norm. ASHAs and ASHA facilitators need to be sensitized and trained to ensure reach to the most marginalised and vulnerable.
- Improve training quality must now progress to specific strategies of choosing and accrediting training sites as well as trainers. Ensuring that books, equipment and communication kits are in the hands of trainers and trainees would also improve quality of trainings.
- Creating career opportunities for ASHAs is essential and can be achieved through skill certification and supporting participation in literacy, equivalency and nurse education programmes as seen in Chhattisgarh and Bihar.
- There is a need to move from adhoc mechanisms to well oiled systems for –a) Performance Monitoring systems; b) Drug kit replenishments; c) Payment efficiency; d) Grievance redressal mechanisms and e) ASHA Welfare schemes. Best practices exist in states visited which can be analyzed, generalized and replicated. These include Chhattisgarh's Grievance Redressal system and ASHA Welfare schemes, and Odisha and Assam's incentive payment processes. States should ensure one fixed day payment process for all ASHAs irrespective of the mode of payments to eliminate delays in payments.
- There is a need to formulate a clear National Guideline and a best practice compendium for VHSNC for use as a minimum package in training VHSNCs. NGO involvement is essential to build additional capacity required for VHSNC training. States should endeavour to reposition the ASHA and her support structure to play a leadership and capacity building role for the VHSNCs and enable both to work in close coordination with PRIs.
- For implementing and scaling up community based monitoring across states and districts additional technical capacity of NGOs is essential.

Preventive and Promotive Health

- States should now move beyond establishing platforms for regular convergent meetings and coordination amongst peripheral workers to integrating information systems and tracking the respective contribution of convergent partners. Where no mechanisms for convergent action exist this should be done on a priority basis.
- The use of the Village Health Sanitation and Nutrition Committees as platform for convergent action should be strengthened, and the ASHAs and VHSNCs as specific modalities of reaching the unreached in the community needs to be built up through focused training and support.
- Increased awareness on girl child protection has led to a reduction in reports of mobile ultra-sound machines. However F- form analysis needs to be improved, and follow up with state and district PC PNDT cells needs to be strengthened.
- Establishment of a state BCC cell in State Programme Management Unit or equivalent with clear accountability to deliverables should be undertaken.
- Civil registration processes should be carefully mapped to identify the existing gaps. Provision of birth certificates within 24 hours of birth should be viewed as an entitlement and a measure of quality of care, and would contribute to building up a system for universal civil registration at

birth. A similar approach to death certification is required. Monthly or even quarterly reporting of death figures at district level would be an important contribution.

- Renewed commitment to social audit and district vigilance committee is required. A platform common for all social sector programmes would probably have a greater chance of success rather than a standalone institution for the health sector.

Programme Management

- Building Institutional Capacity for decentralised Planning and Programme Implementation remains the key. This requires increased and better quality participation of panchayat representatives in governing bodies, development of district plan as a central instrument, and adequate management staff with adequate powers and skills for responsive and effective resource allocation.
- A regular schedule of supportive supervisory visits by directorate and program management staff using checklists and follow up action plans must be instituted.
- Persist with efforts to institute a procurement system linked to logistics demand and utilization pattern. States should consider technical and management agency support to operationalize TNMSC like institutions.
- An HR policy for programme management staff which includes periodic capacity building efforts needs to be established..
- States need to identify those districts which are unable to build institutional capacity to achieving training goals. Such districts would require state or central assistance to build or establish training institutions
- State should establish/ improve the standardization of performance appraisal systems and extend it to non-contractual, regular employees.

Knowledge Management

- The Centre should issue a national guideline on a minimum staffing pattern to establish a viable SPMU, SIHFWs, SHSRCs, ANMTCs, RHFWTCs and DTCs – much as IPHS has done for facilities. Guidelines should also spell out deliverables of each organisation and recommended HR policies and best practices for governance, to enable functional organisation with adequate capacity. External assistance should be aligned with these institutes for capacity building.
- Partner with other state level institutes specially medical colleges and schools of public health for training and technical support. Inadequate internal capacity should be supplemented through partnering with national or institutions in other states.
- Development of training capacity in high focus states through revitalization of existing institutions; leveraging of partnerships; and creation of new institutions should be the main focus of the first two years of the 12th Five Year Plan. Training follow up should be integrated with supportive supervision.
- States should institute Standard Treatment Guidelines (STG) for each cadre – especially AYUSH medical officers, RMAs and medical officers in PHCs-and relate training needs assessment and plans to these cadres, an important measure to enable comprehensive primary care.
- Support to district planning and institutional memory of past plans, data analysis and feedback, and support to community processes, operational research and evaluation studies are all essential functions that require an appropriate institutional mechanism, such as the SHSRC, but there must be clarity on the role and functions of SHSRC as distinct from the priorities of the SPMU and the SIHFW.
- States need to ensure the use of MCTS and HMIS information for planning and review purposes by program managers, and publish the information

annually.

- States could adapt systems based on need, especially for facility and local area information, but systems must lend themselves to local analysis at facility, block and district level, and be able to aggregate and export information required at state and central level. HMIS systems should be able to share data electronically with databases of disease control programmes, MCTS, the ICDS and civil registration systems.
- States should systematically apply data quality assessment tools to identify and remove sources of error relating to poor primary records, data duplication and other easily identifiable and correctable processes.

Financial Management

- Expenditure fund flows for infrastructure development should be separated from fund flows on revenue expenditure so that delays in one do not affect the other. Institutional innovations that would lead to better flow of funds, so that a few islands of poor utilization, do not hold down the rate of expenditure in better performing facilities/districts are needed.
- Persist with and build on accounting reform measures that showed results such as the use of Tally-9 at all levels, clear guidelines, electronic transfers of funds, and concurrent audits. Additional technical capacity for monitoring and supporting accounting processes for solving minor problems should be provided.
- Absorption of untied funds should be expedited by the use of clear guidelines that facilitate use for any operational need whatsoever, guided by a general principle that it should not replace budgetary funds on a sustained basis. Inter-facility allocation, responsive to case loads and usage at facility level including a normative payment should be provided to each facility.
- Timely payments to peripheral health workers especially ASHAs and beneficiaries must be monitored, with state finance managers being accountable.
- Assessments and feedback on newer systems like bank transfers to beneficiaries and ASHAs is required. Local modifications for timely transfers must be permitted.
- Government expenditure on the NRHM in the 12th Plan period, must increase to at least the scale that was originally envisaged in the Framework of Implementation document (2005 to 2012). Over the past seven years, states have begun taking steps to improve poor fund absorption and increase efficiency of fund utilisation, and this is an important first step. Future reform measures must focus on institutional innovations and appropriate changes in rules and regulations to enable better use of investments. However we also caution that unless there is sufficient and corresponding increase in investment, the focussed reforms alone will not make the critical difference for improving health care and health outcomes.

REPORT OF THE 6TH COMMON REVIEW MISSION

INTRODUCTION

- The Sixth Common Review Mission (CRM) of the National Rural Health Mission (NRHM) was organized from the 2nd to the 9th of November 2012.
- The Common Review Mission (CRM) has now become an institution in its own right. A recent study on the institutional dimensions of CRM showed that this is the most common, if not the only, source of evaluation information that most programme managers are aware of. Not only this, even in academic publications, this was the single most commonly cited source of information on NRHM, though there are large scale external evaluation studies available. At the operational level the CRM leads to several incremental changes and corrective measures including some major strategic and policy changes as well. This report is the sixth in the series and the first in this second phase of NRHM (2012-2017).

The Objectives of the 6th CRM

- Review progress of the NRHM with reference
  - Health outcome goals - IMR, MMR, TFR and outcome indicators of various diseases control programmes.
  - Accessibility, equity, affordability and quality of health care services delivered by public health systems including through public private partnerships (PPPs)
  - The approved Annual Project Implementation Plan of the State including the reform measures specified therein. (as documented in the Record of Proceedings of the National Programme Coordination Committee).
  - Recommendations of the last Common Review Mission.
- Where progress is short of expectations, identify constraints and causes for these gaps.
- Document best practices, success stories and institutional innovations in the states.
- Make recommendations to improve programme implementation and design.

Process and Methods of the 6th CRM

- The sixth CRM covered fifteen states, purposively chosen to be representative of all three main categories- High Focus, Non high Focus and North Eastern States. Of the total fifteen states, seven were High Focus States - Bihar, Chhattisgarh, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand, Uttar Pradesh; three were from the North Eastern States - Assam,

Manipur, Tripura and five were Non High focus states – Delhi, Kerala, Punjab, Tamilnadu and West Bengal.

- Of these states, Chhattisgarh, Odisha, Rajasthan and Uttar Pradesh have been visited in all six CRMs. Madhya Pradesh which was visited in all except the fifth. The states of Uttarakhand and Tamilnadu have been part of four CRMs, West Bengal and Kerala were visited thrice, and Tripura and Punjab in two CRMs. Delhi was included for the first time in a CRM.
- A briefing meeting on the Terms of Reference (TOR) and guidance for each TOR was held at the NIHFW, Delhi on November 2nd, 2012. The experts were then divided into 15 teams. State level briefings were held at state capitals on November 3rd, 2012. State meetings focused on the progress and achievements of NRHM in that state. .
- Each team visited two districts between November 4th, 2012 – November 8th, 2012 and was divided in to two groups. The district level briefing was followed by a visit to a district hospital, a sub-divisional hospital (SDH), two Community Health centres (CHCs), two or more Primary Health centres (PHCs) and two or more sub centres and interactions with community, Village Health Sanitation and Nutrition Committees (VHSNC) and ASHAs.
- At each site of interaction, the team met providers, service users and in certain instances community leaders as well. Facility examination, review of office records and observations of the different sections and activities of the facilities were all a part of the visit. In some cases teams also made night visits to ascertain functioning of 24X 7 PHCs.
- The two teams came together at the state capital on the 8th of November, shared their findings, prepared a brief report of key findings and recommendations and presented this to state authorities and other stake holders in a state debriefing meeting held on November 9th 2012.
- Writing the final report of the state visit took a further two weeks to a month, and then was sent to the states & the Ministry for their comments. NHSRC then synthesised the findings from across the states, prepared a draft report, which was circulated to all team members, 171, in this instance. The feedback from team members was incorporated as appropriate before the report went to print for release and wider dissemination. The Ministry then also draws up a list of key points for follow up action at the state and national levels.
- The process that the CRM follows enables findings and recommendation to be acted on even when the CRM is underway. The district and state briefings are the loci of such action. The follow up process is meant not only to monitor, but also to mentor, provide technical assistance and capacity building support. The fact that the team comprises of implementers, academicians and technical support personnel with inter-sectoral representation allows for both inputs and uptake from different stakeholder groups. Further this design also allows for an element of externality in what is essentially an internal assessment process.
- The design of the CRM is meant to ensure that just as it is a learning experience for the states and districts visited, it is also an intense learning experience for the team members, who in the course of internal discussions and participation in the process of building the final report get a more comprehensive understanding of the process of strengthening public health systems.

Team Composition

- The Sixth CRM was constituted by a total of 171 resource persons. Of these, 43 were government officials, 42 public health experts from academic institutions or technical support units, 17 from civil society, 18 were representatives of development partners, and 51 were consultants working in the Ministry. One important feature of this visit was the significant participation of officials from the Planning Commission and

other Ministries.

Terms of Reference

- The terms of reference were designed to reflect the approach taken by NRHM to strengthen public health services and an assessment of outputs and outcomes. It is not possible to measure outcomes during the course of CRM. However, information on outcomes in the form of data from external evaluation and surveys were made available to the CRM teams for their reference. Relevant Health Management Information Systems (HMIS) data was also made available. The CRM process attempts to validate such reports and to understand the reasons for the gaps.
- Progress of NRHM was reviewed on ten broad parameters, each of which had ten components. This 10x10 matrix, or 100 process and output elements, tries to capture all the essential dimensions of government action and accountability required to ensure the necessary outcomes. The ten main terms of reference were:

  I. Progress in Improving Facility based Curative services- Access, Equity, Affordability, Quality.

  II. Progress in increasing Coverage of Outreach Services - Sub - centres, Mobile Medical Units

  III. Human Resources for Health-Adequacy in Numbers, Skills and Performance

  IV. Reproductive and Child Health Programme

  V. Disease Control Programme-Communicable and Non Communicable Diseases

  VI. Strengthening Community Processes - the role of community organisations - PRIs, VHSNCs, NGOs and Community Health Workers – ASHAs.

  VII. Action on Social Determinants and Equity concerns and Promotive Health Care

  VIII. Programme Management: Institutional capacity for professional and participatory management

  IX. Knowledge Management: Training and Technical Assistance Institutions and Partnerships.

  X. Financial Management - especially Absorption, Fund flows, Accounting.

Structure of the Report

- The Report of the 6th CRM is presented in three parts. Part I is Key Findings that contains a summary of the objectives[1], progress, observation of the CRM teams and recommendations made at the national level. This is a cross state analysis. We note that the national recommendations are neither the sum nor the average of those made for each of the states, but flow from an analysis of the patterns seen across states. Part II is a summary of the findings on each TOR on all states. This includes the innovations and best practices in each state. Part III is a state summary of findings highlighting selected positives and areas of improvements for each state.

[1] *The objectives in each section are extracted from the Framework of Implementation of NRHM, 2005*

KEY FINDINGS

1 STRENGTHENING PUBLIC HEALTH FACILITIES: ACCESS, AFFORDABILITY , QUALITY

Objectives under NRHM

- Facilitate increased access and utilization of quality health services by all.
- Access to integrated comprehensive primary health care.
- Access to good hospital care through assured availability of doctors, drugs and quality services at PHC/ CHC level and assured referral/ transport and communication systems to reach these facilities on time.
- Establish fully functional Sub Health Centres/ PHCs/ CHCs/ Sub Divisional / District Hospitals- in line with what is specified under the Indian Public Health Standards.
- Primary health care would be provided without any charge. However in the case of need for hospitalisation, CHCs would be the first referral unit. Only when the CHC or district hospital is not in a position to provide specialised treatment, a patient would be referred to a teaching hospital or accredited private facility.

Progress under NRHM

- There has been substantial increase in utilization of public health facilities. HMIS data recorded 79.1 crore OPD visits in 2011-12 and 3.98 crore in-patient admissions per year which represents 0.65 OPD visits per capita and 33 per 1000 in patient visits. In relative terms, HMIS data shows a 46% rise in OPD attendance and 86% increase in patient admissions and a 42 % increase in major surgeries between 2009 (when HMIS was fully established) and 2012.
- For purposes of comparison if we use three OPD visits per capita and 50 in-patient admission per 1000 population as benchmarks[2], this would account for about 22 % of expected OPD visits and 64% of expected in-patient visits-the rest presumably going to the private sector-or from Municipal Corporations whose data is not included .
- Such increases have been recorded in concurrent

[2]In Sri Lanka OPD visit is 5.1 per capita and hospitalization is 280 per 1000 population. In Bangladesh OPD visits per capita were 1.2 and in patients per 1000 were 25

and external evaluations and in a number of studies of the NRHM[4].

- There has been a considerable increase in the range and quality of services although this is still short of targets. While the increased utilization is at the level of district hospitals and block level PHCs/CHCs, utilization of services at sub-centres and PHCs have also improved.
- The provision of untied funds was meant to substitute user fees as a source of local flexible funds. There was no stipulation against user fees, and this decision was left to the states. As the NRHM evolved, however user fees were recognised as being exclusionary and needed to be phased out. Consecutive CRMs played a role in this change but the main push for the change comes from the Janani Sishu Suraksha Karyakaram (JSSK). The JSSK went beyond the mere abolition of user fees to a reduction of out of pocket expenditure and the necessity of public health facilities to provide complete social protection.
- The NRHM also saw a number of initiatives introduced for improving quality of care such as setting up of Quality Assurance Committees and external quality certification for health care facilities.

Key Findings

- The increasing trend in service utilisation that is visible in HMIS reports corresponds to observations during the field visits. In HMIS the highest OPD utilization was in Delhi (1.97 visits per capita), Tamil Nadu (1.86 visits) and Kerala (1.83 visits), whereas the remaining 12 states register less than 1 OPD visit per capita. Even amongst these Assam, Odisha, Punjab, Rajasthan, Tripura, Uttarakhand, West Bengal perform better whereas the rest (Chhattisgarh, Madhya Pradesh, Uttar Pradesh and Manipur) are less than 0.5 per capita. Past experience suggests that low utilisation of OPD services in public facilities corresponds to proportionately high out of pocket expenses on health care. Another area of concern is that these states are likely to have poor case detection in disease control programmes like tuberculosis, which require robust, well utilized public health systems.
- Utilization of IPD services, using a benchmark of 50 hospitalisations per 1000, shows the best utilization from five states (Kerala, Tamil Nadu, Odisha and Delhi) with a range of 40 - 82 , whereas six states (Assam, Chhattisgarh, Manipur, Punjab, Uttarakhand, Uttar Pradesh) still have a considerable distance to go, although states like Assam and Chhattisgarh show substantial improvements. The increased IPD utilization in these states is primarily on account of institutional deliveries with better utilization reported at the District hospitals and Sub district hospitals. Low IPD has been reported from Manipur, Assam and Uttar Pradesh. In spite of increased footfalls in OPD; Bihar reports bed occupancy in the range of 30-40% at secondary levels. In Assam, increased utilization of services is concentrated in a few facilities. Several facilities with adequate HR are still not performing up to the expectations. In one CRM district of Assam, OPD utilization has reportedly declined in the last one year.
- In terms of range of services, the priority still remains services for Reproductive and Child Health (RCH). The availability and quality of RCH services is described in detail under TOR

[3]Concurrent evaluation of National Rural Health Mission, International Institute of Population Sciences Mumbai, 2009-10 and Evaluation Study of National Rural Health Mission in 7 States, Programme Evaluation Organisation, Planning Commission, Government of India, 2011

IV. The range of non RCH services available is small in most of the high focus states; in non high focus states visited (Punjab, Kerala, Tamil Nadu, West Bengal), treatment for non communicable diseases, as a rule, is generally available. Amongst high focus states, Assam reports a much larger package of services with substantial coverage of Non Communicable Diseases (NCDs), but this may be because Jorhat is one of the pilot districts for NCD.

- Most states have reported adequacy of AYUSH services. However, the lack of AYUSH medicines limits the services provided especially in the states of Assam, Bihar and Uttar Pradesh. Community demand for AYUSH services has been reported from Odisha, Manipur, Delhi, Kerala and Tamil Nadu.
- In terms of facility creation, the pattern varies across states. There have been substantial increases in the number of Sub Centres (compared to the baseline of 2005, RHS) in the states of Chhattisgarh, Odisha, Tripura, Uttarakhand, and modest increases in Madhya Pradesh, Punjab and Tamil Nadu. At CHCs, significant increases are seen across most states, the maximum addition being in the states of West Bengal, Tamil Nadu, Odisha, Madhya Pradesh, and Uttar Pradesh. Seven states (Assam, Bihar, Chhattisgarh, Manipur, Tripura, Uttar Pradesh and Uttarakhand) show an increase at PHC level. The remaining showed actual decrease perhaps because existing PHCs were upgraded to CHCs, without sanction of new PHCs. In these states, the population per PHC far exceeds the norms and more PHCs would need to be created if the outpatient coverage has to increase.
- Public Private Partnerships (PPP) have been tried in many forms. One form of PPP that has unquestionably worked well across states, is the dial 108 emergency response services. The outsourcing of maintenance services and Bio-Waste Management, especially waste disposal also appear to be successful. Early attempts at outsourcing for diagnostics and facility management attempted in Bihar and other states, have either not survived or demonstrated success as yet. It is difficult to determine whether the cause is poor contract design or mismatch with existing systems or whether the problem is inherent to our context. Accreditation for JSY has a reasonable outcome with a number of smaller nursing homes in more backward areas participating, but partnerships for critical gap filling in areas such as cashless emergency obstetric care are not attempted seriously.
- Interface between Rashtriya Swasthya Bima Yojana (RSBY) and NRHM is reported from a few states. There is no sharing of data on RSBY funded case loads or disease categories in any state. Many of the poor admitted in DHs are not covered by RSBY, and those that are report substantial out of pocket expenditures.
- Reimbursements by RSBY to the hospitals are not complete or timely. Denial of claims occurs on technical grounds (eg. non working of smart card readers) or on social patterns (family of five could exclude the younger girl child or the elderly etc). It must be highlighted that no RSBY patient had any idea of what was charged to their card and what sum remains.
- Infrastructure planning as part of the overall facility development plan (with norms of beds to be created and case loads to be addressed), is not in place. Most states have a plan for the next year but they are not working towards a time bound road map for ensuring infrastructure adequacy. The decline of district planning and its substitution by budget format filling for the next year is likely to contribute to such fragmentation.
- A number of states notably Bihar, Tamil Nadu, Odisha, Kerala and Punjab, have a dedicated Infrastructure Management Division with sufficient management capacity. Odisha has a Civil Construction Wing dedicated for all infrastructure work, with engineers at the districts and block levels. Monitoring progress on infrastructure is done through an e - Swasthya Nirman system. In Tamil Nadu, the special

health infrastructure wing is created within the PWD department. Bihar has constituted Bihar Medical Services and Infrastructure Corporation Limited (BMSICL) for addressing specific needs of Healthcare infrastructure. In Chhattisgarh,the state deploys four agencies for infrastructure / civil work which are PWD, RES, Zila Nirman Samiti and Grih Nirman Mandal. Additionally some work is commissioned through the Gram Panchayat and the Jivan Dayini Samiti. Other states are yet to establish such structures. The lack of a dedicated state level qualified team, results in a poor pace of construction, leading to unspent monies choking the pipeline.

- Availability of residential accommodation is a lacuna across most states which is affecting service delivery. Chhattisgarh, West Bengal, Bihar and Punjab reported shortfall of residential quarters in PHCs and CHCs. Odisha and Uttar Pradesh are among the states with better residential accommodation for staff especially at the higher levels. An area of improvement reported from most states is that most facilities are now operating out of government buildings, except for sub- centres. This by itself does not imply adequate infrastructure in a high focus state. Here PHCs are no more than "upgraded sub- centres". CHCs are actually PHCs which have been declared as CHCs. CHCs have been declared as District hospitals in new districts and are yet to reach IPHS infrastructure norms. However these gaps are being addressed as a priority. Most sub-centres in Tripura function from rented buildings, and this is true of many states as well. Even in Kerala, only 47% SHCs are functioning from government buildings.

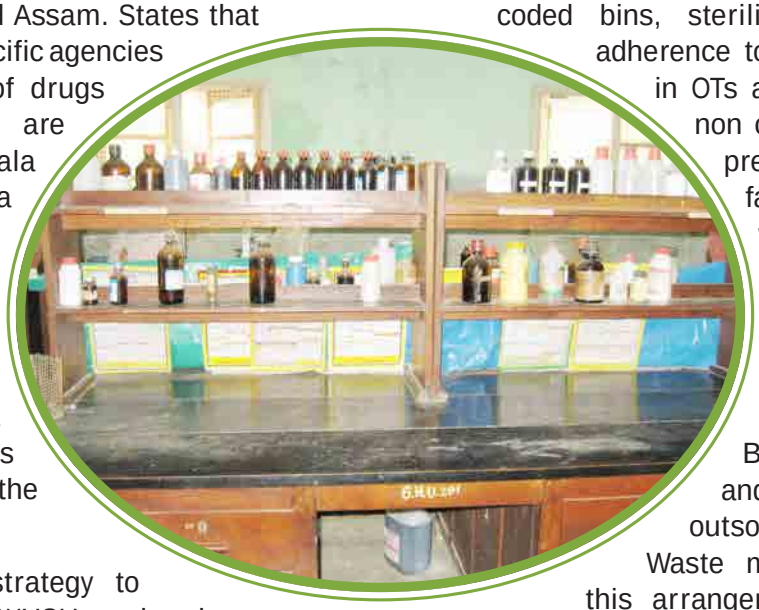
Ancillary services

- Diagnostic services are available in most states. The range of services available is good at DHs and SDHs-but limited in PHC and CHCs. West Bengal, does not have adequate lab services even at the SDH and DH levels and the prime reason cited is lack of laboratory technicians. Laboratory services have been outsourced under PPP in West Bengal. Outsourcing of diagnostic services is reported from Bihar. However, this arrangement does not seem to be working well in the states. User fee for diagnostic services continues to be charged in Punjab, Uttrakhand, Tripura and Delhi. Significant Out of pocket expenditure on diagnostics was reported from Assam, Chhattisgarh, Delhi, Manipur, West Bengal and Uttar Pradesh. Despite in house availability patients are referred to private sector for ultrasound in Manipur. Outside prescriptions for diagnostics was common in both the CRM districts of West Bengal. Lack of reagents in MP and Delhi is a problem in functioning of lab services Non-availability of emergency tests, or tests beyond the day-time working hours, is a limitation in functioning of facilities across the states.

- Availability of drugs in facilities shows improvements in most states, except West Bengal and Manipur. However an effective logistics system that assures an uninterrupted supply and central institutional capacity created for this, is missing except in Tamil Nadu, Kerala, Delhi and Rajasthan. Punjab CRM team reports non-availability of essential drugs in PHCs and SHCs, since procurement is not linked to logistics. In Chhattisgarh, availability of drugs in the facilities was better than earlier but there is shortfall of drugs for basic emergency obstetrics care and management of complicated malaria cases. The supply of essential anti-malarial to peripheral workers and facilities is particularly poor. A common trend seen across states E.g. Assam, Uttar Pradesh, West Bengal, Manipur, Delhi was "outside prescriptions" and consequently high out of pocket expenditure on drugs. Even where provision of free drugs to sick new born and for pregnant women has been mandated under the Janan Sishu Suraksha Karayakaram, availability of required drugs is still problematic. Exit interviews with patients' attendants in Punjab and Odisha showed that most antibiotics for sick newborns are being purchased from outside. Irrational distribution of drugs had resulted in large quantities of fourth generation antibiotics in some facilities in Assam and Odisha , which

are grossly disproportionate to the requirement.

- CRM findings show that facilities are reasonably stocked with equipment, except in Manipur and Tripura (lack of resuscitation equipment). Maintenance and repair of equipment resulting from lack of Annual Maintenance Contract is increasing downtime of equipment in Uttar Pradesh, Delhi and Assam. States that have instituted specific agencies for procurement of drugs and equipment are Tamil Nadu, Kerala Rajasthan, Madhya Pradesh, Punjab, West Bengal, Delhi and Chhattisgarh. However the link between procurement and logistics is established only in the first three states.



- The co-location strategy to improve access to AYUSH services is in place in all states. Kerala has not opted for this. Lack of AYUSH drugs was a constraint for AYUSH MOs in facilities in West Bengal, Uttar Pradesh and Madhya Pradesh. A notable feature in drug procurement is Tamil Nadu's drug supply and procurement system for AYUSH drugs, called TAMPOL.

Supportive services

- Adequate patient amenities were observed in several states (Assam, Bihar, West Bengal, Uttarakhand, Tamil Nadu, Uttar Pradesh and Rajasthan). Supportive services have no doubt improved since the last CRM. However, sanitation is still a problem in the other states. Lack of adequate toilets, labour room without attached toilets and poor hygiene in toilets and wards is reported from several states.

- Diet for pregnant women was available in Tamil Nadu, Madhya Pradesh, Delhi , West Bengal, Uttarakhand (to all in patients), Rajasthan, Uttar Pradesh , Odisha and Manipur (in one district). Cash disbursement in lieu of diet was observed in Kerala.

- Infection control and waste management continue to pose challenges for most states in terms on non segregation of waste, exposure of wastes in the facility area, incorrect use of colour coded bins, sterilization of equipment, adherence to protocols for asepsis in OTs and Labour rooms and non compliance to infection prevention measures by facility level staff. This was more acute in Uttarakhand, Assam, Madhya Pradesh, Odisha, Chhattisgarh. Bihar, Delhi and Tamil Nadu. Odisha, West Bengal, Kerala,Punjab and Tamil Nadu have outsourced Bio Medical Waste management; however, this arrangement has not worked well in most states due to irregularity of service provisioning and lack of supervision. Poor safety measures in facilities (installation of fire safety equipment etc.) for patients and service providers were observed in most states. Problems with regard to availability of generators , non functional generators, regular water supply and drinking water in OPD was reported from West Bengal, Uttarakhand, Madhya Pradesh (especially from delivery points), Manipur, and better in Punjab, Rajasthan, Assam and Tamil Nadu.

- Quality Assurance Committees are formed in some states and not in others, but even where they are formed, functionality is low, and quality as an outcome is uncertain. Structured externally certified processes are reported favourably from Tamil Nadu and one district of Bihar. However on the whole, progress in quality assurance is fragmented and sporadic, with selected dimensions being attended to at each facility.

Cost of care for services

- A small registration fee is being charged in all states for OPD registration. The main charges are however related to diagnostic and therapeutic procedures. The JSSK, aimed at "cashless" services for pregnant women and newborn has been rolled out in all the 15 states. Policy articulation and dissemination of information on the entitlements were seen across all 15 states. Efforts to ensure free entitlements - free drugs, diagnostics, diet and free and assured home to facility transport and drop back was observed during the CRM state visits. Despite this out of pocket expenditure arising from drugs , other consumables, diagnostic tests and referral transport was reported from Madhya Pradesh, Uttarakhand, Assam, Tripura, Manipur, Delhi,

Uttar Pradesh, Chhattisgarh and Punjab. Outside prescription for drugs and diagnostics were the main contributors to OOP. In Manipur and Tripura, OOP on drugs amount to as high as Rs. 1400-1700 on drugs and Rs. 7000 for drugs on C-sections. In other states it was in the Rs 500 range. Informal payments were reported from several states.

Gender / security

- Quality of care with regard to privacy and security is a problem in most states. The most flagrant violation of this was seen in inpatient wards admitting both male and female patients, with no curtains between beds. In some instances providers accepted that this was a problem but in many cases acknowledged as not being sensitive to this dimension. Patients everywhere clearly articulated the need for such privacy.
- Unrestricted entry of male relatives / lack of screens/curtains in OPD examination rooms and labour rooms without attached toilets, were other forms of lack of sensitivity to privacy.
- Security was a concern expressed by service users in the facilities at night in Punjab and also in Odisha. Roaming stray dogs inside the premises of facilities was also reported from a few sites- a clearly unacceptable danger.
- Display of citizen's charter and IEC material and availability of signages was reasonably good in most states.
- Grievance redressal systems are yet to take off in the states. Rajasthan was one state that had established this.

Recommendations

- The district plan must be revived as the basis and road map for achieving NRHM goals in the coming plan period, which would be increasingly synonymous with the goal of universal health care, in rural areas. The neglect of the district plan as a guiding document, so well established, in the first years, should be reversed.
- The district plan must be the strategic document which specifies planned improvement in access to public health services with clarity on package of services that each facility would deliver. RCH services and Communicable disease services would remain the priority for the immediate period for the high focus states. All states need to start to work on Non Communicable Disease services with the non high focus states making it a priority.
- District plans should also clearly spell out the

public facilities where emergency and trauma services would be made available to match the growing presence of Dial 108 pattern of emergency response services.

- State should identify gaps in infrastructure, and plan for augmentation accordingly. States need to put in place an infrastructure development plan which specifies a road map to close all gaps based on current estimates. This infrastructure development plan should be responsive to geographic consideration E.g. Hilly districts, forest areas, tribal areas and consider time to travel and time to care as reference points. There is also a need to plan differentially for tribal areas, rural / urban slums and resettlement colonies. Population norms should be released where necessary to ensure adequate coverage of population. Prioritisation of residential facilities for those sites where even rental accommodation for staff is not available is another necessity.
- There is a need for a clear policy articulation on the supply of free drugs, diagnostics and diet in public hospitals.
- Sensitisation of providers, better logistics, and responsive allocation of untied funds (preferably renamed as “operational costs”) is essential to meet the objectives of provision of free drugs and diagnostics and reduce OOP in public health facilities. Rational drug use and use of standard treatment guidelines, protocols and formularies needs to be ensured.
- Display of information on free entitlements and services available must be ensured in strategic areas such as entrance of facilities, wards, labour rooms and SNCUs.
- A responsive and transparent Grievance Redressal system meeting minimum process standards to be defined by states and put in place in every district and facility.
- State needs to go beyond fragmented quality of care approaches which address one or other dimension at a time. States need put in place a policy and strategy framework in place to address the issues of quality assurance and improvement. Such a framework needs to go beyond merely setting up of QACs- to include a notion of quality standards, processes of measurement, putting in place quality management systems and then a system of un-biased certification. Such a quality system should address at the least cleanliness and hygiene especially of toilets, safe drinking water, patient amenities, privacy, security and bio medical waste management.
- More attention is required to ensuring separate wards for male and female patients, and provision of separate beds with curtains in injection rooms. Security needs to be strengthened in all facilities and the payment of the security staff needs to be increased up to the daily wage norms.
- Within the domain of quality, infection control needs to be addressed immediately. This requires attention to all four dimensions – infrastructure design, infection control practices, sterile supplies and specific technical monitoring as required in high risk areas.
- At the district level, supportive supervision using periodic review and supervisory visits should lead to improvement of quality of care in the facilities. Quality Assurance Committees could be sensitised and revamped to monitor facility level range of care and quality of services.

2 OUTREACH AND PATIENT TRANSPORT SERVICES

Objectives under NRHM

- Strengthening sub centres through better human resource development, clear quality standards, better community support and an untied fund to enable local planning and action and more Multi Purpose Workers.
- Improved outreach services to medically under-served remote areas through mobile medical units.

Progress under NRHM

- There has been a significant increase in the number of sub centres across the states for serving the rural population. Today the total number of sub-centres is 1,48,124. However even this is short of the full requirement- and this shortfall is expressed in the tables below.
- The impetus on infrastructure creation and improvement has enabled a major proportion of sub centres to operate out of government buildings. Quality of infrastructure has also improved with a focus on extension, renovation and addition in those Sub centres, where deliveries are being conducted. As against 63,901 SHCs in government buildings in 2005, the numbers have gone up to 92, 867 in 2011(a 45% increase).

Table : Status of Sub centres in states visited-

States	No. of sub centres required	No. of sub centres in position
Assam	5841	4604
Bihar	18533	9696
Chhattisgarh	4904	5076
Delhi	83	41
Kerala	3525	4575
Madhya Pradesh	12314	8869
Manipur	492	420
Odisha	8136	6688
Punjab	3463	2950
Rajasthan	11374	11487
Tamil Nadu	7516	8706
Tripura	673	632
Uttarakhand	1440	1765
Uttar Pradesh	31037	20521
West Bengal	13036	10356
TOTAL	122367	96386

Source: RHS Bulletin , March 2011

- Over 96% of sub-centres have one ANM and there is a second ANM in about 42% of sub-centres. There is a 56% increase in the number of ANMs as compared to the baseline of 2005 (RHS, 2005 and 2011 Bulletin). Male workers too have increased considerably.
- There are a total of 442 districts with MMUs of which about 60% are in the high focus districts.

Table: Sub centres in govt. building in states visited

States	Total Number of Sub Centers functioning - 2011	Sub Centres functioning in govt. building	% sub centres functioning in govt. building
Assam	4604	2723	59
Bihar	9696	4848	50
Chhattisgarh	5076	2350	46
Delhi	41	8	20
Kerala	4575	2128	47
Madhya Pradesh	8869	7254	82
Manipur	420	316	75
Odisha	6688	3365	50
Punjab	2950	1828	62
Rajasthan	11487	10266	89
Tamil Nadu	8706	6510	75
Tripura	632	335	53
Uttarakhand	1765	1040	59
Uttar Pradesh	20521	15570	76
West Bengal	10356	5001	48
Total	96386	63542	66

Source: RHS Bulletin , March 2011

Key Findings

- Of the 15 CRM states visited, nine states have adequate sub centres as per their rural and tribal population . Sub centres in the remaining six states (Assam, Madhya Pradesh, Odisha, Punjab, Uttar Pradesh and West Bengal) cater to a much larger population indicating a shortfall, especially in the larger states. Sub centres in Madhya Pradesh and Uttar Pradesh typically cover 7000-8000 population. This is despite the number of new sub centres sanctioned by most states, especially in high focus / poor performing districts (E.g. Rajasthan and Odisha).
- State teams report adequate quality of infrastructure in most sub centres (except West Bengal and Tripura). A positive aspect is the sanctioning of additional labour rooms in the sub centre conducting deliveries - called 'delivery points'. Sub centres with ANM accommodation also show an increase in several states.
- Of the 15 CRM states covered, five states (Assam, Kerala, Tamil Nadu, Manipur and West Bengal) have saturated all sub centres with at least one ANM, whereas in four states (Madhya Pradesh, Punjab, Rajasthan, Uttarakhand), only a few vacancies remain. On the other hand, six states (Bihar, Chhattisgarh, Delhi, Odisha, Tripura and Uttar Pradesh) are still seized with the problem of a small percentage (but in absolute terms a large number) of sub centres without ANMs. Assam, Odisha and Punjab have added the second ANMs to a substantial number of its sub centres. In Assam and Punjab, both ANMs have

demarcated areas of operation and well defined work plans managing to provide OPD services

in the facility and outreach services. Assam has an additional Rural Health Practitioner (RHP) to manage the sub centre. Multi Purpose Worker Male- (MPW) workers have been reported from Assam, Kerala and Odisha but short falls are reported from Tamil Nadu and West Bengal.

- Sub centres across most states offer a basic package of OPD services including antenatal care but services for family planning and for adolescent were found to be sub optimal. Despite adequate availability of equipment and reagents, haemoglobin estimation, BP measurement and abdominal examination was not conducted during ANC (facility and outreach) in many states. Gap in skills of ANMs related to BP and Hb estimation was another observation. In Tamil Nadu, Kerala and Punjab, the role of the sub-centre is changing, with decreasing utilisation for care in pregnancy and even immunisation and a greater effort going into screening for NCD, palliative care and school health. This changing role of sub centres is best seen in Kerala – where palliative care, screening for NCD, and weekly NCD clinics are held at most SCs. In the other two states it is sporadic. This preventive role of the sub centres was found to be weak in most high focus states. Use of IEC during outreach was found to be low.
- VHNDs are organized as per planned schedule in most states for providing ANC services and immunization . Lack of space and privacy in the sessions for conducting ANC was a concern in many states. The use of VHNDs as medium of convergence and planning is sub optimal in most states. The exceptions are Tripura and Kerala which report good co-ordination and active involvement of ANM, AWW and ASHA and PRIs. They also report effective use of VHND for convergent action. However in most states VHNDs are yet to be utilized for disease prevention, counselling for spacing methods , nutritional counselling and addressing adolescent health issues
- With the renewed focus on strengthening of delivery sites/points, sub centres have re emerged as sites for delivery, a trend observed in some states. In Assam 4% Sub-centres are conducting deliveries ; 7% in Rajasthan , 12% in UP and 2% in Odisha, and almost 27% in some districts of Chhattisgarh but less than 1 % or nil in states with better health outcomes such as Tamil Nadu and Punjab .
- Sub centres and VHND provide adequate immunization services in most states , with the latter being the main community outreach mechanism with the active involvement of ASHAs and ANMs. The integrity and functionality of the cold chain has improved across states. Very few sites report any short-fall. Preparation of micro plans and tracking of drop outs are somewhat weak areas.
- Menstrual Hygiene (MH) programme has been rolled out in the identified states and ASHAs are engaged in distribution. Good response to the programme was reported from Assam, Odisha, Punjab, Tamil Nadu and Rajasthan. Delhi has a state scheme for MH which function well. However, concerns on quality of sanitary napkins were reported. The Weekly Iron and Folic acid Supplementation (WIFS) programme was reported as functioning well in a few states.
- In many sub-centers, a small number of patients seek first contact curative care. Though this could be as low as two to five per day, given the large number of sub-centers, this could well be higher than the load in PHCs . There is a need to recognize and build on this with better training,

guidelines and drugs given to sub-center staff.

- Mobile Medical Units (MMUs) is a commonly used mechanism in most states for providing outreach in under-served areas. Assam, Kerala and West Bengal have introduced mobile boat dispensaries, boat clinics for remote riverine areas with habitations of tribal people. These boats provide a range of preventive and curative services and have a good response from the communities. Though MMUs are operational in all states, both coverage and range of services provided is somewhat limited. The size of vehicles was found to be a limiting factor in mobility and reaching remote and difficult areas (Manipur and Uttarakhand). Irregularity of services was reported from some states. In Uttar Pradesh and Bihar, the two largest states with large under-served areas, MMUs are currently non functional. Delhi does not have MMUs, but has a state initiative - Mobile health Scheme managed NGO partnerships, for JJ clusters, slums, and construction sites. However there is little clarity on the reasons and location for deployment of MMUs nor the package of services being provided.
- Telemedicine in MP was found to be a good initiative. No other team recorded this form of outreach services from other states

Recommendations

- Augmenting the human resources at the SHC level to enable it to become the first port of call for community should be the next step. Though it is important to prioritize two ANMs at SHC delivery points, this should not be interpreted to mean that one ANM is sufficient for other SHCs. The policy direction should be towards strengthening the SHCs to provide a comprehensive range of services for which second ANM is essential
- Careful distribution of work between the two female health workers and the male worker should ensure all RCH care, considerable effectiveness in disease control work, basic screening and supportive care for a wide range of non-communicable diseases. In states like Kerala where there is little RCH work load, one ANM may suffice. In the high focus states, if there are two ANMs and the population to facility ratio is optimal, provision of entire range of services could be initiated with two ANMs in place. If there are two ANMs, tour timings should be organized such that the sub-centre is open on all working days.
- Instead of a fragmented package of skills training related to IMNCI/ SBA/ NSSK/ IUCD/ ARSH, the ANM should be trained in standard treatments protocols that cover her existing work areas and emerging role in NCDs.
- Basic Infrastructure and supportive amenities like electricity and water to be strengthened in SHCs conducting deliveries.
- The package of services to be delivered by the MMU and the role it plays within a system (whether equivalent to the outreach services of the sub-centre or the referral support of the PHC or both) needs to be defined in each context. The frequency, periodicity, human resource deployed and quality of services need to improve. The impact of MMU services on the underserved needs to be assessed and appropriate design modifications made.
- Identification of those missed from coverage or from follow- up for immunisation or antenatal care using the Maternal and Child tracking system (MCTS) and line listing of all children requires to be improved.
- VHNDs need to provide services beyond immunisation and antenatal care. Counselling, health education and promotive health care needs to be a part of the services. VHNDs should ensure privacy for examination of women.
- Convergence between health and ICDS needs to be strengthened through sharing of information on nutritional status and appropriate allocation of work on addressing malnutrition among children and sharing of counselling roles. VHSNC should also play an active role in organising and managing the VHNDs.

3 HUMAN RESOURCES FOR HEALTH

Objectives under NRHM

- To devise a clear state specific human resource management policy backed by a strong political and administrative will to ensure transparency in management of public health cadre.
- To increase recruitment and deployment of additional human resources in the public health system especially in rural and remote areas.
- To develop a comprehensive human resource strategy for attraction and retention of skilled health workers in rural and remote areas, and categorizing postings into difficulty grades for proportionate incentivization and other workforce measures.
- To increase avenues for trainings and development so that standard treatment protocols can be operationalized.
- To adopt preferential workforce management principles and credible accountability framework for improving the effectiveness of human resources.
- In parallel to the above measures under NRHM, the Central and State Departments of Health could work to increase the availability of health professionals through expansion of medical, nursing and technical education.

Progress under NRHM

- In the last seven years of NRHM there has been an increase of 126 medical colleges with a total 44050 seats till December 2012. There is an increase of 55% in the total number of medical colleges[4]. About 5461 nursing institutes have been added including 1642 ANM Schools, 2674 GNM Schools, 1586 B.Sc. Nursing Courses; 698 post basic B.Sc. Nursing Courses and 500 M.Sc. Nursing Courses. Numbers of such schools and colleges increased from 1646 in 2005 to 7100 in 2012, an increase of 331.3%. A major percentage of the overall increase was in the already well-endowed non-high focus states - from 1284 in 2005 to 4359 in 2012 (331%). The large high focus states showed an increase in numbers of nursing and midwifery institutions from 275 to 2614 (950%). Except for ANM schools, these are

[4] *www.micindia.org accessed on December 22nd, 2012.*

enabled but not directly financed by NRHM.

- One of the major contributions of the NRHM has been the addition of 138374 contractual skilled service providers to the public health services in the space of these seven years including ANMs (65,493), Staff Nurses (32,878), Paramedics (14,884), AYUSH Doctors (10,628), AYUSH Paramedics (4,185), MBBS Doctors (7,219) and Specialists (3,087)[5].
- This is in addition to the substantial increases in workforce as a result of filling up regular vacancies by state governments.
- NRHM has also inducted 574 District Programme Managers, 527 District Data Managers, 550 District Accounts Managers, 3351 Block Managers, 4006 Block Accountants and 3840 PHC Accountants and 500 Management and Public Health Consultants for strengthening state and district management.
- About 82708 ANMs/DEOs are trained in data collection and uploading the formats on MCTS portal[6].
- Across the states, 5004 doctors were trained for BEmOC , 3329 for CEmOC and 10022 for MTPs at various levels. The number of doctors and nurses trained on SBA is 60571. A total of 267377 doctors, nurses and anganwadi workers have received training on IMNCI while 795 doctors trained on SNCU at state and district levels. At district level, number of doctors trained on Mini-lap (10284) and NSV (2612). Number of nurses and ANMs trained on IUCD at state and district levels is 43749.

Type of Training (for doctors and nurses)		April 2005 - December 2011
Maternal Health		
BEmOC	National Level for trainers	548
	State and District Level for medical officers	4456
CEmOC	State and District Level for medical officers	3329
MTP	State and District Level	10022
SBA	State Level for trainers	1587
	District Level for ANMs and staff nurses	58984
Child Health		
IMNCI	State Level- for medical officers as trainers	1672
	District Level- for ANMs and anganwadi workers	265705
SNCU	State and District Level- for medical officers	795
Family Planning		
Mini-lap	District Level for medical officers	10284
NSV	District Level for medical officers	2612
IUCD	State and District Level for nurses and ANMs	43749

(Source: IHFW training database –April 2005-December 2011).

Sr. No.	Category of contractual staffs posted at public health facilities	Total number added in last 7 years
1.	MBBS doctors	7219
2.	Specialists	3087
3.	AYUSH doctors	10628
4.	Staff Nurse	32878
5.	Paramedics	14884
6.	ANM	65493

(Source: State wise Progress Report of NRHM (31st June 2012, MoHFW, Government of India)

[5]*State wise progress Report of NRHM as on 31/06/2012, Ministry of Health and Family Welfare, Government of India*

[6]*State wise progress Report of NRHM as on 31/06/2012, MoFHW, GoI*

Key Findings

- All states have increased the availability of skilled workforce across various categories, in particular MBBS doctors, AYUSH doctor, staff nurses, ANMs and paramedics, often using innovative methods of recruitment such as online application system and direct walk-in-interviews. Regular vacancies under respective

  state governments are also filled up. However, there is little or no progress on specialist vacancies which remain critical. Further efforts to convert contractual NRHM supported posts to regular state government posts have not been fronted on the agenda except in Bihar which has initiated regularization of support staff like ward boys, ayahs, administrative staff, drivers and cleaning staff. This was reported in West Bengal, Uttar Pradesh, Punjab and Chhattisgarh. In some states notably in Chhattisgarh, lack of nurses is a major constraint. One improvement as also observed, in last year's CRM is the substantial increase in AYUSH doctors and improved functionality.

- States such as Odisha, U.P, Bihar, Assam, Chhattisgarh, Kerala and Punjab have introduced various incentive schemes for attraction and retention of service providers in rural and underserved areas. Effectiveness of such schemes is yet to be evaluated in a systematic manner. Financial incentives have helped retention but not led to attraction of human resources to remote areas in many states. The financial incentive for doctors for working in remote and rural areas ranges from Rs.100/- per month in Uttar Pradesh, Rs.1000/- per month in Tamil Nadu and a maximum of Rs.35, 000/- per month in Chhattisgarh. In Madhya Pradesh, Uttarakhand, West Bengal and Manipur, the incentive scheme for retention of human resource in remote areas has not been introduced yet.

- There is no training plan or post training deployment plans. Progress of trainings is poor resulting in low levels of achievements of SBA, NSSK, LSAS and other trainings as reported in Uttar Pradesh, Chhattisgarh, Delhi, Rajasthan, West Bengal and Manipur.

- In Bihar and Madhya Pradesh, the doctors and nurses were deployed preferentially at block or higher facilities for optimum utilization of scarce resources. In Delhi, West Bengal and Manipur, the number of medical doctors and specialists deployed at facilities was not proportionate to case load managed.

- Across the board, AYUSH services was not properly mainstreamed and utilized as noted in Bihar and Delhi though there was high demand of AYUSH services in the community in Delhi and Uttarakhand. There is lack of specific IEC to promote AYUSH and lack of AYUSH pharmacists with instances of irregular supply of AYUSH medicines at many facilities where AYUSH doctors are collocated. This was observed in Bihar, Uttar Pradesh, Punjab, West Bengal and Delhi. In Tamil Nadu, the contractual AYUSH doctors take part in school health program, MMU activities and are also members of RKS committees. However, there is no plan for their regularization and career development.

- One major constraint in all states is the

difference in remuneration between contractual and regular staff for the same service role which is the main reason for attrition and demotivation of contractual staff as observed in Punjab, Uttar Pradesh, Madhya Pradesh and Manipur. Contractual staff are considered preferentially for regular appointments.

- Performance appraisal for contractual employees on annual basis has been adopted in Bihar, Chhattisgarh, Kerala except in Manipur. Madhya Pradesh has proposed a performance based incentive, yet to be implemented.
- Online Human Resource Management Information System (HRMIS) is in place in Odisha, Tamil Nadu, Assam and Bihar. A database of all types of employees (contractual and regular) has been created. Use of the information system for decision making process is limited.

Recommendations

- Although states have made progress in different aspects of public health workforce management, they now need to develop a comprehensive human resource policy which specifies a clear plan of action for meeting public health workforce requirements and ensuring performance.
- States must commit to sustaining an expanded, well trained and supported public workforce made possible through NRHM funding.
- Establish and strengthen the HRH cell for all contractual staff (since regular staff are generally dealt with the establishment division of the Directorate) with an adequate number of qualified staff to manage workforce requirements of contractual staff – recruitments, payments, training, career progression and grievance redressal.
- Distinct from this, states also require an HR policy cell which does the long term planning of the HRH in the state.
- Strategies for attraction and retention of skilled workforce in rural and remote areas should go beyond limited incentivization to a package of measures. Such a package should include well planned non-financial incentives, positive work force environment, rational transfer policies, grievance redressal systems and in service training. Long term measures will include creation of educational reforms to allow selection and training of local candidates for professional categories (Rural Medical Assistants, Nurse Practitioners, Family Medicine Practitioners) as appropriate to the area based strategies aiming at preferential local based selection. Meanwhile the delivery of financial incentives needs to be increased, streamlined and implemented better.
- States need to identify those districts which are unable to build the institutional capacity for achieving training goals. Such districts would require state or central assistance to build / establish training institutions
- State should establish/improve the standardization of performance appraisal systems and extend it to non-contractual, regular employees.
- Ensure parity in remuneration between contractual and regular employees for the similar service role at public health facilities.
- States to design Human Resource Management Information systems which allows for decision making relating human resource deployment to service delivery outcome.
- For improving workforce performance and addressing knowledge and skill gaps amongst all categories of clinical service providers (Medical officers, AYUSH MOs, Rural Medical assistants, nurses and paramedics), states should institute Standard Treatment Guidelines (STG), and base assessment of training needs, training plans and performance on these.

4 PROGRESS IN REPRODUCTIVE AND CHILD HEALTH

Objectives under NRHM

- Universal access to all aspects of reproductive health care services. This would include:
- safe delivery defined as at least skilled birth attendants- which in most contexts would mean an institutional delivery.
  - Timely access to quality emergency obstetric care services.
  - full antenatal and post natal care services
  - medical termination of pregnancy
  - reproductive tract infections
  - reproductive and sexual health services for adolescents.
- Universal access to child health services. This would include:
  - Community based care for child health- preventive, prmotive and curative
  - Facility based care for the new-born and sick child
  - Treatment for sick and severe acute malnutrition.
  - School health care services.
- Social protection from the costs of care in pregnancy and childhood and maternity entitlements related to health.
- Assured emergency response and patient transport services- prioritizing the needs of care in pregnancy- but extending gradually to all emergencies.
- Family Planning -Access to contraceptive services- both limiting and spacing
- Action to prevent pre-natal sex determination and sex-selective abortions through effective implementation of the PC & PNDT Act.

Progress under NRHM

- The reductions in MMR, IMR and Crude birth rates in the period from 2005 to 2012 are as follows –
  - MMR declined from 254 in 2004-06 to 212 in 2007-09, a fall of 5.8% per year. Only three

states have crossed the XIth plan target of 100 (Kerala, Tamil Nadu and Maharashtra) and four more are in close proximity.

- IMR fell by 5% per year over the 2006-2011 period, showing an improvement over the 3% decline in the preceding year. At the current rate it is likely to be 12 points short of the target by 2012. Though decline in IMR has accelerated, an even greater pace is required
- National Crude Birth Rate (CBR) has reached 21.8 which would imply that the TFR would reach replacement level of 2.1 after a lag period. High fertility however remains a problem in eight states and one union territory (Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh, Assam, Meghalaya and Dadra and Nagar Haveli)

Table – MMR, IMR and CBR of the visited states

	MMR 2007-09	IMR 2005	IMR 2011	CBR 2011
Assam	390	68	55	22.8
Bihar	261	61	44	27.2
Chhattisgarh	269	63	48	24.9
Delhi	NA	35	28	17.5
Kerala	81	14	12	15.2
Madhya Pradesh	269	76	59	26.9
Manipur	NA	13	11	14.4
Odisha	258	75	57	20.1
Punjab	172	44	30	16.2
Rajasthan	318	68	52	26.2
Tamil Nadu	97	37	22	15.9
Tripura	NA	31	29	14.3
Uttarakhand	359	42	36	18.9
Uttar Pradesh	359	73	57	27.8
West Bengal	145	38	32	16.3

Source – SRS Bulletin 2012, 2011, 2006

- There is an 165.5% increase in the total number of FRUs as compared to the baseline year of 2005. The total number of FRUs increased from 955 to 2536. Impressive though this may be, it is well short of NRHM targets and the WHO reference norm of at least one facility providing comprehensive emergency care for every 500,000 population. Further the distribution is skewed leading to large areas- where there is only one facility for a 10 lakh or higher population.
- The total number of potential 24X7 public health facilities is 30,969. This includes 23,887 PHCs and 4809 CHCs, plus 705 "other" primary health care facilities and 1053 "other" sub-district facilities. This excludes district hospitals. Of these 30,969 facilities only 2243 facilities (1263 PHCs and 980 CHCs) could qualify by any measure for being called 24X7 facilities when measured at the baseline. Over the last seven years, this number grew to 15,014 – a fivefold increase, - but still a net achievement of only 48% of the target. This perhaps explains the differing perceptions of achievement between those who have worked hard for this 546% increase and those who see the achievement as having fallen short by a huge 52%.
- Quality of care and range of RCH services provided has also shown considerable improvement across all states.
- Further, with the appointment of two ANMs in the sub-centers, closing gaps in cold chain implementation, better vaccine transport arrangements, introduction of mobile medical units, and the extensive deployment of community health workers and community level organisations there have been substantial improvements in immunization coverage and other outreach services like ante-natal and post natal care across all states.

Key Findings

Prioritisation of Facilities for RCH services: The "Delivery Point" Concept-

- The mapping of delivery points and segregation into Levels - 1, 2 and 3 facilities is complete in all the States.. All states are now clearly in a position to identify which facilities are most sought after for delivery services, and are now focusing on increasing quality of care in these facilities, while developing additional facilities to fill remaining gaps.
- In all non high focus states visited, sub-centers

do not provide delivery services any longer. In high focus states approximately one in five to 10 SHCs provide delivery services. Those which are high volume by standard definition however are still few. Sector level primary health centres are sites of delivery services in all non-high focus states and at low volumes (below normative levels) in high focus states. Block and district hospitals and district hospitals are the main delivery points by volume in all states.

- Reporting on levels of achievement in the creation of delivery points were confirmed by the visits. However if case load norms are included as a criterion then it does not hold true. In areas of geographic dispersion, small habitation and where health seeking behaviours have not yet changed, facilities with lower case loads may be considered as delivery points to improve access. One area of concern is lack of systemic analysis of areas where home deliveries are high and ensuring assured midwifery services. Mechanical application of case load norms should not lead to reduced creation of delivery points where such services are needed. The CRM to Delhi reports with concern, that a significant number of home deliveries took place after women were turned back from public hospitals, presumably because they were overcrowded. There are also concerns about quality in terms of provider behaviour with patients. Clearly the decision to restrict delivery points to very few facilities and then fail to increase capacity in such facilities is disturbing.
- There are also concerns about reporting and support services for home deliveries. For example, figures of reported home deliveries in Assam were markedly different from the figures from Annual Health Survey (AHS). Thus, Jorhat district reported 4-5% home deliveries whereas the AHS, 2011 record 30% home deliveries. In contrast high home deliveries are truthfully reported in the districts of Tripura, Uttrakhand and Chhattisgarh visited but the reasons thereof, and the nature of services provided is not clear.
- Are delivery points – literally only delivery points- or is there the larger set of RCH services actually being provided? MTP services are clearly lagging behind. Only Tamil Nadu, West Bengal and Madhya Pradesh report that all emergency obstetric care sites, also provided MTP services available. Basic emergency obstetric care services also lag but comparing to earlier CRMs where this was reported as a non-starter, considerable strides have been made on this. The reports on level of newborn care required to match increasing case loads is similar, there is clear forward movement in most states but not at the same rate, pace or quality as the movement in delivery services. In Chhattisgarh alone facility based newborn care remains a non starter, five years after being flagged as a major issue. While no doubt calls for more action by the state , it also calls for a different way of thinking and acting about such non-starters at the central level. This also applies to areas such as adolescent and reproductive health clinics, which are also across all states, non-starters.

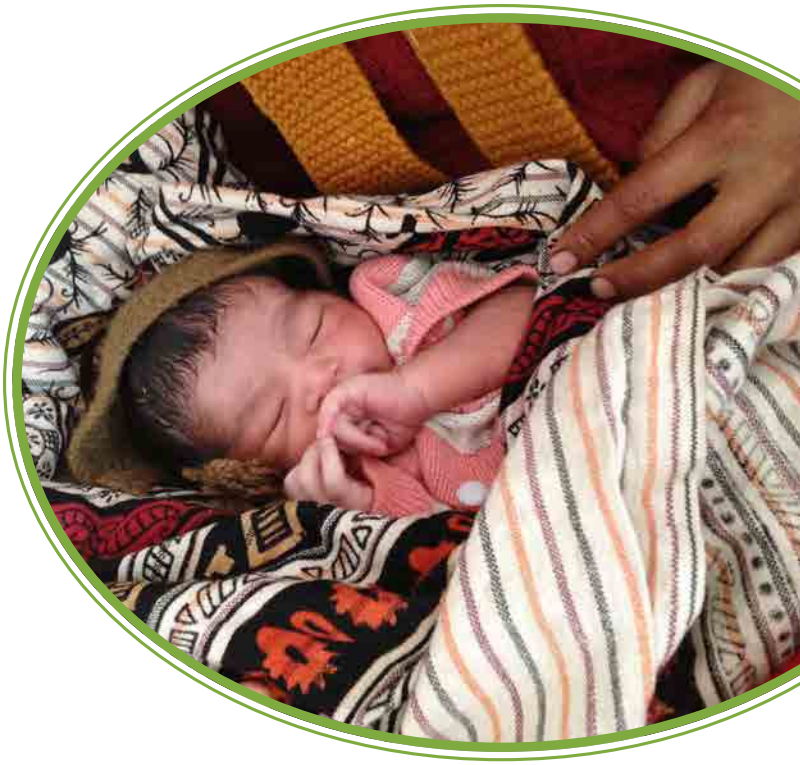
Quality of Care:

- All states report continued increases in institutional delivery, the highest levels being in Tamil Nadu. Even states which had low baseline rates – like Manipur, Chhattisgarh, Uttar Pradesh, Madhya Pradesh and Rajasthan, are showing steady improvement. In contrast to the reports of the first CRMs- more states are reporting systematic efforts at improving quality of care. The uneven case loads across facilities with normative allocation of human and financial resources remains is one of the central problems. There are patients on the floor in many district hospitals, and even patients renting in cots from private entrepreneurs in one medical college hospital.
- SBA trained personnel were posted at the facilities in Rajasthan, Madhya Pradesh, Bihar, West Bengal, Odisha and Assam. On the other hand in Uttrakhand, Uttar Pradesh, Tripura, Delhi and Chhattisgarh the number of SBA trained personnel seen in action were few and this correlated with slow progress in the training. The quality of training was an area of concern in

Odisha and Bihar where the trained personnel were found lacking in skills. Prioritization of training for those providing services was also an issue in Odisha, Delhi and Uttar Pradesh.

- Practice of training skills requires good training outcomes and supportive supervision. The practice of using partographs was noted in Rajasthan, West Bengal, Madhya Pradesh and Tamil Nadu whereas this was still lacking in Uttar Pradesh, Manipur, Chhattisgarh, Delhi and Bihar.
- Poor availability of drugs and diagnostics compromising quality of care was also a problem in a number of states and this is discussed along with the first TOR. The good news is that with the delivery point strategy, compromise of quality of care on grounds of lack of human resources was rarely reported, with some cautions about caseload norms made earlier, this is a considerable achievement.
- The quality of ANC services continues to be a cause of concern and was found to be poor in all the States, except Tamil Nadu and Kerala. Three ANC visits achievement is much less than the ANC registration in states except Tamil Nadu where it is 92.6% (CES, 2009). Basic laboratory tests for anaemia, urinary protein and BP measurements were recorded from a number of states- but were poor in Manipur, Uttar Pradesh and Bihar. One major gap was the lack of adequate identification and follow-up for severe anaemia in all states except Tamil Nadu and Kerala , which has instituted follow up for all women with provision of injectable iron sucrose for management where indicated and follow up till they normalize.
- Quality of care in terms of adherence to standard treatment protocols is also a problem. High levels of C-sections was a problem reported from Kerala- and possibly a wider problem in all states in the private sector. The need to take this up as a public health challenge and address such irrational care through an appropriate strategy needs to be emphasised. Another irrational and hazardous practice reported from almost all states is the inappropriate use and non-use of oxytocin (used in the first stage of labour when it is contraindicated and failure to use in the third stage of labour when it is indicated.)
- Quality assurance committees have been formed in many states, but it seems to be difficult to sustain them or make them effective in actual measurable improvements in quality of care.

Emergency Obstetric Care:



- The rate of C-sections conducted at health facilities has gradually increased over the past years in all states. However, even after reducing targets to what is called the designated L3 levels, achievement is only at about 50%. Of the 143 designated L 3 facilities in the districts visited, 75 do not conduct C-section. In many states it is still the private sector in the district which do a majority of the C-sections- eg Manipur, Tripura, Chhattisgarh. Comprehensive emergency obstetric care is primarily limited to the district and at best sub-district hospitals in a majority of the the States. An exception is TN, where a significant number of PHCs (105) provide

C-section facilities. There were no C-section facilities at Mahasamund District, Chattisgarh and there was no operational FRU at Bageshwar, Uttarakhand. The main reasons for this remain the same as noted in earlier CRMs - lack of specialists, unavailability or inability to forge partnerships with specialists in private sector, a slow and sub-optimal roll out of the short-term courses for creating specialists.

Blood Bank and Blood Storage

- Blood banks were available and functional where L3 facilities are designated. Again the best practice in this is Tamilnadu , where both the blood bank and blood storage centres were fully functional with strong inter-linkages.Along with the DH, there were 130 blood storage centres across the CHCs and 138 PHCs have been identified for operationalisation as blood storage centres. Chattisgarh, Odisha, MP anlso report imporvements in blood banks. Availability of blood was noted to be a major challenge in Bihar, and Rajashthan. There is no blood storage unit at any level in Banka and Gopalganj Districts in Bihar, Bageshwar in Uttrakhand and Udaipur in Rajasthan relies on the Medical College for all the blood transfusion requirements.

Maternal Death Review (MDR)

- MDRs have been initiated at all the States except Bihar. In Manipur and Chattisgarh, MDR committees have been formed but the MDRs have not yet started. In UP, Assam, MP and Uttarakhand facility based MDRs are taking place but community level MDRs are not occurring. TN has a very well established facility and community based MDR system. Certain key issues emerge from the States such as lack of extensive and detailed reviews in UP, lack of analysis of the deaths in Uttarakhand and partially filled formats in Odisha.

Janani Surakhsha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK)

- The JSY scheme is functional in all the States and has led to a substantial increase in the institutional deliveries. Considerable backlogs and delay in payments were observed in Manipur, Tripura, Rajasthan and Bihar while the JSY payments were very streamlined and prompt in Madhya Pradesh, Chhattisgarh, West Bengal etc.

- JSY payments are made through cheques in most states but some like Manipur, and West Bengal continue to pay in cash. Though cash payments are not encouraged, in some facilities in remote areas states are doing this to ensure payment at the time of delivery.

- While in general payments through bank transfers should be associated with speedy payments, delays from state and district health societies transferring to bank accounts may affect timely payments.

- The big step forward is in JSSK. This is now rolled out in all the States. The single most important gain is that it has successfully begin to reverse the culture – (epitomised by the statement 'people-value-services-only-if-they-pay-for-it') that was brought in with user fees about two decades earlier. In academic and policy discourse the argument against user fees has become dominant- but the perceptions that introduction of user fees and cost recovery policies had put in place within the institutions of public care delivery does not change automatically. The implementation of JSSK faces its main challenge because of this culture and precisely because it has become the main form of reform in this direction. It is too early to claim that out

of pocket expenditures are eliminated – but certainly they now average about Rs 400 to 500 for an institutional delivery as against Rs 1400 to 1500 mentioned in earlier studies and reports. Some states – notably Manipur and Tripura still report high OOPs for care in pregnancy. Also the need to factor in measurements of OOPs and not only count what is officially called "user fees" is only now being recognized by service providers and local programme managers. Thus one or other dimension gets left out- in one state it is transport, in another it is diet, in most states it is drugs consequent on poor logistics- that remains the contributor to out of pocket expenses. Out of pocket expenditure is high in Manipur, Tripura, Punjab, and Uttar Pradesh, and less in the other states.

- Many states have put in place adequate publicity for the scheme- but there are a few where this is inadequate- notably Delhi and Manipur.

Facility Based Care of the Sick newborn and child

- The development of facility based newborn care is a priority – especially as institutional delivery rises and the first two days of life are increasingly spent in the public hospital. Even for home based newborn care- complementary facility based newborn care has to develop on as a priority. Home-based newborn care is discussed in the section on ASHA. The good news is that in contrast to earlier CRMs there are reports of increasing numbers of special newborn care units from all but two of the states. Most positive reports are from Tamil Nadu, Madhya Pradesh, Assam and Odisha while it is under construction in Bihar. Where SNCUs become functional, mortality within SNCUs is the next frontier, Eg. the mortality rate for inborn at SNCU in Bolangir DH, Odisha was 20%. Surprisingly state like Kerala and Delhi have not geared SNCU and at best provide some specialist care for in-born newborns.
- The NBSU level (Newborn Stabilization Units) of care is more problematic. It is functional in Odisha and Bihar. In UP and Assam the NBSUs are not operational. Newborn corners are however reported as functional from all states except Manipur and Chattisgarh -where none of the facilities visited had functional newborn corners and indeed all aspects of facility based child care have to start up.
- The state of Kerala has initiated Infant death reviews with the help of Indian Academy of Pediatrics.

Immunization

- Immunization services have improved across the States and some of the weakest states in this regard have shown remarkable improvements Eg- routine immunization has increased to 66.8% in Bihar.
- Reports on cold chain maintenance are now routinely positive across the state- including where earlier CRMs had pointed major gaps. There are still some gaps pertaining to training

and quick replacements- but these are exceptions. Chhattisgarh has solved its power supply gaps in cold chain maintenance by a major investment in solar panels and their maintenance.

Nutrition Rehabilitation centers

- NRCs are established in Uttar Pradesh, Bihar,

Madhya Pradesh and Rajasthan and are being put in place in Chhattisgarh. The programme has many challenges which are discussed further in TOR 7.

Family planning

- CBR around 21 per 1000 in only 6 of the 15 states visited- Assam, Bihar, Chhattisgarh, Madhya Pradesh, Uttar Pradesh, Rajasthan. Though Odisha, Tripura and Manipur are in the high focus list – in terms of population stabilization they have likely reached replacement levels, though it may take some time to reflect in the TFR calculation.
- Unmet needs for family planning services remain a problem in high focus states with the lack of providers and therefore a lack of fixed day services at the block level. Sporadic camps-held in facilities remains the main access to sterilization and IUCD services. ASHAs are doing well in providing access to contraceptive supplies for spacing- but the scale of roll out of this is limited. Functioning of quality assurance committees is also not uniform. In Bihar private sector partnerships help close the gap substantially. Tamil Nadu provides the new multi-load Cu 375 at the DH levels.

Emergency Response and Patient Transport Systems:

- Emergency and Patient transport system, both emergency and non-emergency, have taken off within a short period and found a good response among communities. Some form of assured patient transport system has covered all CRM states visited except Tripura and Manipur. The108 emergency response system is operational in 10 of the CRM states (Uttarakhand, MP, Assam, Bihar Chhattisgarh, UP, Tamil Nadu, Rajasthan and Punjab). Delhi has the 102 CATS services but its reach is limited. West Bengal has the Nischay Van managed by NGOs- which too has limited reach.
- An increasing number of states are finding advantage in combining ambulances of different "business models." The emerging pattern is to develop the main system as an Emergency Response System- the Dial 108 model, which is professionally managed with a call centre and assuring pick up within a time standard, and stabilization care en route; and then supplement this with another system using facility- based basic ambulances without a paramedic for carrying pregnant women back home and for elective patient transfers between facilities (the dial 102 model), and then further add a third for local tie-ups (Janani Express model) to serve as a back up and for remote areas and special situations. Typical of this is Assam which has 108 for emergencies, a 102 for drop back home and inter-facility transport and local voucher based tie-ups in some districts like Dhemaji. Uttarakhand too has a similar model, but with fewer local tie-ups. Odisha has a Janani express which provides adequate coverage in the districts and is now adding on a dial 108 service. MP combines limited 108 deployment with the Janani Express model and now is adding on the 102 model. Chhattisgarh has a 108 model and is adding on a 102 set of vehicles as well. Rajasthan has 108 as well as an additional 104 Janani Express services combined with Medical Advise Services with toll free number. Tamil Nadu has a special neonatal ambulances, but use is reportedly low. The combination of vehicles has helped in a major way.
- All states report a high number of "on the way deliveries" in these vehicles but in contrast to the earlier CRMs, we find the paramedics better skilled and equipped to manage this.
- The main challenge now is ensuring a network of facilities within half hour to one hour of every site to which an emergency can be taken. There are several other measures needed to strengthen quality of care- the development of appropriate and realistic standards, monitoring frameworks, contracting best practices, etc.

Recommendations

- Persist with the strategy of "delivery points"-

taking care to ensure that not only midwifery services, but entire range of RCH services is being provided. . The focus should be on MTP and FP services and care for the newborn and sick child. Where the population served is small, and there are geographical or other barriers to any other site of care, even facilities with smaller case loads should get the inputs prioritized for delivery points.

- Quality of clinical care in RCH areas remains a priority and depends on three dimensions, that need immediate action: better training to carefully prioritized service providers, better logistics to ensure uninterrupted drug supplies, and good quality supportive supervision.
- States and districts that are persistently lagging behind in achieving their training goals especially as regards to key skills/training packages should be assisted by the Center to find partners who can ensure that the current and the next year's training calendars are adhered to. At the same time the state's internal training capacity needs to be strengthened.
- The Nutrition Rehabilitation Centers require more support for effective operationalization especially in states that need them most. The quality of forward and backward linkages to bring in children with severe acute malnutrition and to follow up these children on discharge needs to be addressed urgently.
- The JSSK programme requires further local sensitization of service providers and mid level managers in order for them to appreciate the concept of health care entitlements, and the need to factor in and reduce all out of pocket expenditures, even while expanding the amenities to include dimensions like diet and drop back home. Good drug logistics and free diagnostics is another major component of the effort to reduce out of pocket expenditure.
- Build on the success story of referral transport- with the development of quality standards, monitoring and evaluation frameworks and good contracting processes- that ensure quality services and a number of providers in play. Complementarity between the 108, the 102 and the local tie-ups would be the key to closing the gaps in assured referral transport and efficiency of its provision.
- Challenge on family planning front is to have a well focused especially designed package for the four large high focus states. In all states the frontier is further promotion of Non scalpel vasectomy (NSV), use of spacing methods and counseling.
- Provider training in MTP and increase use of MVA should lead to the establishment of MTP services atleast in all FRUs and should aim progressively to introduce in all 24X7 facilities.
- States that have not been able to establish facility based care for the sick newborn must be linked to technical partners who can help them build the capacity at faster pace. The referral link between home based and facility based newborn needs to be strengthened.
- Efforts at the establishment of L3 facilities or FRUs providing comprehensive EmONC with blood transfusion facilities should be strengthened in a focused manner beginning by prioritizing districts where they are completely unavailable followed by those where they are below threshold levels. In such districts partnerships with private providers if available should be taken up as a priority.

5 DISEASE CONTROL PROGRAM – COMMUNICABLE AND NON COMMUNICABLE DISEASES

Objectives under NRHM

- "Special programmes for Tuberculosis, Malaria, Filaria, HIV/AIDS., and other diseases, initiated and funded by the center have worked on the assumption that there is a credible and functional public health system at all levels in all parts of the country. The challenge of the NRHM is therefore to strengthen public health systems with positive consequences for all health programmes. NRHM attempts to bring them under an umbrella of village, district and state health plans- so that preventive and promotive and curative aspects are well integrated at all levels.
- "Tobacco, cancer, diabetes, and renal diseases, cardio-vascular diseases, neurological diseases and mental health problems and consequent disabilities of chronic diseases are major challenges the Mission has to deal with. The already over-stretched health system has to absorb the additional burden of chronic diseases, especially in rural areas. Both preventive and curative strategies with mobilization of additional resources are needed. It is proposed to integrate these with the regular health care programme at all levels.

Progress under NRHM

- Revised National Tuberculosis Control Programme (RNTCP): Sputum conversion rates are over 90% and treatment success rate is 88% in the new smear positive patients. New Smear Positive Case Detection Rate has increased from 66% in the first quarter of 2005 to 72% in 2011 but continues to be low in many states. Integration of RNTCP with NRHM has improved laboratory support, availability of equipment, human resources, and community level support through ASHAs.
- National Vector Borne Disease Control Programme (NVBDCP): There has been a 29.67 % reduction in malaria cases; from 18.17 lakhs in 2005 to 12.79 lakhs (Prov.) in 2011 with an adequate Annual Blood Examination Rate (ABER) of about 10 crore persons. This improvement can be attributed to availability of new technologies, the facilitation by ASHA and community processes, the increase in trained human resources especially male health workers and laboratory technicians and

the overall revival of public health facilities in many places. Kala-azar and filariasis have seen significant improvements. However dengue has spread to more geographical areas and control of JE remains a difficulty in certain areas.

- Integrated disease surveillance programme (IDSP): The IDSP has been extended to all states and 618 districts. The NRHM has contributed by providing support to recruitment and training of district level epidemiologists, entomologists and microbiologists for the programme as well as infrastructure requirements.
- National Leprosy Eradication Programme (NLEP): Only three states now have prevalence above the 1 per 10,000 target. The number of new cases is decreasing. Focussed efforts in endemic blocks involving the ASHAs and community awareness programmes have contributed to these positive results.

Key Findings

- IDSP: All states have made considerable improvements in terms of human resources, and infrastructure for IDSP. Reporting of presumptive and laboratory confirmed cases has consistently increased. Reporting of suspected cases however remains incomplete and of indifferent quality. There are operational difficulties in remote areas in sending timely reports.
- Coordination between medical colleges and Disease Surveillance Units (DSU) needed for improved quality of disease reporting is poor.
- The DSUs are not optimally operational at several places, mainly due to vacancies, high turnover, and lack of training and support for contractual epidemiologists.
- The data analysis and interpretation is done at the state level, which does not allow for integration and triangulation of IDSP data and the HMIS. IDSP data is considered an important tool for district health review and planning, and is confined to responding in the event of outbreaks, and that too not consistently across districts.
- Malaria: Declining trends are seen in Manipur with API remains less than one for the last five years except in one district where it is 2.58. Distribution of Long Lasting Insecticide Treated Bed Nets (LLIN) and the IRS programme is on track in Odisha, West Bengal and Chhattisgarh with a decrease in positive cases and deaths. Monitored by VHSNCs and Panchayats bed nets are distributed through a robust public distribution system. However, in Dantewada district, despite a reduction in API level from 70 in 2009, it was still as high as 40 in Kuakonda block with three to four fever related deaths per village, clearly a cause for alarm. The reports are more guarded from Rajasthan and Madhya Pradesh. One key finding from many states is that the new MPWs deployed are poorly trained and poorly equipped with RDKs and there is reluctance or inability to ensure that ASHA drug kits are stocked with antimalarials. In some states there are reports of ASHAs unwilling to get involved in preparing slides or using RDK. Similarly, though the LLIN and IRS strategy may be performing well overall, it is still – sub-critical in the high endemic areas.
- Other Vector Borne Diseases: Banka district of Bihar reported unknown origin of fever cases and smaller number of malaria and dengue cases. JE surveillance, reporting and response has improved over a period of time in Odisha. JE vaccination has been carried out in Tamil Nadu, Uttar Pradesh, Assam. In Tamilnadu, JE vaccination is part of the routine immunization program covering all the children at the age of 18 months. In Tamil Nadu dengue cases reported increased in comparison with 2011.
- Sentinel site for diagnosis of Dengue and Chikungunya have been established at Gwalior medical college and DRDA centre in Gwalior. In Uttar Pradesh over 22 sentinel surveillance labs and one apex lab are established and functioning for dengue in Uttar Pradesh.
- Mass Drug Administration (MDA) has been done only in 14 districts of Uttar Pradesh due to inadequate budget.

- Bihar reports 75% of the nation's Kala Azar cases and though is at the cusp of eliminating Kala Azar, more focused effort is needed in a Mission mode for the final thrust.
- RNTCP: Case detection and treatment for TB improved in Chattisgarh, Tripura, Assam, Delhi, Madhya Pradesh, Rajasthan and Odisha. Nevertheless, in other states, the progress has not been satisfactory. The annual case detection rate remained between 68 to 70 for last 4 years in West Bengal. Case detection in Tiruppur district of Tamil Nadu, has fallen below 49% of the expected and defaulter rate is 6.1% which can be attributed to migration. Bihar and Chhattisgarh too report poor case detection, possibly due to low per capita out-patient attendance and consequent low sputum testing in chest symptomatic. Though linkages with private facilities certainly help to improve case detection, in districts with poor private sector presence, a more vibrant and comprehensive availability of primary care services is the key.
- The Programmatic Management of Drug Resistant TB cases (PMDT) has been implemented in Odisha and Uttar Pradesh but not yet across the other states. Diagnosis and treatment centre for Multi Drug Resistant (MDR) TB is yet to be established in Chhattisgarh; no drugs were available in Bihar. Laboratory Technician (LT) vacancies also adversely impact not just the RNTCP, but all disease control programmes in general.
- The National Programme for Control of Blindness (NPCB): is successful in detecting and treating cataracts, refractive errors and corneal blindness in all states. Close coordination with school health programmes was observed in Delhi, Odisha, MP, UP, WB and Tripura. In Tamil Nadu it was observed that the coverage is still mainly urban and the rural clientele is not being adequately covered necessitating action from the public health system. Across states, the operative facility in the public sector is limited to district hospitals on account of human resource constraints.

- The National Leprosy Eradication Programme (NLEP) has reported significant progress. 32 states and UTs have already achieved the level of elimination, which is less than 1 case per 10,000 populations. Bihar too has achieved this level, but is yet to be declared as having achieved elimination status. Chhattisgarh, despite considerable efforts, continues to have a PR of over 1. The Annual New Case Detection Rate (ANCDR) is reported to be 10.35 per 100,000, which indicates a further reduction in ANCDR of 1.24% from 2010-11.

However, increased number of new cases was detected in 15 states and UTs. Very encouragingly, the participation of ASHAs under NRHM in endemic blocks has increased substantially this year. Similarly the progress of reconstructive surgery and increased numbers of MCR footwear distributed is consistent with previous year.

- Programme for Non Communicable Diseases (NCD): While Punjab, Tamilnadu and Kerala have instituted programmes for NCD, amongst the high focus states, Odisha has started screening of NCDs through ASHAs who have been provided with glucometer and BP instrument to check for diabetes and hypertension. Similarly, all sub-centers have begun maintaining records for these Jorhat, in Assam, is one of the pilot projects on National Programme for Prevention and Control of Diabetes, Cancer and Stroke (NPCDCS). Encouragingly, MPWs are screening for NCDs at PHC and district level. Referral mechanisms for NCDs are not in place at PHC and at district level.
- In other states, laboratory testing facilities or drugs for NCDs are limited and data was not available at the state level. Chhattisgarh is implementing a special program for Sickle Cell Anaemia.
- High accident related deaths and suicide deaths are reported especially in those villages of Chhattisgarh. Other state teams have not commented on this.

AYUSH

- AYUSH doctors were in place in health facilities visited by the CRM team in Odisha, Tamil Nadu, and Uttar Pradesh with adequate availability of drugs. Nevertheless, the AYUSH doctors are not involved in NCD programmes in any state and some AYUSH doctors were not aware of their role in national health programmes. In Uttar Pradesh a total 1061 male and 753 female AYUSH doctors appointed in 2012. In Kerala AYUSH services are provided by both public and private sectors but there is little involvement or coordination with non-communicable disease control programmes, or other national health programmes.

Other Non- Communicable diseaes : Genetic disorders and disabilities

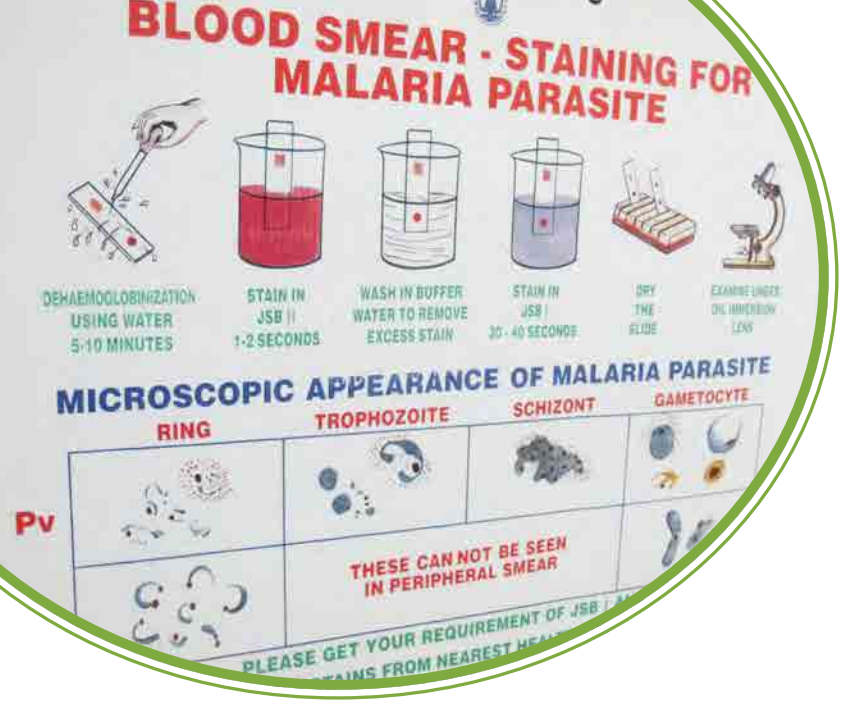
- Screening programmes for sickle cell anaemia, thalassemia, and genetic disorders were operational in medical colleges in Odisha. Tamil Nadu has started need based programme for thalasemia in the tribal pockets of Coimbatore district in partnership with NGOs and screening programmes for muscular dystrophy, early anomalies and delayed milestones on a pilot basis in Thiruppur district. Screening facilities for genetic disorders are available at SGPGI, Lucknow but not at district levels in Uttar Pradesh. Referrals from the periphery and sub-district to district hospitals was relatively weak. Similarly, though linkages of disability screening programmes with school health programmes have been announced the institutional mechanism for referral and follow-up action are not yet in place.

National Iodine Deficiency Disorder Control Programme (NIDDCP)

- All states have the NIDDCP programme in place and have banned or are in the process of banning the sale of non-iodized salt.

Recommendations

- IDSP: The IDSP needs immediate direction and focus to be able to provide an appropriate public health response to disease outbreaks and use the information for local planning. Both S and P forms should be analyzed at the block level and quick feedback from the district level should be provided to the blocks leading to action. The HR strategy for recruiting, training and retaining the microbiologists, epidemiologists, data managers and data entry operators requires to be worked out. There is also a need for innovative strategies to train epidemiologists who are willing to live and work in remote and difficult districts.
- National Vector Borne Disease Control



Programme (NVBDCP) Malaria:

- Accurate estimates of the quantity of RDKs and anti-malarials required and rapid supply, to reach all peripheral workers in high endemic areas is an immediate and urgent action. There is a gross under-estimation of quantities required. This needs to be accompanied by improved training- especially for the male Multi Purpose Worker.
- Identify and close surveillance gaps in districts and facilities that fail to achieve Target ABER. Achieving targets of 2 LLINs or even more family and ensuring 2 rounds of IRS should be other priorities in these areas.
- The use of mass active case detection surveys and Fever Radical Treatment (FRT) to supplement these measures should be urgently considered to break the malaria transmission chain in high endemic blocks- with a national team specifically supporting blocks with API as high as 40 ! Special Action Plan in PIP 2013-14 should be prepared for such blocks and all fever related deaths – should be counted and monitored in such areas.

- Other VBDCP (Kala Azar, Japanese Encephalitis (JE) and Dengue)
  - Bihar contributes to 75% of the Kala Azar cases in the country and disease elimination activities in a Mission mode should be considered. Adequate supply of Miltefosine is required. A listing of endemic villages – and a village level calendar of activities should be included in the district plan, and monitored. A full time officer with a team of supervisors in all districts where there are a large number of affected villages is required.
  - Cases of lymphoedema and Hydrocele should be mapped for each district and PHC Medical officers should be trained in Hydrocele operations.
  - Sentinel surveillance system for Dengue, Chikungunya and JE should be established in endemic districts and local bodies should be promoted to consider legislative measures.

- Revised National Tuberculosis Control Programme (RNTCP)
  - Active case detection can be increased, through ensuring higher out-patient attendance in the public health care system- with adequate testing in chest symptomatics. Concurrently, case detection from private sector clinics and referrals of chest symptomatics from informal service providers needs to be strengthened and made mandatory.
  - Parity in salaries of contractual staff across programmes under NRHM is important to improve morale and performance.
  - The establishment of MDR- TB detection facilities, treatment sites and assured drug supplies and follow up all need improvements.

- National Blindness Control Programme
  - Better convergence with school health programmes and expanding coverage of schools is needed
  - Enhance programme out reach in rural areas through innovative measures.

- National Leprosy Elimination Programme
  - More tertiary care hospitals should be built up as sites of reconstructive services.

- Patients known to be in seasonal migration need a follow up strategy to ensure treatment completion.
- In all districts one nodal officer should be accountable for the programme, and in districts with prevalence above one or with new cases detection, the nodal officer should be dedicated exclusively to this programme.

Non-communicable Disease Programme (NCD)

NCD programs at sub-district levels should be well integrated with the rest of the district health systems. This requires districts plans backed by state government policies that spell out the following:

(a) Careful choice of a limited number of indicators to report on from every facility

(b) A clear role for each peripheral health care provider with standard treatment guidelines. In particular we see a major role of the ANMs in areas where RCH workloads have decreased and even more so if there are two or more health workers in place in a SHC in such a context.

(c) Similarly ASHAs would have a enhanced role in NCDs in states where TFR is below 2.0 and IMR below 30- Pilots for community level care approaches for NCD needs to be implemented in this plan period.

(d) Clarity on the services (including drugs and diagnostics) that would be made available at each facility level, with referral and follow up mechanisms to ensure a continuum of care would have to be defined.

(e) Greater involvement of AYUSH doctors and AYUSH remedies.

(f) A clear choice of messages for inclusion in an integrated BCC plan.

(g) Better integration with school health programmes.

(h) Policy/administrative measure which would have an impact on preventing non communicable diseases and disabilities.

6 COMMUNITY PROCESSES: ASHA, PRI, VHSNC, COMMUNITY MONITORING AND NGOS

Objectives under NRHM

- Deployment of one trained community health worker who would be resident in the community, trained and deployed and supported to function in her own village to improve the health status of the community through securing people's access to health care services.
- Constitution of Village Health and Sanitation committee in every village to act as a platform for convergent action on social determinants and access to health care services specifically for vulnerable sections of community.
- Improving role of Panchayat in-
  - Accountability of health care facilities and functionaries.
  - Ensuring access to public services.
- Community based monitoring to enable community and community-based organisations to become equal partners in the planning process and increase the community participation in improved functioning of the public health system.

Progress under NRHM

- Findings of recent evaluations and monitoring visits acknowledge the important role played by ASHAs in better utilization of health services and improving health outcomes. "Evaluation Study of National Rural Health Mission (NRHM) In 7 States by Programme Evaluation Organisation; Planning Commission; Government of India" stated ASHAs to be highly functional -

	Target	Selected	%	Training status	Support structures
High Focus	496837	489266	98.48	• Module 5 - > 80% trained except in Rajasthan (68%) and Bihar. • Round 3 Module 6 &7 – 92% in UK • Round 2- recently initiated in Bihar, Odisha, Jharkhand and MP. • Round 1- > 70% in Odisha and Jharkhand; 48% in MP & Bihar (Mod 5,6& 7) and 46% in Rajasthan. Chhattisgarh – 100% trained in Module 14 & 15 • TOT – UP (CCSP training complete in 17 districts)	• Support and supervisory mechanisms at state, district, block and sub block levels in place in all states except for UP and MP. • No ASHA resource centre in UP but the programme is managed by a dedicated team. • Process of selection of ASHA facilitators is underway in UP and MP
Non High Focus	54411	53785	98.85	• Module 5 – > 97% in Karnataka and Punjab; 72% - 82% in Gujarat, Haryana, J &K, Kerala, West Bengal and 42% in TN, Maharashtra, Delhi • Round 3 &4 – 40% in Gujarat, 22% in Karnataka • Round 2- 69% in Gujarat and 9% in Maharashtra and 33% in WB, • Round 1- 99% in Punjab, 60-63% in Karnataka & AP; 21% in WB and 17% in Maharashtra. • TOT – Delhi, J &K and Haryana Kerala and TN to start NCD based module.	• Punjab, tribal districts of Maharashtra and Gujarat have district level support structures and have started appointing ASHA facilitators. • Other states have no support systems below the state and not even at the state in Delhi, Haryana, J&K, Kerala, Punjab and WB. Programme is managed by existing staff.
North East	356291	322977	90.65	• Module 5 – Completed in all states • Round 3- 100% in Manipur • Round 2 - > 92% in Meghalaya, Nagaland, Sikkim and Tripura; 75% in Mizoram and 45% in Arunachal Pradesh • Round 1- 48% in Assam	• State and district level support mechanisms are in place in all states except Mizoram and Sikkim. • Block community mobilizers have been engaged only in Nagaland. • ASHA facilitators are in place in all states except Nagaland and Mizoram.
Total	908281	866726	95.42		

- "ASHA's role turns out to be extremely important in terms of motivating pregnant women for utilization of the ANC care from public sector health facilities. Pregnant women in villages where ASHA makes weekly home visits and carries and distributes free medicines clearly depict higher propensity to seek ANC from public sector health care facilities. Interestingly, we find that tendency to utilize private health care institutions for ANC also declines in rural areas where ASHAs are functioning responsibly in terms of visits, carrying medicines and providing counselling to pregnant women"
- "Role of ASHA seems to important as patients from households which are visited more frequently and where free medicines get distributed depict higher tendency of using public compared with private health facilities for treatment of chronic diseases. Similarly households where general counselling on health matters is provided by ASHAs and other health functionaries report higher utilization of public health institutions for the purpose of treatment"
- In total about 4.8 lakh VHSNCs have been constituted across the country. However levels

of functionality vary across states. States have lagged behind in strengthening VHSNCs through adequate training and timely fund flows thus failing to explore the full potential of VHSNCs

Key Findings

ASHA

- ASHAs across all states have consistently been described in terms such as “vibrant” and “enthusiastic” etc. Most ASHAs are functional in areas of promotion of institutional deliveries, immunization and family planning services. In Kerala ASHAs are mainly facilitators for NCD services. Their role as community level care provider is limited even where training of three rounds of Module 6 and 7 has been completed. Home visits as per Home Based Newborn Guidelines are being conducted in Assam, Chhattisgarh, Odisha, Madhya Pradesh, Punjab, Manipur, Tripura and Uttarakhand.
- Selection of ASHAs is complete in all states except Delhi (88%), West Bengal (77%) and Tamil Nadu (57%) where the final selections are ongoing. Turnover rate of 1-4% was reported across states. Mechanisms of systematic replacement of non functional or drop out ASHAs are reported only from Uttar Pradesh. States of Odisha and Tripura need to plan for more ASHAs to achieve adequate coverage of one ASHA per AWC. Most common reasons for dropout were reported to be the selection of ASHAs as AWWs, Panchayat members and ASHA Facilitators etc.
- Performance monitoring based on functionality indicators has been introduced in states of Bihar, Delhi, Chhattisgarh, Odisha, Rajasthan and Uttarakhand while other states are yet to start. Detailed data base of ASHAs is maintained in Bihar, Chhattisgarh, Odisha, Uttar Pradesh, Kerala and Delhi.
- State specific adaptation of Module 6 and 7 has been made in Uttar Pradesh, Bihar, Delhi, Tamil Nadu and Chhattisgarh. In Kerala non communicable disease focused modules are proposed as Module 6 and 7. Training of Module 6 and 7 and is proceeding at a varying pace across states, the gradient being as follows – 4 Rounds for ASHAs – Gujarat , Round 3– Uttarakhand and Manipur, Round 2– Tripura and just initiated in Bihar, Madhya Pradesh Odisha (in 18 high focus districts); Round 1– Bihar, Odisha, Madhya Pradesh, Punjab, Rajasthan and Tamil Nadu; TOT – Uttar Pradesh, Delhi and Haryana. Chhattisgarh has completed training of Mitanins in 16 modules with Module 14 and 15 as equivalent to Module 6 and 7.
- Adhoc measures used for refilling of ASHA drug kits lead to frequent stock outs of drugs. No refilling of the drugs was reported in Uttar Pradesh and West Bengal after one time distribution. In Manipur, Tripura and Uttrakhand neither have drugs been supplied as per HBNC package nor have newborn referrals picked up. Communication kit was provided to ASHAs in Bihar.
- Support structures for the ASHA programme has been set up in states as follows: all four levels – Bihar, Chhattisgarh, Rajasthan, Uttarakhand, Tripura; at three levels – Assam, Manipur; at two levels – M.P., Gujarat, Odisha and Punjab; at one level – Uttar Pradesh. In the five non high focus states of Delhi, Haryana, Kerala, Tamil Nadu and West Bengal the programme is managed by existing staff. Strengthening of support structures with appropriate training has not been done in most states.
- ASHAs met across states reported incentive range from Rs. 500- Rs. 2500. Lowest amount was reported from Chhattisgarh and Manipur where ASHAs have been selected at 300-400 population. Highest incentive is reported in Odisha which can rise up to Rs.5000. In Uttar Pradesh some ASHAs with large population coverage also make similar amounts. Rajasthan and Kerala have an assured monthly compensation of Rs. 1100 and Rs.500 respectively. Delays in payments and irregular payments are a problem in many states.
- Many states have provided non monetary incentives. Best performer in this area is Assam which provided uniform / sari, umbrella, torch,

ID card, radio and mobile sets. Assam has introduced a medical insurance scheme for ASHAs while Chhattisgarh has a more elaborate welfare programme. Radio programme for ASHAs has been initiated in Assam, Manipur, West Bengal and Chhattisgarh. Rest rooms for ASHAs were available at DH and SDH level only in Odisha and Assam while in Uttar Pradesh ASHAs are expected to use the rest rooms built for patient relatives.

- A formal mechanism for Grievance Redressal was reported from Chhattisgarh and Assam with a dedicated help line. Madhya Pradesh, Odisha and Manipur are in the process of setting up grievance mechanisms for ASHAs. Reports of grievances being addressed through an informal process during monthly meetings were shared from Odisha, Tripura and Uttar Pradesh. Rajasthan has also started a helpline for complaints related to payment but the awareness about helpline was low among ASHAs
- Chhattisgarh has a sponsorship programme for ASHAs to enter ANM training schools and Bihar has supported about 1000 ASHAs to clear the Class Xth exam through National Institute of Open Schooling (NIOS).

VHSNC

- States which have shown an active VHSNC are Chhattisgarh, Odisha, Uttar Pradesh, Punjab, Kerala, Tamil Nadu and Tripura. The best practice in this area is clearly Chhattisgarh where VHSNCs maintain birth and death records for their own information and monitor access to services on a list of 24 items and take remedial steps where needed. States like Odisha, Rajasthan, West Bengal, Uttarakhand, Uttar Pradesh, Tamil Nadu and Tripura have had training for VHSNC.
- Most states report improving utilization of VHSNC funds. ASHAs were reported to be member secretaries of VHSNC only in Assam, Madhya Pradesh and Uttar Pradesh. However irrespective of the membership status of ASHAs, the functionality of VHSNCs was seen to be dependent on ASHA's engagement and participation. In states where ASHAs are trained and supported to provide leadership roles to VHSNC, the VHSNCs are performing better. In West Bengal and Uttarakhand transfer of VHSNC funds to rural development department was observed but the outcome of this convergence was reported to be poor.
- Four of the fifteen states visited had Community Based Monitoring programme, these are Chhattisgarh, Odisha, Uttarakhand and Bihar.

Role of PRI

- Rogi Kalyan Samitis (RKS) has been constituted in over 97% of the facilities in all states. PRI are member of RKS and DHS in all states. However the level of participation varies. At one end they are the chairpersons as in Tripura and Kerala and at the other end they do not participate in meetings as seen as Tami Nadu. Their ability to influence critical issues like better fund utilization of user fees and lower exclusion seems to be limited. There are no training programmes for PRIs to enhance their participation.

Recommendations

- Most states have made 95% selection of ASHAs against the set targets. However findings of various reviews and monitoring visits highlight that the areas where ASHAs are yet to be selected are usually the most critical areas with high proportion of vulnerable population or difficult geographic terrain. States should therefore complete the ASHA selection to ensure that all vulnerable areas have an ASHA even if it means reducing the population norm.
- Though states have set up support structures

at various levels, training of support structures has lagged behind. States must expedite the training of Handbook for ASHA facilitators to strengthen the support structures especially ASHA facilitators. ASHAs and ASHA facilitators need to be sensitized and trained in Reaching the unreached brochures to ensure adequate coverage.

- Gaps in quality of trainings have been identified and need to be corrected through periodic refresher rounds with better establishment of training structure and ensured availability of equipment and modules during training. Recognition of the need to improve training quality must now progress to specific strategies of choosing and accrediting training sites as well as trainers. Special emphasis to ensure that books, equipment and communication kits are in the hands of trainers and trainees would also improve quality of trainings. Creating career opportunities for ASHAs is essential and can be achieved through certification of their skills and supporting them in education programmes as seen in Chhattisgarh and Bihar
- There is a need to move from adhoc mechanisms to well oiled systems for –a) Performance Monitoring systems; b) Drug kit replenishments; c) Payment efficiency; d) Grievance redressal mechanisms and e) ASHA Welfare schemes. There are some best practices from the states visited in these areas which can be analyzed, generalized and replicated in other states. For instance Chhattisgarh is an exemplar for setting up grievance redressal system and ASHA Welfare schemes, Odisha and Assam for incentive payment processes. However states are still grappling with issues of setting up drug kit replenishment system and performance monitoring system. States should ensure one fixed day payment process for all ASHAs irrespective of the mode of payments to eliminate delays in payments.
- There is a need to formulate a clear National Guideline and a best practice compendium for VHSNC for use as a minimum package for training the VHSNCs. Involvement of NGOs is essential to build additional capacity required for training of VHSNCs. States should now endeavour to reposition the ASHA and her support structure to play a leadership and capacity building role for the VHSNCs and enable both to work in close coordination with PRIs.
- For implementing and scaling up community based monitoring across states and districts additional technical capacity of NGOs is essential.

7 ACTION OF SOCIAL DETERMINANTS AND EQUITY CONCERNS-AND PREVENTIVE AND PROMOTIVE HEALTH UNDER NRHM

Objectives under NRHM

- Key objectives of NRHM for enabling preventive and promotive care and addressing the wider determinants of health such as drinking water, sanitation, female literacy, nutrition and women and child health include-
- Increased involvement with PRIs and a large range of community based organization like- Self -help Groups, School, Water, Health, Nutrition and Sanitation Committees, Mahila Samakhya, Zilla Saksharta Samitis for seeking local level accountability in delivery of social sector programmes.
- Ensure village and facility level convergence of programmes and move towards one Village Health Committee covering all these activities and further adopt a convergent approach for intervention under the umbrella of district plan
- Increase the range and depth of programmes on health education/IEC activities which are an integral part of activities of Mission at every level
- Enable the community and community-based organisations to become equal partners in the planning process and increase the community sense of involvement and participation to improve responsive functioning of the public health system .

Progress under NRHM

- Progress across all states in addressing preventive and promotive care is gradual. Gender concerns are being addressed through implementation of PCPNDT and augmented efforts for girl child promotion. Amongst the states visited, an increasing trend in the child sex ratio (0-6 years) is seen in Punjab andTamil Nadu while a minimal decrease for Delhi and Kerala were noted. Punjab had faced major declines in the past and the reversal of the trend is a positive feature.
- As on May 2012, 675 Nutrition Rehabilitation Centres (NRCs) have been set up in various states to address severe acute malnutrition and its underlying complications in children. Table below contains status of NRCs that have been set

up in the chosen CRM states. High prevalence of malnutrition in Madhya Pradesh and Rajasthan explains their relatively large numbers, further indicating that prioritization of actions perfectly complement the extent of need.

- Convergence and coordination platforms across different levels are being established but innovative mechanisms for effective interdepartmental coordination are yet to be implemented. Other aspects of preventive and promotive care have been discussed in detail below.

Name of the State	Number of NRCs
Bihar	34
Chhattisgarh	40
Jharkhand	53
Madhya Pradesh	262
Odisha	5
Rajasthan	140
Uttar Pradesh	19
Uttarkhand	0
Assam	3
Kerala	0
Tripura	0
Punjab	0
Tamilnadu	0
West Bengal	6
Delhi	3

Source Press Information Bureau Government of India reported by Ministry of Women and Child Development as on May 2012.

Key Findings

Inter Department Coordination and Convergence

- All states showed effective field level convergence of ANM, ASHA and AWW in organizing VHND and promoting health awareness at the community level. In most states inter departmental coordination platforms have been established at district level while block level platforms exist in Uttar Pradesh and West Bengal. Innovations in convergence include ASHA Sahyogini of Rajasthan, the software bridge between MCTS and Anganwadi in Assam and interdepartmental overlap for training in Tripura. Sub centers have been set up at panchayat level in Tripura

Status of establishment and effectiveness of Nutrition Rehabilitation Centres

- Operational NRCs were present in Assam, Bihar, Chattissgarh, Odisha, Madhya Pradesh, Rajasthan and Uttar Pradesh at district and block levels. Functionality was variable across the states. Bihar, Chattissgarh and Assam reported high bed occupancy while other states are struggling to achieve it. High functionality in these states correlates with systematic referral and identification of cases at the community level and was closely linked with the awareness and involvement levels of the Anganwadi workers.
- Incentivization to ASHA for post discharge follow up of severely acute malnourished patients has received positive reports from Chattissgarh and MadhyaPradesh.
- NRCs have not been set up in Tamil Nadu, Uttarakhand, West Bengal and Tripura. Alternative mechanisms for addressing malnutrition have been adopted in Delhi such as- IYCF centres backed by reserved beds for SAM children in a tertiary care hospital

Coverage of Water and Sanitation programmes- role of ASHA and VHSNC in water and sanitation activities:

- Support for water and sanitation activities through ASHA and VHSNCs in states correlates with a strong, well constituted and functional VHSNCs. This was evident in Odisha, Chhattisgarh and Tamil Nadu. Odisha has vibrant Gaon Kalyan Samitis that meet regularly and effectively use untied funds for water and sanitation activities and awareness programmes on Water, Sanitation and Hygiene (WASH). ASHA plays an important role in mobilizing communities for promotion of individual household toilets. In Tamil Nadu vigilant VHSNCs ensure adequate coverage of water and sanitation programmes. However, in

Chhattisgarh in spite of good village level convergence through the medium of VHSNCs, a prominent involvement of VHSNC and/or Mitanins in water and sanitation activities could not be established.

- In Uttar Pradesh VHSNCs are active in water purification, prevention of water logging, vector control etc. but challenges such as, low utilization of allocated funds on account of lack of co-ordination with PRI, or delayed fund transfer remain. They are yet to adopt the new nomenclature of 'VHSNC'. Inclusion of nutrition component is limiting their efficiency on this aspect.

PCPNDT:

	Name of the State	Sex Ratio(0-6years age group)	
		2001	2011
1	Assam	965	957
2	Bihar	942	933
3	Chhattisgarh	975	964
4	Odisha	953	934
5	Manipur	957	934
6	Tripura	966	953
7	Delhi	868	866
8	Tamil Nadu	942	946
9	Rajasthan	909	883
10	Madhya Pradesh	932	912
11	Kerala	960	959
12	Punjab	798	846
13	Uttarakhand	908	886
14	Uttar Pradesh	916	899
15	West Bengal	960	950

State wise Sex Ratio(as per Census 2001 and 2011)

- Earnest efforts with reference to PCPNDT such as regular registration and renewal of Ultrasound Clinics and machines, vigilant monitoring mechanisms, good F-form reporting and analysis were reported from Odisha, Delhi, Tripura, Uttarakhand, Uttar Pradesh, West Bengal, Tamil Nadu and Manipur. In other states improving awareness of legal provisions, inspection of ultrasound clinics and filing of court cases needs strengthening.
- District level Advisory Committees have been constituted in all the states but gaps in functionality were observed. If lack of reconstitution of the committee as per the Act appears to be a problem in Bihar; irregularity of committee meetings is a concern for Rajasthan and Assam. Further low conviction pattern (almost nil in Bihar) of registered cases was observed in most states. Usage of silent observers was reported from Madhya Pradesh
- IEC and BCC are seen at facility level for most of the states. (BetiUtsav/Beti Shakti Abhiyan from Delhi is one example of the very few BCC/IEC activities undertaken at the community level with reference to girl child protection. In Uttarakhand IEC messages on facilities and bus panels etc were evident.

District Specific IEC/BCC strategies to identify key health behaviours that need to be addressed

- Odisha and Kerala have an integrated approach for IEC/BCC interventions and good display of IEC-in the facility for citizen's charter, ASHA incentives, labour protocols, user charges, family planning and gender awareness etc. They have a dedicated BCC Cell at the state level. Radio Health Initiative from Kerala and Odisha's efforts

of an Integrated 52 week multimedia calendar to address 12 key behaviours and themes, Swasthya Kantha branded as 'Kantha kahe Kahani' reaching 42,000 GKS, covering over one lakh front line workers are worth appreciating. None of other states have any separate BCC and IEC plan.

Civil registration of births and deaths and linkages with other departments

- In most states health department is not the Registrar of births and deaths. Delhi and Tamil Nadu reported an effective birth and death registration systems. The Swami Dayanand Hospital (SDH) in Delhi has instituted a hospital based birth registration system in which birth certificates are provided to all new borns within 24 hours of birth.

Mechanisms for social audit and other accountability measurement for health and other public services; Status of District Vigilance Committee and their effectiveness

- Mechanisms for social audit and other accountability measurement for health are yet to be instituted in many states. The district vigilance committees have been constituted only in a few states, in others they have not been formed or are in process of being formed. Meetings of the committee are yet to be initiated even in places where they have been constituted as seen in case of Uttar Pradesh. Odisha has mandatory disclosure system about staff, MMUs, Ambulances, procurements and constructions for ensuring transparency and accountability to the public.

School Health Programmes:

- School health programme is being implemented in all states. Extensive coverage has been reported from Tamil Nadu, Odisha, Chhattisgarh, Punjab, Delhi and Kerala, while other states are in process of strengthening the intervention. Tamil Nadu utilizes school set up effectively to address preventive, promotive, basic curative health care needs of school children and has integrated ARSH as part of the School Health Programme. This can be replicated in other states as well. A comprehensive package of services is provided with dedicated medical officers for all government and government aided schools to undertake screening, basic treatment and referral. School health programme incorporates special initiatives in Chhattisgarh. These include the Swastha Tan Man Yojana where doctors are incentivized for undertaking fortnightly visit to residential school. For majority of states children are screened for health problems but percentage of those referred for tertiary care is fairly low.

Recommendations

- Many states have performed well when assessed in terms of establishing platforms for regular convergent meetings and coordination amongst peripheral workers. These states should now move to next level where there is integration for information systems and the respective contribution of each organization is tracked. Those states who have not established any mechanisms for convergent action need to do so as a priority.

- Use of Village Health Sanitation and Nutrition Committees as a platform for convergent action is emerging but needs to be strengthened.
- Use of ASHAs and VHSNCs as specific modalities of reaching the unreached at the level of community need to be built up through focused training and support measures.
- Clear criteria should be developed for need based positioning of Nutrition Rehabilitation Centres with strong backward and forward linkages for identification and post discharge follow up to ensure full functionality and effectiveness.
- Increased awareness on girl child protection has led to a reduction in reports of mobile ultra-sound machines. However F- form analysis needs to be improved, and follow up with state and district PC PNDT cells needs to be strengthened.
- Establishment of a state BCC cell in State Programme Management Unit or equivalent with clear accountability to deliverables should be undertaken for full implementation of programme.
- Civil registration processes should be carefully mapped to identify the existing gaps. We recommend that provision of birth certificates within 24 hours of birth should be viewed as an entitlement and a measure of quality of care. This would contribute to building up a system for universal civil registration at birth. A similar approach to death certification is also required. Monthly or even quarterly reporting of death figures at district level would be an important contribution.
- Renewed commitment to Social Audit and District Vigilance Committee is required. A platform common for all social sector programmes would probably have a greater chance of success rather than a standalone institution for the health sector.

8 IMPROVING PROGRAMME MANAGEMENT – BUILDING INSTITUTIONAL CAPACITY

Objectives under NRHM

- In order to provide managerial support, for tracking funds and monitoring activities under the Mission, there is provision for setting up Program Management Units at state and district levels. The NRHM also emphasizes the setting up of fully functional block and district level health management systems, since under NRHM, 70% of resources are to be utilized at block and sub block levels and 20% at district level.
- The NRHM would establish strong managerial capacity at the block level as blocks are to be the link between the villages and the districts. At the district level the Mission supports the development of health management capacities and introduction of policies in a systematic manner so that over time all district program officers and their leadership are professionally qualified public health managers.
- Management structures at all levels will be accountable to the Panchayati Raj Institutions, the State Level Health Mission and the National Level Missions/Steering Group.

Progress under NRHM

- State Health Societies are in place in all the states.
- District Health Societies with PRI representation are in place in all the states.
- All states have State Program Management Units with a team of contractual staff with interdisciplinary skills. The same structure is present at the district level. The Block program management units are also in place.
- Procurement and logistics systems have shown improvements in all the states.
- There is an E governance system in place.

Key Findings

- • The state and district program management units are well established at different levels in all the states covered under the sixth CRM. It was observed that the Program Management Unit (PMU) is managed by multidisciplinary professionals appointed on contract in all states except Tamil Nadu and Kerala, where medical

doctors in regular service with public health qualifications are posted as district program managers. This helps in better coordination between Directorate and SPMU and thus results in high quality of performance.

- Regular meetings of State and District Health Societies are held but frequency is low in some states.
- The main problem is high attrition rates, turnover and vacancies in the contractual staff undermining functionality. The problem is highest in UP, MP, Rajasthan, Uttarakhand and Chhattisgarh and correlates to lower salaries and unavailability of skilled workforce. In all the states lack of career progression is another contributory factor.
- The HR posts sanctioned under program management units varied from state to state. At one end state like Orrisa has a large workforce in SPMU, but states like Chhattisgarh have only six persons managing the whole SPMU.
- It was observed that the states which have a structured HR policy in place were able to manage and improve the workforce. States like Madhya Pradesh, Chhattisgarh and Uttar Pradesh are struggling with retention of the staff while Bihar, Assam and Rajasthan have shown a steady increase in workforce. All states are yet to establish grievance redressal cell for the staff. An effective grievance redressal cell helps in addressing the needs of providers and contributes to higher retention.
- Capacity building programs that were well established in initial years are not sustained in most states. There are limited and inadequate structured systems of capacity building sessions in the states visited except Tamil Nadu and Odisha. Most available management training programs provide theoretical backgrounds but are weak in problem solving techniques and special skills like District planning.
- Supportive supervision system is well structured in Tamil Nadu and Odisha and moderately functional in many other states visited. They are however weak to nonexistent in the rest of the states, and this is the major impediment to successful scaling up of programme to achieve good health outcomes.
- Delegation of financial and administrative powers to the district is limited. An exception to this is Tamil Nadu. Powers for recruitment of contractual staff are also unnecessarily centralized to the state level delaying appropriate selection in most cases.
- Quality and seriousness of district planning has declined in last two years in a number of states which were doing well in this area. This correlates in some states to the failure to build technical support structures at state level and in others in the inability to match resource allocation to the plans submitted. The CRM notes that some states notably West Bengal and Bihar are still sustaining this practice. Difficulty in accessing and using data for district planning due to the nature of information support system also contributes to this decline.
- Establishment of a procurement and logistics system benchmarked to TNMSC has not yet happened in any state except Kerala and Delhi. Many states have made progress in reforming procurement policies. However even in these states, logistics remain very poor and facilities visited had frequent stock outs.

- States which have recently created corporations for a procurement system have been slow in processes such as hiring of staff and establishing linkages with logistics.
- State and district level monitoring of referral transport system was not seen in most states.

Recommendations

- Insist on at least quarterly meetings of the Executive Committee and annual meeting of Governing Bodies of all Societies created.
- Strengthen the representation and participation of elected panchayat representatives in all management bodies.
- Revive the district plan as a central instrument of strengthening public health systems. This requires dedicated institutional capacity at both state and district levels. Filling formats may help in aggregation for the state plan but cannot be a substitute to district planning which involves clear delineation of priorities and activities.
- Regular schedule of supportive supervisory visits involving Directorate and program management staff needs to be insisted on with checklists and follow up action plans.
- Efforts to institute a procurement system linked to logistics demand and utilization pattern need to be persisted with. State should consider technical and management agency support to help the state operationalize TNMSC like institutions.
- An HR policy for programme management staff which includes periodic capacity building needs to be established in all states.

9 KNOWLEDGE MANAGEMENT: TRAINING, TECHNICAL ASSISTANCE, AND INFORMATICS

Objectives under NRHM

- Establishment of National Health Resource Center (NHSRC) at the central and state levels (SHSRC) to provide technical support to the mission.
- Enable other national institutions to respond to the request of states and districts for technical support in planning and implementation of program. Examples of such institutions are NIHFW, ICMR funded research institutes, School of Public Health, Technical support NGO, PFI, VHAI, FRCs etc. Enabling these institutions would require both Grant-in Aid to some institutions to expand their` man power and skills as well as ensuring policies by which they can respond to such requests for assistance with incentives for those experts who invest their efforts in laying such demanding roles without detriment to their core research work.
- Strengthening nursing institutions, linking medical colleges for providing skill development support to rural health workers, involving the voluntary sector in skill development are few key interventions to be taken up.
- Strengthening a hierarchy of training institutions that can ensure that the skills needed by service providers and managers are always in place.

Progress under NRHM

- National Health Systems Resource Centre provides technical assistance for programme implementation to MOHFW and to states.
- National Institute of Health and Family Welfare (NIHFW) is strengthened and is conducting a number of in service trainings and regular distance learning programmes.
- Strengthening of SIHFWs and establishment of SHSRCs-work initiated in many states-but struggling to develop capacity needed for delivering on their roles, and to sustain its workforce.
- Induction of public health and multi-disciplinary management skills into SPMU and at national level for improved programme management.
- Active technical assistance from development

partners - is seem but partnerships with medical colleges and public health schools are slow to develop.

Key Findings

- State level training institutes – SIHFW or equivalent are in place in all states visited with Delhi, Tripura and Manipur as the exceptions. Tripura is in the process of establishing an SIHFW. Tamil Nadu has six regional training institutes and other training centers at medical colleges and district hospitals and this kind of arrangement has helped in fulfilling the training needs.
- SIHFWs are active in conducting clinical and non clinical trainings. However in no state are they in overall charge of the training programme- remaining limited to trainings allocated to them. In some states like Odisha, however, despite having good technical team, most of the core clinical trainings are outsourced and SIHFW is limited to some non clinical training areas such as FP training. In Uttar Pradesh and Odisha, and a few other states, the SIHFW has a major role in BCC. The UP SIHFW also plays a limited policy support role.
- All states except Assam and Odisha report a dearth of appropriate human resources in SIHFW. There is similar lack of capacity in RHFWTCs. Functional District training centers do not exist in any state. Many states have revived ANMTCs and made them functional- but in some of the states that need them most- like Chhattisgarh this is yet to happen.
- In all states quality of training in terms of need based training, pre assessment of training and post training follow up needs attention and there exists no system of performance evaluation for staff after the training. The probable reason for this is the lack of manpower in most of these settings.
- SHSRCs are in place in Chhattisgarh, Odisha, Rajasthan, Uttarakhand, Punjab and Kerala. For Tamil Nadu and Uttar Pradesh, SHSRCs have been approved this year. The North Eastern states have Regional Resource Centre for North East (RRC-NE) of GOI which provides technical support for developing state plans and the SPMU provides support for district plan. SHSRCs vary widely in capacity and in their roles and responsibilities.. In Chhattisgarh it is now limited to providing support for all aspects of the community programmes (Mitanin) and VHSNCs in particular and to urban health), but have withdrawn from their role in district planning- considerably weakening their reform and capacity building potential. SHSRCs, which are not allocated the district planning, and community processes role, remain marginal to the health systems strengthening process. SHSRCs fail to retain their consultants- due to lack of clarity in both HR policies and governance arrangements. Delhi has neither an SIHFW nor an SHSRC, and the lack of public health managers adversely affects programme planning and management.
- UNICEF is an active technical support provider in child health areas- especially for establishing SNCUs, NRCs and immunization planning. Other development partners presence were WHO in West Bengal; DANIDA in Tamil Nadu; NIPI, UNFPA, IPAS and JHPIEGO in Rajasthan and a few other large states, DFID and Gates Foundation in Bihar The range of activities vary from state to state and include nutrition, IEC activities, training, capacity building, strengthening of HMIS and community outreach program. Despite working in response to state requests, the gamut of agencies working, and their involvement in selective programme dimensions raise concerns of fragmentation and poor co ordination among agencies and with the state. Their presence has not contributed or been leveraged for strengthening SIHFWs and SHSRCs in the states. This is not necessarily their problem, but is the result of ad hoc approval for their inputs and the lack of a policy articulation on building state-owned and managed technical support institutions as the long-term strategy.
- Partnerships with medical colleges- are usually for one-off training programmes- and there is

no long term strategy in place. Partnerships with schools of public health or public health centred non-government research institutions, or even with ICMR funded research institutions have yet to begin in a serious way. This is linked to the lack of recognition of knowledge resources as an important component of building institutional capacity at state and district level- and public health planning being either divorced from, or being reduced to a budgeting and accounting exercise. District planning is seen as a one-time effort with a deadline- not as a dynamic process requiring both institutional memory and extensive partnerships.

- The HMIS system is in place in all states and regular feeding of data is taking place. Facility based reporting is not yet functional in Uttar Pradesh where field-level functionaries are yet to be trained on HMIS formats and a dedicated data entry operator for the MCTS is not yet posted at the block level.
- Despite all the constraints of poor internet connectivity, insufficient staff, lack of clarity, system design issues and weak supervision, states are making a sincere effort to improve the MCTS data entry and output. In Delhi MCTS registration number is being given only to the women coming from villages where ASHAs are available.
- There are two major concerns as far as the data pool of NRHM is concerned. The first is the poor quality of data, which relates to a number of process issues – and limited usage of data. Only Tamil Nadu and West Bengal report a structured system of review meetings that is based on HMIS data. Their reports are likely to be more accurate. The concern of quality of data also applies to the IDSP and malaria reporting.
- The second concern is limited usage and analysis of data at district level, which is due to the above reasons and the inability of the technical design of the HMIS systems in place to support local analysis and use. Many states are developing parallel systems for their own use and are uploading data on the central HMIS only as a national requirement, without relevance to themselves. Some states have developed inter-connectivity with the central HMIS- but others just duplicate the work or have given up local use of data altogether. Even on central HMIS, district aggregate data has to be manually totaled and added separately from the facility level data entries – by the district team.

- On the positive side states have developed a wide variety of local decision support data analytics, such as for human resources in Bihar, Assam and Odisha. Tamil Nadu reports over 30 systems in use. Inter-operability between systems is however a problem at all levels- and neither at state or at national levels do these have the ability to talk to each other. Tamil Nadu has initiated some innovations in this regard too.

Recommendations

- There is a need for the Centre to issue national guidelines on a minimum staffing pattern to establish a viable SPMU, SIHFWs, SHSRCs, ANMTCs, RHFWTCs and DTCs – much as IPHS has done for facilities. Guidelines should also spell out deliverables
- State level technical support institute should

be supported through public funds, and developmental partner assistance and national technical support should be aligned with these institutes so as to build their capacities.

- Similarly, recommended HR policies and governance issues of SIHFWs and SHSRCs should be disseminated to improve the functioning capacity and sustainability of these institutions.
- Partnership with other state level institutes specially medical colleges and schools of public health for training and technical support need to be instituted. Where there is inadequate capacity internally, state partnerships or twinning with national institutions or state level institutions of other states should be encouraged and supported.
- A baseline on training status in every district needs to be undertaken by states. Every district needs to be linked to a district or a regional training centre for in service training for specific HR categories. Where there are no government training institutions available, strategic partnerships with an appropriate organization within or outside the state should be built. All this requires a major national and state level partnership strategy for capacity building.
- Clarity on the role and functions of SHSRC as distinct from the priorities of the SPMU and the SIHFW is required. Support to district planning and institutional memory of past plans, data analysis and feedback, and support to community processes, operational research and evaluation studies are all essential functions that require an appropriate institutional mechanism.
- All states need to ensure the use of MCTS and HMIS information for planning purposes. It is imperative that the programme managers should conduct regular reviews on the basis of this information. This information should also be annually published in book format.
- States could be encouraged to put in systems as required at any level especially those which have facility and local area information, but such systems must lend themselves for local analysis at facility, block and district level, and be able to aggregate and export the information required at state and central level. Further HMIS systems should be able to share data electronically with databases of disease control programmes, MCTS and even the ICDS programme and civil registration systems.
- States need to systematically apply data quality assessment tools to identify and remove sources of error. Most common data quality issues relate to poor primary records, data duplication and other easily identifiable and correctable process errors.
- Development of training capacity in high focus states through revitalization of existing institutions, leveraging of partnerships and creation of new institutions should be the main focus of the first two years of the Twelfth Five Year Plan. Post training follow up needs to be integrated with supportive supervision to ensure training outcomes. Training evaluation should also be institutionalized .

10 FINANCIAL MANAGEMENT

Objectives under NRHM

- Increase Public Health Expenditure in Health to 2 to 3% of the GDP. Of this the envisaged NRHM outlay as stated in the "NRHM Framework of Implementation" over the seven year period was Rs. 175,000 crores.
- Improve the capacity of states to absorb the funds being placed at its disposal.
- Provide social protection against the rising costs of health care.

Progress under NRHM

- The actual release and expenditure of funds under NRHM is given in the table below. NRHM funds have been released to states through the state health societies as four components- RCH Flexipool, 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 seven years was Rs. 18,689 crore and under the Mission flexi-pool the total amounts released was Rs. 20,749 crore. For Immunisation and Pulse Polio, a sum of Rs. 3,066 crore has been released. In these seven years, for disease control, the amount released was Rs. 5,059 crore. In addition through the treasury route, Rs. 18,756 crore was released for infrastructure maintenance. This represents a substantial increase in expenditure over the Tenth Five year Plan period.
- However the rate of expansion of financing is well short of the envisaged outlay. Against an estimated expenditure of Rs. 175,000 crore over seven years; about Rs. 71,963 was actually released and over 98 % of this was absorbed.
- The capacity to absorb funds rose after a lag period. Increased absorption has resulted largely from the deployment of considerable human resources for accounting and financial management and of building computerized systems. It has also resulted to a large extent from the expansion of the public health workforce. There are however still considerable problems in the flow of funds which limit absorption.
- When commenting on NRHM's physical achievements and the improvement in service delivery, this gap between envisaged expenditure and actual allocation and expenditure also needs

consideration.

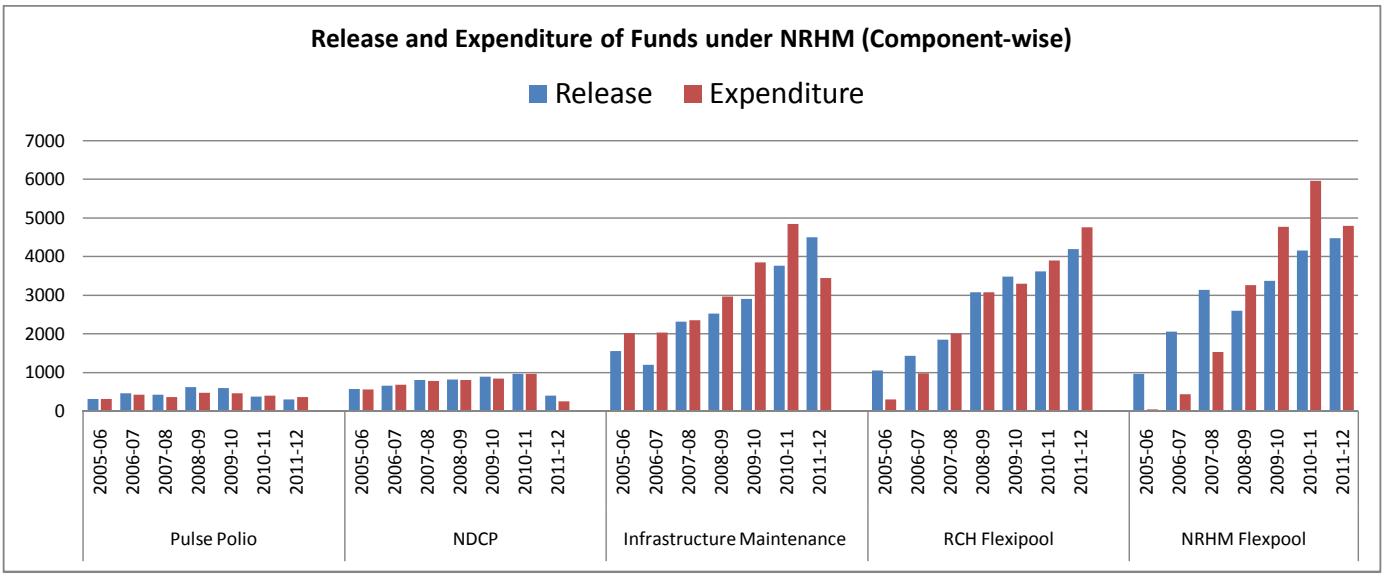
- In terms of social protection one macro-indicator is government expenditure on health care as a proportion of total health expenditure. This rose sharply from 19.1 % in 2005 to 30.3 % in 2009 , which is the most recent figure available. However this is far from what is required, and in the community of nations India is ranked a low 178 amongst 194 nations.

Key Findings

- Financial Management has improved across all states on the following parameters:
  - All states are using Tally ERP 9. In Madhya Pradesh it is not adequately used and in Odisha they are developing a new software.
  - Payments are being made through e- transfer up to the block level and at lower levels through cheque allowing speeding up of funds flow.
  - Compliance with concurrent audits has been noted. However there are inadequacies in adhering to it especially in Uttar Pradesh and Tamil Nadu.
- Utilization of funds as compared to the previous years has improved. The key limitations are:
  - Several posts of financial professionals are vacant, more so at district level as noted in

Table 1: Release and Expenditure of Funds under NRHM (Component-wise)

Year	NRHM Flexi Pool		RCH Flexi Pool		NDCP		Pulse Polio		Infrastructure Maintenance		Total NRHM	
	Release	Expenditure	Release	Expenditure	Release	Expenditure	Release	Expenditure	Release	Expenditure	Release	Expenditure
2005-06	962	40.76	1,050	291	564	551.84	313	307.42	1,546	2,013	4,434	3,204
2006-07	2,054	431	1,426	973	648	670.74	452	417.89	1,195	2,026	5,774	4,519
2007-08	3,133	1,527	1,843	1,999	795	777.91	422	352.96	2,317	2,353	8,509	7,010
2008-09	2,597	3,256	3,070	3,077	812	805.02	618	461.55	2,527	2,965	9,625	10,565
2009-10	3,366	4,777	3,478	3,301	893.88	838.92	593	452.61	3,139	3,846	11,470	13,216
2010-11	4,154	5,964	3,622	3,905	961	963.65	370	395.44	3,765	4,850	12,871	16,078
2011-12	4,483	4,796	4,200	4,760	391.35	241.81	297.56	355.42	4,506	3,441	13,877	13,593
Total	20749.33	20791.9	18,689	18,306	5065.23	4849.89	3065.56	2743.29	18,995	21,494	66,560	68,185



Madhya Pradesh, Odisha, Kerala, Assam, Tripura, Tamil Nadu, Delhi and Chhattisgarh.

- Slower turn over in infrastructure expenditure.
- Lower utilization in untied funds due to stagnation of funds in subset of facilities.

- Quality of Accounting is an issue: Most common problems are
  - Training gaps especially in Rajasthan, Madhya Pradesh, Assam, West Bengal and Bihar.
  - Accounting weaknesses like non observance of reconciliation of funds at district level and non-maintenance of advance registers.
  - Monthly reconciliation of bank accounts and unspent balance has been observed from many sites. Details are mentioned in state reports.
  - Lack of accounting staff at facility and district levels.
- Financial contribution of state Governments has increased over the years and all states are making efforts to honor their commitments.
- Annual district budgets are not being declared or not plan linked or governed. Equity sensitive increased resource allocation to districts and within districts is not established on a regular basis-and mechanisms for achieving this are unclear.
- RKS reports show that while they have been constituted in all facilities, though not all of them are formally registered. They are all functional, but effectiveness in terms of quality of care or cost of care or better use of funds are not yet within its ambit. They are not yet playing a positive role in accountability. Out of pocket expenditures in the public hospital have decreased – but they are still high- and are mainly on account of drugs and diagnostics.
- JSY payments are being paid by cheque or cash. Bank transfers are less common and not necessarily more effective.

Recommendations

- Improved recruitment and deployment policies should be in place to ensure prompt recruitment and retention of financial staff.
- Expenditure flows of funds for infrastructure development should be separated from flow of funds from revenue expenditure so that delays in one do not affect the other.
- Need to put in place additional technical capacity for supporting accounting processes on a regular basis so that minor issues are solved on a day to day basis.
- Untied funds absorption should be expedited by
  - Use of clear guidelines that facilitate use of funds.
  - An allocation that is more responsive to case loads and usage at facility level including a normative payment provided to each facility.
- Payment on time to peripheral health workers especially ASHAs and to beneficiaries must be monitored. State finance managers should be accountable for ensuring timely payments.
- Careful study and feedback is required; though bank transfers speed up payments, paradoxically many states face difficulties related to bank to user interface. The actual protocols across states for bank transfer and cheque payments need to be reviewed closely.
- Allow local modifications for timely transfers and let the districts set their time based standards.

THEMATIC SUMMARIES OF 6TH COMMON REVIEW MISSION

I
FACILITY BASED CURATIVE SERVICES-ACCESS, AFFORDABILITY, QUALITY

1 ASSAM

Adequacy of facilities and infrastructure: Adequate facilities in the state for complete coverage of population with good quality infrastructure especially SC with ANM accommodation. Most facilities are located in government buildings.

Utilization of services: More than 300% rise in both OPD as well as IPD in the NRHM implementation years. However, a few facilities are pressurized since they take up the increased OPD & IPD numbers and many other facilities with very good HR are not contributing.

Ancillary services

- Drugs: Drug management system is weak .The state has a huge supply demand mismatch of drugs; irrational distribution of drugs was seen in most facilities. Outside prescription being written for drugs already available in facilities.
- Equipment: Non-availability of AMC for equipment is a major concern; it was observed that many new and lifesaving equipments (such as at BSU and SCNU) do not have an AMC place leading to disruption of critical services.

Supportive services: Improved patient amenities in terms of clean facilities , waiting area, sitting arrangements and drinking water available in most facilities.

Bio-Medical Waste and Infection prevention: Bio-medical waste management is an area of concern as seen from non segregation, no disinfection of waste , poor use of deep burial pit and non adherence to waste disposal protocols

Cost of care: Out of pocket expenditure on drugs due to outside prescription and a weak supply chain not based on demand.

Quality Assurance: Patient privacy not maintained, overcrowding in patient care area, poor inventory management. No state level or district level functional quality assurance mechanism is evident.

2 BIHAR

Adequacy of facilities and infrastructure: Considerable improvement in number of facilities; capacity of APHCs is weak , with 6 indoor beds yet catering to 1 lakh population .Quality of infrastructure better in DH,

SDHs and RH, but poor in APHCs. Infrastructure of PHC inadequate to cater to the current population of 1 lakh. Planning for infrastructure creation is not rational. Availability of residential accommodation and deteriorating infrastructure is a lacuna in FRUs and 24/7 ; 30% SCs in the state is operate out of govt. Buildings.

Utilization of services: Utilization pattern in secondary care hospitals is sub –optimal. The bed occupancy rate in the facilities is in the range of 30 to 70 %. Basic emergency obstetric care is not available in PHCs , CHCs and DH and patients are referred to higher facilities .

Ancillary services:

- Drugs : Essential Drug List is available with 33 and 112 drugs for outdoor patients and indoor patients respectively at all health facilities (Additional Primary Health Centres to Sadar Hospitals). Availability of drugs was satisfactory at the visited facilities. Construction of 209 Generic Medicine Shops within the premises of the health facility is one of the appreciable initiatives, taken up by the State Government.
- Diagnostic : Diagnostic facilities is outsourced at all health facilities, but delays in turn around time for availability of the reports was a problem. Outsourced radiological services do not meet AERB guidelines, in terms of deployment of trained Radiographer/ X-ray technicians, Radiation safety norms, TLD badges.
- Equipment : Availability of equipment is better in facilities including SNCUs and ICU, but yet to be utilised .
- Blood : Blood Storage Units do not receive supply for required quantity of blood from the parent blood bank.

Supportive services : Adequate sitting arrangements, fan, availability of safe potable drinking water, clean toilets but need strengthening in delivery points . Free diet to mothers currently available only at DH level.

Bio-Medical Waste and infection prevention : Practice of segregated collection of waste found at all visited facilities. Reach of Common Waste Treatment Facility (CWTF) has increased in the state.

Cost of care: Significant no. of pregnant women are unable to avail free referral transport services both from home to facility and drop back because of either non- availability of ambulance or the response time of less than 30 minutes is not adhered too. This is one area where OOP is being incurred. Informal payment are also reported from the state.

Quality Assurance : There is a major issue of quality of diagnostic services provided by outsourced agencies. Most of the technicians at X-Ray are also not qualified. Outsourced laboratory services also do not have any internal or quality assurance system in place.

Facility level quality improvement programs are going on in Bihar since last two years. This year 5 district hospitals and one sub district hospital got ISO 9001 certificate under NHSRC quality improvement program. Family Friendly Hospitals Initiatives is also going on in around 250 facilities. State has also taken up implementation of quality management system through self implementation model with support of NHSRC.

State has formed state and district quality assurance committees but they are not functioning at most of the places. A Directorate of Radiation Safety has been set up this year.

3 CHHATTISGARH

Adequacy of facilities and infrastructure : Overall status of infrastructure shows improvement. The ratio of beds to population at primary and secondary level is 11.2/ 1000, the two medical colleges account for 1265 beds. Additionally, the State has 1159 AYUSH institutions. Infrastructure norms per population has been relaxed using geographic consideration and equity. Sanctioning of facilities is adequate in terms of population and access. However, pace of construction slow, especially in the Left Wing Affected districts. Good quality of construction in all facilities. Shortfall in residential accommodation with efforts underway to close gaps through new construction.

Utilization of services: Substantial increase in outpatient and to a certain degree in-patient admissions contributed by institutional deliveries and fever. Most of the PHCs have AYUSH MOs posted doing OPD and prescribing drugs for all the major and minor complaints of the patients.

Ancillary services

- Drugs : General availability of drugs is better in facilities except for drugs for basic emergency obstetrics care and management of complicated malaria.
- Diagnostic : Generally available in most facilities, except urine tests in PHCs; user fee charged for lab tests.
- Equipment : Lack of radiant warmers were reported in some facilities
- Blood : Blood banks are available in the CRM districts and blood provided free of charge.

Supportive services: Maintenance of facilities in terms of cleanliness, hygiene was satisfactory in both districts. Availability of diet and transport are a problem in most of the facilities.

Bio medical waste management and Infection prevention : In both the districts procedures for sterilization of equipment needs improvement.

Cost of care : User fees are relatively less or absent at the PHC level . User fee charged in both districts for diagnostics with exemptions for BPL. Out of pocket expenditure is higher at the district hospital in both Dantewada and Mahasamund, (approximately Rs 400 on drugs and / or diagnostics). Out of pocket expenditure on drugs and diagnostics was also incurred by RSBY cardholders .

Quality assurance: Privacy of patient is an issue due to shortage of bed in female wards. Quality of cleaning services like cleaning and laundry is also compromised due to shortage of trained manpower. State quality assurance cells have formed this year at directorate. Quality assurance cell has prepared Standards Operating Procedures. District Quality cells are still in formative stage.

4 DELHI

Adequacy of facilities and infrastructure : The state has undertaken GIS mapping for facility gaps towards developing an infrastructure plan, and created 53 new centres and strengthened/renovated others in underserved areas of the city.

Utilization of services : Quantum leap of IPD in the last 5 years – OPD has doubled with a slight drop during 2010-11.In last four years there has been 61.62% increase in the institutional deliveries. AYUSH services well accepted , especially homeopathy. AYUSH MOs in all facilities and some conducting deliveries.

Ancillary services

- Drugs : Drug availability is better with a EDL of 61 medicines most of which were available in the facilities. Medical officers are following the standard treatment guidelines and are rarely prescribing medicines outside the EDL.The AYUSH medicines were available in all the facilities visited with sufficient stock to deal with the case load, unlike the allopathic medicines which were less than required.
- Diagnostic : Basic diagnostic services are available at all levels. However, there are certain constraints in procurement of reagents and timely AMC of equipment .

Supportive services : Supportive services for patient comfort and safety were found to be good in some facilities visited, but weak in many primary and secondary level facilities. Shortfall of beds in maternity wards and labour rooms (two-three patients on the same bed) was a cause of concern because of huge caseload. Signages and Citizen's Charter were not conspicuously placed and where-ever observed, were in English . Kitchen hygiene and quality of diet was found to be satisfactory in the facilities visited. Seating arrangement were inadequate in tertiary level facilities owing to high number of footfalls.

Bio medical waste management and Infection prevention : Bio-medical waste management is outsourced .Generally better hygiene and infection control measures seen in facilities .However the huge case load in the wards compromised expected infection control at some places.

Cost of care: Out of pocket expenditure incurred by pregnant women on diagnostic in peripheral facilities and also on transportation.

Gender : Lack of sensitivity to issues of privacy and respect for women's dignity seen in many facilities .

Quality Assurance: Quality assurance manual has been prepared but program is still to be rolled out. Secondary care hospital is overcrowded making it difficult to provide quality services. Delhi has many large hospitals but except few none have gone for a formal quality management system or accreditation program.

5 KERALA

Adequacy of facilities and infrastructure: The Public Health infrastructure in the State shows nearly adequacy in terms of numbers ,but needs improvement especially for sub-district hospitals. Over 50 % Sub-centres , 90 % PHCs and all CHCs are in government buildings A well structured infrastructure development wing is present. Quality of infrastructure was good. Provision for residential accommodation for doctors and other staff is weak.

Utilization of services: Primary level facilities i.e. non-FRU CHCs, PHCs are underutilized for delivery care. Number of institutional delivery in public hospitals shows a marginal increase due to over dependence on the private sector. There was no IPD in PHCs visited. AYUSH system has good acceptance and functioning in parallel ; services well developed and utilised in the private sector. There is no cross-referral of patients between AYUSH and allopathic systems.

Ancillary services

- Drugs: Availability of drugs in the facilities as per EDL and there is no shortage of drugs. State has initiated project to supply free generic drugs of 952 medicines including Anti cancer Drugs to BPL and non taxpaying APL patients through government institutions

- Diagnostic: Essential laboratory services are adequately provided in all facilities.
- Equipment: Essential equipment available in the facilities .However, there is a lack of ownership and monitoring to ensure equipments are in working order.

Supportive services: Sufficient arrangement for cleaning the premises of the hospital and sepsis rates were reported to be low by hospital authorities. Overcrowding was seen in female wards .Lack of shelter arrangement/stay arrangements for the accompanying relatives. Free diet available is available in facilities . Grievance redressal mechanism yet to be made functional in both districts.

Bio medical waste management and Infection prevention: Infection management implemented by PPP and outsourced . However, in the secondary care facilities, infection control practices are not satisfactory;segregation of Biomedical waste and disposal not being followed.

Cost of care: Out of pocket expenditure incurred on normal deliveries by women accessing private sector facilities was in the range of Rs 4000-5000.

Gender : Lack of privacy for female patients was reported in the floating clinics.

Quality Assurance: State has formed its own "Kerala Accreditation Standards for Hospitals" and board for accreditation. 14 Public health facilities are accredited against these standards so far.

6 MADHYA PRADESH

Adequacy of facilities and infrastructure: The existing public health facilities are less as per the population norms, one FRU catering to average 10 Lakh population and one 24x7 facility catering to average 2.5 Lakh population. Construction of 20 bedded maternity wards, Pediatric wards and Model Labor room at DH is almost completed against the sanctioned requirement.

Utilization of services: Hospitals providing delivery services have increased from about 335 in 2006 to about 900 at present. DH offers a wide range of IPD services-Delivery-normal and C-Section, MTP, Trauma care, all orthopedic surgeries and major general Surgeries. Medico- legal cases and post mortems performed in large numbers in block level .

Ancillary services

- Drugs: State Public Health Procurement Corporation has been approved by state to handle drug procurement as well as medical equipment. Free drugs are available for JSSK beneficiaries. Good supply of drugs in SCs and also for use in the VHNDs.
- Diagnostic: Diagnostic services are sub optimal in the facilities.
- Equipment: State Public Health Procurement Corporation has been approved by state to handle drug procurement as well as medical equipment.
- Blood: Blood Banks were functional at district hospitals with collections from voluntary camps and replacement by relatives.

Supportive services: Supportive services like electricity, water supply remains a problem at all delivery points visited. Either generators are not available ,or not functional . Poor electricity supply and water supply has been a constraint at the facilities visited. The display of IEC material and signages, citizen charters was found adequate and impressive erratic. Inadequate display of JSSK information in some facilities.

Bio medical waste management and Infection prevention: Biomedical waste management remains a concern in most of the facilities visited-sharps spread around in open, soiled clothes and placenta are dumped in open pits.

Quality Assurance: State quality assurance cell is functional. State has prepared quality assurance checklist and score cards for different level of facilities. But quality assurance program at state level is yet to be rolled out. Some facilities have gone for formal quality management system and certification against ISO 9001 standards.

7 MANIPUR

Adequacy of facilities and infrastructure: Inadequate facility development in the state; only 2 FRUs are functional in the state at DH Churachandpur and DH Bishnupur. Remaining 5 districts are yet to plan for FRUs. 24/7 are deficient in the state.

Utilization of services: IPD has increased substantially and OPD has doubled with a slight dip in 2010-11. Institutional deliveries has increased by 61.62% increase in the last four years. AYUSH services are well accepted and AYUSH MOs are available in all facilities. However, in Ukhrul district, there has not been much improvement in service delivery in Ukhrul district in the past three years. The number of IPD admissions & institutional delivery is almost stagnant, in fact the number of Institutional deliveries has slightly reduced.

Ancillary services

- Drugs: The AYUSH medicines were available in all the facilities visited with sufficient stock to deal with the case load, unlike the allopathic medicines which were less than required.
- Diagnostic: Diagnostic facilities are weak ; USG is not available in facilities and even where available patients are being referred out due to lack of lab technicians and irregular power supply.
- Equipment: Lack of equipment was seen in most facilities especially equipment for new born

Supportive services: Lack of electricity for most of the time, even at the level of the district headquarters is a constraint in service delivery . Water supply is a problem in the hill districts . Diet is available for pregnant women in one district.

Bio medical waste management and Infection prevention: Infection management protocols are not being followed in the facilities.

Cost of care: user charges for JSSK beneficiaries not waived off and are being charged for registration & diagnostics in DH & for registration in CHC. Very high out of pocket expenditures for drugs e.g. women admitted at DH spent Rs.1700 & Rs. 1400 for purchase of drugs for normal deliveries, it was found both in Ukhrul & CCP. In CCPur women had to spend Rs. 7000 for C- Section.

Gender: Privacy was an issue as two of the windows did not have curtains, there was no toilet attached to the labor room.

Quality Assurance: Quality Assurance Committees are not functional in the state. The District Hospital Chrurachandpur received ISO certification last year.

8 ODISHA

Adequacy of facilities and infrastructure: State has added substantial new infrastructure during the

NRHM period : 2 DHs, 146 CHCs and 762 Sub centres, with maximum facilities sanctioned in the high focus districts. 74% of all infrastructure funds allocated to delivery points.Maximum shortfall in SCs and PHCs against required as per population norms – 450 PHCs and 3928 SCs. Residential quarters for ANMs at SC improved from 43% to 50.3% (RHS 2007 and 2011).Civil Construction wing dedicated for all infrastructure works with engineers at the districts. Monitoring progress on infrastructure through e Swasthya Nirman system.

Utilization of services: Consistent increase in OPD and IPD, especially in the CHCs and DHs but very low in PHCs; increasing patient load in delivery points. AYUSH OPD is substantial in the collocated facilities and units.

Ancillary services

- Drugs: Shortfall of drugs in facilities as per EDL and irrational supply of drugs especially in Sub centres which had stock of higher antibiotics while essential drugs - IFA syrups , anti rabies and anti venom.
- Diagnostic: Routine investigations conducted in all Level 2 and 3 facilities; emergency tests are available at the DHs;well performing multiskilled lab technicians.
- Equipment: All delivery points had adequate supply of equipments. Sterlization of equipment needed improvement.
- Blood: Blood blanks available in both districts and 50-60% blood is replaced by Voluntary Blood donation camps remaining by replacement. The frequency of Blood donation camps is 4 camps per Blood bank.

Supportive services: Supportive supervision for quality of services is weak. Poor sanitation & facilities lacked basic hygiene, cleanliness, in spite of appointment of Programme Managers, MCH Coordinators and Hospital managers. Display of IEC on JSSK and FP, disease control programmes was weak.

Bio medical waste management and Infection prevention: Bio medical waste management and infection prevention is a major issue; protocols not being followed; service providers lacked awareness on the IMEP protocols . Waste disposal outsourcing in one CRM district wasn't found to be effective.

Cost of care: Cost of care in the public facilities is still high in the state –although user fee has been waived off as per policy directive under JSSK for pregnant women and sick newborn. Out of pocket expenditure largely on drugs, diagnostics and referral transport. Practice of informal fee charged by providers is rampant in most facilities.

Gender: AWW centres lack adequate infrastructure for ensuring privacy during ANC check ups during VHNDs. Lack of hygiene in toilets and curtains in OPD areas and labour rooms.

Quality Assurance: State and District Quality Assurance Cell has been formed. These cells have been trained by NHSRC. Eight District Hospital are also going for formal quality management system and certification against ISO 9001 standards under NHSRC quality improvement program.

9 PUNJAB

Adequacy of facilities and infrastructure: Punjab Health Systems Corporation acts as a Nodal Agency for health infrastructure up gradation. State is making good progress on completion of infrastructure projects..Augmentation of Maternity Wards and Labour Rooms of all DHs required. Good condition of infrastructure in all facilities.

Utilization of services: OPD services are in demand, with maximum bed occupancy in the DHs and SDHs, but very low IPD across all the facilities visited. Range of services is limited to RCH. Child care including Newborn Stabilization Unit, Sick Newborn Care Unit (SNCU) and Comprehensive Abortion Care (CAC) is missing in the facilities visited. AYUSH services are constraint by the lack of AYUSH medicine.

Ancillary services :

Drugs: EDL was displayed and drugs were available at the hospital level; common drugs like IFA, Paracetamol, ORS were not available in most SCs.Drugs for newborn i.e. antibiotics were being purchased by the patients from outside as well as higher antibiotics for the mothers at the PHC in both districts. DH Moga has a Jan Aushadhi store which is open till 10 pm. However, it is stocking both branded as well as generic drugs.

- Diagnostic: Lab at both the districts provide X-ray, USG and full range of path tests .
- Equipment: Better availability of most equipment in most facilities visited. Procurement of equipment is done by the PHSC which also has an online system of monitoring of equipments.
- Blood: Blood Bank is functional at Civil Hospital Moga with adequate no. of blood units in storage.

Supportive services: Condition of toilets and power back up needs improved. Diet was available for pregnant women. Display boards and signages for service guarantees, citizens charter, JSSK etc. were not visible in the facilities visited in Moga, the exception being, IEC material for JSSK which was displayed at every facility

Bio medical waste management and Infection prevention: Poor in terms of segregation of waste, use of colour coded bins, use of protocols and signanges.In Patiala, Biomedical waste management at the district as well as facility level was outsourced and managed well .

Cost of care: User charges being levied for OPD, IPD registration with exemptions for delivery cases, BPL and Punjab Govt. employees. OOP expenditure incurred by patients on drugs for newborn and higher antibiotics for mothers . Patients purchasing almost 80% of the prescribed medicines from outside chemist shop.

Gender: Privacy arrangements (curtains, examination table) for ANC check-ups was inadequate at many of the sites . Lack of curtains in OPD and labour room was a concern. Night security needs strengthening.

Quality Assurance: Two quality accreditation program are underway in- NABH in 5 district hospitals and ISO certification in 10 public health care facilities.

10 RAJASTHAN

Adequacy of facilities and infrastructure: Good progress is made in the constructions. Out of the 5393 works sanctioned, 4226 works have been completed and handed over. Engineering wing working under NRHM for infrastructure development .

Utilization of services: The OPD, IPD and institutional deliveries in the State have improved and there is a corresponding improvement in the mortality as well. Use of protocols was better in Udaipur, with nurses well versed in AMSTL; oxytocin was available, partograph was maintained and privacy was maintained in labour room.

Ancillary services :

- Drugs: Drug availability has improved considerably.Transparent drug procurement and distribution management system is in place and drugs are available to patients..
- Equipment: Medical Equipment's were found in sufficient numbers and were being utilized
- Blood: Availability of blood is a problem, with equipment planned and brought, but not operational. Blood storage center do not undertake blood transfusions. The district relies on the Medical College hospital for all blood transfusion requirements of the public sector.

Supportive services: Patient amenities-availability of drinking water, seating arrangements, diet and citizen charters were good. All pregnant women in IPD received meals 3 times a day at the hospital.

Bio medical waste management and Infection prevention: The infection prevention and bio-medical waste management gives a mixed picture, better in one district , but poor in another , with problems in service delivery from the outsourced agency.

Quality Assurance: The state quality assurance committee headed by mission director and district quality assurance committee headed by the district collector exist in Rajasthan for the facilitation of the process of quality assurance. Various quality assurance programs have been initiated in Rajasthan .The quality assurance in Rajasthan has been mainly focused on Reproductive and child health..

11 TAMIL NADU

Adequacy of facilities and infrastructure: The State has adequate facilities for primary care services. All CHCs, SDHs and DHs are functioning in government building and 94% of PHCs and 75% of HSCs function in government buildings. State has 33% shortage of sub centers as per population norms . The infrastructure development is weak in terms of architecture design and needs further improvement. Separate Infrastructure Development Wing, exists under PWD for health infrastructure . District specific Infrastructure development plan prepared and district needs prioritized at state level.

Utilization of services: Service delivery has improved over the years. Significant improvement seen in IPD services post NRHM,resulting from institutional delivery. Maximum increase at the PHC level. indicating better inpatient and emergency care services at facilities.

Ancillary services

- Drugs: Well maintained pharmacy with adequate stock of drugs
- Diagnostic: Laboratory and radiography investigations available free of cost.
- Equipment: Available in all facilities due to smooth supply by TNMSC.
- Blood: Blood banks found to be maintained properly with adequately trained staff & records. Temperature monitoring and monitoring of expiry date of each unit of blood was done meticulously by the staff.

Supportive services: State has made good progress in providing supportive services and amenities with adequate quality to the patients. Seating arrangements and accommodation for ASHAs is a weak area and needs strengthening. Unclean toilets was common in the facilities. Signagaes, citizen's charter were displayed well. Grievance Redressal could be better. Cooked meals, prepared in-house was provided in the SDH/DH for all patients

Bio medical waste management and Infection prevention: BMW is outsourced in the state. However the waste segregation at source was not done properly in both the districts and the sharp waste was found lying in the open in some of the facilities

Cost of care: No Out of pocket expenditure recorded on drugs, however significant out of pocket expenditure was noted in the drop-back services for delivery cases.

Gender: Efforts to maintain privacy was seen across the facilities in both the districts. Separate wards available for male and female patients.

Quality Assurance: State has been pioneer in getting quality management system implemented at 48 PHCs and now getting it implemented at 30 more facilities. Though state has been pioneer in facility based quality assurance but it is yet to form state Quality Assurance Cell. .

12 TRIPURA

Adequacy of facilities and infrastructure : Expansion of facilities is adequate to cover current population. There is an overall shortfall of 41% and 29% respectively in the targeted construction of building for new sub centres and sub centres being run in rented buildings (as approved under NRHM during the years 2009-10 to 2011-12).Maximum shortfall on the construction of neo-natal intensive care units in DH/SDH approved under NRHM for the year 2011-12

Utilization of services : IPD load better in PHCs and above due to institutional delivery .

Ancillary services :

- Drugs : Inadequate drugs in most facilities visited , especially shortfall in emergency drugs.
- Diagnostic: Diagnostic services available in DH.In PHCs and CHCs diagnostic services are limited & only routine tests are available .
- Equipment: Neo-natal intensive care units and resuscitation equipments are not in place: Oxygen cylinders are available in 50% of PHCs ;
- Blood: Well functioning blood bank and blood storage facilites were available in DH & SDH in both districts visited

Supportive services: Cleanliness, toilet facilities and safe drinking water provisions are in bad shape in almost all the facilities. Power back-up Generators are non functional in almost all facilities.

Bio medical waste management and Infection prevention: General waste disposal and bio-medical waste management including hospital infection control systems were found to be inadequate .

Cost of care : User fee charged for diagnostic with exemptions for BPL in spite of the state's policy of no user charges. Instances of high OOP on drugs and consumables was noted in many facilities.

Quality Assurance: Quality assurance committees have not been formed at most of the places.

13 UTTARAKHAND

Adequacy of facilities and infrastructure : Substantial increase in infrastructure , maximum addition being at the SC level ; from 1576 in 2005 to 1765 in 2011. 59% SCs functioning in govt. Buildings. SCs are mostly collocated with another higher facility (PHC/APHC/CHC). Infrastructural planning is a problem with inappropriate labour rooms at all the facilities visited.

Utilization of services : OPD substantial in most facilities .

Ancillary services :

- Drugs : Availability of emergency drugs such as Magsulph and Misoprostol was a problem. Expired drugs available in some facilities.
- Diagnostic : Availability of laboratory services was a problem in most facilities and patients were getting routine tests done in private labs.
- Equipment : Delivery points are adequately stocked with new equipments , but skills to use them is lacking in staff.
- Blood : Provision of blood is available only at DH, Pithoragarh and not elsewhere in both districts (not even at DH Bageshwar).

Supportive services : Overall health facilities are spacious, clean and well maintained. Availability of attached toilets with running water was scarce except in a few facilities . Security arrangements were not available in the facilities . Diet is provided to pregnant women in most facilities. Record keeping was observed to be poor;JSSK entitlements displayed in the facilities visited. ASHAs Ghar are available in DHs.

Bio medical waste management and Infection prevention : Bio medical waste management system was in place in the facilities in both districts

Cost of care : User fee is charged for OPD registration and also for IPD with exemptions for BPL. User fee is being charged from pregnant women for investigations and registration at some facilities. Out of pocket expenditure observed in drugs and diagnostic services.

14 UTTAR PRADESH

Adequacy of facilities and infrastructure : Infrastructure status improved over the years , but large gaps still exist since facility creation is based on 1991 census population. Most facilities were located in govt. buildings and residential accommodation is adequate. Infrastructure development has been affected by delays and poor quality of construction. Shortfall in SCs due to no sanctioning of new facilities .

Utilization of services : IPD trend does not match the significant increase in OPD footfalls and most IPD is on account of delivery cases at all levels of health facilities. Functionality of AYUSH MOs is affected by irregular supply of AYUSH medicines .

Ancillary services

- Drugs : Adequate supply of drugs was observed in the facilities in both districts.
- Diagnostic : Availability of diagnostic services was weak even at the DH level ; 24/7 lab services not available. Emergency tests are not available in any govt. Facility in Jhansi.
- Equipment : Lack of equipment common in all facilities leading to non provisioning of services –surgeries (major/ minor) and C-sections.
- Blood: In Jhansi, Blood Component Separation Units are located in the lone Government Medical College and District Hospital at Jhansi. Blood Storage Units are absent at designated FRUs.

Supportive services : Irregular electricity is affecting post natal stay and maintenance of cold chain equipment. Most facilities above PHCs had seating and drinking water amenities and patient information

was adequately displayed, but toilets were in adequate. Facilities for over night stay of ASHAs or attendants was not available though Jhansi DH and DWH had facilities 'rein basera' or night shelter for overnight stay of the relatives . Free diet available in most facilities.

Bio medical waste management and Infection prevention :Non adherence to bio medical waste management protocols by health care providers and infection control system highly compromised. Outsourcing of waste management is not effective ; irregular services by agency due to lack of funds.

Cost of care : Out of pocket expenditure on drugs, diagnostic tests and travel to facility was evident during interaction with patients.

Quality Assurance : State Quality assurance cell has been formed but District Quality Assurance Cells are still in formative phase. Quality scoring of the priority facilities has been done.

15 WEST BENGAL

Adequacy of facilities and infrastructure: Acute shortfall of infrastructure at state level as well as in both the districts due to low sanctioning of facilities . Shortage of staff quarters for MOs and GNMs in all the facilities and existing ones need repair.

Utilization of services : Increasing footfall reported in all the public health facilities. The daily average OPD load is 100 per day in PHCs and 200 -250 per day in BPHCs and RHs. There has been increasing OPD, IPD, delivery (especially night deliveries)

Ancillary services

- Drugs : Availability of drugs in most of the facilities. List of availability of medicines not displayed in any of the facilities visited in Murshidabad.
- Diagnostic : Diagnostic equipment was in short supply in the BPHCs and RH. Sanctioned posts of lab technicians in Murshidabad district are vacant. None of the facilities including the District Hospital had a 24/7 functional lab; Laboratory Investigations are charged.
- Equipment : Shortfall of diagnostic equipments in facilities in both districts.
- Blood : Blood banks functional in both districts but need strengthening.

Supportive services : Overall environment of facilities was - unhygienic, especially in higher facilities with dirty toilets and unclean wards. Shortfall of beds leading to overcrowding in wards. Toilets in facilities are not attached to labour room; common toilets available for male and female ; drinking water facility is scarce in OPD. Security was an issue with , rodents, cats, dogs and even goats in the hospital premises. Diet was being provided to all the in-patients in public health facilities.

Bio medical waste management and Infection prevention: Waste segregation is done, but not as per rules; outsourced to 3 firms who are doing waste disposal in Common Bio Medical Waste Treatment Facility.

Cost of care : There are no user charges in PHCs and BPHCs. User fee are charged in DHs, with exemptions for BPL / SC / ST patients in all level of Hospitals. Approximately 50 - 60% patients attending the hospitals are exempted from user charge.

Quality Assurance; State and District Quality Assurance Cells established but not functional. No meeting held since last one year in the district visited. 12 District & Sub District hospitals are under implementation for formal quality management system and certification. State has also formed "West Bengal Hospital Standards" but they are yet to be implemented .

II
OUTREACH SERVICES - SUB CENTRES, MOBILE MEDICAL UNITS

1 ASSAM

- SCs in both districts cater to a population much higher than norms (6096-15000).
- State has a two ANM norm and the area and work distribution of both ANMs is well defined . 4% SCs are conducting deliveries and each SC 'delivery point' has been provided with a Rural Health Practitioner equipped to conduct normal delivery.
- Outreach provided through MMUs and 15 boat clinics. The positioning of MMUs and cost implications incurred when these vehicles are taken to field without the availability of suitable provider needs to be looked into.
- Emergency transport is provided by the 108 services which largely caters to pregnancy related emergencies.

2 BIHAR

- Sub-centers provide essential packages of services. MCP cards and MCTS registers were maintained but the ANM did not receive any MCTS work plan. The HB and urine examinations are not done due to unavailability of instruments.
- No MMU in Banka District and only one in the Gopalganj district. The MMU scheme is implemented through PPP mode but agency has been blacklisted due to some issues.
- The emergency referral transport services has been introduced recently. The 102 ambulance are well equipped with GPS system and have emergency drugs. Each of the PHCs visited had an ambulance with records of usage.

3 CHHATTISGARH

- There are no second ANMs in the districts, since the second ANMs appointed initially have been absorbed under the state services.
- The state has started conducting biannual round for Vitamin A supplementation programme for under-five children.
- EMRI is operational in state and has adequate coverage but there is lack of publicity of the services. 30

to 40% of the cases are pregnancy related

- District Dantewada was not covered under social marketing of contraceptives and menstrual hygiene. In Mahasamund, ASHAs are distributing Freeday sanitary napkins among local community. Quality of the napkins is an issue.

4 DELHI

- Outreach is provided through dispensaries, PUHCs, seed PHCs and VHNDs.
- There is a shortfall in ILRs and deep Freezers and domestic refrigerators were being used for vaccine storage at many sites.
- Immunization and health talks are the primary focus in VHNDs. Sanitary napkins and spacing contraceptives are provided free of charge through schemes run by the Delhi government.
- The State has no MMUs but a state-supported mobile health scheme with NGO partnerships, for JJ clusters, slums, and construction sites.

5 KERALA

- Sub Centers in the state are equipped with one JPHN (ANM) and JHI (Junior Health Inspector/Male Health Worker) . JHIs are actively engaged in surveillance and house hold visits for source reduction for communicable and non communicable diseases.
- Package of services provided in Sub Centres is beyond RCH services - palliative care, screening of non-communicable diseases, ante-natal registration, and immunization activities.
- WHSNDs are organized through ANM/JPHN & AWW on every 2nd Saturday. ANMs counsel on immunization, nutrition, breast feeding, ANC, PNC & Family Planning.
- Availability of government ambulances was limited only at the district level and call centre based network of EMRS has been developed only in Trivandrum and Allapuzha
- A total of 16 functional MMUs in seven districts (tribal areas) provide facilities for basic lab tests like blood sugar, hemoglobin.

6 MADHYA PRADESH

- Sub-centers are inadequate as per population norms and one sub centre caters to almost 7000-8000 population. Moreover, in Gwalior, of the 234 ANM, only 40% are posted at the sub center level
- Special sessions like “Baal Suraksha Mah” are conducted to cover immunization. Telemedicine is another excellent initiative, working well to reach out to the unreached.
- It was observed that average time gap to visit a village by MMU is two months and drug dispensed is for 5 days, which may not be sufficient for chronic diseases or those who need follow ups.

7 MANIPUR

- Sub centres are not up to mark in providing ANC and skill of ANMs was low in Hb testing & BP checkups.
- MMU vehicles are a not suitable to provide service in remote hill districts .

- Non availability of micro plans, shortfall of ILR points and lack of maintenance of equipment was observed across the state. State does not have a fixed day for immunization and alternate vaccine delivery system is not functional.

8 ODISHA

- The state has 6688 sub centres against a requirement of 10616 SCs. Of these, 153 SCs have been identified as delivery points and 76 SCs are conducting over 3 deliveries per month.
- 1043 second ANMs have been deployed, mostly in SCs catering to larger population and those where deliveries are being conducted.
- ASHAs are actively promoting social marketing of sanitary napkins for the menstrual hygiene of adolescent girls. Weekly IFA supplementation is done in both the districts.
- State has Mobile Health Units (MHU) in hard-to-reach areas but there is a need for linkage with VHND and SCs to provide services to pregnant women, adolescents.
- State uses Janani Express (JE) ambulances and also empanelled vehicles for providing home-to-facility services.

9 PUNJAB

- The number of sub centres are inadequate as per population norms ; shortfall of ANMs was also reported from the districts .
- State has added second ANMs to most sub centres but there are no MPW (M) at SCs. Most ANMs are trained in SBA, IUCD.
- Drugs were in short supply during the VHNDs and privacy during ANC check-ups (curtains, examination table) needs to be improved
- ASHAs were active in mobilizing children to SC but no convergence was seen with ICDS department.
- Utilization of 108 and MMU services was satisfactory. AYUSH drugs are available at PHC and CHC level. BCC and IEC could be strengthen during VHNDs and MMUs visits

10 RAJASTHAN

- There are 793 SCs functioning as delivery points. Labour rooms in 383 SC delivery pointa have been upgraded. Residential facilities for ANM in 700 Sub centres were sanctioned in this Financial Year.
- 1014 AYUSH doctors have been employed under NRHM and they have conducted 15331 (April to Sep. 2012) normal deliveries.
- 49 Mobile Medical Units and 143 Mobile Medical Vans operational. Janani Express vehicles are also operational. Emergency transport services (108 and 104) are also in place.

11 TAMIL NADU

- Sub centres are managed by one ANM; shortfall of MPW (M) in most sub centre was reported from the districts.
- In all HSCs visited in both districts no ANM is conducting Hb estimation, and she is directing pregnant

women to the PHCs for all investigations.

- Vaccinations have been recently restarted in SCs to enhance coverage in the state.
- A total of 385 MMUs are functioning and providing OPD, laboratory investigation, medicine & family planning supplies distribution, follow-up, counseling, referral and screening. Frequency of MMU visits need to be improved in the remote tribal blocks.
- Adequate EMRI ambulances available in state - 1 per 1,40,000 population. Additionally 4 neonatal ambulances are available.

12 TRIPURA

- Infrastructure in terms of availability of equipment, power and drinking water is insufficient in sub-centers. Services provided by SC needs to be strengthened with respect to ANC (Hb test, BP, Abdominal Examination) and IUD insertion.
- VHND is being used very effectively for social mobilization, convergence and a wide range of services including OPD services.
- 4 MMUs are integrated with the VHNDs and provide OPD services, dental care and diagnostic including ultrasound.
- Institutionalized emergency and patient transport services do not exist in the state.

13 UTTARAKHAND

- Immunization coverage is good but ASHAs are not mobilizing children and no line listing is available with them. There is shortfall of stabilizers and thermometers to monitor cold chain temperature.
- The staffs posted in MMUs are not trained in national programs and conduct only immunization and OPD services.
- EMRI covers most of the geographical area in the districts except areas with no road connectivity where Doli/Palki needs to be made available.

14 UTTAR PRADESH

- State has a shortage of sub-centers due to delay in sanctioning of new sub centres.
- Out of the existing 20521 sub-centers in the State, 12% are delivery points, some with high caseloads. Sub-center/ delivery points lack basic amenities and need to be strengthened. ANCs conducted at these SCs are limited to provision of IFA and TT injection to the pregnant women.
- 131 Urban Health Post are functional to cater the urban slum population.
- The outreach services provided by the MMUs are not functional owing to the legal hassles.
- Transport Services are provided by Emergency Medical Transport Services (108 Service) through GVK EMRI and Patient Transport Services (102 Service) under the U.P. Ambulance Seva. Drop back for pregnant women started under PPP , but all delivery points are yet to be covered.

15 WEST BENGAL

- Sub centres provide a good package of services but there is major shortfall in sub centres as per population of the state.
- Second ANMs are posted in 80% SCs in Murshidabad and 85% SCs in PM. However, there are huge vacancies of the male workers in both the districts.
- MMUs are operated by 6 NGOs in 11 LWE blocks. Good coverage of areas by MMUs based on monthly block and district plan .
- SCs are the nodal points for immuization with good attendance of pregnant women and children
- Nischay Yan is a free referral transport service for pregnant women and infants and paid service for other patients available in the state. NGOs and commercial small vehicles are allowed to run the services that had MoU with block health officials.

III
HUMAN RESOURCES FOR HEALTH – ADEQUACY IN NUMBERS, SKILLS AND PERFORMANCE

1 ASSAM

- Measures to ensure availability of manpower in underserved areas includes deployment of contractual employees at facilities where no regular post is sanctioned, compulsory one year rural posting for MBBS doctors for admission in PG courses, initiation of Rural Health Practitioners course and posting them at sub-center delivery points.
- Establishment of e-HRMIS, an online portal developed for manpower planning and management.
- Increase in HR has resulted in improved performance especially in terms of institutional deliveries and C-sections as observed in Jorhat district where IDs have increased from 15737 in 2010-11 to 16656 in 2011-12 and C-sections from 2707 to 3756

2 BIHAR

- Increase in the number of nursing institutes, particularly in private sector from 6 GNM schools with an annual intake of 376 in 2005 to 12 in 2012 with an annual intake of 660
- Rational deployment of civil surgeons done through Screening Committee and LSAS / EmOC trained MOs deployed at FRUs and IMNCI trained nurses at SNCUs and NBCCs for optimal utilization of manpower.
- Massive recruitment drives for contractual appointments of doctors, nurse, ANMs are in place to meet the shortage of staffs through online application systems and walk-in-interviews. A policy of stable tenure is followed and contracts are signed for a minimum of three years.
- Special incentive scheme is in place for difficult areas and incentives for rural postings is under consideration
- A structured performance appraisal system for contractual employees is in place and being conducted every year.

3 CHHATTISGARH

- Chhattisgarh Rural Medical Corps (CRMC) for attraction and retention of service providers in rural and remote areas is in place along with deployment of AYUSH doctors for filling up gap in MBBS doctors and deployment of RMA for peripheral rural posting. RMAs undergo a 10 day training at CMC, Vellore for skill improvement

- There is no system in place for performance management of contractual employees; contracts are given for 5 years, after which they are either absorbed or terminated; and no increment or incentives for these staffs.
- In both districts visited, there is urgent need for capacity building of service providers at all levels. Moreover, the few existing training facilities are inadequate with poor infrastructure having low case loads.

4 DELHI

- 60% of the contractual staffs (total approved 5564 positions) appointed have made a significant contribution to increasing access to services, but lack of in-service orientation or trainings, arbitrary transfers has diminished the potential outcome of additional HR
- Irrational deployment of manpower observed at facilities, for instance 2 MOs were posted at a facility with an average OPD load of 70-80 per day while 1 MO managed an average of 150 OPD on daily basis at another facility.

5 KERALA

- Service providers such as doctors are given incentives and special incentives for working in difficult areas (Rs.3000/month) and in most difficult rural areas (Rs.5000/month)
- But vacancies exist at all levels of care providers - gynecologist (16%); pediatrician (12%), anesthetist (29%), MO (13%), staff nurse (3%) and ANM/JPHN (4%). 1399 positions for Health workers (Male) are sanctioned out of which 114 positions are vacant.
- There is a system for performance appraisal against benchmarks and contract renewal based on the appraisal, which is also linked to increments.
- Specialist Cadre has been created as part of motivational measures.

6 MADHYA PRADESH

- In the last 7 years of NRHM, approximately additional 100 specialists, 400 MOs, 1000 staff nurses, 4000 ANMs and 100 laboratory technicians have been added to strengthen the public health systems. - uptake of services like institutional deliveries are increased from 30 percent (NFHS-2 2005-06) to 76 percent (AHS- 2011-12)
- Many other strategies have been take up to ensure availability such as increasing number of sanctioned posts, increasing salary and incentivizing personnel for working in hard-to-access areas and high focus districts.
- Poor workforce management, particularly for contractual staffs - contracts have not been renewed after the first appointments. The contractual ANMs were not being provided salary for last 6 months as observed in PHC Barai and Sector Sub Centres.

7 MANIPUR

- Irrational deployment of HR including specialists is paramount across all facilities visited and facilities having minimal work-load has more HR in place. Some sub-centers had 3 to 4 ANMs while others had no ANM.

- Contractual staffs were not paid the consolidated monthly salary since the beginning of the current year; only the basic pay was given in lump sum amount on irregular basis.

8 ODISHA

- State has introduced various retention strategies such as providing incentives for Medical officers and specialists posted in difficult districts, extending the age of retirement age of M.O to 60 years, and up-gradation of posts along with compulsory rural postings.
- Yet the state has a vacancy of 33% for gynecologist, 69% for anesthetist, and 52% for pediatrician and 84% for staff nurses.
- For professional development of doctors steps such as in-service training, skill development PDC course, exposure visits, participation in conferences and workshops have been introduced.
- Law to prevent violence against medical personnel and institutions is in place
- The State is developing an online software called ITEMS to assess the service delivery of trained HR. An online HRMIS having database of all types of employees (contractual and regular) is already in.

9 PUNJAB

- Significant numbers of posts are lying vacant in Patiala district. 123 MPW (M), 35 Field workers, 2 insect collectors and 1 zonal entomologist posts were lying vacant. In Moga, 12 regular posts of SNs and 26 regular posts of ANMs are vacant.
- AYUSH services were neglected and supply of AYUSH medicines is poor.

10 RAJASTHAN

- The vacancy rate of specialists is 62.1% and 2.9% for MOs at PHCs while the state has excess HR (in position vs sanctioned) - pharmacist (152%), staff nurse (211%), ANM (122%), laboratory technician (145%).
- Difficult area allowances has not been implemented by the health service which cause great dissatisfaction among most service providers.
- Promotions take a long time and most doctors receive their first promotion after many years of being in service and most retire after two promotions at the most.
- An HRD cell has been created under NRHM headed by a Senior RAS officer but many of the HR policy directives have not been implemented. Many of the recruitment of paramedical personnel could be decentralized.
- The recruitment of medical personnel has been handed over to Medical University to expedite the process. A data base of health personnel is also being created.

11 TAMIL NADU

- State has two separate cadres-medical services and public health; the public health cadre being supported by a separate Public Health Directorate having its own budget and legal support. There is also a nursing cadre with clear cut career progression and promotional avenues.

- There is a policy for rational deployment of HR at various facilities having 2-3 MOs in all PHCs of 6-10 beds and 5 M.Os in all CHCs with 30 beds.
- There is no 2nd ANM policy adopted by the state except in very few sub-center delivery points.
- There is a promotion policy in place for different categories of service providers except for AYUSH and MMU doctors.

12 TRIPURA

- Acute shortfall of staffs in all categories such as 50% shortfall of medical doctors, 10% of staff nurses, 28% of pharmacists, 33% of laboratory technicians etc. affecting the quality and availability of basic services
- Low motivation of staffs due to low salary and job insecurity with lack of career progression and promotional avenues.
- Good practice for career development of medical officers in form of sponsorship of PG studies after 3 years of service.

13 UTTARAKHAND

- While there is a shortfall of all staff is noted maximum shortfall for MOs at 52% and specialists at 24% against the sanctioned positions
- In the last six years of NRHM, no effort to attract or retain doctors in remote areas was made and it was observed that concentration of specialists/ contractual MOs/ multi-skilled MOs in the plains is seen.
- The state has a large number of underutilized paramedical staff including Health Supervisors, 500 pharmacists, 1100 Sudurwati Swasthya Sahayak
- Doctors are not deployed from other district for yatra duties. Instead, the already thin human resource from Rudraprayag district is utilized, thereby many facilities are without MOs for six to eight months

14 UTTAR PRADESH

- Irregular recruitment process and lack of candidates has resulted in inability to fill vacancies. There are 4525 MO, 2557 paramedical and 2412 ANM posts lying vacant and only 2566 Male Health Workers are posted against a sanctioned number of 8857. No comprehensive strategy to attract and retain healthcare providers in the rural areas – existing financial incentive (Rs 100 per month for doctors) is too low to make a difference
- Due to inadequate number of faculty members, admissions in ANMTC have been affected- the last admission process was carried out in 2009. ANMTC at Moth, Jhansi has produced only 1 batch of ANMs in the past 6 years.
- There is no system for performance appraisal and workforce management, particularly for contractual workforce- including their renewal process, pay parity with regular employees and increments.
- Training plan and post training deployment plan not in place in the districts visited, resulting in low levels of achievements for critical trainings that include SBA, NSSK, LSAS, F-IMNCI, BeMOC and EmOC.

- In Murshidabad, more than 50% of vacancy was observed in district for all non-technical jobs, in particular clerical staffs, sweepers and drivers. The posts of GNMs for Annwesha are largely vacant even though 80% of the 2nd ANMs and ASHAs were in position
- State has no policy or strategy for retention of manpower deployed in rural and remote areas and only Doctors working in rural areas are entitled to only Rs. 200/- per month
- There is an acute shortage of ward boys/ayas (group D staff) in the facilities visited. A total of 397 posts are lying vacant in the district.
- Presently, the state is in the process of recruiting over 600 Medical Officers and 160 Specialists on contract (adhoc) basis under state service who shall be posted in PHCs, BPHCs and FRUs (for specialists.

IV
REPRODUCTIVE AND CHILD HEALTH PROGRAMME

1 ASSAM

- Planning of the facilities, Health services and Human resource -The delivery point and FRU infrastructure is well in place and now the state requires focusing on improving the service delivery at these points. Labour rooms were in general in good condition barring the emergency dug availability in these facilities. The infection prevention practice as observed in both the districts requires strengthening. There is a system of quality assurance in place but the monitoring schedule for the same is not defined and no action plans and action taken reports are being formulated. The cold chain maintenance is good across the facilities and most of the facilities are tracking drop outs by making due list and beneficiary list.
- Maternal health - Assam presently has highest recorded MMR. On the positive, side it has witnessed almost a 20% decline in MMR during the NRHM implementation period. There is a huge gap in home deliveries between the AHS and reported HMIS figures depicting that the home deliveries largely go unreported. State has taken some initiative to improve the 48 hr. stay like issuance of Mamta kit.
- JSSK and JSY -JSY physical and financial matching is still in a nascent stage in the state. JSSK was launched a year back in Assam and the team observed few gaps in terms of diet provision at the facilities below CHC, drug availability and increased out of pocket expenditure.
- Family Planning services -The sterilization has decreased across the state. Data reported in HMIS (for sterilization) and separately to FP division does not match leading to misleading analysis of the situation. ANMs, LHVs and GNMs are aware of right technique of IUCD insertions. All the SHCs are equipped to provide IUCD insertion services; however, lack of motivation on part of providers is leading to poor output. The ASHAs are highly motivated and helping to motivate male clients to undergo NSV.

2 BIHAR

- Maternal health –
- Antenatal care: Records of pregnant women registered for ANC were maintained in the MCH register, but the ID no. for entering the details in MCTS data base was not mentioned in the register. At few locations, a mismatch was found between the records and perception of the beneficiary. It was observed that the Maternal Child Health (MCH) register at subcentre had recorded three ANC visits for majority of pregnant women, however, during interaction with beneficiaries, all of them reported to have undergone at the most two antenatal check-ups.

- Quality of care in Institutional deliveries: Partographs were not plotted for women undergoing vaginal delivery at any of the health facilities.
- Emergency obstetric care: It was observed at Sadar Hospital Gopalganj that indication for most of the caesarean sections has been due to obstructed labour (as per OT register). Upon further probing for the reason for high number of caesarean sections due to obstructed labour, it was reported that women coming with the obstructed labour already had IV bolus Injection of Syntocinon (usually of 2 ampoules), perhaps by private practitioners, having their own clinics outside the hospital.

3 CHHATTISGARH

- Planning of the facilities, Health services and Human resource: In Mahasamund there are 118 (46%) delivery points out of 255 health facilities, in which 92 are SHCs. Major proportion (37.5%) of institutional deliveries are taking place at SHCs. In Dantewada though volume is low and deliveries are at sub-threshold level at several delivery points, they should still qualify for delivery points on the basis of equity.
- Maternal health
- Antenatal care: In both the districts, most of the facilities except DH were not doing lab tests other than Hb, UPT and MP ROT in both the districts. Hence the detection of high risk pregnancies as well as early referral is limited.
- Emergency obstetric care: The provision of emergency obstetric care and safe abortion is limited due to absence of trained human resource in the districts including C-sections facilities. Hence the care is provided in nearest FRU either in adjacent district or border state or in private facility.
- Quality of care in Institutional deliveries: Overall, the improvement in maternal health is gradual but steady with the proportion of institutional deliveries gradually reaching 40 to 50% in Dantewada and 44.9 % in Mahasamund. Facilities for normal deliveries were largely satisfactory with the RMAs filling the critical gaps of MOs and standard protocols including partographs being used where trained in. Only the aseptic precautions and infection control practices can be improved upon in Labour rooms. Approximately 15% of the delivery cases were referred to higher facilities mostly by government or EMRI vehicle.
- JSSK and JSY: JSSK is implemented with exemption of charges on stay, diagnostics, diet, drugs and OPD and IPD services at District Hospital, CHC and PHC level. There are no delays in JSY payments.
- Child health: In the districts visited, NBCC / NBSU / SNCU are not functional neither were any delivery points equipped with functional newborn care units. The community level management of sickness is mostly by the Mitanin who identify cases of diarrhea and ARI, initiate the treatment for diarrhea using ORS and refer cases of childhood ARI. ANM provide postpartum visits in case of home deliveries.
- Family Planning services: TFR is 2.8 in the State. Family planning services in the state are provided through camp based approach at places like Dantewada with lack of specialists. Fixed day IUCD services at PHC and SHC and supply of IUCD, Condoms, OCPs, ECPs and PTKs up to the peripheral facilities is present in the state. Social marketing of contraceptives by Mitanni's has started.

4 DELHI

- Planning of the facilities, Health services and Human resource
- A critical challenge is the prioritization of facilities so that more women access the maternity homes,

rather than directly access to tertiary institutions. But in order to do this there has to be better outreach, birth planning and close contact with pregnant women. This is the role of the ASHA who has clearly not been empowered to undertake this role. Training progress for F-IMNCI, SBA, or NSSK was very slow. Abortion services are being provided in all delivery points, but MVA is not in use anywhere. Facility level inventory management is an area of concern. There is no uniformity in the availability of checklists and protocols. QAC have been established for family planning services but little else. Both facility based and community based maternal death reviews are being undertaken but the pace is so slow that the process loses its value. Of 223 deaths so far, MDRs have been conducted in 92. ARSH services are provided primarily through fixed clinics on Saturdays, but it appears that services are restricted to curative care, with little counselling taking place. WIFS is yet to start in the state.

- Quality of care in Institutional deliveries: Institutional delivery is the most visible component of the RCH package, with high caseloads burdening the Level 2 and 3 facilities where quality of care and patient dignity and safety stand to be compromised. Reporting of home deliveries was found to be lower in the NE districts in comparison to the SW district. (2% versus 5.86%). This is contrary to the higher proportion of unreported deliveries, AWW and ASHA reports of higher home deliveries and sizeable population groups with poor health seeking behaviour.
- Emergency obstetric care: C-section rate is about 23% in both districts and across the state in tertiary centers.
- JSSK and JSY : JSY beneficiaries are low on account of stringent conditionalities. Payments in GTB were being made in cash, and it was here that patients reported high OOPs on account of informal payments and on drugs and consumables. Given the high levels of overcrowding patients tend to leave earlier than 24 hours.
- Family Planning services: Fixed day services for NSV and tubectomy are being provided in Level 2 and 3 facilities, and PPIUCD is being undertaken in all maternity centres. 71 facilities in the state have been accredited for sterilization services.
- Child health: Newborn care facilities in secondary and tertiary level facilities were adequate, but gaps were seen in provisioning of Essential Newborn Care in the maternity homes.

5 KERALA

- Planning of the facilities, Health services and Human resource: Inadequate labour room infrastructure (M'puram); demarcated areas for first & second stage of labour and postnatal care (Alappuzha). No display of Standard technical protocols. Availability of safe abortion services is inadequate, outdated technology used by facilities. One accredited private hosp. under PCPNDT was providing USG services with expired license in Alappuzha district. Systems for Maternal death review exist, however not as per GOI protocol. Under the Menstrual Hygiene scheme the uptake of sanitary napkins shows decreasing trend because of issues of poor quantity and quality.
    - Maternal health
    - Few home deliveries in tribal pockets (Malappuram)
    - Quality of care in Institutional deliveries: Use of partograph and stay for at least 48 hours in all cases .
    - Emergency obstetric care: Elective labour induction in most of the cases resulting in adverse outcome (Alappuzha).C-Section Rate is high even in public sector .
- JSSK and JSY: Nil out-of-pocket expenditure for drugs, investigation and diet, Rs. 500 in cash for

transport from home to facility and drop back.

- Family Planning services: FP acceptance and service delivery good in Alappuzha but acceptance by community poor in Malappuram.

6 MADHYA PRADESH

- Planning of the facilities, Health services and Human resource
- There are 1598 facilities prioritized for RCH services (known as delivery Points) in the state. Out of these 859 are functional. A total Level I- 142(all of them are SHC), L II-666 and LIII-151. MTP First trimester services available in all facilities visited (PHC, CHC) and comprehensive abortion care at DH. The Cold Chain WH infrastructure was also very impressive. All the ILRs, DFs and WIF/WIC were working properly. NRCs are well functional in the state with 90 %(State average) bed occupancy. However NRCs are releasing children without adequate nutritional rehabilitation as they are bound to release the children by day norm and not by improving status of nutrition. The facility based MDR is taking place however community based MDR is almost non-existent in both the districts. Functional Adolescent Health Clinic was not observed in both districts visited.
- JSSK and JSY: JSSK being implemented with provision of free drugs, vehicle, diagnostics. JSY payments are through account payee cheques.
- Family Planning services: Family planning counseling is still not happening in facilities though 48 hr stay is good. The LR registers is just entering counseling for lap ligation irrespective of parity and age of beneficiary.
- Child health: There are 37 SNCU, 42 NBSU and 840 NBCC are functional in the state. However Baby warmers in NBCC are not being used due to poor supply of electricity in the facility visited.

7 MANIPUR

- Planning of the facilities, Health services and Human resource:
- The total number of expected deliveries is 2748, however only 29 % of the expected deliveries have been conducted at health facilities. The state has two FRUs in the government sector-District Hospital , Churachandpur and DH Bishnupur, the latter one is a new one. At the state level private sector is conducting more C-sections than public health facilities. In spite of availability of basic HR, most facilities are underperforming.
- In Churachandpur district as per norms there is only one delivery point, that is DH Churachandpur which conducted 1980 deliveries in 2011-12. There are 12 other facilities (11 PHCs, 1 CHC) in the district that conduct deliveries but they cannot be designated as delivery points as they are performing below GOI norms.
- Maternal health
- JSY : Delay in JSY payments not made to beneficiaries & there is a delay of upto 2 -3 months whereas for ASHAs there is a delay of upto one year. Payments are made in cash to beneficiaries and ASHAs .There is a lack of clarity on the ground level regarding the process of payment to patient & ASHA .
- JSSK has been was, but awareness among the staff and beneficiaries is weak. Awareness about it is quite weak at the ground level. Hoardings at the road side and posters in the facilities have been recently put up. Diet facilities are available for JSSK beneficiaries in Ukhrul but not in CCPur. Notification/

Assurance issued of NIL out of pocket expenses in all govt. health facilities. However, free drugs are not available for JSSK beneficiaries. Women admitted at DH spent Rs.1700 & Rs. 1400 for purchase of drugs for normal deliveries. JSSK patients have out of pocket expenditures of upto Rs.1200 to 2500 in the PPP mode too, which is mainly towards medicine.

- Family Planning: Tubectomy is the preferred choice and vasectomy holds a back seat. FP performances, especially IUD have dropped as compared to previous year's performance.. Same is the case with IUD insertions. The acceptance of FP methods is to be promoted across the districts
- Child Health : Essential new born care is not being followed as per guidelines in any health facility in the district. New born baby corners had radiant warmers, largely unused . Essential equipment were missing in all labour rooms.
- ARSH : State has trained 29 State Trainers from 19th - 21st April, in the Year 2010. State nodal officer identified in the month of June 2011. ARSH Nodal Officers have been identified in 9 districts in the Month of Sept. 2012. Training of 70 MOs on ARSH, SHP & WIFS completed out of 90 targeted from 26th Sep-5th Oct 2012 Training of 106 ANMs/LHVs on ARSH, SHP & WIFS completed out of 136 target from 8th Oct- 2nd Nov. 2012.

8 ODISHA

- Planning of the facilities, Health services and Human resource: In Odisha, 8% (700 facilities) of total health facilities are identified as delivery points . Of these 145 (32 DHs +25 SDH+ 88 CHC) are functioning as Level 3, 331(240 CHC and 91 PHCs+ OH)as Level 2 and 224 as Level 1 (71 PHC +OH, 153 SCs). Prioritisation of delivery points visible and most inputs are directed towards strengthening the DPs. All delivery points had good infrastructure, equipments and reporting increasing caseloads , but performance as per desired MNH standards is low. MOs and SNs available in the delivery points; however irrational posting of LSAS and EMOC trained MOs -in Level 2 facilities, making their skills redundant. Knowledge and skills of staff in management of basic obstetric complications is weak and needs to be strengthened. Availability of Safe abortion services is available in very few facilities . In Bolangir,4 MTP trained MOs have been placed in 4 facilities , but only one is providing the services.
- Maternal health: Antenatal care: ANC registrations are late and full ANCs is often not done . Lack of MCP cards was a problem in recording and tracking ANCs.
- JSY: JSY payments reportedly in time ; 10& beneficiary checks yet to be carried out.
- Family Planning services: Provision of FP services provided through camp mode in DHs and CHCs ; shortfall on sterilization sets in camps ; uptake of IUDs low in spite of IUD trained ANMs in SCs who are not practising ; Contraceptive Logistics Management Information System is useful in ensuring full stock in SCs.
- Child health: Facility based care for new born has been initiated through 21 SNCUs , 28 NBSUs and 370 NBCCs. However, capacity of the units to manage neonatal complications was weak (Bolangir DH's SNCU recorded 14% neonatal deaths during April-Sept 2012) . Shortfall of Pead/MO and also inadequate training/orientation of the staff posted in the SNCU.

9 PUNJAB

- Planning of the facilities, Health services and Human resource:
- Delivery points plan is not comprehensive. Facilities designated as FRUs lack the critical component of BSU – e.g. CHC Kot Isse Khan .Several facilities are designated as 24/ 7 , but performance of 24x7 delivery facilities is not uniform – some are conducting much more deliveries than other. In Moga

disOut of 22 PHCs of district, 13 have been made 24x7 services PHC . In terms of range , only ANC and delivery care are made available in these 24X7 PHCs.. Load of delivery is low at the PHC level and only four PHCs have more than 10 deliveries per month fulfilling criteria of delivery points. However availability of services as assured under RCH, new born package and MTP care were not available in any one of them. EMOC training has not yet been started; NSSK training has been done however, SBA training of ANMs is not yet complete.

- Maternal health
- JSY - payments given by bearer check regularly within a week of delivery. State also has a scheme 'Mata Kaushalya Kalyan Yojana" where every pregnant woman delivering in Government hospital is being given Rs. 1000/- irrespective of caste/ class/ other considerations. This scheme is in addition to JSY already being implemented. The amount is being paid to the mother before discharging her from the hospital.
- State also has a Surakshit Janepa Yojana scheme for promoting institutional deliveries in PPP mode. Private institutions in under-served/ un-served areas are accredited for conducting deliveries and paid Rs. 2500/- per case for delivery of BPL pregnant women. 76 Institutions have been empanelled under the SJY scheme.
- JSSK : State is working on modalities to waive off user charges being levied for pregnant women.eg- for USG, lab diagnostics, blood etc. (other than during delivery). Approval of cabinet is required.Provision for free diet at all health institutions for pregnant women during their stay in the hospital for delivery (3 days for normal and 7 days for C-section).Diet services are outsourced. Diet is provided through local vendor, ASHA or any other local lady at PHC level.Grievance redressal help desks is yet to be formed at all delivery points in all districts.
- Child health : Comprehensive newborn care plan is non-existent – there are no SNCU in the dist. No plan for NBSU. NBCC non-functional at CHC Kot isse Khan.
- MDR : All MDR are discussed or reviewed in monthly meetings by the District MDR committee. Every case is discussed with Deputy Commissioner. Common reasons for Maternal mortality are anaemia, PPH, Eclampsia, Hypertension(PIH) other cases not related to pregnancy i.e. Jaundice. Only 5 Maternal deaths in Patiala have been reported.
- RTI/ STI : Regarding RTI/STI services: the hospital is providing HIV testing, VDRL and the report of 6 positive HIV cases and 37 VDRL positive cases have been detected since Jan 2012. RTI/STI colour coded kits for syndromic treatment were available at DH and being given to patients.

10 RAJASTHAN

- Planning of the facilities, Health services and Human resource: Total delivery point in the State are 1665, out of which L1 is 583; L2 is 220 & L3 is 31. Delivery points fairly well distributed geographically. Essential drugs and equipment for safe delivery care were available at most facilities visited. Though there is a comprehensive plan for FRUs but there were very few functional FRUs at district (only 1 in Sawai Madhopur and 3 in Udaipur). Numbers of FRU functional have even come done from 223 in 2010 – 11 to 206 in 2011 – 12.
- Maternal health:
  - JSY -
  - JSY payments through cheques are regular and found to be made before the discharge from the health facility. In Level 2 and 3 facilities, 48 hrs of stay after delivery was variable across the two districts.

- JSSK –
- JSSK is being implemented and free package of services are provided for pregnant women and newborn. Food for pregnant women was being provided by self-help groups at some facilities

- Family Planning Services – Fixed days services for sterilization and IUCD was not available at most facilities in districts. ANMs and staff nurses were found to be unfamiliar with IUD insertion techniques. ASHAs reported distributing contraceptives to beneficiaries at doorsteps
- Child Health-
  - SNCU has been established at district hospitals; however the staff had not received training related to facility based newborn care (or NSSK) or in handling the equipment.
  - Some equipment (50% of radiant warmers) was non-functional and had been out of service for a period of 6 months to several weeks in district Udaipur. In DH Sawai Madopur SNCU was overcrowded with 3 newborns to one radiant warmer.
  - The NBSU and NBCCs are in early phases of establishment; grappling with the issues of untrained personnel, improper use/ cleaning of equipment and improper functioning of new born corners.
- MDR-Maternal death audits are being conducted but documentation was poor. However awareness on maternal death audits was generally lacking among service providers. Trainings have been conducted up to block level and ASHAs have started reporting maternal deaths. But notification of institutions for conducting FBMDR and subsequent review in the institutions is yet to happen.

11 TAMIL NADU

- Planning of the facilities, Health services and Human resource: All PHCs are providing 24x7 delivery services with three staff nurses trained on SBA, IMNCI, NSSK and IMEP. In addition MOs at PHCs are well trained to manage complications. Vibrant PHCs are seen in the State, managing significant case load. State has initiated various innovative schemes which have helped building more trust in public health centers among community members. Blood bank and blood storage centers are available and have good coordination among others for blood supply. Adolescent health clinics only at the medical college need to be revisited in the state.
- Maternal health Antenatal care: TN is the only state to have started injectable iron sucrose for treatment of maternal anemia. However the State needs to track the outcome of the treatment.
- Emergency obstetric care: One third of CHC, half of SDH and all DH provide c-section services.
- JSSK and JSY: In addition to the JSY State has another conditional cash transfer scheme for mother which pays 12000RS at four intervals of ANC, Delivery, PNC and Child full immunization at government facilities. State has not accredited any private clinic or hospital for JSY, only for family planning private hospitals are accredited. JSSK entitlements are not displayed in facilities and significant out of pocket expenditure identified in the drop back services.
- Family Planning services: The family planning is more inclined towards permanent methods and limited focus is given to the spacing methods which need to be improved.
- Child health: The state has 47 SNCU at Medical Colleges, DH & in some SDH. Currently tracking of children from SNCU is not done which is required to assess survival post discharge.

12 TRIPURA

- Planning of the facilities, Health services and Human resource: 65/82 PHCs, 15/15 CHCs, 07/11 SDH & 1/3 DH are functioning as 24X7 facility and 04/11 SDH, 02/03 DH are functional as FRU (first referral unit).Out of 8 PHCs visited 6 are functioning as 24/7 delivery points. Both DHs and two SDHs of the four visited are conducting C-section. But none of the CHCs visited are conducting c-section. Only one SC in state is conducting deliveries (158 deliveries done from Dec 2009 to Nov 2012).The state has trained 265 SNs and 195 ANMs on SBA training, but trained staff did not have a 100% overlap with the delivery points. Infection Control Protocols, provisions of visual privacy and toilets in labour rooms and supplies like, gloves, cannulas, gauze, syringes, IV sets need attention. Magnesium Sulphate and Misoprostol were not available in most of the facilities visited. ARSH clinics were functional in one of 2 DH and some of the SDHs visited, but counselors need strengthening of training and sensitization on WIFS and many other ARSH programme issues. WIFS program is still being operationalised and supplies have not reached AWCs and schools. Only facility based MDR was being done in some facilities, and none at community / village level. Safe abortion facilties are available only in DH & 1DH.
- Maternal health:
- Out of the total expected delivery (51298) only 13% is home delivery, 7% is unreported deliveries, and 79% is institutional delivery, of which Public hospitals cover 95% but cover only 14.6 % of total C section deliveries (all done at SD/DH level) . Of the total complicated deliveries, 76.8% are done at SD/DH level, 4.2% at CHC and 19% at PHC level, as per the HMIS data.
- Emergency obstetric care: Emergency obstetric care is available only in DH and some of the SDHs, and competencies for conducting vacuum delivery and manual extraction of placenta is not available in any of the 24X7 PHCs which the team visited.
- JSSK and JSY: Under JSSK, free drugs and referral transports are not being provided but reimbursements are provided at fixed rates, leading to high OUPs. Free drugs and diagnostics services are available but outside prescriptions are common practice. Staff did not have full knowledge of entitlements under JSSK. Free meals are being provided but complaints were being made by patients about its quality.
- JSY – OUP is being reported by patients up to Rs. 2000-3000. JSY payments are by cheque, and delays in payments are up to 1 month. No grievance mechanisms found. Transport cost is reimbursed, no ambulance system in place.
- Family Planning services: FP - Uptake of family planning services is low, (though TFR is low at 1.7). ASHAs & ANMs distribute OCPs and Condoms, IUDs done at PHC and above, though 342 of 720 ANMs are trained in it. The fixed-day approach for permanent methods is not followed. PHCs conduct 40% of Laproscopic but none of Minilap, rest is all at SDH/DH level (21% of minilap is at Pvt sector).
- Child health: SNCUs were not available in any of the facilities visited. Newborn Care Corners are present at most facilities but their functionality and maintenance needs strengthening. 5 SNCUs, 5 newbornstablisation units and 2 NRCs are in process and will be functional by March, 2013. State has one functional NRC at state capital.

13 UTTARAKHAND

- Planning of the facilities, Health services and Human resource: Sex Ratio is a big issue in Uttarakhand. The sex ratio at birth in Bageshwar is 823 (AHS 2011) and Pithoragarh is 764 SRB (AHS 2011).There is lack of clarity of interpretation of PC&PNDT Act (although training workshop was conducted for implementing agencies).A total of 18 ultrasound clinics are registered with District Appropriate

authority in Pithoragarh and 5 in Bageshwar2 clinics de-registered recently in Pithoragarh, operated by BAMS (not qualified as per norms). Regular inspections and monitoring need to be scaled up, including provision of a system of reward for informers. Facility based Maternal deaths are not being analysed. Community deaths are not being reported. (specially deaths in EMRI. Schools are being visited on once a year basis by AYUSH doctors. It is not linked with ARSH programme.There is no referral linkage with any health facilities or follow up for disease, disability or deficiency. For ARSH, Fixed day services with doctor offered in district hospitals. No counselling services available in DH Bageshwar on other days. ICTC counseller are counselling adolescents in DH Pithoragarh and CHC Baijnath. First lot of sanitary napkins have reached PHC Baijnath under Menstrual hygiene scheme but not in other PHCs. Udaan - NGO has started peer education training. Targetted Intervention for Single male Migrant (TI-SMM) operational in DH PTG through 2 NGOs

- Quality of care in Institutional deliveries: Labour rooms are cramped with extra `equipment.Toilet facility not available in the Labour rooms.
- JSSK and JSY: Referral and drop back has improved significantly. User fees are still being charged for investigations and registration at some facilities. Diet is being provided in most of the facilities. Linking 48 hour stay to drop back is not being practiced.
- Family Planning services: NSV cases are not being done in Pithoragarh due to non-availability of trained doctor .Only one SN in FDH Pithoragarh was trained on IUCD but has not inserted PPIUCD after training.No PPIUCD is being done in this district.Condoms and OCPs were available in adequate quantity and were covered under door to door social marketing scheme (Bageshwar).Spacing methods and family planning counselling needs to be strengthened further.
- Child health: In rural area in Uttarakhand , the IMR has gone down by 17 points from 2005 to 2011, but in urban, it has gone up by 4 points. The gap between rural and urban has been constantly going down from 37point in 2005 to 16 points in 2011, a reduction of 43%.

  There are no dedicated staff available for NBSUs.Tests for serum bilirubin not available leading to poor utilization of phototherapy. There is slow progress in F-IMNCI training. Delivery points not saturated with staff trained in NSSK. Implementation of HBNC has started, ASHAs were aware of the conditionality. However, there is severe lack of quality monitoring including delay in payment of incentives. Nutrition Rehabilitation Centres are not yet operationalized and there is lack of awareness of GoI norms for their operationalization.

  ANMs' knowledge for immunisation was quite good , they knew about the, dosage, side effects etc.

  Most of ANMs and cold chain handlers have received training in last 2 – 3 years.

14 UTTAR PRADESH

- Planning of the facilities, Health services and Human resource: Operationalization of First Referral Units has been hindered by non-availability of specialists and slow pace of multiskilling of doctors - Comprehensive RCH services were effectively available in the two districts at the DH/DWH. However, even these two facilities do not offer the full complement of services - neonatal and adolescent health services are nonexistent at DWH Hardoi. Drug availability was satisfactory with most drugs available. Cold Chain points were well maintained and 'Alternate Vaccine Delivery' mechanism in place. RI micro-plans have been prepared
- Maternal health: In Jhansi, it was observed that Sub Centers are conducting more deliveries than its CHCs - Barata SC with only one ANM has an average delivery load of 40 per month while the adjacent

CHC Baragaon, within 5 km distance from the sub center, with 4 MOs including one gynecologist and 2 AYUSH doctors has a delivery load of only 10-15 per month.

- Antenatal care: Line listing of severe anemic women is not being done at the Sub Centers and PHCs, as Hb is not being tested during ANC. BP monitoring at some facilities is not being done due to non-functional BP instruments.
- Quality of care in Institutional deliveries:
- Emergency obstetric care: The DWH at Jhansi has started C-Sections only a month back and is dependent on the Medical College Blood Bank for emergencies.

- Family Planning services: Camp approach is largely being followed for performing sterilization procedures for women. Minilap and Vasectomy are not performed at any of the health facilities; ECPs are not available within the system. Overall the effort to promote or motivate clients for adoption of contraceptives is weak. Post partum family planning has also not received its due focus.
- Child health: New born care is an area of weakness and NBCCs at most delivery points have not been set up. NRC and SNCU were seen only at the Medical College. The Still Birth Rate and Intrauterine Death in Hardoi District is higher than the reported neonatal deaths - while there may be reporting issues it is also a reflection of inadequate antenatal care at the peripheral facilities, lack of skills, transport facilities and emergency obstetric care services.

15 WEST BENGAL

- Planning of the facilities, Health services and Human resource
  - 3.8% of the public health facilities were functional as delivery points in the State. Out of 10356 SCs only 11 are conducting more than 3 deliveries per month. Among 272 PHCs which are 24x7, 54 are conducting more than 10 deliveries in the State. Among 102 FRUs (CHCs and other FRUs, includes DH), only 96 are conducting C-Sections and are functional FRUs. Therefore there are in total 444 delivery points in the State in the public sector which need to be strengthened and 68 among accredited private health facilities. One delivery point caters to more than 4 lakh population.
  - The state in addition to the existing delivery points in the public health system has introduced ayushmati scheme to scale up the delivery points in the state. This scheme caters to both normal and C- Section deliveries.
  - Considering the CBR of 25 births per 1000 population, total expected deliveries and requirement of the facilities to cater the delivery load for Murshidabad and Paschim Medinipur are mentioned below. As per international norms, a BEmOC facility is to cater a population of 1.25 lakhs and CEmOC facility is to cater to a population of 5.00 lakhs. The entire delivery load in both the districts is on the L2 & L3 level of facilities. The districts need to strengthen their sub centres for conducting deliveries. It can also be observed that 50% of the facilities are still to be upgraded for L2 and L3 level facilities.
- Availability of delivery points in the two districts visited

	Ideal scenario	Murshidabad		Paschim Medinipur	
		Required	Available	Required	Available
District Population	20,00,000	7102430		5943300	
Expected Deliveries	54000	195000		162000	
L1	50	175	3	150	0

L2	20	70	29	60	26
L3	4	14	6	12	10 (6 functional)

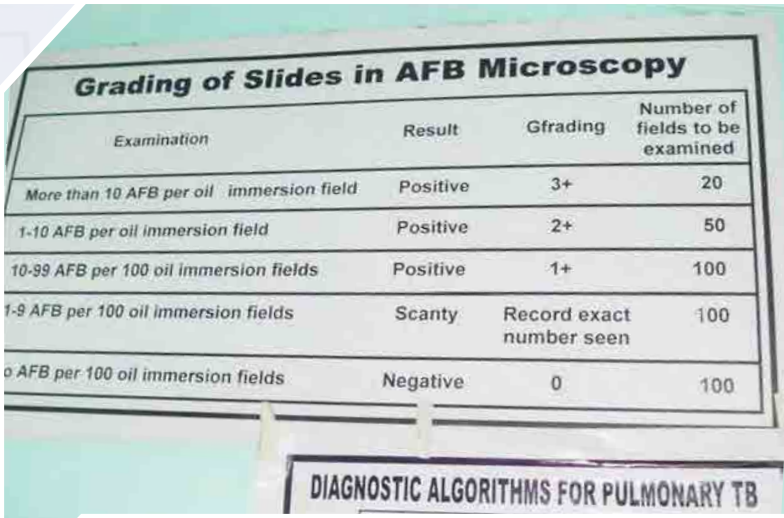
- The GNMs available in the CemONC and BEmONC centre visited had received training in SBA. The GNMs are well versed with ANC, delivery and are using partograph. A total of 359 GNMs have been trained in SBA. SBA training is only for 15 days duration and does not have a supportive supervision component for post training follow-up and performance improvement.
- In Murshidabad district, RTI/STI services are reported to be provided in 33 facilities. However, it was observed that the RTI/STI services were not being given at the PHCs and higher facilities as the state has not yet procured the RTI/STI drugs.
- In Murshidabad and PaschimMedinipur, there are District Quality Assurance Committees headed by the DM along with members of District Health Service like the Dy. CMHO, DPHNO. The DQAC was formed for accreditation of trained Surgeons and MOs of hospitals for performing sterilization operation and compensation following failure or death during sterilization operation. The members were trained in 2008-09 by GTZ. The DQAC has not met for last 1 year. Hence, the DQAC is non functional. The DQAC has not been trained for quality checking of the hospitals quarterly and grading them. There is no visit to the hospitals for quality assurance and grading. Govt. of West Bengal has universalized ARSH Clinics named Anwesha across all blocks in 18 districts and Adolescent Health Clinics at District Hospitals or Medical Colleges.

- Maternal health
  - MMR had been declining since (1997-98) till (2004-06) in the state. However, there has been an increase in the Maternal Mortality Ratio in the State from 141/100000 live births as per SRS 2004-06 to 145 /100000 live births as per SRS 2007-09.
  - In PaschimMedinipur district 45maternal deaths were reported in 2011-12. Although the MDR committees have been formed at District level and facility level and the MOs in these facilities have been trained, no maternal deaths have been reviewed by the District MDR committee so far. Instead, 38 of these deaths were reviewed by the CMHO. The major causes identified were anemia, PIH and hemorrhage. Among the facilities visited, maternal deaths were recorded at Chandrakona RH, Dwarigeria BPHC and at Jhargram DH. All the cases have been reviewed by the Hospital MDR committees. A common deduction across the reports was that the quality of ANC done in the field was poor with no proper screening of high risk casess and there was delay in referral. Screening of high risk cases and early referrals are not in place.
  - In Murshidabad district the MDR committee has been formed at District level and facility level and the situation is similar to PM. FBMDR is being done in the district Murshidabad and CBMDR is still to start in the district. MMR in Murshidabad district is 210 per 100000 live births, i.e 288 Maternal Deaths of which 253 deaths (88%) are was reported. Only 50% of maternal deaths were audited in Murshidabad. Of those audited major reasons identified Haemorhage, Hypertensive disorders and Sepsis.
  - Antenatal care: The ANC registration is almost 100%, but within 12 weeks is around 70%. The 3 ANC check up has increased from 63% (2009-10) to 75% (2011-12).
  - Quality of care in Institutional deliveries: The hospital delivery has increased from 64% (2009-10) to 75% (2011-12).
- JSSK and JSY

- The total incentive under JSY for rural mothers is Rs. 700 (NRHM) + Rs. 300 (State Govt.) totalingRs. 1000 and for urban mothers is Rs. 600 (NRHM) + Rs. 300 (State Govt.) totalingRs. 900. The rural mothers on completion of 3 ANC are given Rs. 500 out of Rs.1000 and rest Rs. 500 is given on hospital delivery. The urban mothers on completion of 3 ANC are given Rs. 500 out of Rs.900 and rest Rs. 400 is given on hospital delivery.
- The JSY payment is made to the mothers on spot in cash for institutional delivery. The payment is regular. The PW who deliver in Govt. hospital and are BPL/SC/ST are eligible for JSY payment. There is no backlog in JSY payment. The JSY incentive is added on with Rs. 300 for institutional delivery being contributed by the State Govt. The JSY beneficiary list was not displayed in the facilities visited.
- State has launched the JSSK program from 15th Aug 2011. Free diagnostic is an issue in the state as only limited free diagnostics services are available in many of the PHCs. There is a lot of out of pocket expenditure on drugs for normal and C- Section. Free diet was being provided in all the facilities. Referral transport services under the Nischay Yan scheme has been started in the state, but the availability of the vehicles at night is an issue.

- Family Planning services: The sterilization services need to scale up. Laparoscopic sterilization is being done in camp mode in OTs of the public health facilities. The motivation level for NSV is less in the community particularly in PM.
- Child health
  - Infant Death Review: No specific steps have been taken by the State for institutionalizing Infant Death Reviews. No Infant Death Review Committees have been constituted in the State. However, infant deaths were being recorded in both the districts. The two major causes of deaths were prematurity / LBW and birth asphyxia.
  - In 2005, there were no SNCUs/ NBSUs / NBCCs in the State. As on 2011-12 the state has established 545 NBCCs, 125 NBSUs and 22 SNCUs and the state targets to raise these facilities to 640 NBCCs, 305 NBSUs and 49 SNCUs by the end of 2012-13 FY.
  - Two NRCs out of 11 sanctioned in Paschim Medinipur are functional. These are in Birpur and Kharaikamathani. They have been recently operationalised from 1st Nov'12. No malnourished child has been admitted so far.
  - Under 5 deaths are still very commonly observed in Murshidabad. Most common causes of death are Pneumonia and Diarrhoea. Over the years the diarrhea cases and diarrheal deaths have also decreased. In 2011, there was no diarrheal death and this year also there is no death reported because of diarrhea. ORS was available in the facilities visited and also with the ASHAs. The ASHAs are aware of the sign and symptoms of dehydration and use of ORS. However, no Zinc tablet was available in any of the facilities visited. Nor there was separate ORT corner in the health facilities visited
  - The ARI cases as reported by the districts have decreased. There has been no reported death because of ARI. Tab. Sulphamethoxazole and Trimethoprim combination was available in all the facilities visited and with the ASHAs. The pediatric dose was available.
  - The mothers who deliver in hospital are home visited by ASHA on 3rd/7th/14th and 28th day if the birth weight is more than 2.5 Kg and 2 extra days i.e. 10th and 42 days if birth weight is less than 2.5 kg. The ASHAs are given incentive of Rs. 175 and the scheme is in place for more than 1 year before the ASHA were given training on 6th and 7th Module. The ASHAs have not received any separate training on PNC or HBNC.

V
DISEASE CONTROL PROGRAMMES - COMMUNICABLE AND NON COMMUNICABLE DISEASES



1 ASSAM

- There has been a sharp decline in the malaria SPR from 3.12 in 2008 to 1.2 in 2011. The state is however now facing a burden of increasing JE cases.
- IDSP Data and Individual Progam Data do not match, making data analysis questionable.
- Under RNTCP, linkages with private facilities are not optimal and the programme information in private nursing homes not being notified.
- NPCB online MIS system has not started though training for the same was conducted in Guwahati.

2 BIHAR

- In the year 2011, the state had recorded three outbreaks - 66 cases of Chikungunya, 915 cases & 211 deaths due to AES/JE, and the last outbreak was that of unknown etiology in Muzaffarpur
- Kala-azar: The state reported 25,009 cases of Kala-azar in the year 2011 with 76 deaths, while in the year 2010, a total of 23,084 cases of Kala-azar were reported. The State is faced with shortage of Kala-azar drug – Miltefosine, but supply from NVBDCP is yet to materialise. The state had also put a demand for RDT Kit Kala-azar.
- Tuberculosis: Mechanism for notification of Tuberculosis needs to be strengthened. The state is also faced with shortage of Drugs for MDR – TB.

3 CHHATTISGARH

- IDSP reporting: There is reporting from block and major hospitals and there is one week turnaround time of reporting of key diseases which are part of the IDSP reporting framework.
- NVBDCP: Dantewada is highly malaria endemic where LLIN distribution and IRS program is on track with VHSNCs monitoring. 181300 bed nets @ 2 per household has been distributed so far. Of the 220 villages to be covered under IRS, 123 covered so far. Due to lack of supply from the Center of Synthetic Pyrethroid, the state had to purchase 100 Mt against the total requirement of 113 Mt. There were approximately 3-5 fever related deaths in each VHSC area but the malaria workers are underutilized.
- RNTCP: The case detection of TB is low though the follow up and treatment / cure rate is satisfactory.

- NPCB: Visiting surgeons have performed 105 cataract operations in Dantewada. In Mahasamund NPCB is linked with school health programme. 457 IOL were implanted during eye operation camps in the district.
- NLEP: Overall, the case detection has increased with 4603 new cases detected during 6 months in 2012-13 as compared to 6999 in 2011-12.
- Non Communicable Diseases: Separate program on sickle cell anemia is being implemented in the state

4 DELHI

- Though all nine district surveillance sites have been established and there is an epidemiologist at the state level, there are several vacancies
- Malaria testing is irregular owing to problems in lack of supply of kits.
- RNTCP is beset by challenges of poorly paid HR, a large private sector unwilling to partner but undertaking diagnosis and treatment on its own terms, and inconsistent reporting across facilities.
- Cataract surgeries under NPCB were primarily being performed in the public sector, with adequate supply of IOL. School level screening for refractive errors and was observed. A vision centre in NE at Old Seemapuri dispensary is an innovation that needs to be further studied for scaling up.

5 KERALA

- Districts are getting information from all public and select private sector health facilities on P, S and L Forms.
- No data of OPD/IPD from AYUSH health facilities, including TB cases coming to AYUSH facilities.
- Sub Centers are the first port of call for detection and monitoring of non-communicable diseases like hypertension and diabetes

6 MADHYA PRADESH

- IDSP: Both S & P unit reporting has decreased in 2011 & 2012. There is no Epidemiologist for analysis and feedback in the District IDSP team
- Malaria : positive cases (91,851) and Deaths (109) have increased in 2011 as compared to 2010 (87165 and 31). 42 posts of DMOs (now designated as DVBDO) are vacant.
- RNTCP: Achievement of targeted Case detection rate and cure rate has improved.
- NLEP: Prevalence Rate and New Cases Detection have increased in 2012. Physiotherapist is available but no Physiotherapy Unit is available.
- NPCB: IOL Operations perfromed are more than the targets during last 5 years.
- AIDS Control Program: Total tests done in 2012 are about double of 2011; where as % of TPR has decreased to 0.43% in 2012 to 0.65% in 2011.

7 MANIPUR

- NVBDCP
- Malaria : The state is one of the lowest malaria endemic states in north-eastern India. The ABER has remained very low Pf percentage is 43.4% in the State. However, three districts are reporting high Pf % (more than 75%). The State API has remained less than one for last five years. Highest API was reported from Tamenglong (2.58) district while rest all were having less than 1 API. The ABER has remained very low and API has remained less than one for last five years: Pf percentage is 43.4% . However, three districts are reporting high Pf % (more than 75%). The. Highest API was reported from Tamenglong (2.58) district while rest all were having less than 1 API. 50000 LLINs have been distributed in the high risk areas in 2010. The programme is affected by the shortfall of MPWs in SCs.
- E/ Dengue: Outbreak of Dengue was recorded in 2007 in a border town Moreh of district Chandel in which 275 suspected cases were examined for Dengue out of which 51 cases were confirmed, but no death occurred; 6 cases reported during 2010 with history of acquiring infection from outside the state. In 2011, an outbreak has been recorded in Churachandpur with 216 out of 747 with 14 cases (10 females + 4 males) and one death due to Dengue Shock Syndrome . The issues of the programme implementation are that Surveillance /Outbreak investigation of AES cases not well organized; Lack of knowledge of systematic documentation of records and reports, lack of timely availability of Testing Kits, systemic follow up of cases, sample transport from periphery not available. Routine JE is yet not started
- NIDDCP : Sample surveys conducted in all the districts showed that in all the districts (except Senapati and Chandel) more than 98% samples were with adequate Iodine content (> 15 ppm).

8 ODISHA

- IDSP : Good recording and reporting of data from 60% reporting units – however analysis of data for use in planning response to epidemics is limited . Shortfall in essential manpower for operational units at all levels and Rapid Response Teams- vacancy of 24 district epidemiologists, 7 districts managers and 5 data entry operators in the state.
- NVBDCP : Considerable progress in malaria control : cases have decreased by 20% and deaths by 30% (2011 Vs 2012 by September). 38 lakh LLINs have been distributed in 21 clusters of 26 districts (around 85 lakh Population protected); cluster approach, distribution and intensive follow up through Gaon Kalyan Samitis (GKS)
- JE surveillance reporting and response time to out breaks has improved.
- RNTCP : Availability of human resources is a major constraint : 78 out of 109 LTs posts sanctioned are vacant. The Programmatic Management of Drug Resistant TB Cases (PMDT DOTS Plus) is currently being implemented in 22 districts of the state.
- NPCB: Only 10% of cataract surgeries are done at public health facilities whereas 90% are being carried out at private hospitals.
- NLEP : State has achieved Leprosy elimination at the state level; however transmission of disease is still active in many districts and pockets.
- NCD : The state has taken up case detection in non-communicable diseases - ASHAs have been provided with glucometer and BP instrument to screen for diabetes and hypertension. All the sub-centres visited

were having the record of the same. And currently screening programmes for Thalassemia, Sickle Cell Anemia is being carried out in medical colleges.

9 PUNJAB

- IDSP : is functional – the surveillance work of IDSP is satisfactory in Moga district and the IDSP unit is working with district administration for e.g in combating an outbreak of cholera reported in Moga in October 2012 with speed and efficiency. District epidemiologist is the nodal officer in charge of surveillance as well as other activities of IDSP in the district.
- NVBDCP : Punjab is endemic for Malaria and Dengue. During 2011 up to September, only 1402 Malaria cases were reported with 22 Pf cases with average ABER > 10% and API is less than 1.3 with no deaths so far. Dengue cases during 2012 up to September, only 433 cases with 9 deaths were reported. Dengue is being monitored in the States with 15 Sentinel Surveillance Hospital (SSHS) throughout the State. Regarding vector borne diseases like malaria, dengue the surveillance activities are below the benchmark for ABER is handicapped due to severe shortage of MPW (Male) but are supplemented by ANMs. At the CHC level, screening for malaria is done and slide positivity is very low (only 5 found positive out of 870 for p. vivax). Urban Malaria control scheme (UMS) is being implemented in Patiala district with the help of 7 MPWs and 38 field workers. Temephos is being used as a larvicide for the treatment of mosquito breeding places and Pyrethrum extract for the control of adult Anopheles mosquitoes in and around Malaria case houses. Vacancies in the posts of State Entomologist (1)and Zonal Entomologists, MPWs(M), and medical lab technicians for several years is affecting surveillance for VBD.State has filled 27 posts of Malaria supervisors. Laboratory service for malaria was found satisfactory in the visited CHCs/ PHCs in the district. Technicians were found trained in malaria microscopy. The microscopes found in the labs were binocular and good. Stains used for the staining of malaria parasite were of JSB I&II and of good quality. Various reports and records of the laboratories were up to the mark.
- RNTCP : At the CHC level, DMCs are functional and 40-50 cases are detected per month on average. All the designated microscopic centres are doing smear microscopy and there is no dearth of lab technicians and lab consumables. Case detection in dist Moga is poor. Less than 75% but cure rate is over 85%.
- NPCB : The performance of Moga district is satisfactory with most cases cataract and it was reported that cataract surgeries have increased over the last year. Eye OPD has 60-70 patients per day, 597 cataract surgeries were conducted in 2011 and 503 in 2012 (Sep -30, October - 54). However, separate beds for eye surgeries are not available. Staff for Opthalmology at DH: 3 Eye Surgeon, Ophthalmic Asst.
- NLEP : The disease is not a major public health concern, only 5 cases have been detected in 2012 in Moga.

10 RAJASTHAN

- IDSP : The State has one surveillance Unit and 34 district surveillance units functional with IT manpower. The State surveillance officer and district surveillance officer and state and district epidemiologists are all in place. All districts are reporting on time Early Warning System (EWS) is in place and is reporting outbreaks. The IDSP data are analyzed at District level every week & the epidemiological situation assessed. Vacancy in epidemiologists in the districts. Weekly reporting of Key diseases done regularly.
- RNTCP : Annualized case detection rate has declined from 172.5 per lakh population to 170 from 2006

to 2011. New Smear Positive Rate (64 %) has remained constant from 2006 to 2011. Success rate for treatment has improved from 85 % in 200 6 to 89 % in 2011Financial Managements guidelines of NRHM are being shared with programme officers. State TB Cell and 34 district TB centres has been established. 825 Microscopy centres established (one in one lakh population and one in 0.5 lakh population in desert areas). 2000 Treatment centres established (one in 15 000 to 30 000 population). 2 culture labs and one DOT Plus centre established.

- NVBDCP Malaria : ABER recorded more than ten during last three years in the state. Surveillance has been found to be satisfactory. The API & SPR of last three years recorded less than one which indicates that low level transmission is being maintained in few pockets/villages and remaining areas are free from Malaria. The post of Zonal Entomologist at Udaipur and state entomologist at Jaipur are lying vacant. In most of the PHCs & CHCs monocular microscopes are still being used for detection of Malaria parasites even though the binocular microscopes were available . Disposable lancet were not used for preparing blood slide .
- NLEP : Prevalence Rate of Leprosy decreased from 0.20 in 2007 to 0 .15 in 2012 (NLEP), the State has achieved elimination level for some years now. (Provisional CBHI 2011) As per HMIS the prevalence rate is 0.16. Prevalence rate at Udaipur is per 10000 and at Sawai Madhopur is per 10000. The district wise annual new case detection rate (ANCDR) at Udaipur is per 100000 and at Sawai Madhopur it is per 100000 populations. None of the districts have a prevalence rate of more than one per 100000 with district having the highest prevalence of and District has the lowest prevalence of 0.23 per 100000 . MDT drugs are readily available at every PHCs/CHC and DHH.
- NPCB : Refractive error and low vision is reported to be second most important cause of visual impairment next to cataract. More than 19.70% of population is having refractive error. They are easy to detect and treatment is easy and cost effective. Out of the approximately 115 lacs students in the age group of 6 to 14, the State has screened 10372031 students against a target of 73,000,00 up to November 2011. (April 2004 to Nov. 2011).

11 TAMIL NADU

- IDSP : online data reporting from all districts, however in newly carved districts district surveillance unit is yet to be established.
- Surveillance related activities for Vector Borne Diseases are being undertaken. JE has emerged as major issues in State in last decade. JE control units have been established in four districts and vaccination is being carried out in the nine districts which report JE cases. Diagnostic centers for JE, Chickengunya and Dengue are functional at 3 regional centers.
- Under RNTCP: case detection is low and MDR TB is a new challenge.
- NPCB: Availability of eye surgeons in the state is an issue, facilities where case load is high a dedicated team can be provided for this. Although NGOs & private practitioners provide a significant proportion of eye care in urban areas the rural areas are still under-serviced. Government health care facilities need to enhance services for eye care.
- Additional programs on NCD screening at the PHCs, Cancer screening, deafness clinics and fetal congenital anomaly detection from CHCs has started in state.

12 TRIPURA

- IDSP: PHCs have surveillance teams of local MO, MPS & MPW, but district IDSP units are yet to be put in place in new districts. Delays in fund flows affect supplies.
- NVBDCP: Inadequate supplies, stock outs and poor quality of RD Kits and expired or soon-to-expire anti-malarials reported by PHC doctors and ANMs. ACT and Chloroquine for EDPT and RD kits was not available even in endemic areas. 40000 LLINs have been distributed is state and a Lot Quality Survey in November 2011 in North Tripura indicates that 70% of the community is using LLINs.
- RNTCP: No patient of MDR–TB has been identified to date. There are no testing facilities in state and the linkage with the MDR testing lab at Guwahati is yet to be made functional.
- NPCB: DBCS organize four eye camps/ month/ district with a focus on cataract screening. As a local arrangement in a DH, patients get spectacles @ Rs. 150 from a private shop.
- National Leprosy Elimination Program: Leprosy elimination achieved in state in 2002.
- NCD: In small pocket of Thalassemics in state, blood transfusion being provided.

13 UTTARAKHAND

- Iodized salt distribution has improved and Cases of endemic goitre have dropped significantly.

14 UTTAR PRADESH

- IDSP online data reporting is above 85 % from all districts, but 6 districts are yet to start reporting due to lack of HR. There is no timely renewal of contracts and no salary increments since 2009, which has discouraged staff working for the program
- NVBDCP: 22 sentinel surveillance labs and 1 apex lab is functioning for dengue. For JE Government of India has approved funds for 10 bedded Intensive Care Unit for Children in 9 highly JE /AES affective districts. Construction of 100 Bedded JE ward at BRD Medical College, Gorakhpur is in progress.
- RNTCP: During 2012, the state has achieved the objectives of 70% NSP case detection and 85% NSP cure rate. Currently 8 districts are implementing Programmatic Management of Drug Resistant TB (PMDT) and 25 districts have been appraised and ready to roll out. At present, 91 MDR-TB patients are receiving treatment in the state
- NPCB: Although, availability of eye surgeons in the state is an issue, during the last 5 years, the percentage of IOL operations among total Cataract surgeries has been more than 98 %.
- Irregular release of funds is a common issue with DCPs such as IDSP, RNTCP & NLEP.

15 WEST BENGAL

- IDSP : Reporting for IDSP is not adequate and complete in both the districts.
- NVBDCP : While in Pashchim Medinipur, API has been coming down from yearly, there has been a recent upsurge of malaria over the last three years in Murshidabad. 60% of all cases of Kala-azar in the state are among the tribals. Two rounds of active surveillance for KA cases over a fortnight have been conducted in all the 11 endemic districts in 2011.
- RNTCP : The annualised new smear positive case detection rate in both the districts are below the

desirable level. However, the cure rate is above 85% in both the districts.

- NPCB : The achievement for cataract surgeries is much below the targets set in both the districts as well as in the State. In 2011-12, of 12.96 lakh children screened for refractive errors, 80592 children were found to have refractive errors. Of these 38, 761 children were given glasses to correct the refractive error.
- National Leprosy Elimination Program (NLEP), the prevalence of leprosy has increased due to active case detection. Last year 2011 it was in 11 blocks and this year 2012 it has been under taken for 18 blocks.
- NCD : Both the National Programme for Control of Cancer, Diabetes and Stroke & National Programme for Health Care for the Elderly were launched in the State in the District of Darjeeling in 2010-11. During 2011-12, Jalpaiguri & Dakshin Dinajpur were included in the programme.

VI
COMMUNITY PROCESSES : PRI, VHSNCS, ASHA, COMMUNITY MONITORING

1 ASSAM

- Training of round 1 of Module 6 & 7 has been completed in Jorhat but modules were not distributed to all the ASHAs. Training is yet to start in Sonitpur district.
- Average monthly incentive earned by ASHAs is within Rs.1000- 1500 with no payment delays. To streamline the payments, state has made it mandatory for ASHAs to submit their claims on or before 3rd of every month and block officers to clear the claims on a fixed date - 10th of every month.
- Various non financial incentives like uniform, cycle, mobile sets, radio sets etc have been given to all ASHAs. A medical insurance and reimbursement scheme – "ASHA Kiron", post cards and a radio programme for ASHAs have also been introduced.
- ASHAs are member secretary of VHSNCs. VHSNC fund is largely being used for water and sanitation activities. However ASHAs from Sonitpur district were instructed to use untied fund for buying weighing machines and BP instruments for VHNDs.
- PRI members are members of RKS in all districts except in Jorhat where they are also the signatory for RKS fund release. Large amounts of unspent balance and low participation of PRIs in RKS were reported.

2 BIHAR

- State has introduced support structures for ASHAs at all four levels but still has to fill up 30-40% of the vacant positions at district and block level.
- In order to expedite the training and ensure quality, state has adopted innovative strategy of combining training of Module 5, 6 & 7 and contracting four NGOs as state training sites. Each NGO supports the ASHA training in its respective region.
- 48% of ASHAs have received training in round 1 of Module 5, 6 & 7 and have been provided with a communication kit. However procurement of the essential HBNC equipment kit is yet to begin in the state.
- Payment of ASHAs is done through bank transfers or cheques and even mobile transfers in one district. However reports of payment delays of three to nine months were reported.

- Cash awards of Rs. 300, 500 and 1000 is given to three best performing ASHAs in each block at the district ASHA sammelan. State has also assisted 1000 ASHAs in enrolling with National Open Schools or IGNOU for completion of 10th grade
- VHSNCs are formed at Gram Panchayat level and about 8224 GPs out to 8478 have VHSNCs. Participation of PRIs in VHSNC, RKS and DHS was reported to be very poor. State has developed a manual and a film for VHSNC training.
- Community based monitoring is being piloted in five districts through PFI.

3 CHHATTISGARH

- Mitanins have been trained in 16 modules, of which modules 14&15 ensured parity with 6& 7.
- State has a detailed data base and a performance monitoring system in place.
- State has undertaken initiatives like – welfare and insurance scheme for Mitanins, dedicated help line for grievances, radio programme and supporting Mitanins in enrolling for ANM schools.
- Helpdesk is functioning at DH and CHC level with 2 full time workers placed on rotation basis.
- Payment to Mitanins was reported to be delayed and insufficient.
- Replenishment of drug kits is an unresolved issue in the state. In Dantewada district Mitanins didnot have Chloroquinine even in areas with API more than 40.
- 19929 out of 20308 revenue villages have formed VHSNCs. VHSNCs are quite active with active involvement of Mitanins in both communiy monitoring and village planning. Key strengths of VHSNCs are systematic recording of deaths and births and monitoring access to health care service on 24 points.
- Village level planning is done by 5 prominent person of a village (Mitanin, School teacher, Secretary of VHSNC, Panchayat member and ANM) under the initiative - “Panch Prayas”.
- Community monitoring has been implemented in Mahasamund district since 2010.

4 DELHI

- State has only undertaken the ASHA component of the entire package of community processes interventions.
- Commitment and motivation levels of the ASHAs were observed to be high despite the fact that in NE district, ASHAs were not paid incentives till date.
- Average take home by ASHA ranges between Rs 1300-1800/month. State pays an incentive of Rs. 500 linked to performance on seven indicators but if achievement is less than 50% for three consecutive months then ASHAs are dropped from the programme.
- Attrition is high, and is due to a mix of voluntary opting out or because the state has dismissed non functional ASHAs based on remuneration
- Pace of ASHA training is slow, and state has just initiated TOT for Modules 6 and 7.
- State has a database and a performance monitoring system, but neither is used for programme planning and monitoring.

5 KERALA

- ASHAs play the facilitator role for NCD and palaitaive care in Kerala. State has proposed training of ASHAs in non communicable diseases module as Module 6 & 7.
- Monthly average incentive is Rs. 1000-2000 per month with an additional Rs. 500/- provided by state.
- Detailed database is maintained in the state but there is no performance monitoring system.
- All 19291 wards have VHSNC equivalent Ward health sanitation and nutrition committee. Participation of PRIs is high in WHSNCs and RKS equivalent Hospital Development Committees.

6 MADHYA PRADESH

- Training of 1st round started in 33 districts and completed in 12 districts. HBNC home visits have also started in these districts.
- Unavailability of RDK and Antimalarial drugs were reported by ASHAs however these were available at district, sub-district and sub-center level.
- State has set up the grievance redressal mechanism for ASHAs but needs to improve the functionality.
- VHSNCs have been formed at revenue village level but the members are not aware of their roles, in fact they expected to receive a remuneration for participation in VHSNC.

7 MANIPUR

- All ASHAs have completed third round of training on Module 6&7 however the HBNC equipment kit had not been provided to ASHAs. This has resulted in reduced retention of skills as ASHAs were not able to utilize and practice the skills.
- Due to sparse distribution of population, state has selected ASHAs at 300-500 population in many areas, these results in low performance based income for ASHAs. On an average ASHAs earn around Rs. 600 – Rs.1000 in six months
- Adhoc payment systems and lack of clarity about ASHA incentives among all nodal officers was also observed. Eg- In Ukhrul monthly meetings of ASHAs were reorganized to quarterly meetings due to lack of transport services. Payments are made on lump sum basis & not as per schedule. Payment for immunization is given at the end of year from VHSNC funds while JSY incentives has not been paid for more than a year.
- ASHA Grievance Committee is in place in 5 out of 9 districts namely Thoubal, Chandel, East Imphal, West Imphal and Bishnupur.
- Non monetary incentives provided to ASHAs include - umbrella, raincoats, radio sets and bicycles in valley districts. A weekly radio programme is aired for ASHAs.
- ASHA facilitators have been appointed through open advertisements on regular salary but they were not clear on their salary amounts even after being on the job for three months.
- 3878 VHSNCs have been formed at village level but due to low fund utilization untied Fund of Rs.6000/- per VHSNC has been approved for FY 12-13.
- NGO Karuna Trust is actively engaged in managing three inaccessible PHCs and PPP for EmONC is

done with Comprehensive Health Services & Research Centre (CHSRC), in Hamleikhong East and Ukhrul Districts

8 ODISHA

- Strong ASHA programme with 458 ASHAs deployed in 11 urban slums areas and additional ASHAs deployed in difficult areas at the level of- one per 100 population.
- Round 1 training of Module 6 & 7 completed in 18 High Focus districts and round 2 is being initiated in these districts. There is no mechanism for training of newly selected ASHAs.
- ASHA Gruha available in DH and SDH levels. ASHA are also given award based on performance at each block level.
- ASHAs receive incentives ranging from Rs 1000 to 5000 or above, with a state average of Rs 1800. Non-monetary incentives include uniform (given annually), cycle, umbrella and ID cards
- District level ASHA grievance redressal committee has recently been setup.
- VHSNCs are in place in 45262 villages out of total 51313 revenue villages. Well established VHSNCs with active involvement of PRIs. Utilisation of untied funds has improved but it still stands at 68%. For the FY 12-13, Rs 7,200 is transferred to VHSNCs. District has prepared guidelines for VHSNCs to assist VHSNCs in fund utilization.
- Pro active NGO involvement, several areas like Mobile Health Units management in LWE areas, logistic support for Modules 6 and 7 training; GKS training etc.

9 PUNJAB

- ASHAs have been trained in Round 1& 2 of module 6&7 for HBNC however, HBNC kit is yet to be provided. ASHAs have started making HBNC visits.
- ASHAs are paid incentives for a total of 26 activities by the State. Payment is done directly into accounts of ASHAs but most ASHAs complained of delays in payments lasting for months (as long as 9 months) and cited this as a major demotivating factor.
- State has provide uniforms to ASHAs however in some areas ASHAs expressed need for winter uniforms due to extreme temperatures.
- No proper channel existed for grievance redressal.
- PRIs are found to be involved in VHSNCS and are also taking interest in the community level activities. ASHA was convener of VHSNCs and for VHND activities.
- VHNSCs need to be further oriented and strengthened to carry out regular monitoring of health facilities and VHNDs through a systematic monitoring system.
- Mother NGO scheme is extended to 17+1 out of 20 districts of Punjab. MNGOs, Field NGOs have worked in underserved sub-center area and slums, providing RCH services to about 5,00,000 population.
- In addition SNGOs in district Amritsar, Ludhiana, Gurdaspur and Pathankot are catering to underserved population in slums, targeting about 1.5 Lakh of population.

10 RAJASTHAN

- Training of round 1 of module 6 & 7 is completed by 46% of ASHAs. However the HBNC kit has not been provided to ASHAs.
- ASHAs manage an income between Rs. 1500 - 2500 which includes the monthly honorarium of Rs. 1100 from WCD. Delay in payment extending up to 2-3 months was observed in District Sawai Madhopur.
- State has set up a help line 104 for registering complains about non payments but the awareness about 104 was found to be poor among the ASHA.
- 43440 VHSNCs have been constituted at village level but meetings were reported to be irregular. In case of more than one ASHA in a village, the incentive of Rs.100 for holding VHSNC meeting is paid to every ASHA in rotation on alternate months.
- Community Monitoring process was carried out in 180 villages, 36 PHCs and 12 blocks of four districts Alwar, Chittorgarh, Jodhpur and Udaipur in the first phase.

11 TAMIL NADU

- In the first phase 2650 ASHAs were recruited in tribal areas of 12 districts. In second phase 4200 additional ASHAs were recruited for malaria program, for home based new-born care and for Leprosy and blindness control programs.
- Training in module 6 and 7 and relevant training for program specific ASHAs such as blood smear collection, IEC, fever surveillance and HBNC is underway.
- VHSNC known as Village Health Water and Sanitation Committee were found to be active. 12618 VHWSCs are in place at gram panchayat level in the state. VHWSCs were trained with the help of SHG/ NGOs on maternal and child health and on the rights and responsibilities of people.

12 TRIPURA

- ASHA trainings have been quite regularly done and 7009 ASHAs are trained in round 2 of module 6 & 7. However, some ASHAs informed that they did not take the weighing machines as it was given to them without the baby sling.
- State government has recently declared 33.33% additional amount for every performance incentive to ASHA from state funds.
- Some common problems highlighted by the ASHAs related to: delayed payment of Incentives, informal payments at facilities, ill-treatment by some staff of the facilities and non-receipt of SMSs under MCTS etc.
- Involvement of PRIs in various bodies like VHNSC, RKS, DHS, etc is strong. PRI representative are chairpersons in Governing Bodies of RKS and DHS.
- VHSNCs have been formed at level of Gram Panchayat in all of 1038 villages (GPs/ADCs). State has also conducted trainings of VHSNC members.

13 UTTARAKHAND

- Uttrakhand is one of the only states where State and district ASHA resource centres are being managed by NGOs.

- Training of ASHAs in three rounds of Module 6 &7 is near completion in the state.
- Average Monthly income of ASHAs is Rs 800-1000 but payment delays of up to 2 months were common.
- Convergence between Health and Rural development department i.e, untied funds for VHSNCs are transferred to Rural development department which manages the VHSNC in the state. However VHSNCs are not very active in the state.
- Community based monitoring is implemented through AMS in the district of Pithoragarh. About 96 Jan SunwayiDiwas (JSD) have been held in Pithoragarh.

14 UTTAR PRADESH

- Training for Modules 6 & 7 are yet to take off in the state, although ASHAs in 17 districts have been trained under the Comprehensive Child Survival Program (CCSP).State has adapted Module 6 &7 to eliminate duplication with the contents of training of CCSP. Training in the adapted module will be done in phases i.e, first phase will include 17 districts where ASHAs are trained in CCSP.
- There is no ASHA Resource Centre but a team of three professional consultants led by General manager community process manages the programme.
- 3000 ASHAs have been selected against 6000 drop outs but are yet to receive training.
- ASHAs contribute largely towards the RCH program and were found reluctant to work for the disease programs due to delay in payments.
- Average monthly incentive range between Rs. 1,000 to 4,500 per month, depending upon their population coverage, which ranges from 700 to 3,000.
- ASHA database has been prepared for 62 of the 75 districts and uploaded on the state NRHM website. No formal mechanism of performance assessment is done but ASHA's performance is judged from the payment pattern.
- VHSNCs are formed in 51914 villages out of total 52002 villages. PRI representatives actively participated in VHSNC meetings but their participation in RKS is poor. There has also a problem in transfer of funds - the cheques from NRHM are drawn in favour of VHSNC, while the account are still in the old name of VHSC. Two days awareness training of about 30% of the VHSNC members was conducted in 2008-10.

15 WEST BENGAL

- About 33% ASHAs are trained in Round 1 of Module 6 & 7 and 21% in round 2.
- State has initiated - Receive Only Terminal (ROT) which is a one way satellite communication with live sessions being conducted at the State level. A radio ASHA Talk show is aired every Wednesday on All India Radio (AIR) and FM Rainbow.
- E-payment has also been introduced throughout the State. However, in both the districts visited there was a delay in payment of incentives of up to 6 months.
- VHSNC has been formed at Gram Panchayat level but it is not quite functional. The funds of the VHSNCs are transferred to the Ministry of Rural Development however PRIs were completely unaware of the NRHM funds given for VHSNCs.
- RKS have been formed at all the facilities but are not registered as a society under the Societies Registration Act and have an account under the Block Health and Family Welfare Samiti.

VII
PROMOTIVE HEALTH CARE, ACTION ON SOCIAL DETERMINANTS AND EQUITY CONCERNS

1 ASSAM

- The state currently has four NRCs and is soon planning to expand it to six more at district level and add fourteen at the block PHC and CHC.
- There are very few instances of convergence in the district.
- The School health program is rather weak and the state is yet to include pre-school population in the existing program.
- Linkages with School health programme and the national disease control programmes.

2 BIHAR

- BCC continues to be a stand-alone activity. There are no rigorous evaluations of BCC campaign impacts, and most development partners work in isolation with little or no sharing with other stake holders.
- State reportedly has large number of SAM children but does not have the adequate capacity to treat all of them. The main reason is that the facility based management of SAM through NRCs though effective but is facing challenges of high bed occupancy.
- There is need for IEC to improve sanitation and hygiene practices, and inter sectoral coordination for provision of safe drinking water.
- About 1,52,40,033 children were screened in school health camps during FY 2011-12. However there were no follow ups done after these camps.

3 CHHATTISGARH

- There is good convergence at village level through medium of VHSCs. Mitanins are active in drinking water issues and playing an important role in reaching the community.
- In Mahasamund, seasonal health camps are organized for migratory population jointly under NRHM and NACO and specialized services are provided.
- Adequate bed occupancy in NRCs was noted. Most of the cases of malnutrition are referred by AWWs with the help of Mitanins, Incentive also paid to Mitanis as per number of follow up visits.
- In Dantewada, the main focus of School Health Programme is of having a Doctor/RMA assigned to

every residential ashram school.

- Financial assistance from Chief Minister Funds provided to school children requiring major surgeries.
- Co ordination between health and Panchayat department for analysis of birth and death reported is weak.

4 DELHI

- At the field level there is effective convergence of ANM and ASHA with the AWC, and quarterly convergence meetings were reported with the Gender Resource Centres (an initiative of the state government), ICDS (CDPO/Supervisors),Health (MO) and NGOs.
- Water and sanitation is under the management of the MCD, with little involvement of the health department in promoting effective sanitation measures.
- Reaching the vulnerable remains a key challenge despite state level action such as appointing ASHAs in these areas, setting up infrastructure and human resources.
- School Health Melas are organised in collaboration with the Education Department.
- There are no mechanisms instituted for social accountability and the District planning and Vigilance Committees are just being established.
- Overall the North East district fares the worst and has had the last attention from the state (seven monitoring visits versus 53 in the South West district).

5 KERALA

- More than 40 % schools have been covered under School Health Programme.
- There is robust Civil Registration System in the state.
- Alappuzha District has initiated against substance abuse amongst school children – Vimukti.
- School Health Programme needs to be structured as per GOI guidelines. NRHM Quiz competition involving School children is a good practise.
- Palliative Care clinics and out- reach activities are models worth emulating .
- State has a separate Water and Sanitation project for utilizing backwaters where supply is done after Reverse Osmosis treatment.

6 MADHYA PRADESH

- State has established the largest number of NRCs in the country. Aganwadi workers are identifying malnourished children and sending them to NRCs.
- Ultrasound machines have been installed with silent observer to prevent sex selective abortion but this needs to be backed up with legal prosecution of the violators in court of law.
- The pace of implementation of school health program is slow.
- Coordination between ICDS and Health departments with AWW providing the due list of children.
- Coordination with other departments is nonexistent as there is no such need felt at the field level. Water and Sanitation is a missed opportunity in the field. Social audit is not practiced.

7 MANIPUR

- State has made efforts towards PCPNDT Act by enrolling private service providers, though there of few only. As a social norm, people do not go for abortions, a limited trend is being seen in urban areas.
- The village chief holds the authority for facilitating implementation of all the development programmes and health department has good coordination with all of them.
- State has been holding planning exercise from village upwards for last two years.
- The school health programmes are continuing but needs to be strengthened further.

8 ODISHA

- Unique mechanism of coordination between Health and Women and Child Department in the Mamta Cash transfer scheme have been implemented for health and nutritional support to mothers
- Sarpanch from tribal population is the convener of GKS.
- 16 NRCs functioning but with relatively low effectiveness on account of unavailability of dedicated staff. Fortnightly screening and referral of severely underweight children on Pustikar Diwas at the CHC level is an innovation but lack of awareness and non-functionality of AWW is an area of concern.
- State has made sincere efforts for PCPNDT Act implementation. Complaint registering mechanisms have been established with a toll free number and an online complaint registering system is available on the government's website.
- State has initiated Gram Sabha Sasaktiran Karyakrama campaign to disseminate messages on scheme entitlements of the community.
- School health coverage is 60% but dedicated teams as per norms are not in place.
- Gender and Equity Cell with an Equity Advocacy Manager is functional under DoHFW, with funding from the NRHM.
- Differential financial allocations have been made and extra 34% is provided to high focused districts since 2010.

9 PUNJAB

- Effective convergence with education, WCD and Water and Sanitation is noted. Special campaign for treatment of Rheumatic Heart Disease, Congenital Heart Disease, Cancer and Thalassemia among School going children has been initiated.
- Panchayat showing sex ratio more than 1000 for 4 consecutive years are rewarded Rs. 1.5 lakh each for carrying out developmental activities in the villages.
- Huge financial awards are provided for undertaking sting operations or to informers to address sex selective abortions.
- ANM has been designated as registrar of births and deaths till one year of age which has strengthened the registration system.

10 RAJASTHAN

- The declining child sex ratio (883, Census 2011) is a cause for concern. The PCPNDT act is being implemented in the districts and appropriate authorities have been appointed, however conviction rate of cases is poor (2 conviction out of 469 complaints filed). Rajasthan Medical Council has suspended registration of 21 doctors pending trials.

11 TAMIL NADU

- While good convergence was observed with ICDS and Panchayati Raj but convergence with Water & Sanitation needs strengthening.
- State has well- functioning modified school health program with a dedicated MO.
- Sex Ratio is good across districts.
- Birth civil registration has improved in the State.
- IEC/BCC efforts need to be strengthened in the State.
- Under PC-PNDT, a committee is formed at state and district level and 71 cases are currently being prosecuted. Form-F which is a legal requirement is not filled at all in the facilities.

12 TRIPURA

- PRIs are playing an effective role in health issues but quality trainings need to be planned for their enhanced involvement in planning and monitoring of health.
- IEC/BCC strategy is mostly confined to printing information leaflets and display boards at strategic places which is very less at community level.
- Coverage under School Health Programme is low (approx. 30%).
- Mid-day-meal implementation is good and eggs are given twice a week.
- A positive initiative to improve access in a tribal area was observed with PHCs being established, much below the population norm.
- No Nutrition Rehabilitation Centres have been set up. At present, such children are receiving Double Ration in AWCs and are referred to nearest facilities.
- PCPNDT Committees are in place and meet quarterly. A team consisting of Representatives of District Magistrate, Chief Medical Officer and Ultra sound Technician inspect the units. Besides, CMO is authorized to conduct monthly check and report.

13 UTTARAKHAND

- Convergence with ICDS, Education department, civil society organization was found to be missing. RKS, DH Pithoragarh was having no member of civil society on board ANMs and ASHAs were not aware of drugs available with ICDS workers.
- Convergence for functioning of VHSNC between Health and Rural Development department was reported however VHSNCs were not very functional.

- Nutrition Rehabilitation Centres were not available.
- District Vigilance and Monitoring Committee is not formed.

14 UTTAR PRADESH

- Under PCPNDT, only few clinics were reported to be submitting proper reports.
- Proper scrutiny and analysis of submitted forms were not being undertaken.
- NRCs have been established but linkages for referral and identification are weak and almost no follow up of patients is done after discharge.

15 WEST BENGAL

- Monthly convergence meetings are held at the block and district level.
- Nutrition Rehabilitation Centres are not yet operational in the district.
- The number of Ultrasound machines is 75. There are 12 Portable machines and 63 fixed machines.
- No IEC or BCC activities and monitoring of PCPNDT Act is being undertaken.
- Excessive arsenic in drinking water poses a major threat. As per the WHO norms - 10µ/l of arsenic content is permissible but the state has raised it to 50 µ/l as 'safe'. 5.3 million population is already affected from the arsenic in 4 districts Murshidabad, Nadia, Malda and South Parganas. Immediate action is needed by PHE and health department on this issue. Alternative water sources, supplying field kits to measure concentrations and promoting deep tube wells below 200 meters are needed.
- Equipping ASHAs and members of VHSNC with the knowledge on the health problems due to arsenic would help in promoting awareness and early identification of signs of hazard if any.

VIII
PROGRAM MANAGEMENT INCLUDING LOGISTICS, INTEGRATION AND INSTITUTIONAL CAPACITY

1 ASSAM

- There are around 1692 programme management personnel at state, district and block levels. However the system of monitoring is largely on ad hoc basis.
- No system of facility monitoring to ensure quality of service delivery.
- HMIS data is entered but not analyzed at any level. It has also been observed that data reported by the state in HMIS does not always match with the data sent by state to the GoI separately.
- Planning process at district and block level is not participatory and is mostly format based with real demand from the facilities not being included.

2 BIHAR

- SPMU and DPMUs are functioning well in the state, however, involvement of district level programme officers is not adequate and uniform.
- A large number of contractual posts are vacant, since these are earmarked for the reserved categories. Hence, it is proposed that SHSB may seek approval of appropriate authority for filling of reserved vacancies with suitably qualified general candidates, if repeated efforts have not resulted into filling of vacancies.
- It was observed that 1384 Medical Officers under AYUSH stream of medicine have been appointed at APHCs but these doctors are not practicing AYUSH stream of medicine due to non-availability of AYUSH medicines and required infrastructure.

3 CHHATTISGARH

- DPMU and BPMUs are functional in both the districts. DPMU has been given dedicated space at district. Both districts conduct the monthly meeting of block level officers to provide feedback on the block performance. There is good coordination among DPMU, Mitanins and NRHM Officers and RCH Officers.
- Lack of clear HR policy for career progression of NRHM staff. There is no grievance redressal cell at district level for NRHM staff. However an appraisal system is in-place at the sub block level for NRHM staff (RMA, Staff Nurse etc).

- PMU doesnot have any role in field supervision except the DPM.
- Procurement of drugs and equipments is a critical issue in the state with inadequate supply, not responsive as per the utilization pattern. Districts do rate contract based on competitive prices centrally to purchase essential drugs due to short supply from state. Untied funds of SHC and RKS are used respectively by ANMs and PHCs to purchase essential drugs.

4 DELHI

- Health department officials head the SPMU and DPMU. Directorate of Family Welfare and Directorate of Health Services are responsible for RCH and disease control programmes respectively and SPMU primarily concentrates on Mission flexi-pool activities. This appears to lead to better integration between SPMU / DPMU and the directorate.
- MCD or Central Government (for facilities and services provided in the NCT) are represented on all NRHM institutional structures, but have no co- convening or executive role.
- 45 out of 76 positions at SPMU are vacant while post of DPM is vacant in one district.
- State level monitoring and follow up particularly in the poor performing and challenging districts is weak.
- Frequent change in Mission Directors affects programme functioning, especially as all authority is vested with the Mission Director's office and the CDMOs (at the district level), leading to long delays in decision making.
- Although MCD accounts for provision of a significant proportion of service delivery, there is little attempt for joint planning, monitoring and supervision.
- State has had a central procurement agency in place for 15 years and has recently introduced a system for better management. Some gaps are evident, but overall the system functions well.
- Medicine procurement is not computerized at facility level, affecting the accuracy of the consumption pattern and demand forecasting resulting in supply gaps.

5 KERALA

- State Programme Management Units have regular staff. Doctors are on deputation as DPMs and Block Programme management Unit is not adequately functional.
- Government has issued orders for recruitment of more Doctors and support staff.
- Gaps in the supply of drugs were noticed Eg- in District Hospital Thirur drug supply was less than the requirement.

6 MADHYA PRADESH

- All the programme management structures (e.g. State Health Society, District Health Society, Rogi Kalyan Samiti etc.) are in place.
- State Drug Management Information System (SDMIS) is working well with extensive online search options in 50 district hospitals, 59 civil hospitals and 333 CHCs.
- Job TORs are not defined for DPMU and staff shortage is severe.

- State Public Health Procurement Corporation has been approved by state to handle drug and medical equipment procurement. There is availability of drugs with reasonable shelf life and any shortage of drugs occurred is dealt promptly. Store keepers at facilities have not received any store keeping training. Some instances of supply shortfall due to delayed delivery of high turnover drugs indented against the central rate /TNMSC rate contract. Supply of reagents was found to be a problem leading to decreased range of lab services available to beneficiaries.

7 MANIPUR

- SPMU and DPMUs are functioning well in the state, however, involvement of district level programme officers is not adequate and uniform.
- The planning process gets initiated from sample village every year with people's participation. There after the block planning process incorporates the outcomes of village plans. A similar exercise of incorporating block plans into district plans takes place and finally states plans considers inputs from all the districts. This planning process required more clarity on the contents of each programme under NRHM both at the state and district level
- Governing body meeting are held annually. There is a need for structured field monitoring system in place at state and district level.
- The state programme management unit is properly setup and functioning well but the DPMUs need to be strengthened.

8 ODISHA

- State has initiated a good system for integration with the Directorate. The technical officers from respective Directorates provide advisory support to strategize and develop technical designs.
- Odisha has a large State Programme Management unit staffed with 2556 Staff. There are 27 % vacancies at SPMU, DPMU and BPMU levels with maximum vacancies at the DPMU and BPMU levels. Job description/TOR is available for all the PMU staff.
- State has a structured system of training of program management staff through on-job training, management development programs etc.
- Governing body meeting are held regularly. There is a structured field monitoring system in place at state level but it needs to be replicated at district and block level.
- For quality check, Drug Testing and Data Management System software has been developed. Similarly to ensure effective supply chain management, Drug Inventory Management Process (DIMS) is being used. At the district level a full-fledged network exists to look after the logistics & supply chain issues. DMIS and Pro MIS are used at district and state level. State needs to ensure that there is no duplication of efforts.

9 PUNJAB

- The State and district program management units are functional, with good coordination with Directorate of Health.
- Reviews are made only at district Head Quarter level. At block level no Block Programme Manager is present but accountant, statistical assistant and computer operator are in place.

- Punjab Health Service Corporation is the nodal Agency under the Health Department for procurement of Drugs, Equipments and Logistics and construction of the Health facilities. There is no system of supply of Drugs to the facility on basis of case load or Pass Book system. Drug Availability at the facility and their indenting system is not systematic and there is no district warehouse and ProMIS at the district level.
- Institutional mechanism of timely construction and handing over of infrastructure is under Punjab Health Service Corporation. However, at the district level poor quality of infrastructure and its maintenance and long pending construction could be seen during the team visit.
- There is no regulatory mechanism for the private sector and no system in place for clinical establishment.

10 RAJASTHAN

- District health societies are well established. District Health Mission meetings are conducted regularly.
- Contractual positions like DPM/BPM are vacant in many places.
- Participation of programme managers in the visited facilities was observed to be poor.

11 TAMIL NADU

- NRHM activities are managed by regular staff, no additional contractual staff hired
- Robust supportive supervision in the state at all levels.
- State has one of the best drug procurement and distribution systems, functioning very well for AYUSH also. The State has legal support in form of an act to guide all procurement process.
- There is requirement of one DPM to coordinate with both the directorates and also help implement NRHM activities. Additionally Data Entry Operators and Accounts Manager are required at district and block level.

12 TRIPURA

- Integration between SPMU/DPMU DHFW is very good. But DPMUs and Sub-divisional PMUs need strengthening in the newly created districts. Technical component in SPMU needs strengthening.
- Supervision and monitoring schedule has been made by SPMU and DPMUs.
- Gaps in drug supply were observed. Most of the Medicines, Medical Equipments and General Items are procured through open national bidding. Though three drug houses were sanctioned only one has been constructed. Procurement Management Information System (Pro MIS) has been introduced in the state.
- Regulatory system for registering and ensuring quality care in private health facilities through clinical establishment act is in place.
- State is doing facility based reporting for all the facilities, though data entry is done from the block - CHC level.

13 UTTARAKHAND

- SPMU and DPMUs are in place but capacity building of DPMU staff needs strengthening.
- There is a lack of delegation of powers to program management staff.
- Most staff positions are vacant which need to be filled.
- Block Program Managers only do data entry for MCTS.
- Procurement is being done both at state and district levels and even block level e.g. for JSSK entitlements.

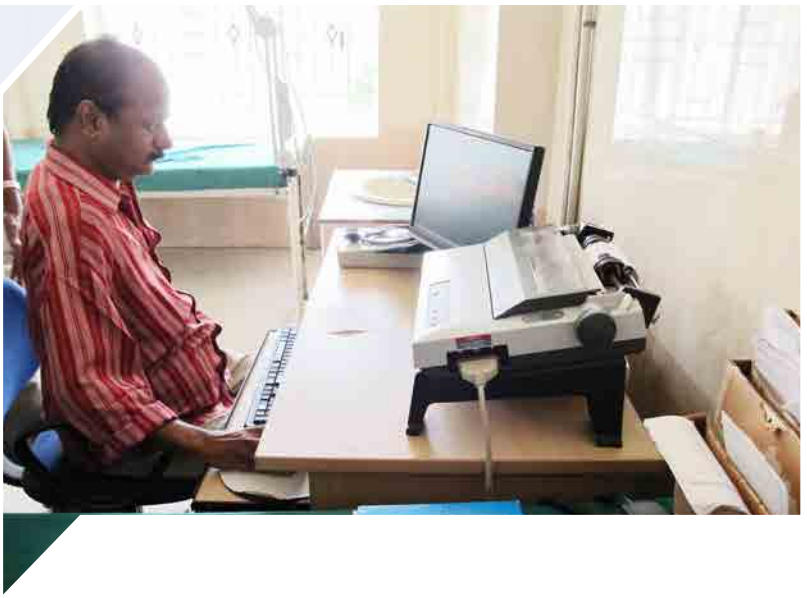
14 UTTAR PRADESH

- The structure of the SPMU is being strengthened and this year 18 new cells have been formed. Most of the position of the General Managers have been filled from officers 'on deputation'
- Out of 75 DPMUs, only 52 have DPMs, 43 have District Account managers (DAM) and 47 have District Data cum Account Assistants (DDAA). Overall, there are 100 vacant posts under DPMUs and most of the vacancies are there since 2008. At BPMU level 293 BPM and 75 BDAA posts are vacant.
- At the State level, the estimation of quantity of drugs is done on a normative basis for each level of facility. Rate Contract (RC) for different types of drugs is fixed by the State and the district level procurement of drugs is done. Inventory management system is not computerized at district and facility level. ProMIS implementation was not seen in any of the facilities visited..

15 WEST BENGAL

- SPMU and DPMUs are functioning well in the state. There are regular meetings of program management staff at both state as well as district level. There is no integrated monitoring team. Attrition rate in DPMU and BPMUs is negligible.
- No human resource policy at District or Block level for ensuring career progression.
- Capacity building efforts are not sufficient and only one round of training has been given to the DPMU.
- SPMU reviews HMIS data and provides feedback to DPMU however this is not done at DPMU and BPMU level.
- Procurement of some drugs and equipments is done by West Bengal Medical Services Corporation. Majority of drugs and equipments are procured through Central Medical Stores (CMS) at provided rates and empanelled vendors. Procurement of drugs and equipments based on this list does not require any tendering by the District. However for procurement of other d
- A Store Management Information System (SMIS) is operational in the state.
- Construction wing has been introduced in DPMU since September 2010 to facilitate completion of construction and timely hand over.

IX
KNOWLEDGE MANAGEMENT: SIHFW, SHSRC, TRAINING, TECHNICAL ASSISTANCE AND USE OF INFORMATION



1 ASSAM

- SIHFW is present at the State level providing the major training assistance. It is involved in conducting, evaluating and monitoring of trainings.
- SIHFW has set up a MCH Cell in collaboration with UNICEF.
- The ANMTC at Sonitpur has been newly constructed.
- Jorhat district has ANM, GNM and RHP training institutes. The ANMTC has taken no batch of ANM since 2007 due to legal case. GNM institute takes in fresh batch every 3 years and not annually. The institute lacks training aids and audio visual equipments.
- MCTS data is being entered at different levels; however it is not utilized by block / district officials for follow-up. There were also instances of missing and duplication of User IDs.

2 BIHAR

- The District Health Ranking system has been introduced on some of the key indicators which is a good initiative to ascertain the performance of different districts on monthly basis.
- ANMs reported not receiving any micro plans made by the MCTS software. ANM needs to fill the data on an MCTS formats and MCTS register at the sub-centre which are then uploaded by the Data entry operator at PHC level. The forms are then returned to the ANM with the 18 digit registration number for the beneficiary. It was however seen that many of the forms that were sent back to the sub-centres did not still have the registration numbe.

3 CHHATTISGARH

- SHSRC is functional in the state and playing important role in implementation of Mitanin programme and VHSNC.
- Infrastructure of SIFHW is satisfactory but it is not functioning as per the requirements and there is no leadership by SIHFW at the district level.
- UNICEF coordinator supports the monitoring and supervision for leprosy and malnutrition initiatives at district level.

- In Mahasamund CINI is providing support in training and programme management under Shishu Suraksha Maah (SSM) and Nutrition Rehabilitation Centers (NRCs).
- Facility based reporting is operational in state but the use of data for corrective action is limited.

4 DELHI

- State has no dedicated state level training/technical support institutions (SIHFW, SHSRC). All RCH training is coordinated by a Health and Family Welfare Training Centre, funded by the GOI, but this has a limited role for other training needs.
- District Training Centres are no longer functional now.
- Bank account of HFWTC has been closed by state officials, leading to delays in rolling out the smooth trainings in the state.
- USAID has provided support to Mission convergence on IEC materials for WASH education for communities under its HUP program.
- State has developed an integrated web based software system based on GIS mapping, which is soon to be rolled out.
- Use of information from HMIS & MCTS for planning and programme monitoring and management is limited. However out of 407 sub-centres on HMIS only 41 exist and the rest are created notionally to capture field data. State faces constraint regarding streamlining the data uploading from varying agencies
- Data on various indicators is collected through available RCH registers in the facilities but it is not being vetted by authorized signatories.
- Lack of dedicated “data entry operator” for HMIS & MCTS at District Hospitals is also a matter of concern.
- State has also proposed to grade the facilities and districts on the basis of HMIS data. Tracking is less effective where ASHAs are not involved.

5 KERALA

- Mismatch between HMIS data and MCTS data was observed at the state level however at the PHC level no mis-match has been observed.
- Lack of capacity for analysis of HMIS data for planning, programme monitoring and management.
- Up-dation of data in the MCTS web portal and utilization for tracking of service delivery is a challenge.
- Telemedicine unit established in Malappuram but it is not functional because of lack of staff.

6 MADHYA PRADESH

- The infrastructure at SIHFW was excellent and the In-House faculty is adequate. Currently the joint director division is also holding Director SIHFW’s post. There is need to give more autonomy for SIHFW on lines of NIHFW.
- No post training follow up is being undertaken by DHFWTC or SIHFW in the field.

- Mandatory participation in training/refresher courses for the service providers at pre-decided intervals needs to be worked out.
- Data entry in Pro MIS was not being done since last 20 days. The matter needs to be taken up by State/ Regional office with EPW in MoHFW for making it functional.

7 MANIPUR

- There is no central training plan with no training need assessment & post training supervision / follow up being done.
- Thus most of the trained staff are not posted appropriately and not utilizing the skills gained from their training.
- State has an urgent need for training in NSSK and child health services in facilities conducting deliveries.
- Though discrepancies in HMIS data were observed validation of HMIS Data is not institutionalized.
- Supervisory visits from State and District Officials to the health facilities need to be strengthened.

8 ODISHA

- SIHFW has been restructured into a Centre of Excellence for communication with well equipped facility and trained manpower for health communication.
- Most of the core clinical trainings are outsourced to the Medical College and SIHFW is conducting mostly non clinical training and some FP training.
- State has substantial support from international technical agencies like DFID, UNICEF, NIPI and UNFPA. Mapping of areas of technical support is done by the agencies, but there is much overlap in this .
- Despite large presence of donor partners, there is no district specific comprehensive ownership of any Donor Partner for building the capacities of the districts resulting in weak managerial capacity of the districts in planning, implementation and monitoring.
- State Health Systems Resource Centre (SHSRC) provides overarching support to NRHM and Directorates in development of PIPs, monitoring and data analysis, systematizing trainings, and developing guidelines. SHSRC members are often involved majorly in implementation and day to day management of the programme, diverting them from their domain area of policy support and building
- Facility wise data entry is being done. Irregular internet connectivity at the block level is a constraint in timely entry and updation of data. Analysis of the HMIS data within the district is done through the data validation sheet innovated by the state.
- Functioning of MCTS is better at the block level than at the higher level.
- Use of information technology for health is well adopted by the state. Several soft wares for Data management is in use - HRMIS for HR management, OVLMS for drug logistics , CPSMS for finance; online SNCU application is functioning in 21 SNCUs (also in Bolangir).

9 PUNJAB

- SIHFW plays the key role in formulation of training plan and its implementation and monitoring.

- Training of EMOC is yet to start but LSAS training is underway however, the performance of the trained doctors at FRU level was reported to be poor. The status of the training of the SBA, MTP etc is not satisfactory.
- Minilap training and Laparoscopic sterilization training is also yet to start.
- Training of NSSK, IMNCI and FIMNCI is poor in the State.
- Community processes including ASHA programme is monitored by SHSRC.
- Data entries for MCTS started since December 2010. ANMs are using generated work plans for service provision. However, data entry needs supervision to increase accuracy. Internet connectivity is a great concern for data entry
- District health officials need to be sensitized and ANMs need to be given a refresher training.

10 RAJASTHAN

- District training centres are yet to be made fully functional. ANMTC buildings at districts are not being used to full potential (ANMTC at Sawai Modhopur was being used temporarily as a drug store and in Udaipur students were found to be staying outside due lack of basic amenities at the ANMTC). Faculty positions at ANMTCs were being filled through deputation from regular ANM and GNM cadre who were not trained in teaching students.
- State has active presence of NIPI, UNICEF, UNFPA, IPAS and JHPIEGO.

11 TAMIL NADU

- State has adequate training institutes at region, and district with a strong system to follow-up.
- State has strong IT-based information systems and is in process of developing State health data resource center in line of health information exchange.
- Five studies/ surveys have been conducted in the State post NRHM and findings are used for strategizing the activities.
- Various IT applications, with one application for each program been designed. However these systems are not inter-operable and users have to enter same data in different systems. There are also multiple forms in the reporting systems which need to be reduced.

12 TRIPURA

- SIHFW for the state has been sanctioned and construction of building is underway.
- Training Programmes of service providers are ongoing but gaps exist.
- Regional Resource Centre for North East (RRC-NE) provides technical support for developing state plans and SPMU provides support for district level planning.
- State is reporting facility based data on web-portal but huge challenges in internet connectivity were reported. Data entry is done at sub-divisional level.
- Data entry of MCTS faces difficulty because data errors are quite high in data reported from ANMs and ASHAs. Dates of LMP / EDD are reported in local calendar. Printed MCTS registers have not been provided in some of the facilities.

13 UTTARAKHAND

- SIHFW is under construction.
- SHSRC has only two staff, data entry operator and documentation officer.
- Facility wise data is uploaded but data entry is incomplete. Two days training for HMIS was given last year but there is poor knowledge of data element. The data is not used for planning and decision making to improve the health services.

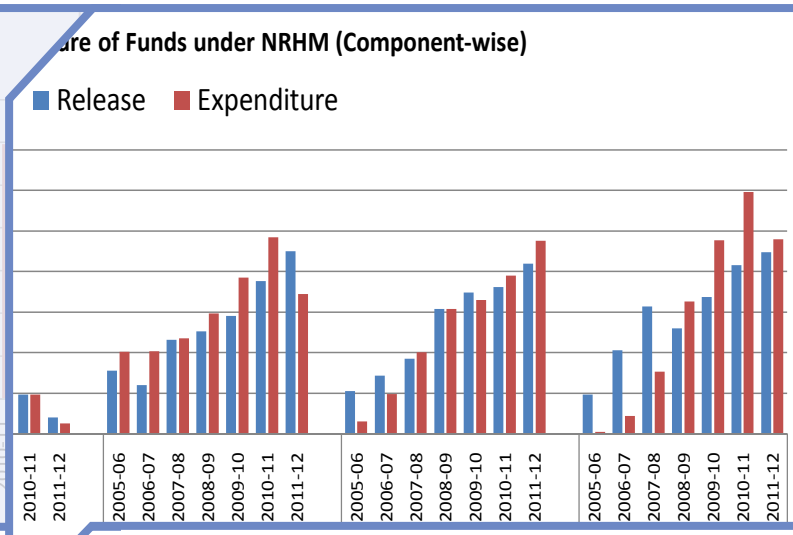
14 UTTAR PRADESH

- SIHFW provides technical support in preparation of comprehensive training plan of allotted trainings, but SIFHW, RIHFW, NRHM Directorate/ Health and Medical Directorate conduct different trainings independently and training achievements are low.
- District training infrastructure is not available and no residential facilities available except at SIHFW. There is vacancy of 9 out of 15 faculties in SIHFW.
- SIHFW /Directorate/NRHM worked in partnerships with project driven trainings – UNICEF, WHO, Manthan, Intra health, The PATH, etc. Partnerships also exist with Medical Colleges for Clinical Trainings.
- ANM training Schools are less utilized and not all 40 are functional.
- There has been an inordinate delay in setting up of the State Health Resource Center, although approval and sanction of funds has already taken place.
- All the districts started reporting on HMIS portal in 2009, but districts are yet to initiate feedback system to the facilities based on the monthly reports.
- Monthly feedback is sent to districts by SPMU on reporting quality, however, use of data at district level was minimal. State has facility based reporting but only 10 districts have started uploading facility wise monthly reports.
- Online feeding on Mother Child Tracking System Portal was initiated in July 2011, however, data entry of only 45.7% pregnant women and 29.6% Children under MCTS is completed in the state. Appointment of data entry operator for MCTS for 820 blocks of UP is pending.

15 WEST BENGAL

- SIHFW have adequate number of faculties and also involves state trainers/ state officials/ experts in different disciplines when required.
- At the State level, Regional Resource Centre, CINI is working as the State Training Centre. Usually the training outcomes are evaluated by use of pre- and post-exposure questionnaire.
- World Health Organization (WHO) is supporting the District in Acute Flaccid Paralysis programme for polio eradication and technical monitoring of the RNTCP while UNICEF has provided training support during the take-off of the Fluorosis Control Programme.
- HMIS data are used for state planning and mid-term corrective actions. This helps the state programme officers and authorities to prioritize areas for monitoring and resource inputs.
- MCTS is being implemented in the District as per the guidelines. MCTS data is entered but not used in identifying the low performing units and devising remedial measures.

X
FINANCIAL MANAGEMENT



The NRHM funds have been released to states through the state health societies as four components- RCH flexipool, 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 seven years was Rs. 18,689 crore and under Mission flexi-pool the total amounts released was Rs. 20,749 crore. For Immunisation and Pulse Polio, a sum of Rs. 3,066 crore has been released. In these seven years, for disease control, the amount released was Rs. 5,059 crore. In addition through the treasury route, Rs. 18,756 crore was released for infrastructure maintenance.

Rate of expansion of financing did not keep pace with expectations. Implementation estimated an expenditure of Rs. 175,000 crore over seven years; But in fact we have reached only Rs. 68,185 crore or less than one thirds of this projected amount.

Findings

1. Financial Management has improved across all states on the following parameters:
   (a) All states are using Tally ERP 9. In Madhya Pradesh it is not adequately used and in Odisha they are developing new software.
   (b) Payments are being made through e- transfer up to the block level and at lower levels through cheque allowing speeding up of funds flow.
   (c) Compliance with concurrent audits has been noted. However there are inadequacies in adhering to it especially in Uttar Pradesh and Tamil Nadu.
2. Utilization of funds as compared to the previous years has improved. The key limitations are:
   (a) Several posts of financial professionals are vacant more so at district level. In Madhya Pradesh, Odisha, Kerala, Assam, Tripura, Tamil Nadu, Delhi and Chhattisgarh.
   (b) Training gaps especially in in Rajasthan, Madhya Pradesh, Assam, West Bengal and Bihar.
   (c) Accounting weaknesses like non observance of reconciliation of funds at district level and non-maintenance of advance registers.
   (d) Monthly reconciliation of bank accounts and unspent balance has been observed from many sites. Details are mentioned in the state reports.
   (e) Slower turn over in infrastructure expenditure.

(f) Lower utilization in untied funds due to stagnation of funds in subset of facilities.

(g) Lack of accounting staff at facility and district levels.

3. Financial contribution of state Governments has increased over the years.
4. Annual district budgets are not being declared or not plan linked or governed.
5. RKS reports show constitution is complete and working.
6. JSY payments are being paid by cheque or cash.

Recommendations

1. Improved recruitment and deployment policies should be in place to ensure prompt recruitment and retention of financial staff.
2. Expenditure flows of funds for infrastructure development should be separated from flow of funds from revenue expenditure so that delays in one do not affect the other.
3. Need to put in place additional technical capacity for supporting accounting processes regularly so that minor issues are solved.
4. Untied funds absorption should be expedited by

   (a) Use of clear guidelines that facilitate use of funds.

   (b) An allocation that is more responsive to case loads and usage at facility level including a normative payment provided to each facility.

5. Payment on time to peripheral health workers especially ASHAs and to beneficiaries must be monitored. State finance managers should be accountable for ensuring timely payments.
6. Careful study and fee back is required; though bank transfer speed up payments, paradoxically many states are facing difficulties related to bank to user interface. Review closely the actual protocols across states for bank transfer and cheque payments.
7. Allow local modifications for timely transfers and let the districts set their time based standards.

1 ASSAM

- Tally ERP software was implemented upto BPHC level but not implemented at MPHC level.
- Integration of NDCPs with SHS and DHS is yet to be achieved. SHS need to open Group Bank account having linked sub-accounts as advised by GoI. SHS is also to prepare a consolidated FMR incorporating physical and financial data obtained from vertical programs.
- DHS is not preparing monthly FMR on the basis of approved budget vis a vis actual expenditure. Instead of approved budget, funds receipts are shown as budgets for each activity. DHS is receiving funds on activity basis instead of flexipool basis or DHAP basis thus hampering funds allocation for all activities at DHS level (35 releases received in12-13).
- There is delay in disbursement of Untied Funds, Annual Maintenance Grants and RKS Grants to CHC, BPHC, MPHC, at DHS and for SC and VHSC at BPHC level.
- Adequate funds has not been made available for JSSK and EOPD to BPHC, MPHC, FRU by DHS and

affecting implementation of these scheme. Funds releases for RNTCP, NPCB and NCD are not made through DHS and FMR prepared without obtaining expenditure data from vertical programs.

- Sub-centres and VHSC are not submitting monthly Statement of expenditure and Utilization Certificates thus impacting overall funds utilization level and showing high unspent balances. SoE & U/Cs submitted by PPP-TE are not being analyzed at DHS level and releases made in 2012-13 despite high unspent balances without approval from SHS.Outstanding advances have registered sharp upturn (up by 31%) from 31-3-11 till 31-3-12 under RCH & MFP.
- Accountants posted at MPHC/BPHC not imparted Tally ERP Training. Accountants should be fully trained in Tally ERP as well as Operational guidelines for Financial Management. Also, ANMs and ASHAs should be given one day orientation training in Untied Funds, annual maintenance and RKS funds utilization.

2 BIHAR

- Tally ERP-9 software is being used at all levels and uniform accounting practice is being followed by the District Health Society (DHS).
- Electronic transfer of funds has been established up to PHC level.
- Concurrent audit has been implemented for the financial year 2011-12 and 2012-13 at DHS but concurrent & RKS auditors for year 2012-13 not yet appointed at State Health Society (SHS)
- State has high unspent balance of funds. Unspent balance under mission flexi pool is Rs. 613 crore as on 30.9.2012.
- Funds have not been utilized at VHNSC under the Shambuganj PHC at Kamatpur, Bhojpur and Kunta and Paithanpatti villages.
- JSY registers, records and photographs of beneficiaries are being maintained properly at CHC/ PHC level. However, JSY payments are being made in cash.

3 CHHATTISGARH

- Tally ERP 9 software has been implemented up to the block level and accounts are being maintained properly. However in Dantewada there was double counting of JSSK expenditure as part of JSSK, as well as part of JDS.
- Transfer of funds is being done through Electronic transfer to all the District Health Societies and up to block level but no bank reconciliation statement has been prepared at the District and Sub District level.
- Several posts within the financial management unit are vacant. The state can consider rationalizing their recruitment policy and relax the qualification or experience criteria depending on the human resources available in that CHC/PHC area.
- Training sessions for recruited personnel are not being planned below the District level. The District Health Societies may be instructed to organize the training programmes at the CHC/PHC level on quarterly/half yearly basis.
- There has been progress in the utilization of the Untied Funds, AMG and Corpus Grants but the State

is having very low expenditure against their approved budget. The low expenditure has been observed in Infrastructure, Untied Funds and RKS. The unspent amount is Rs.2.64 crores in infrastructure. The expenditure against Untied Grants is 17.21%, AMG (13%) and Corpus Grants (28%). Funds are also stagnating in closed head accounts in VHSNCs.

4 DELHI

- Statutory and concurrent audits have been held.
- Utilization Certificates till FY 2011-12 are pending.
- Fund utilization is low on account of slow pace of implementation in accordance with the ROP.
- There is a mismatch between data of State and Govt. of India in respect of the pending Utilization Certificates amount, which is to be reconciled.
- Expenditure in the NE is not in accordance with accounting procedure with cash transactions for amounts more than Rs. 5000.
- There is an urgent need for filling up crucial Finance Management Unit posts to avoid financial mishaps and mismanagement besides delays due to less staff.
- The state has one SFM and Accounts Managers, with the position of Deputy Director, Finance vacant, and of six accounts assistant only two are in place.
- At the district level all positions related to Finance were filled.
- Financial Norms are not appropriately followed in both the districts (one hospital in SW and many facilities in NE) reflecting poor monitoring.
- RKS meetings are not held as per the guidelines and the Statutory Audit are not being undertaken.
- The Medical Superintendents of the hospitals interviewed, had little clarity on TORs, Bye-laws and fund utilization under RKS.

5 KERALA

- TALLY ERP-9 is introduced at district level, but not at lower levels.
- Electronic transfer is happening everywhere, except in the case of Cooperative Banks
- Separate audit through Chartered Accountants are not undertaken for HMC accounts in all health facilities
- The state is unable to utilize the amount allotted under the head 'Training' to the optimum extent.
- Low utilization has been seen in untied funds, Annual Maintenance Grants of HMC (RKS) at CHCs and PHCs.(Malappuram District)
- Inadequate human resources for the management of accounts; and those who are handling accounts, orientation and training is lacking on financial manual.
- Financial Indicators not being used for improving programme management at each level.
- JSSK scheme was started in the state only in August 2012. Consequently no significant expenses have been incurred so far.

6 MADHYA PRADESH

- The State Health Society and District Health Society are using Tally ERP9 but it is not customized version of Tally ERP9 as they have faced problems with the customized version.
- The transfer of funds from State Health Society to DHS is through Electronic transfer and from DHS to Block/CHC/PHC is through account payee cheque. The registration for CPSMS has been completed at DHS and Block level.
- Reconciliation of releases between State Health Society and District Health Society were not done by the District for RCH, MFP, and RI for the year, 2012-13 (up to October).
- ATR has not been prepared by the State on Concurrent Audit Report, 2011-12 as the State has received Concurrent Audit Report in the month November, 2012.
- 103 posts of Block/CHC/PHC accountants and other posts of financial personnel at district level are vacant.
- The funds are being released in a flexi pool by the SHS to DHS according to ROP and DHS to Block/CHC/PHC also in a flexible pool in all cases except Untied Fund, Annual Maintenance Grants and RKS. State generally sends the fund a week to DHS when they get the demand from the DHS and 12-15 days takes in fund disbursement from District Health Society to blocks/CHCs/PHCs.
- The procurement manual has not been made by the State Health Society. The State is following the procurements guidelines of Government of Madhya Pradesh and the SHS sends procurements guidelines time to time to DHS when it is required.
- Funds absorptive capacity is still low. Out of the approved annual PIP of Rs.52977.67 lakh, reported expenditure is Rs. 14649.18 lakh up to 2nd quarter, 2012 under RCH Flexi pool which is only 27.67% of the approved PIP.

7 MANIPUR

- Tally installed in both the district hospitals and at the block facilities only and not below it but it was not found to be operational.
- All blocks have bank accounts, but not below block level. There is a system of E-transfer of funds up-to Block Level, but a computerized system for maintaining the records is lacking. Hence, Manual System of Book Keeping is being followed, hence Cash book and Ledgers needs periodic updating
- Manipur was the first State in India to submit audit report in the first week of July 2012 along with all UCs.
- Due to huge pending advances, fund was received at the end of FY which led to high Unspent balances. At the periphery finances are managed by drawing cash or by self cheques since there are no banks available in those areas. State has issued instructions to either discontinue this practice or keep it to minimum. The expenditure under untied funds, maintenance grants and corpus grants are not frequently monitored. For example, PPI not done but 2011-12 fund utilization statement shows 100% expenditure.

8 ODISHA

- The State Health Society (SHS) is not using Tally ERP.9 software. It is developing new accounting

software that is ERP based accounting system.

- Currently, the SHS is reporting the physical data in FMR to GoI. Expenditure booked by the SHS is not tallied with District FMR. The FMR format used at district level is different from that circulated by the SHS.
- Several posts for the following titles District Accounts Manager, Accountant at DPMU/CHC /Sub District Hospital are vacant.
- Fund utilization under NRHM has been low, until September 2012, only 17 % of the approved budget and the committed unspent balance have been utilized.

9 PUNJAB

- Tally ERP.9 has been procured and implemented in the state. Books of accounts are maintained through the Tally ERP.9 at the State, District and Block lavel. It was found that Tally ERP.9 has crashed since last 4 months in Kot Ise Khan Block of Moga district. Further, it was observed that there are some problems in implementation of Tally ERP.9 due to which Tally ERP.9 is not able to generate financial reports like Financial Monitoring Report (FMR) and Statement of Fund Position (SFP). Last year state have trouble shooting mechanism on Tally but this year the same has been discontinued.
- At state level customised version of Tally ERP.9 is used for maintaining Books of Account till block level. However, below the block at PHC level specified books of accounts like cash books, ledger etc, are not maintained.
- Funds are transferred from state to district and district to block electronically through RTGS and NEFT. Below the Block funds are transferred through the cheque. Under CPSMS 96% registration has been completed.
- It was observed that funds are released from State to District mostly Pool wise and District to Block activity wise.
- Statutory audit for the 2011-12 has been completed and audit report has been submitted by the state to the Ministry. Audit report for the year 2009-10 has been laid before the Governing Body. Concurrent auditor for the audit of year 2012-13 has been appointed in all districts. However, the State is yet to submit executive summary for the 1st and 2nd quarter of 2012-13. CAG Audit till 31st March, 2012 has been completed.
- Fund utilisation was not more than the approved PIP of 2011-12. Funds are distributed to District as per the approved DHAP.PNDT Activities, New Construction/Renovation and setting up and Panchayati Raj Initiative are some activity having low utilisation in 2011-12.
- Further, it was observed that there is decreasing trend of fund utilisation upto 2nd quarter of 2012-13 in comparison to the same period of 2011-12 in Moga and Patiala District.
- All Financial management positions adequately filled
- The State has planned to organise one training at state head quarter and one training at district level for finance and account personnel for capacity building of finance personnel. However, State has not maintained any training calendar. One training was organised on 13th & 14th September on Expenditure filing on CPSMS portal for all District Account Officers and State Account Officers.
- Monitoring and evaluation are being made by the state through regular review meeting, field visit and

implementation of the concurrent audit systems. However, it was observed that State needs to make more extensive visit for improving the Financial Management.

- Interest has been clubbed into the pool and shall be utilised against the approved activities in the PIP.
- Model Accounting Handbooks for sub-district level finance staff has been implemented in Moga and Patiala both districts. However, need of a refresher training was felt.

10 RAJASTHAN

- Disbursement of funds is done through e-transfer.
- Single Bank Account for all funds i.e NRHM and non NRHM funds in the visited facilities. There is no Separate Bank Account for VHSCs. Adjustment of Advance for closed activity (RCH-I) is not yet done.
- Lack of adequate training to finance personnel at all levels was observed. Fast track Plan for training of existing finance personnel in financial management and customized Tally ERP.

11 TAMIL NADU

- The State has started E-Transfer of funds up to Block level. SHS had regularized the placing of Statutory Audit Reports in the GB meeting.
- Internal Audit Mechanism needs to be strengthened in the State.
- Frequent diversion of funds from one pool to another at State Health Society level occurred which needs to be dealt with proper planning.
- It has been observed that financial absorption capacity under the two major pools (RCH and MFP) in respect of last year has decreased in the State.
- In addition AMG funds have been given to Non functional HSCs which need to be looked further.
- The State needs to create the position of the Block Accountants and action plan for filling up of the vacant positions. Presently, those were being managed by the Block Medical Officer, as they were designated for the purposes.
- SHS, DHS and Block CHC, PHC, HSC staff has developed positive attitude to improve the Financial Management. The Positions of the District Accounts Managers is vacant in 30 Districts.

12 TRIPURA

- Usage of customized version of Tally ERP software has not been adopted in the state till date for technical reasons.
- Audit reports on the accounts for 2011-12 due to be sent to GoI by 31st July 2012 is still pending.
- Timely release of NRHM funds reported from both districts visited for state to district and from district to facilities, however, there is a shortfall of Rs 28.38 crore in the contribution of state share for the years 2007-08 to 2012-13. Programme was having unspent balances in excess of RS 100 Crore at the end of each financial year 2010-11, 2011-12 and 2012-13 (up to September 2012). This excludes unspent balances observed at district / sub-district levels. Utilisation certificates for an amount of Rs 54.40 crores under RCH 2010-11 and Rs 74.71 crores under mission flexipool for the year 2009-10 and 2011-12 are pending.

- There are vacancies in HR under FMG. SFM: 1; DAM: 5; BAS: 24). Action to fill up this gap may be taken.

13 UTTARAKHAND

- No record of AMG/ RKS fund/ untied funds at any facility. MOIC and the accountant unaware of the guidelines for using the funds.The untied/RKS/AMG are clubbed together at the facility level, and the decision making power regarding the utilization of this pool of funds lies with Chiktisha Prabandhan Samiti at the facility-Bageshwar.The meetings of CPS irregular/ in the entire district except in CHC Baijnath
- TDS was not deducted as per the Income Tax rule. This method of tax deduction should also be followed by the DHS. Bank account should be separate for each programme. State is also diverting funds between the programs.
- E-banking at all level, JSY payment through cheque & JSY register maintained at all level in Bageshwar. Advance Registers are not maintained at state & district level. Bank Reconciliation are not prepared on monthly basis at PHCs and CHCs.

14 UTTAR PRADESH

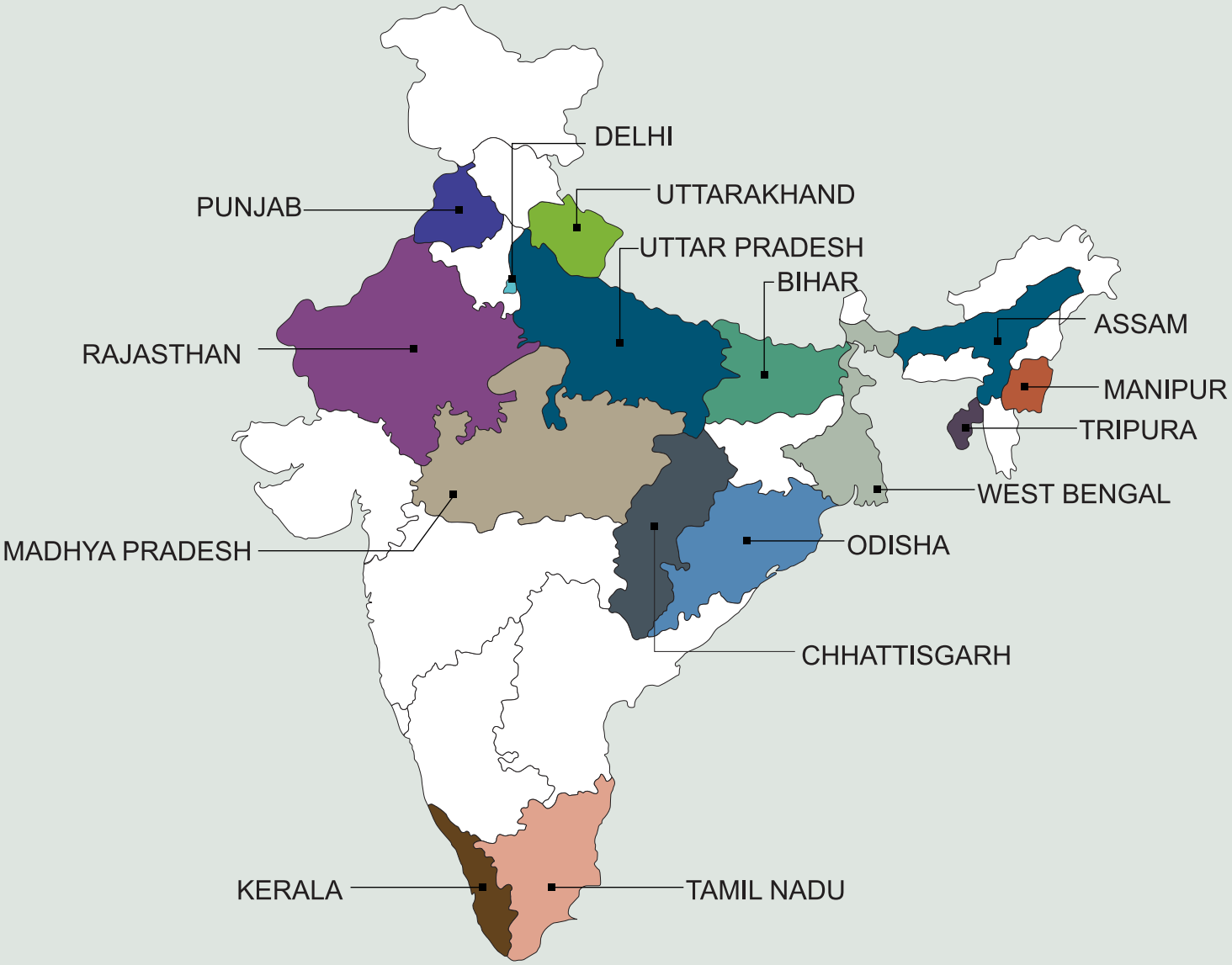
- The Tally accounting software was operational both in SHS and DHS visited, however block level implementation of tally is yet to be initiated
- Books of accounts are being properly maintained as are the registers except in DHS Jhansi where fixed assets/stock register was unavailable for review. The accounts are being maintained on cash basis. The Bank accounts at the SHS and DHS are being operated jointly as per the NRHM guidelines except in Hardoi, where for the period Sept, 2011 to June, 2012 the DHS bank accounts were operated by CMO and F& A officer of Basic Sikhsha Adhikari ,which is not as per the guidelines
- The statutory audit for the period 2011-2012 was pending as concurrent auditors for year 2011-2012 were yet to be appointed as on October, 2012. Actions based on the statutory audits of DHS for period 2010-2012 are yet to be initiated. The SHS and DHS's are operating without income tax registration pertaining to exempt status under income tax act. 1961. Also, no Income tax return of the SHS and DHS's are being filed
- The annual district budgets were not available. Expenditure planning were based on the receipt of funds from the SHS, rather than annual activity planning leading to delay in the planning the activities
- The positions of DAMs were vacant both in DHS Jhansi and Cardio and the position of DDAA was vacant in Jhansi. There is however, no block level accountant to oversee financial transaction in Blocks. It is observed that regular training to the staff dealing in accounts and finance is not being imparted.

15 WEST BENGAL

- Electronic transfer – in position, tally ERP 9 used at District and sub-district level
- Audit conducted in a timely fashion. Audit completed for FY (11-12), ATR submitted as per observation
- Statutory Audit on the accounts of Block & District Health & FW Samiti for the year 2011-12 has been completed. The audit on the accounts of State Health &FW Samiti is in progress. It is expected that the audited account of State H&FW Samiti would be submitted to the GOI by end of Oct, 2012.

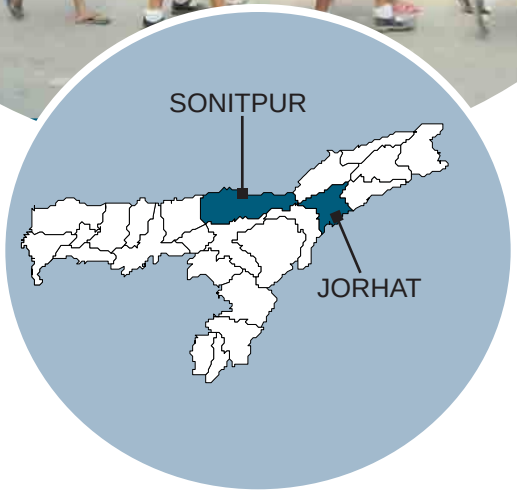
- There is no unspent balance under RCH - I and EAG scheme.
- No UC pending at block and district level.
- Interest fund are utilized for those activities where the grant fund are short. It is also utilized for some contingencies expenses of respective programme on which it is earned.
- There is no diversion of fund from one programme to another.
- Fund position is adequate and proper utilization at BPHC and PHC level. The fund SC at Sc level is exhausted. No fund received in BPHC, PHC and SC for the FY 2012-13 till date. The meeting of RKS is not regular.
- Financial Monitoring is not regular at PHC level. No monitoring at SC level accounts.
- Records / register are maintained properly at BPHC, PHC and SC level.
- FMR is submitted (district and sub-district) on a monthly basis.
- Fund flow is timely
- Staffs are adequate and in position. Additional Accounts person required at PHC level (as the RKS fund is flowing, user charge is generated, JSY payment is done). This lack of manpower at PHC level has added to increase work load of Block Accounts Manager.
- Training conducted only once, more training required to other medical and para-medical staff on basic accounting. There is no visit by the higher authorities from State / District level.

States of India Visited By 6th CRM Teams



STATE-WISE KEY FINDINGS

ASSAM



FACILITIES VISITED BY THE TEAMS

Facilities Type	JORHAT	SONITPUR
DH	Jorhat Medical College	Kanaklata Civil Hospital
CHC/SDCH/ FRU	Garmur, Kamalabari, Teok and Titabor	Biswanath Chairali
BPHC/ MPHC	Dhekorgorah, Kakojan, Nakachari, Moriani and Baghshung,	Haleswar
State Dispensary	Rangachahi	
SHC	Nimati, Gharbolia, Mokhuti, Phuloni, Komar Khatuwal, Rajabari, Dholi & Na-Ali-Dhekiajuli	Borjarani, Shankar Maidan, Pub Jamugiri and Bakarigaon
ANMTC	Jorhat, GNM & ANM TC	Nursing School
Other	DPMU and Boat Clinic	DPMU, Boat Clinic, TE PPP

REVIEW TEAM

JORHAT DISTRICT

Dr. S K Sikdar
DC i/c FP, MoHFW, Govt of India

Dr. S. S. Das
Consultant (School Health Program), MoHFW, Govt of India

Mr. Rahul Pandey
Senior Consultant, MoHFW, Govt of India

Mr. Utpal Kapoor
FC (FMG), MoHFW, Govt of India

Dr. Pragati Singh
Consultant, PHP, NHSRC, New Delhi

SONITPUR DISTRICT

Dr. D K Mangal
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Sh. Ashish Tiwari
Director, HUP Project, Plan India, New Delhi

Dr. Swati Patki
SPM, Training Division, PHFI, New Delhi

Photo Top Left - March for Adoloscent health

Photo on Right - MCH Services-Garmur SDCH, Jorhat

POSITIVES

- State has achieved substantial increase in infrastructure through the creation of new and undertaking major/minor renovations to make them patient friendly. PHCs functioning in government building have increased by 46%, CHCs by 8% and HSC by 3%.
- Better infrastructure and HR have resulted in quantum jump in OPD and IPD numbers during the NRHM period.
- There is good progress in addressing the HR gaps by using various retention strategies : compulsory one year rural posting for MBBS doctors; introduction of the three year Rural Health Practitioner course and posting the RHP at Sub center 'delivery points; initiation of e-HRMIS and database on HR. Most sub centers have 2 ANMs. Process for developing a new cadre for the specialists is in progress.
- Adequate availability and functioning of cold chain equipments at all levels.
- Dramatic improvement in referral transport due to drop back facility - 'Adorni' under JSSK and EMRI for emergency transport.
- High motivation, knowledge level and commitment of ASHAs have transformed them into a major strength of the system. First round of training of Module 6 & 7 completed in high focus districts; training in non high focus districts going on.
- Sharp decline in the malaria SPR from 3.12 in 2008 to 1.2 in 2011. Regular visits by epidemiologists have improved case investigations and data generation.

CHALLENGES

- Need for comprehensive infrastructure development plan including the facilities above BPHCs (i.e. CHCs, SDCH, FRUs etc) which have been generally excluded in district planning.
- Non-availability of AMC for equipment leads to frequent interruptions of critical services .
- Supply demand mismatch leading to stock outs of common drugs and storage of fourth generation injectables in lower facilities needs correction to avoid a high OOP.
- State has an MDR committee and verbal autopsies are conducted as per protocols, but community based deaths are largely missed, necessitating better systems for reporting of home deliveries.
- Out of pocket expenditure remains high despite JSSK and a good referral transport. Expenditure on drugs and diet has maximum contribution to high OOP.
- A system for performance appraisal of service providers need be put in place.
- State has reported decline in sterilization numbers and provision of IUCD services despite reasonable progress in training.

Rented Beds-Jorhat Medical College

BIHAR

REVIEW TEAM

GOPAL GANJ DISTRICT

Dr. Renu Shaharawat,
NIHFW, Govt of India

Mr. Ajit Kumar Dungdung,
MoHFW, Govt of India

Dr. Sai Subhasree Raghavan, SAATHII

Dr. Neha Kashayap, MoHFW, Govt of India

Mr. Anisur Rehman, MoHFW, Govt of India

Mr. Dushyant Meher,
Planning Commission, New Delhi

BANKA DISTRICT

Dr. J N Srivasrava, Advisor QI, NHSRC,
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Dr. Manoj Patki, PHFI, New Delhi

Mr. Rajeev Agarwal,
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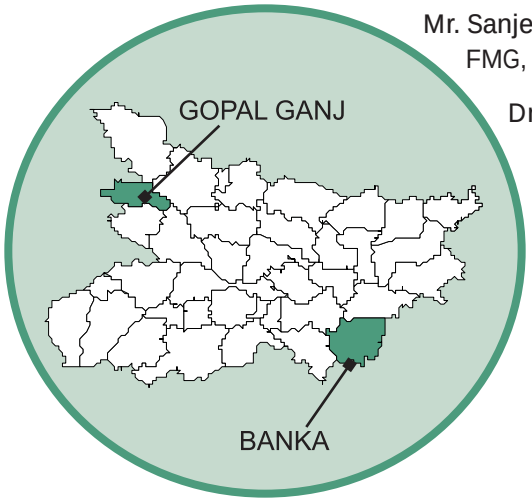
Dr. S A Pasha,
Dept of AYUSH, Govt of India



FACILITIES VISITED BY THE TEAMS

Facilities Type	GOPAL GANJ	BANKA
	Sadar Hospital Gopalganj	Sadar Hospital Banka
SDH, Referral Hospital	SDH Hathua, Referral Hospital Bhore, Referral Hospital Phulwaria	Referral Hospital Amarpur, Referral Katoriya, Referral Hospital Baunsi
PHC, APHC	Manjha, Uchkagaon Thave, APHC Miraganj	Chanan, Dhouraiya Barahat, APHC Ahiro
HSC	Miraganj, Hussepur, Basadila, Dahibhata, Paithanpatti, Batarde	Sultanpur, Bhairuganj, Mirzapur, Shyam Bazar, Kadhar, Jaipur
Others	AWC Basadila, Dhanwatri Rath (MMU), and 102 Ambulance (EMRI)	VHSC Inavaran, VHND-Letwa and Kunda, AWC Kunata.

POSITIVES

- Encouraging trends in IMR reduction; down to 44 from 61 in 2005, on par with national average. Neonatal Mortality rate is 31 against national average of 33.
- Bihar Medical Services and Infrastructure Corporation Limited (BMSICL) constituted for addressing specific needs of healthcare infrastructure and work has been initiated in 19 facilities.
- Construction of 209 Generic Medicine Shops within the premises of the health facilities; quality improvements in terms of better signages in facilities; improved Biomedical Waste management in Patna, Muzaffarpur, Bhagalpur and Gaya and free drugs, ultrasound, and laboratory services provided to all pregnant women under JSSK.
- Initiatives to attract and retain skilled professionals, such as regularization of the contractual health posts where vacancies exist and against sanctioned posts and signing all contracts for three years are notable achievements in the HR front.
- Better performance monitoring through review and performance appraisal against benchmarks.
- Public health capacity of doctors is being built through enrolment to MPH programmes in IIPH
- Medical Protection and Clinical Establishment Act passed by the state.
- Low annual attrition rate of ASHAs. ASHA Divas held every month for sharing health updates.
- Rogi Kalyan Samitis are formed at more than 96% of the health facilities and working very well.
- A total of 8224 (97% of the target) VHNSCs are constituted and the members of VHNSC are orientated with guidelines. The state has developed a manual entitled VIKAS KI DAGAR PER HAMARA GAON and a film on conducting VHNSC meetings towards orienting the members.
- 1384 Medical Officers under AYUSH stream of medicine have been appointed/ posted at APHCs against GDMO posts.

CHALLENGES

- High under-5 mortality rate at 77 does not compare well with the national average. Achievements in indicators like the MMR and TFR have a long way to go to catch up with rest of the country.
- Infrastructure deficiencies in PHC, APHCs and Sub centres continue to be high.
- Despite availability of required infrastructure the State Health Systems Resource Centre (SHSRC) remains in-operational. Out-sourcing it to a consulting organisation was unsuccessful.
- The District PIPs were almost single handedly prepared by the District Planning coordinator with few inputs from the Civil surgeon and the CMO. Lack of public health planning capacity at the district level remains a constraint to carry out need based planning.
- Technical support for various programs is deficient resulting in reliance on the support of development partners and management consultancies on project basis where sustainability is an area of concern.
- Bed strength at District Hospitals remains short of meeting the norm of 200 secondary care beds per 10 lakh population, with sub-optimal bed occupancy at 30 to 70 % of capacity.
- While lab facilities under PPP mode remain deficient due to long turnaround time; PPP mode has resulted in underutilized and even dysfunctional in-house labs.
- Only 4-5 SNCUs are functional in the state. Procured equipment not being put to use.
- Emergency services are not well prepared for mass casualty and disaster.
- Maternal Death Review is not being done either at facility level or community level.
- Free drop-back facilities are not available to approximately 60% of the beneficiaries due to lack of awareness, dearth of vehicles and refusal to serve far flung areas.
- Training of ASHAs lagging behind with only 48% trained in Module 5-7. Backlog in payment of incentives, lack of facilities for stay of ASHAs at health facilities while accompanying a pregnant woman remain further constraint in their function

CHHATTISGARH

FACILITIES VISITED BY THE TEAMS

Facilities Type	DANTEWADA	MAHASAMUND
DH	District Hospital Dantewada District Hospital Sukma,	District Hospital Mahasamund
CHC	Geedam, Kuakonda	Pithora, Bagbahara,
PHC	Palnar, Pondum, Metapal, Bhusara	Tumgaon, Bhithdih, Jhalap, Komakhan, Khallari
SHC	Mokhpal, Matena, Pondum, Balud, Metapal	Garh Sivani, Sarkada, Mudipur, Vrindavan, Khopali, Pachera, Sivani Kalan, Nandgaon, Kosrangi

REVIEW TEAM

MAHASAMUND DISTRICT

Dr. R. P. Meena, Director, NVBDCP, MoHFW, Govt of India

Mr. Akshay Kumar Sahoo, Under Secretary, Maternal Health, MoHFW, Govt. of India

Dr H. Sudarshan, Secretary, Karuna Trust, Karnataka

Mr. Kapil Dev Singh, Public Health Foundation of India, New Delhi

Dr. R. P. Saini, Consultant, MoHFW, Govt of India

DANTEWADA DISTRICT

Dr. T. Sundararaman, Executive Director, NHSRC, New Delhi

Dr. Ankur Yadav, Associate Professor, NIHFW, Govt of India

Mr. A. K. Panda Director, Planning Commission, Govt. of India, New Delhi

Dr. Anand Bang, Sr. Consultant, NHSRC, New Delhi

Ms. Isha Rastogi, Consultant FMG, MoHFW, Govt of India

Dr. Nitasha M. Kaur, Consultant Planning, MoHFW, Govt of India

POSITIVES

- Availability of professional manpower improved with three Medical colleges, 2 Government and 4 Private dental and AIIMS in Raipur. State has large number (1159) of functional AYUSH institutions with at least one medical officer posted in each.
- The ratio of beds to population at primary and secondary level is 11.2/ 1000.
- State has improvised the design of SHC as a double storied building, with health facilities on the ground floor and residential facilities on the first floor. Solar power panels are installed for back up especially in the PHCs and CHCs.
- JSY payments are being done in a timely fashion.
- State has started EMRI-108 services in the year January, 2011 providing services for 2 to 5 times per day.
- Human resource gaps have been well covered; every SHC in Dantewada has now one male and one female worker, every PHC has one RMA and one AYUSH doctor and 2 or 3 nurse equivalent
- Both VHSNC and Mitanin progress in Chhattisgarh are best practices in term of social mobilization and active community participation.

CHALLENGES

- RSBY implementation not streamlined or monitored to ensure transparency and prevent unnecessary treatments.
- Major weakness is procurement and logistics affecting all types of service delivery
- The pace of infrastructure construction and provision of semi-furnished residential facilities is slow
- Blood storage units in CHCs with potential to be FRU are yet to be operationalized.
- Infection prevention practices are sub optimal in facilities visited in both the districts.
- Irregular supply of Chloroquinine and FRT (Fever Radical Treatment) for Malaria control
- Erratic payment of incentives to Mitanins and refilling of drug kits .
- Inadequate technical capacity of the training institutions.

DELHI

FACILITIES VISITED BY THE TEAMS

Facilities Type	SOUTH WEST	NORTH EAST
DH	RTRM Hospital (DH) Dadadev Hospital(SDH) Delhi Cantonment Board Hospital	GTB Hospital Swami Dayanand Hospital
PHC/PUHC	Ujjwa, Najafgarh	DGD Seemapuri PUHC Mustafabad PUHC Soniya Vihar Zero Pushta PUHC Soniya Vihar 4.5 Pushta PUHC
Sub centre	Mitroan, Dilchoan	
Maternity home		Seemapuri Maternity home Yamuna Vihar Maternity home M&CW New Seemapuri
Others	RHTC Najafgarh AWC- Mitroan AWC- Dilchoan DPMU-SW District	AWC Centre (Number 26) St. Stephen's Outreach centre Sunder Nagri

REVIEW TEAM

SOUTH WEST DISTRICT

Dr. N. K. Dhamija, Dy. Commissioner, MoHFW, Govt. of India

Mr. Basavraj, Managing Director, TMSA, New Delhi

Dr. S.K. Barik, Sr. Consultant NRHM, MoHFW , Govt. of India

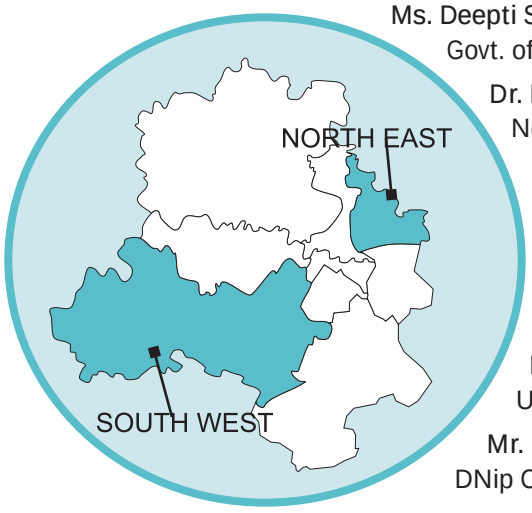
Ms. Anamika Saxena, Consultant Trainings, MoHFW , Govt. of India

Mr. Puneet Jain, Consultant NRHM MoHFW, Govt. of India

Dr. Priya John, Acting Head, Comm. Med, CMAI, New Delhi

Dr. Ritu Agrawal, Consultant UNICEF

NORTH EAST DISTRICT



Ms. Deepti Shrivastava, Jt. Director MoHFW , Govt. of India

Dr. Rajani R. Ved, Advisor, NHSRC, New Delhi

Dr. G.P Garg, Sr. Chief Chemist, MoHFW, Govt. of India

Dr. Anubhav Srivastava, Consultant NRHM, MoHFW , Govt. of India

Mr. Anand Rudra, Project Management Specialist – USAID, New Delhi

Mr. K.V.Hamza, Gen. Secretary, DNip Care, New Delhi

Sitting on stretcher, waiting for their turn at GTB Hospital

POSITIVES

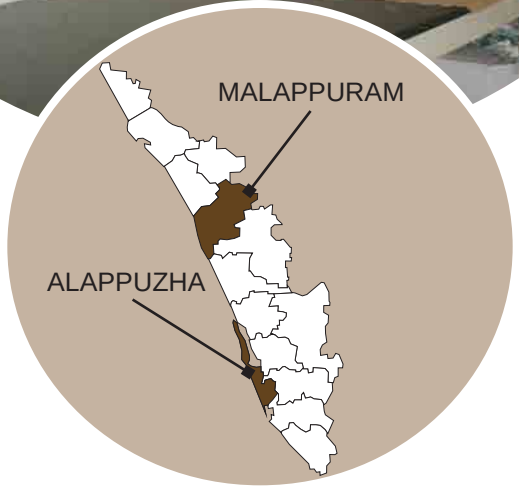
- NRHM funds serve as a significant lever to State health budget enabling strategic gap filling in infrastructure and HR.
- Improved convergence between state and MCD facilities, leads to high OPD and IPD, and expanding access of the public sector for women and children.
- 53 new centres created and strengthened/ renovated others in underserved areas. city.
- Functional Diagnostic centres in a majority of the dispensaries and MCW Centres.
- Newborn care facilities in secondary and tertiary level adequate, but gaps observed in provisioning of Essential Newborn Care..
- State funded programmes for school health, HIV/AIDS, convergence, non communicable diseases, and civil registration systems have potential for scaling up.
- Functional free drug scheme in place with 361 EDI, and 120 for primary health centres, with little disruption in supply.
- JSSK operational in most facilities.
- An integrated ICT platform developed to improve reporting.

CHALLENGES

- Improve coordination between the multiple agencies and high turnover of senior official leading to poor management; duplication of services at one place and unavailability at large remaining areas
- Strengthen monitoring, supportive supervision (on job training, problem solving), and effective feedback and review mechanism.
- Differential planning for the districts is lacking, despite significant divergence (infrastructure, HR, population composition, size, and socio –economic features)
- Poor community outreach particularly among the poor and vulnerable due to inadequate community involvement and lack of mainstreaming of ASHA.
- The lack of HR policies for in service training, arbitrary transfers and irrational deployment have diminished effectiveness of HR .
- Informal payments by lower cadre staff and transport costs lead to high out of pocket expenses despite JSSK.
- A critical immediate step is the prioritization of facilities so that more women access the maternity homes, rather than directly access tertiary institutions, with overwhelming caseloads, resulting in highly compromised service quality. But in order to do this there has to be better outreach, birth planning and close contact with pregnant women. This is the role of the ASHA who needs to be empowered to undertake this role.
- Training progress for F-IMNCI, SBA, or NSSK needs to be speeded up.
- Inadequate inter - sectoral convergence and engagement with NGOs to support the community processes, such as mentoring and training for ASHA.
- Lack of quality management processes in all facilities

Photo above - Jhuggi near Dispensary (DGD Old Seemapuri)

KERALA



FACILITIES VISITED BY THE TEAMS

Facilities Type	MALAPPURAM	ALAPPUZHA
DH	DH - Thiru	Women & Children Hospital, TD Medical College
THQH	Mallapuram	Cherthala
CHC	(FRU) - Edappal (Non - FRU) - Vengara	Chettikkad Champakulam
PHC	Thiruveli	Purakkad
HSc	FWC and Anganwadi-Kollapuram	Kalavur, Mararikulam South, Champakulam Kutlamangalam Kainakary
Other institution	NRHM Quiz Competition at St. Gemma's school, Mallapuram Arya Vaidya Sala Hospital Kottakal Malabar Institute of Medical Sciences Hospital (MIMS) District Homeo Hospital at Munduparanbu GNM School Manjeri	GNM School Ayurveda District Hospital KVM Multispecialty Hospital Floating Dispensaries

REVIEW TEAM

MALAPPURAM DISTRICT

Dr. Manisha Malhotra, DC Maternal Health, MoHFW, Govt. of India

Ms C.N. Bhargavi, OSD Nursing, MoHFW, Govt. of India

Mr Sahil Chopra, Consultant NRHM, MoHFW, Govt. of India

Dr. Aditi Bana, Consultant PHFI, New Delhi

ALAPPUZHA DISTRICT

Mr. H.P. Sharma, Director Planning Commission, Govt. of India

Dr. Sanjeev Upadhyaya, Health Specialist, UNICEF, Hydrabad

Dr. K. S. Nair, Asst. Professor, NIHFW, New Delhi

Mr. Ajit Kumar Singh, Consultant PHA, NHSRC

Dr. Sunita Paliwal, Consultant MH, MoHFW, Govt. of India

Photo above left - NBCC in labour room

Photo on the right - Fully Occupied Wards

POSITIVES

- A well structured infrastructure development wing is present in the state. The upgradation of health institutions are carried out with the participation of local authorities, hospital authorities and other stake holders. Cherthala CHC is the first NABH accredited Taluka Hospital in India.
- All Sub-Centres are equipped with one JPHN (ANM) and JHI (junior Health Inspector/Male worker).
- State provides free generic drugs of 952 medicines including Anti cancer Drugs to BPL and non taxpaying APL patients in facilities; drugs are available as per EDL in the facilities
- Well maintained, clean faciltities with most services in house; negligible out of pocket expenditure being incurred other than user fees.
- Effective AYUSH care system with 29,945 registered AYUSH practitioners.
- Floating Dispensary in Allapuzha is an innovative step to cater to the health needs of the population living in geographically isolated inaccessible areas. There are total 16 well-equipped, functional MMUs in seven districts of the State, all in tribal areas.
- Health, sanitation and nutrition committees are functional in rural and urban areas and active on chlorination, spraying and advocacy for provision of clean drinking water .
- More than 800 ASHAs have been elected as Panchayat members in the state and they are putting health and nutritional issues on priority.

CHALLENGES

- The MDR process should be institutionalized as per GOI guidelines and state should ensure orientation and training of health functionaries.
- Interventions for migrant populations need to be strengthened.
- AYUSH providers should be included in IDSP for OP Reporting and IEC/training for various programmes.
- Training Infrastructure at districts need strengthening to cope up with the increasing training needs. Existing trainings are not integrated in nature.
- There is no financial uniformity across all the levels. Strengthening of financial management at block level is required.

Upper photo - Doubling of babies in spite of two warmers

Lower photo - Overusage of Inducing Agents

MADHYA PRADESH

FACILITIES VISITED BY THE TEAMS

Facilities Type	GWALIOR	HOSANGABAD
DH	Morar Prasuti Griah	General Hospital Hosangabad
SDH		Itarsi
CHCs	Bhitarwar, Dabra, Mohna	Babai, Sukhtawa, Seoni Malwa, Panchmari, Pipariya
PHC	Chinnaur, Atari, Barai, Pichaur	Semari Harchand
Sub centre	Rahi, Simaritaka, Sukhapada, Chinnaur, Ghatigao	Ghana, Doomer, Kaisla, Paraswada, Matkuli, Pagara
Nutritional Rehabilitation centre	Mohana, Thatipur	Hosangabad, Itarsi, Sukhtawa, Pipariya
SIHMC,RHFWTC	Gwalior	
DPMU	Gwalior	Hoshangabad
Drug warehouse	Regional Drug and Immunization warehouse, Gwalior	
AWC	Rahi	Matkuli, Pagara
VHSC & VHND	Rahi ,Ghatigaon	Amlakala, Ghana, Doomer, Matkuli, Pagara
ASHA Training	PHOTC, in front of Madhav dispensary	
Community Interaction	Village & urban slums: Rahi, Simaritaka, Chinnaur, Ghatigaon	
Urban Field Centre	Thatipur	
Civil Dispensary	Shabd Pratap Ashram	
Urban delivery Points	Harijan Basti Ausdhalaya	

REVIEW TEAM

GWALIOR DISTRICT

Dr Sila Deb, DC Child Health, MoHFW, Govt. of India

Dr Sher Singh, NVBDCP, MoHFW, Govt. of India

Mr. Will Starbuck, World Bank, New Delhi

Dr. Anuradha Jain, NHSRC, New Delhi

Mr. Surojeet Chatterji, PFI, New Delhi

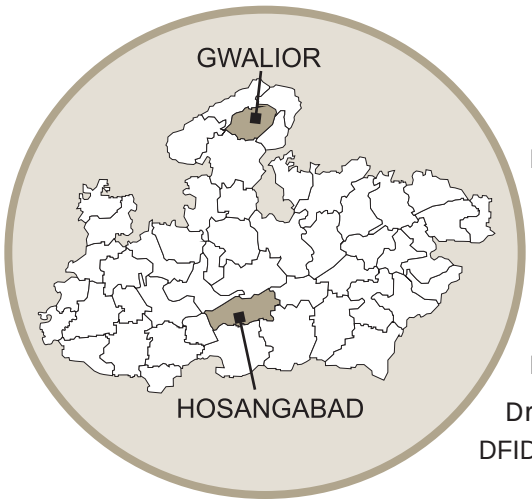
Dr. Navneet Ranjan, NHSRC, New Delhi

Mr. Sanjiv Rathore, FMG, MoHFW, Govt. of India

HOSANGABAD DISTRICT

Mr. Deep Shekhar, Director, MoHFW, Govt. of India

Ms. Geetanjli Agrawal, Consultant, Adolescent Health, MoHFW, Govt. of India



Ms. Mona Gupta, MSG, TMSA, New Delhi

Dr Nimisha Goel, Consultant FP MoHFW, Govt. of India

Dr Dinesh Jagtap, PHFI, New Delhi

Dr Rashmi Kukreja, DFID, New Delhi

Early Intervention Clinic Samarpan 9 Hosangabad

POSITIVES

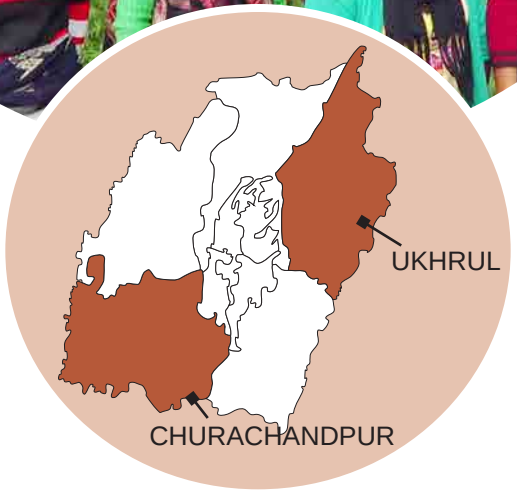
- Most drugs were available at the Sub Centers, Primary Health Centers, Community Health Centers, Civil Hospital and the District Hospital visited. Drugs and Diagnostics for JSSK beneficiaries are free in most of the facilities visited.
- Sub centers were performing immunization, ANC and OPD functions .The concept of Sector Sub centre was found to be good.
- SNCUs are very efficient and at a few facilities 'Breast Milk Bank' was established as an innovative initiative.
- NRCs are functioning well in the state with 90 % bed occupancy.
- Exemplary work is being done by the Janani Express.
- The Cold Chain WH infrastructures are functional and all the deep freezers as well as ILRs were working properly.
- The display of signage's, citizen charters and IEC material were impressive across all the facilities.

CHALLENGES

- Facility development plans should factor in facility wise case loads to ensure quality of service delivery .
- HR gaps in Programme Management Units needs to be filled –currently posts of 26 District Account Managers (DAM), including 103 Block Accountants are vacant.
- Supply of drugs of high demand and reagents in the facilities needs to be improved for facilitating service delivery in facilities .
- There is a need to create common call centre for 108 and Janani Express. Majority of the pregnant women use 108 as the Janani Express call centers are busy.
- Biomedical waste management was poor across all facilities ; needs to made a part of the supervisory quality management checklist.
- Capacity building of the VHSNC members and post training handholding is required.
- The pace of implementation of school health program is slow in the state in terms of coverage of number of schools and school-going children.
- E-transfer of funds from District Health Society to the health facilities and other agencies should be operationalized.

Training Centre Hoshangabad DH

MANIPUR



FACILITIES VISITED BY THE TEAMS

Facilities Type	UKHRUL	CHURACHANDPUR
DH	Ukhrul	DH Churachandpur
CHC	Kamjong	Parbung
PHC	Somdal	Thanlon, Sagang, Saikot
Others	Shirui PHSC Teinem PHSC Sirarakhong PPP CHSRC	PHSC Sainoujang PHSC Leisang

REVIEW TEAM

UKHRUL DISTRICT

Dr. Pradeep haldar, DC, Immunisation, MoHFW, Govt. Of India

Dr. Rajesh Kumar, NIHFW, New Delhi

Mr. Arun B. Nair, IPH, Bangaluru

Mr. Sharad Singh, Consultant, MoHFW, New Delhi

Dr. Salima Bhatia, Consultant, MoHFW, New Delhi

CHURACHANDPUR DISTRICT

Padam Khanna, Senior Consultant, Public Health Planning, NHSRC, New Delhi

Dr. S.N. Sahu, Dy. Adviser, AYUSH, Govt. Of India

Dr. H.G. Thakor, NVDCP, Govt. of India

Dr. Raveesha Mugali,
Consultant, Immunisation, UNICEF, New Delhi

Ms. Shraddha Masih,
Consultant, NRHM, Govt. of India

Photo Top Left - ASHAs with young facilitator

Distribution of Baby Carriers and Mug to JSY Beneficaries

POSITIVES

- OPD has doubled and IPD has increased by five times during the NRHM period.
- Good primary health indicators with IMR – 11 (best among small states), TFR – 1.5 and sex ratio is 987
- State has 3878 ASHAs and almost all have completed third round of training on Module 6 & 7. ASHAs available in all the villages irrespective of size and distance.
- Availability of AYUSH doctors and drugs at all the PHCs with Homoeopathy being a more accepted system in the state.
- Institutional deliveries have increased by 61.62% in last four years.
- State and district level vigilance committees have been set up.

MOIC Displaying a bag in which placenta is return to the family to take back with them

CHALLENGES

- District specific resource allocation should to be as per the terrain and difficult areas.
- Availability of essential drugs at health facilities is a major issue and out of pocket expenditure is high on drugs .
- District Officials as well as MOs need to be oriented on ASHA incentives.
- State & Districts need to prepare a comprehensive monitoring plan with allocation of funds for monitoring visits & supportive supervision.
- JSSK has been launched recently; however, awareness of it is low among service providers. There is a need to strengthen availability of drugs, diagnostics & especially referral Transport. State needs to operationalize already sanctioned ambulances.
- Urgent need for rational deployment of HR to operationalize FRUs in District hospitals
- To set up Grievance Redressal mechanism
- To improve upon Maternal & Child Tracking System & HMIS
- Improve Quality of ANC: line listing of severely anemic women
- To implement Essential New Born Care & Home Based New Born Care
- Immunisation requires lot of improvements, plans to be prepared and schedules to be improved. Storage points to be increased. To introduce birth dose of Hep B and Polio vaccine
- Identification of training need and rational deployment of trained HR.
- Streamlining of financial management systems is required e.g: recruitment & training of finance staff in Tally and maintenance of records
- Payments to ASHA are not streamlined and their monitoring mechanisms need to be operationalised
- State to focus on operationalizing tele opthalmology facilities which was sanctioned

ODISHA

FACILITIES VISITED BY THE TEAMS

Facilities Type	BOLANGIR	KENDRAPARA
DH	District Headquarter Hospital Bolangir	District Headquarter Hospital Kendrapada
SDH	Sub Divisional Hospital, Patnagarh, Titilagarh	
CHC	Ghasian, Saintala	Marsaghai, Pattamundai, Rajnagar
PHC	PHC(N) Belgaon	Kurtunga, Ram nagar, Korowa
Other	SC Jogimunda,Jogisuguda, Desil, Bhadra, VHND Dharapgarh, FGD with GKS members at Convention at Ghasian, FGD with ASHA at Module 6& 7 training, School Jogimunda, AWC Madiapali, District Vaccine Store in Puintala Block,	SC Mahakalapada, Pareshwarpur, Damarpur, Manikapur, GKS Mulabasanta, School Napangaurnita VHND Baharsobala, Tankidelari, Medinipur

REVIEW TEAM

BOLANGIR DISTRICT

Dr. Himanshu Bhushan, Deputy Commissioner MH, MoHFW, Govt. of India

Dr. Suryamani Mishra, Deputy Director, WCD Department, Ministry of Women & Child Devlopment, New Delhi

Dr. Vijay Aruldas, Cristian Medical Association of India, New Delhi

Mr. Anders Thomsen, Deputy Representative India / Bhutan, UNFPA

Dr. Munish Joshi, National Consultant Training, Directorate of NVBDCP, MoHFW, Govt of India

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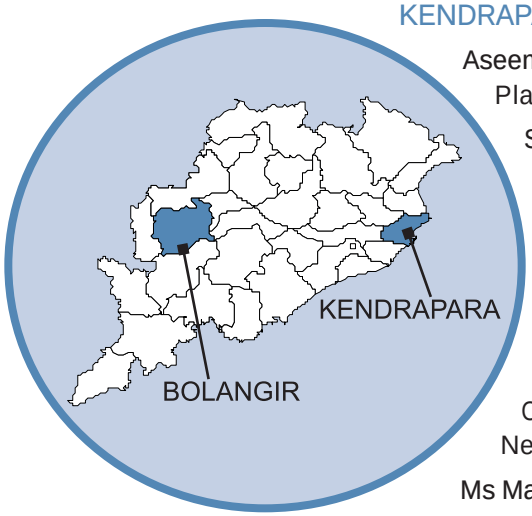
Ms. Jhimly Baruah, Consultant, Public Health Planning, NHSRC, New Delhi

Dr. Ravinder Kaur, Consultant, Maternal Health, MoHFW, Govt. of India

KENDRAPARA DISTRICT



Aseema Mahunta, Consultant, NRHM Planning and Policy, MoHFW, Govt. of India

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Dr. Umesh Chandra Sahoo, Medical Consultant, RCH-II/ NRHM, NIHFW

Sh. Saswat Rath, Sr. Consultant, TMSA, New Delhi

Sh. Tarun Arora, Research Officer, Planning Commission, New Delhi

Ms Manjula Singh, DFID, New Delhi

POSITIVES

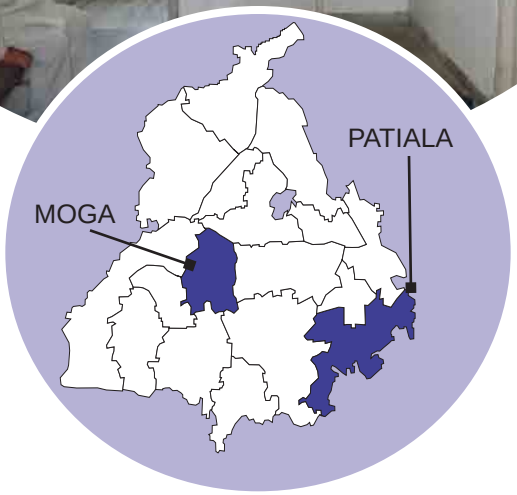
- State has added substantial new infrastructure during the NRHM period: 2 DHs, 146 CHCs and 762 Sub centers, with maximum facilities sanctioned in the high focus districts. 74% of all infrastructure funds are allocated to delivery points. Monitoring of progress on infrastructure is done through the e-Swasthya Nirman system.
- There has been a consistent increase in the patient load across the delivery points. Multi skilled AYUSH MOs play an active role in monitoring of VHNDs, immunization sessions and participating in school health teams.
- Specialists and nurses are available in Level 3 and 2 facilities. Routine tests are carried out in all L2-3 facilities. All FRUs are provided an additional recurring grant (apart from AMG, RKS and UF) for non clinical service.
- Facility based care for new born has been initiated through 21 SNCUs, 28 NBSUs and 370 NBCCs.16 NRCs functioning in state .
- There is a strong ASHA programme with focus on community mobilization and support mechanism. Well established VHSNCs/ GKS with PRI and women members undertake planning for routine activities and identifying and responding to local health needs.
- Notable initiatives in HR are online HRMIS for HR data base and ITEMS software for monitoring performance of trained manpower and performance management system.
- State has shown commendable progress in malaria control. Positive cases have decreased by 20% and deaths by 30%.
- There is effective coordination between depts. of health and WCD : Mamta Cash transfer scheme for health and nutritional support to mothers ; monthly joint coordination with CDPOs and MOIC (chaired by the DM); coordinated efforts by frontline providers (ANM, AWW, ASHA) for delivering services at VHND

CHALLENGES

- Facility based new born care needs to be strengthened .There is a need to ensure optimal utilisation of SNCUs and NBSU through adequate posting of staff trained in NSSK and F-IMNCI. NRCs need to made functional through trained staff and linkage with VHNDs for referral of SAM children to be strengthened.
- Infection control measures and bio waste management are weak in all facilities. Staff sensitization, following up on protocols especially in labs should be ensured.
- Patient amenities and hygiene conditions in high load facilities need urgent attention from the MCH managers and district managers. Supportive supervision should direct towards building the capacities of district and block personnel and improve outcomes.
- Out of pocket expenditure still high in drugs and diagnostics and referral transport in spite of JSSK and awareness on entitlements is low. Availability of drugs needs improvement and diagnostics for PW and sick new born should be provided free of cost , preferably in house . Better availability of JE required for home to facility and drop back . Information on JSSK entitlements to be disseminated widely. Steps should be taken to address the menace of informal fee in facilities.
- Technical support at State from multiple agencies haven't percolated to the district and sub district level. The SHSRC should be the window for routing the technical support and engage proactively in policy support and handholding the districts for district planning, monitoring and implementation.
- State has established the HMIS system. To make it effective, a system for analysing and use of HMIS data for monitoring outcomes and informing planners and administrators at all levels needs to be introduced.

Team Members of Gaon Kalyan Samiti, Nasipur

PUNJAB



FACILITIES VISITED BY THE TEAMS

Facilities Type	PATIALA	MOGA
DH/SDH	MKH, Rajpura	Dr. Mathura Das Civil Hospital
CHC	Bhadso Ghannaur	Kot Isse Khan Dhudike
PHC	Sauja, Kakrala Kalyan, Sauja Harpalpur, Ajrawar	Dharamkot Buttar Kalan Chand Nawan
Sub Centre	Rohti Maura Agheti, Smadh Bhai SHC	Kot Sadar Khan Baduwal Daudar Sharki Samadh Bhai,
Others	Chotti Rauni AWC, Dhandrala VHND MMU- Faridpur Jattan	ANM Training Centre, Moga

REVIEW TEAM

PATIALA DISTRICT

Dr. V.S. Salhotra, DC Adolescent Health, MoHFW, Govt. of India

Dr. K.S. Gill, Jt. Director, NVBDCP, MoHFW, Govt. of India

Dr. M.A. Qasmi, Asst. Advisor AYUSH, MoHFW, Govt. of India

Dr. Preeti Kumar, Aj. Associate Prof. PHFI, New Delhi

Ms. Chhaya Pachauri, PRYAS, Chittorgarh

Ms. Ankur Vaidya, Consultant ARSH, MoHFW, Govt. of India

MOGA DISTRICT

Dr. A.C. Baishya, Director NE-RRC, Guwahati

Mr. Sanjay Kumar, Dy. Director MMPC, MoHFW, Govt. of India

Mr Dharmendra Kumar, Consultant Finance, MoHFW, Govt. of India

Dr. Sonali Rawal, Consultant NRHM, MoHFW, Govt. of India

Dr. V.K. Anand, Health specialist CS, UNICEF, New Delhi

Ms. Neha Agarwal, Young Professional, Planning Commission

Photo top left- Dental OPD and Labour Room in same complex without privacy at Kot isse Khan CHC

Beneficiaries at Mamta Divas (VHND) Smadh Bhai SC (Moga)

POSITIVES

- State has made good progress in completing infrastructure projects with the support of the Punjab Health Systems Corporation.
- Good responses to the emergency response system '108' providing free services to pregnant women, sick children, trauma and other emergencies.; 22% of beneficiaries being pregnant women.
- Special campaign under school health programme for providing free treatment of school children for Rheumatic Heart Disease, congenital heart disease, cancer and Thalassemia and linked with Tertiary care centres .
- De-centralized Purchase of Drugs has been initiated. The State has concluded a State Rate Contract for 159 essential drugs and is in the process to have more drugs on the rate contract. The districts can procure drugs through these rate contracts.
- 24 MMUs, dedicated team, functional in all districts; service utilization is good with 50-60 OPD cases per day. Basic diagnostic facilities and drugs are available
- Financial and career promotion incentives are yielding results to attract manpower to work in difficult areas

CHALLENGES

- Health facilities below District Hoppitals do not attend to emergencies are limited to providing maternal health services. MOs are not available only for limited hours in the facilities affecting service delivery.
- State needs to expedite the process for filling the vacant regular positions of SNs, MPW (male) and ANMs.
- Use of clinical skills by providers is weak; Partographs were not being used at the labour rooms; SOPs were not available at facilities visited. Privacy arrangements in most facilities were weak.
- In case of delivery points the comprehensive plan for HR deployment was not seen and critical positions of specialist, MOs, LTs and specialists in FRUs were found to be vacant. Plans for creating additional manpower to minimize the gap were not available.
- AYUSH services are neglected in the State. Drug supply of AYUSH Medicine in Patiala is poor and least attention is being paid towards these systems of Medicine. System of drugs and logistics management in general is not uniform and needs attention.
- ASHAs trained in HBNC are yet to be provided HBNC kit. Delay in receiving payment of incentives ASHA is a major de-motivating factor ; reasons need to be addressed. Grievance redressal mechanisms for ASHAs and ASHA facilitators need to be established.

Patients waiting at OPD , Moga district hospital

RAJASTHAN

FACILITIES VISITED BY THE TEAMS

Facilities Type	SAWAI MADHOPUR	UDAIPUR
D H	Sawai Madhopur ,	Satellite Hospital-Hiran magri
SDH	Ganagapur	Salumbar
CHC	Khandar	Mavli, Bhinder, Kotda
PHC	Bharwanda , Bhadoti	Charand Tidi, Barapal, Dabole
Sub Centers	Khedli, Kilchipur Kusthala Peepalda Kijuri	Gadoli Balua
Others	ANMTC Anganwadi Centre Rasulpur Kilkari Pvt Hospital	District Drug Ware House Virathala village Kabaiya village

REVIEW TEAM

SAWAI MADHOPUR DISTRICT

Dr. Baya Kishore, Deputy Commissioner, MoHFW, Govt. of India

Sh. K. N. Verma, Dy Dir NRHM), MoHFW, Govt. of India

Ms. Renuka Patnaik, National Consultant FP, MoHFW, Govt. of India

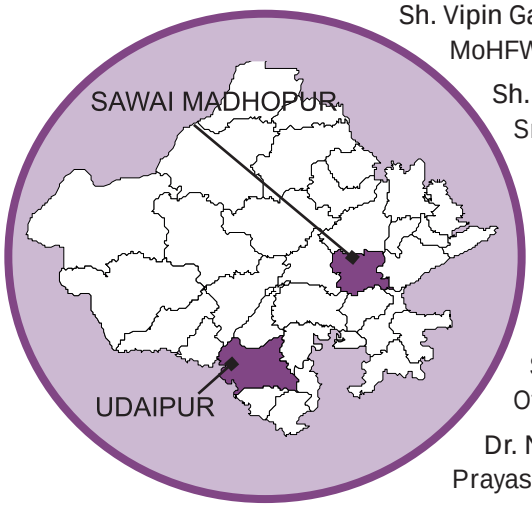
Sh. Kaushalendra, Sr. National Consultant FMG, MoHFW, Govt. of India

Dr. Faisal Shaikh, National Consultant NRHM, MoHFW, Govt. of India

Dr. Narottam Pradhan, Immunisation Officer, UNOPS, NIPI

UDAIPUR DISTRICT

Sh. Ravindar Pattar, Director FMG, MoHFW, Govt. of India



Sh. Vipin Garg, National Consultant JSY, MoHFW, Govt. of India

Sh. Prashanth Subramanium, Sr. Consultant,NHSRC, Govt. of India

Dr. Gyan Singh, Sr. Medical Officer, NIHFW, Govt. of India

Dr. B. R. Thapar, National Consultant, NVBDCP, MoHFW, Govt. of India

Sh. Satyavrat Vyas, Programme Officer, PHFI, New Delhi

Dr. Narendra Gupta, Director, Prayas, Rajasthan

Burning of waste in open at DH and open disposal of syringes at PHC in Sawai Madhopur

POSITIVES

- Good progress is made in construction. Out of the 5393 works sanctioned , 4226 works have been completed and handed over. Engineering wing working under NRHM for infrastructure development Substantial increase in the OPD, IPD and delivery services across facilities.
- Drug availability has improved considerably. There is a transparent drug procurement and distribution management system in place and drugs are available in most facilities .Sufficient medical equipments are available and utilized.
- The outreach services have improved with the contribution of the ASHA Sahyoginis.

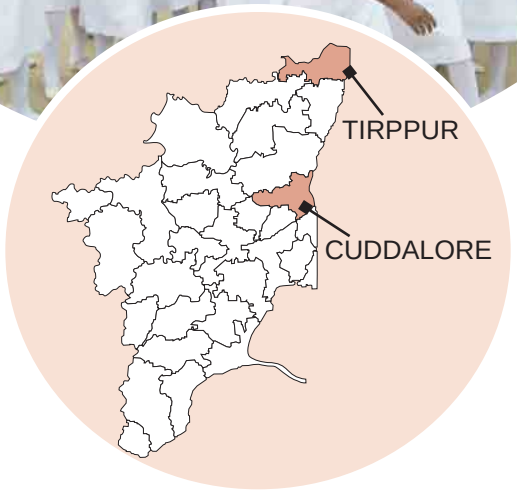
CHALLENGES

- The blood storage centres in the state should be operationalized at the earliest.
- All areas of Human resource planning and implementation - recruitment, training (strengthening of training institutions and quality training), rational deployment, and performance monitoring - requires attention.
- There is need to strengthen district (DM/ CMO) review and Facility based review for implementation of the Maternal Death Reviews.
- Strengthening of Quality Assurance Cells and Implementation of Supportive Supervision is required.
- IEC especially for JSSK, Janani Express should be up scaled and improved.

Emergency department at SDH, Salumbar, Udaipur is managed mostly by Male Nurses

Non – pneumatic Anti-shock garment demonstration by staff nurse at Tidi PHC, Udaipur

TAMIL NADU



FACILITIES VISITED BY THE TEAMS

Facilities Type	TIRUPPUR	CUDDALORE
D H	Tiruppur	Cuddalore
Govt. Hospital	Kangeyam & Udumalapet	Vridhachilam
CHC	Mutthoor & Vellakovil	Oraiyur & Kammapuram
PHC	Gudimangalam, Perumanallur, Amravati & Kunnuthur	Melpattambekkam, Puduchathiram, Mangalore & Buvanagri
Health Sub Centre	Mettupalayam, Manupatty, Appiyapalayam, Pattam-palayam, Velamyapam & Velliravlli	Attapi, P N Palayam, Tunisilamed, Allichi-kudi, C.Pudupettai & Periyakurichi
Villages	Kodandur, Pattampalayam & Thoravallur	Periyakurichi, C.Pudupettai Tunisilamed & Avatti

REVIEW TEAM

TIRUPPUR DISTRICT

Dr. Teja Ram, DC(FP), MoHFW, Govt. of India

Sh. B. K. Pandey, Director, Planning Commission, New Delhi

Mr. Rajiv Saurastri, Project Director HUP PHFI, New Delhi

Dr. Shaji Kumar, AD, AYUSH, MoHFW, Govt. of India

Sh. Jayant Mandal, FMG, MoHFW, Govt. of India

Dr. Pooja Passi, TMSA, New Delhi

CUDDALORE DISTRICT

Dr. Yashpal Sharma, Mission Director, NRHM, J&K

Mr. Michael Alexander, Attaché, Delegation of the European Union to India

Dr. (Ms) Naveeda Khatun, AD, NIPCCD, MWCD, Govt. of India

Dr. Amit Shah, RH&FP Advisor, USAID, New Delhi

Dr. Amit Mishra, Consultant, NHSRC, New Delhi

Dr. Nikhil Utture, Consultant, MoHFW, New Delhi

Drug management system

POSITIVES

- Adequate facilities for primary care services, with maximum facilities functioning in government buildings.
- All facilities have good supportive services for patient amenities. Good availability of drugs , consumable and diagnoctics-no out of pocket expenditure reported on drugs, medicines, consumables and on lab investigations across facilities.
- Vibrant PHCs , with managing significant case load providing 24x7 delivery services with three staff nurses trained on SBA, IMNCI, NSSK and IMEP and with skills for managing complications
- Comprehensive package of services available at the SDH/DH level, psychiatric clinics and counseling centers are also available at DH level. ANMs are well trained and knowledgeable.
- Urban primary health centers have created in the districts to cater the need of the urban slums.
- State has a Public Health Cadre with separate directorate, budget and legal support for management of primary care services.
- State has a good surveillance and reporting system in the State. Additional programs on NCD screening at the PHCs, Cancer screening, deafness clinics and fetal congenital anomaly detection from CHCs has started in state.
- A very good convergence observed with ICDS, Panchayati Raj and Water & Sanitation department. State has well functioning modified school health program with a dedicated MO.
- NRHM activities are managed by regular staff, no additional contractual staff hired. Very robust supportive supervision in the state at all levels.
- State has one of the best drug procurement and distribution systems in TNMSC and additionally TAMPOL available for AYUSH. The State has legal support in form of an act to guide all procurement process.

CHALLENGES

- Infrastructure development should be done looking at the case load and facility service utilization. Planning and design for infrastructure should be intended towards functional integration of services. An infrastructure development team in the district with an inter disciplinary team of district health officials, PWD engineers and architect would be useful.
- Quality Assurance Cell needs to be constituted at State level and Quality Assurance team needs to be strengthened at district level for speedy implementation of quality management system.
- Immunization needs renewed focus .Power-backup to the ILRs at the PHC should be made available to maintain cold-chain status and avoid vaccine wastage/AEFI.
- Grievance redressal mechanism needs to be put in place in all facilities and monitored for follow-up. In addition patient information kiosks need to be developed in all SDH/DH.
- State needs to improve the frequency, periodicity, range and quality of services rendered by MMU's to the tribal areas.
- The SHDRC should plan to integrate various data sources for data warehouse and data analysis is the right direction through inter-operability of different system rather through manual integration of reports. Each system needs to relook at its reporting system and remove duplication and process errors through business process reengineering.
- Although NGOs and private practitioners provide a significant proportion of eye care in urban areas the rural areas are still underserviced. Government health care facilities need to enhance services for eye care.
- Urban slums largely lack drinking water and sanitation.

TRIPURA

FACILITIES VISITED BY THE TEAMS

Facilities Type	NORTH TRIPURA	SOUTH TRIPURA
D H	Rajiv Gandhi Memorial Hospital, Unnakoti	TS District Hospital, Gomati
CHCs/SDHs (FRU/Non FRU)	Kanchanpur (SDH) Panisagar (SDH) Dharam Nagar (SDH)	CHC Monubazar SDH Belonia (FRU) SDH, Subroom CHC Nautan Bazar
PHCs (24x7)	Dasda Dhamcharra Kadamtala	Rupaichari Rajnagar Kakarabal Silachari Shanti Bazar
SCs (Delivery/ Non Delivery point)	Shantipada Satnala Lakshmipur - (Delivery point) Rajnagar Krishnapur Churibari Deochara	Rani Radha Nagar East Jalepa Ailmara Chotakhill
Others	Newly constructed buildings of DH, PHCs, SCs, Anganwadis, Schools, Villages, Meetings with ASHAs, VHND sites, MMUs, Training Centres etc.	

REVIEW TEAM

NORTH TRIPURA DISTRICT

Dr. M.K. Aggarwal (4-5 Nov)
Deputy Commissioner, MoHFW, Govt. of India

Dr. D.K. Saikia
Faculty, NIPPCD Regional Centre Guwahati, WCD, Govt. of India

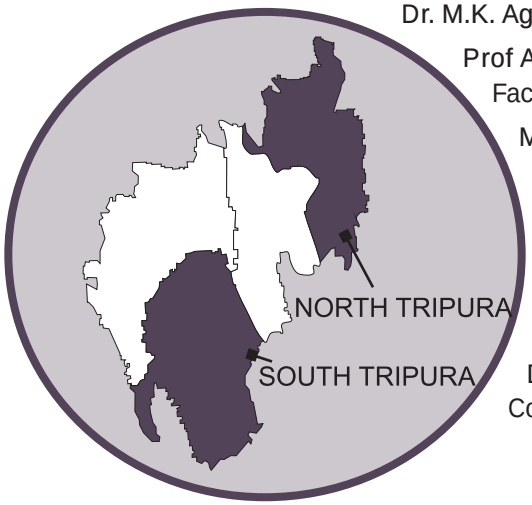
Ms Sangeeta C. Pinto
Operations Officer, World Bank, New Delhi

Dr. S. N. Bagchi
Senior Programme Manager, PHFI, New Delhi

Mr. Arun Srivastava
Consultant, NHSRC

Dr. Anil Kashyap
Consultant, MoHFW, Govt. of India

SOUTH TRIPURA DISTRICT



Dr. M.K. Aggarwal, (6-7 Nov)

Prof A. M. Khan,
Faculty, NIHFW, Govt. of India

Ms.Sulakshana Nandi,
State Convenor, SHRC Chhattisgarh

Mr. S.J. Sultan
Consultant, MoHFW, Govt. of India

Mr. Rakesh Shokeen
Consultant, MoHFW, Govt. of India

Dr. Ashalata Pati,
Consultant, MoHFW, Govt. of India

Expansion of PHC underway with new construction

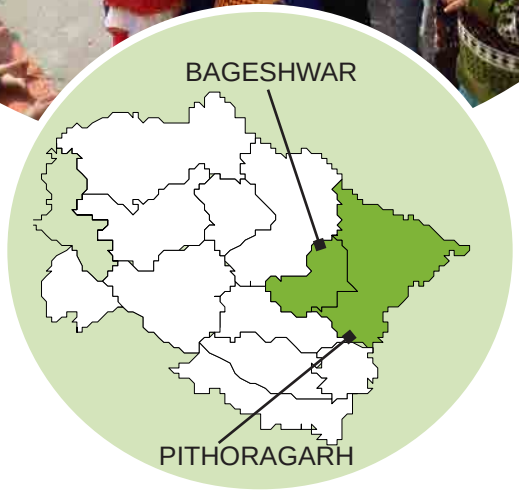
POSITIVES

- State has placed strong emphasis on expansion of infrastructure through creation of new facilities ;rate infrastructure development is adequate vis-a-vis population norms.
- Despite HR gaps state has ensured basic availability of HR in facilities across the state, which has ensured their functionality.
- Mainstreaming of AYUSH doctors is very strong. State has policy of sponsoring PG studies for medical officers after 3 years of mandatory rural service
- Access to health services has improved through use of innovative approaches like Tele- Medicine, tele Opthalmology centers and outreach villages health camps using helicopter.
- VHND is being used very effectively for social mobilisation, convergence and a wide range of services including OPD services. Strong presence and participation of PRI members in community processes .
- Training of ASHAs on Module 6&7 has been completed till the second round. ASHA Facilitators are in position. Additional 33.% performance incentive is given to ASHAs from state funds, and 10% seats have been reserved for ASHAs in ANM training course.

CHALLENGES

- In spite of operationalsing the JSSK, provision of free drugs and referral Transport to pregnant women/mothers is not being done as per guidelines, resulting in high out of pocket expenses. State needs to ensure provision of the free entitlements and not cash reimbursements.
- Inadequate supportive supervision and quality of services in the Sub centres.
- Facility based supportive services are weak : toilet facilities, safe drinking water provisions and medical waste disposal systems were across the facilities.
- Equipment maintenance and supply-chain management systems for drugs, consumables and equipments need strengthening.
- Non availability of essential drugs and medical supplies is leading to high OOP expenditure.
- State is yet to set up patient and emergency transport system.
- In spite of strong community and PRI participation , state has not started community based monitoring systems.
- Generators for power back are non functional in almost all facilities
- Untimely incentive payments, Drug Kit refill and weak training and monitoring of ASHA programme

UTTARAKHAND



FACILITIES VISITED BY THE TEAMS

Facilities Type	BAGESHWAR	PITHORAGARH
DH	DH Bageshwar	DH Pithoragarh
CHC	Kapkote, Baijnath	Dharchula, Gangolihat
PHC/APHC	Kausani, APHC Sama, Chani, APHC Kanda	Berinag, Kanalichina Askot, Egyadevi Muwani, Gauchar Thal
SC	Sama, Kasauni, Chani, Kanda Kupkote, Baijnath	Askot, Gangolihat Gauchar Thal Egyadevi
others	Arogya Rath (MMU) DARC, 3 FGDs (ASHAs, AWWs , community) EMRI	FGD (ASHAs, ANMs, RKS and VHSNC)

REVIEW TEAM

BAGESHWAR DISTRICT

Dr. Anjana Saxena,
ex-Deputy Commissioner, MoHFW,
Govt. of India

Smt. Rekha Chauhan,
Under Secretary, MoHFW, Govt. of India

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Dr. Meerambika Mohapatra, NIHFW, New Delhi

Sh. Prabhash Jha, Consultant-FMG, MoHFW, Govt. of India

Ms. Asmita Jyoti Singh, Consultant NRHM, MoHFW, Govt. of India

PITHORAGARH DISTRICT

Ms. Anuradha Vemuri, Director, MoHFW, Govt. of India

Sh. B B Sharma, Director, Planning Commission, New Delhi

Dr. Satish Gupta, Health Specialist, UNICEF, New Delhi

Dr. Sharmila Neogi, USAID, New Delhi

Sh. Sanjay Samadar, Project Director, HUP

Dr. Manpreet Khurmi, Consultant RCH, MoHFW, Govt. of India

IEC for JSSK Programme at Bageshwar

POSITIVES

- Health facilities have good infrastructure, adequate equipments and essential drugs.
- Prioritization of 'delivery points' for providing comprehensive services was visible in state and district plans.
- JSSK has been implemented with adequate display of IEC, diet and drop back.
- Designated space earmarked for SNCU, NBSU and knowledge for planning of new-born care facilities was found to be excellent.
- Line listing of severely anaemic pregnant women is being maintained by ANMs in Pithoragarh.
- ASHAs active in social marketing of contraceptives and maintaining the work/visits registers properly. ASHA Ghars are available in the DHs.
- Special transport arrangements for drop back of mothers 'Khushi ki Sawari' is utilized well .
- Good display of IEC material in all the facilities

CHALLENGES

- EmOC, LSCS training have not been conducted for MOs in last one year; No training for Medical Health Managers so far.
- Immunization micro plan needs to be prepared and child tracking should be done for left out and drop out children using due list or MCTS work plan
- Irrational deployment of multiskilled MOs; transfer policy needs to be put in place along with incentives for remote, hard to reach and inaccessible areas
- Records of AMG and RKS needs to be maintained at the facility level.
- State should plan for a prudent mix of basic level ambulances and emergency response vehicles. DHs need to use their ambulances for interfacility transfer wherever there is shortfall of EMRI vehicles.
- Lack of supportive supervision/monitoring of NGO (MMU DRC)
- Entry of field level data in HMIS formats and MCTs registers needs to be improved.
- No grievance redressal system in place in the facilities visited

Approach to PHC Kanda - Bagheshwar

Users' fee display at CHC Baijnath

UTTAR PRADESH

REVIEW TEAM

JHANSI DISTRICT

Dr. P K Prabhakar,
Deputy Commissioner CH, MoHFW, Govt. of India
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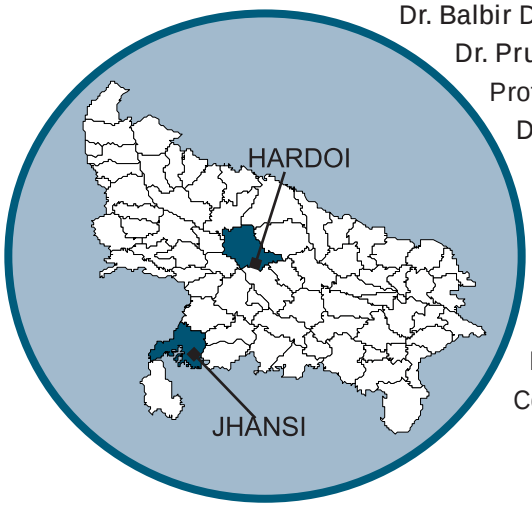
Dr. Shailesh Jagtap,
Public Health Specialist, PHFI, New Delhi
Sh. Naresh Kumar,
Economic Officer, Planning Commission,
Dr. Pushkar Kumar,
Lead Consultant MH, MoHFW, Govt. of India
Sh. Sameer Thapa,
Finance Controller FMG, NRHM, Govt. of India
Sh. Vipin Joseph,
Consultant RCH Monitoring, MoHFW, Govt. of India

HARDOI DISTRICT

Ms. Limatula Yaden,
Director NRHM, MoHFW, Govt. of India
Dr. Balbir Dewan, Public Health Expert, NIHFW
Dr. Pruthvish Sreekantaiah,
Professor CM, MSR Medical College
Dr. Devendra Khandait,
Program Officer (Immunization), BMGF
Dr. Amit Katewa,
Consultant, NVBDCP
Dr. Deepti Agrawal,
Consultant RCH, MoHFW
Dr. Shahab Ali Siddiqui,
Consultant NRHM, MoHFW

FACILITIES VISITED BY THE TEAMS

Facilities Type	JHANSI	HARDOI
D H	District Male Hospital, District Female Hospital	District Male Hospital, District Female Hospital
C H C	Babina, Bangara, Baragaon, Mauranipur, Moth	Kacchuna, Shahabad, Sandila, Tadiyavan
PHCs	BaruvaSagar, Sakrar	Toderpur, Sursa, Hariyawan, Urban Post
Sub-Center	Ghughuva, Barata, Sakrar, Kotara, Jawan, Moth	Suthena, Saank
Anganwadi Center	Barata	Saank
Villages	Ghughuva, Barata, Sakrar, Kotara, Jawan, Moth	Suthena, Saank
ANM Training Center	Moth	-
Medical College	Maharani Laxmibai Medical College & Hospital (NRC & SNCU)	-



Walking in Tandem - ANM & ASHA House Visits, Jhansi

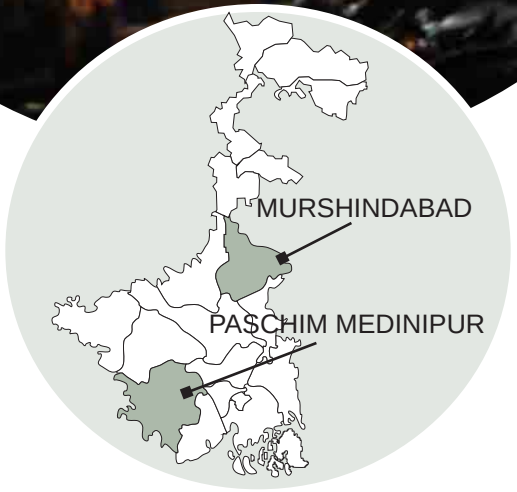
POSITIVES

- Infrastructure developed during the NRHM period includes 2 District Hospitals, 328 CHCs, 779 PHCs and 10604 Sub Centers.
- There has been significant increase in OPD footfalls. Increase in IPD is mainly on account of Institutional Deliveries. Patients, villagers, and PRI members, during interactions reported huge enhancement in the public health system in last few years with improved presence of service providers in the facilities and better drug availability
- Out of the existing 20521 Sub Centers in the State, 12% are delivery points, some with high caseloads, as found in Jhansi district. Emergency & Ambulance services have started up – 133 '108 ambulances" and 500 '102 ambulances' deployed.
- Under NRHM, 1498 AYUSH Doctors and 549 AYUSH Pharmacists have been added to the Public Health Workforce
- Cold Chain points were well maintained and 'Alternate Vaccine Delivery' mechanism in place. RI micro-plans have been prepared
- IDSP online data reporting is above 85 % from all districts, other than the 6 where it is yet to be implemented properly
- For JE Government of India has approved funds for 10 bedded Intensive Care Unit for Children in 9 highly JE /AES affective districts. Construction of 100 Bedded JE ward at BRD Medical College, Gorakhpur is in progress
- State has achieved the RNTCP objectives of 70% NSP case detection & 85% NSP cure rate and 8 districts are implementing Programmatic Management of Drug Resistant TB (PMDT)
- About 136094 ASHAs have been selected and 89% up to Module 5. During the field visits, ASHAs were vibrant, knowledgeable and very enthusiastic about their work
- 80% ASHAs in 17 districts have been given Comprehensive Child Survival Program (CCSP) Training.

CHALLENGES

- Existing public health facilities are based on 1991 census population - large gaps exist according to 2011 census norms. Sub Centers on an average cover a population of 9725 and there is a need of 20,000 additional SCs.
- Irregular recruitment process and lack of candidates has resulted in inability to fill vacancies. There are 4525 MO, 2557 paramedical and 2412 ANM posts lying vacant and only 2566 Male Health Workers are posted against a sanctioned number of 8857. No comprehensive strategy to attract and retain healthcare providers in the rural areas – existing financial incentive (Rs 100 per month for doctors) is too low to make a difference
- Due to inadequate number of faculty members, admissions in the ANM Training Center affected - the process was last carried out since 2009. ANMTC at Moth, Jhansi has produced only 1 batch of ANMs in the past 6 years. Training plan and post training deployment plan not in place in the districts visited - Low levels of achievement for critical trainings that include SBA, NSSK, LSAS, F-IMNCI, BeMOC and EmOC.
- Operationalization of First Referral Units hindered by non-availability of specialists and slow pace of multiskilling of doctors - Comprehensive RCH services are available in the districts mostly at DH/ DWH only. Limited range of available diagnostic services and laboratories mostly remain non-functional beyond OPD hours. Many delivery points, especially in sub centers, lack appropriate/usable labor tables, newborn care corners, power supply, piped water, compromising on the quality of care being delivered from these centers
- Camp approach is largely being followed for performing the sterilization procedures for women. Minilap and Vasectomy are not performed at any of the health facilities; ECPs are not available within the system. Overall the effort to promote or motivate clients for adoption of contraceptives is weak.
- There has been an inordinate delay in setting up of the State Health Resource Center, in spite of approval and sanction of funds.
- The statutory audit for the period 2010-11 pending as on October 2012. District and Block Account Manager posts are vacant – regular trainings not being conducted for those who are in position. Overall, there are 100 vacant posts under DPMUs. Most of the vacancies at DPMUs are there since 2008. At BPMU level 293 BPM and 75 BDAA posts are vacant.

WEST BENGAL



FACILITIES VISITED BY THE TEAMS

Facilities Type	MURSHIDABAD	PASCHIM MEDINIPUR
DH	New General Hospital and Sadar Hospital	Jhargram District Hospital Mednipore Medical College & Hospital
SDH/RH	Sagardighi RH Jangiapur SDH Lalbaugh SDH	Daspur Rural Hospital Chandrakona Rural Hospital
BPHC/PHC	Gokarna BPHC Arjunpur PHC Anoopnagar PHC Panchgram PHC	Panchkuri PHC Dwaregeria Block PHC Lalgarh PHC
SC	Harhari SC Sopara SC Gokarna SC Khasbaspur SC	Lalgarh SC Kanko SC Krishnapur SC Koshba SC
Others		Mednipore Nursing School

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MURSHIDABAD DISTRICT

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Corrrider of the labor ward in the DH Murshidabad with pregnant women waiting their turn

POSITIVES

- Improved Infrastructure has increased the service utilization; daily average OPD in PHCs is 100 and about 200 -250 in BPHCs and RHs. community was appreciative of services provided in health facilities.
- Community was appreciative of services provided by service providers in health facilities.
- Fair Price Outlets for Medicines in 35 medical institutions of the state. Diet was being provided to all the in-patients in public health facilities.
- MMUs are functional and alternate vaccine delivery system in place. Outreach activities in islands of Padma River are appreciable.
- The ASHAs are highly educated and further trained through new initiatives - Receive Only Terminal (ROT) and ASHA Talk Show
- Display of protocols for high risk pregnancy identification uptil sub-centre level, referral transport in place.
- 30%-35% in increase in number of JSY beneficiaries since 2009-10 in Murshidabad. JSY payment made all the women timely.
- Infrastructure has been improved; 545 NBCCs, 125 NBSUs and 22 SNCUs have been established since 2005 and fully functional
- NGO involvement has been seen. Eg: Ambulances, MMUs, ASHA training, help desks in various facilities.
- Effective Disease Control Programmes; Testing for malaria, kala azar, sputum for AFB being done in all the facilities. Active case search for Kala Azar cases has improved identification of additional cases
- Joint review meetings occur regularly to take stock of programme progress, Staff & Fund position
- Special drives/ camps are being organised to improve delivery outcomes.

CHALLENGES

- Infrastructure: Despite huge shortfall of Health Infrastructure at state level and district level only one more PHC is sanctioned In 2012-13.
- Existing Facilities are unhygienic and rodent infested. Provision of staff quarter is inadequate and need repair.
- VHSNC and RKS have been formed but non functional. RKSs have huge unspent balances.
- High out of pocket expenditure due to User charges at Sub-divisional Hospitals and District Hospitals and prescription of private drugs and diagnostics.
- Increase in the Maternal Mortality Ratio in the State from 141/100,000 live births as per in 2005to 145 /100000 live births in 2008 (SRS).
- Delivery points: 3.8% of the public health facilities were functional as delivery points in the State. Out of 10,356 SCs only 11 conduct > 3 deliveries per month, while 54 out of 272 24/7 PHCs conduct > 10 deliveries. Among 102 FRUs, only 96 are conducting C-Sections and are functional FRUs. Murshidabad has only 4 % delivery points leading to overcrowding in the facilities. The stay for 3 days and 7 days for normal and C-Section is not possible.
- Capacity building initiatives are limited and need to be scaled up in the State especially for SBA, BEmOC, NSSK, F-IMNCI.
- Inadequacy of referral transport, 'Nishchay Yans' and unavailability at night was an issue.
- Out of 135 MoUs signed in state to provide institutional deliveries under Ayushmati scheme only 71 are functional delivery points.
- Reporting for IDSP is not adequate and complete in both the districts. ABER is much below the recommended level and annualised new smear positive case detection rate in is below the desirable level.

Bhano' – the cycle rickshaw used for transporting a variety of goods in Murshidabad district including patients

EMRI in action, Tamil Nadu

SC Damarpur, Odisha

Services available in PHC, Chhattisgarh

Public health services in Tamil Nadu

Newborn corner with mosquitoe protection, West Bengal

Early Intervention Clinic Samarpan 2

National Rural Health Mission

Ministry Of Health & Family Welfare
Government of India
Nirman Bhawan, New Delhi

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