13|CRM

COMMON REVIEW MISSION 2019

SYNTHESIS REPORT

13th

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2019

SYNTHESIS REPORT

NATIONAL HEALTH MISSION
Ministry of Health & Family Welfare
Government of india

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व पृथ्वी विज्ञान मंत्री, भारत सरकार
Union Minister for Health & Family Welfare,
Science & Technology and Earth Sciences
Government of India

<u>MESSAGE</u>

It is with great pleasure that I write this foreword to the report of the 13th Common Review Mission (CRM). This CRM marks fourteen years of implementation of the National Rural Health Mission and six years of the National Urban Health Mission.

2.   The National Health Mission (NHM) denotes a coordinated effort towards health systems' reforms in the country. The report demonstrates that all States appear to have made remarkable improvements, particularly in the area of maternal, new-born and child health. It is also relevant to note that NHM's sustained investments in strengthening the public health systems have enabled last mile delivery of health services particularly those related to pregnancy, delivery, immunization, new-born and child care.

3.   I am also happy to note that longstanding programmes such as ASHAS, the Ambulance services and Mobile Medical Units continue to play a key role in improving access to healthcare services. NHM initiatives to reduce out of pocket expenditures such as Free Essential Medicines Services Initiative, Free Essential Drug Services Initiative and the Pradhan Mantri National Dialysis Programme have particularly been popular among the masses.

4.   The report also shows that all states are putting their best efforts to provide Comprehensive Primary Health Care by operationalizing the Ayushman Bharat-Health and Wellness Centres (AB-HWCs) and at this rate, I am confident that we will achieve the target of 1,50,000 AB-HWCs needed to ensure the delivery of CPHC closer to the community.

5.   I am sure that States will use the findings of this CRM in order to ensure better health outcomes and leverage these learnings for further strengthening of their public health systems in rural and urban areas of the country.

(Dr. Harsh Vardhan)

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<u>Message</u>

Common Review Missions (CRMs) have played a key role as a key monitoring tool particularly for assessing the progress of National Health Mission (NHM) implementation on ground. It has proven to be a valuable mechanism for the Ministry of Health & Family Welfare to review programme and policy changes. From a governance point of view, it provides both Centre and the States an opportunity to take stock of the present situation and adopt appropriate mid-course policy/strategy changes.

The 13th Common Review Mission has covered 16 states, with the task of assessing various domains of health systems. The improvements in key indicators in the field of child and maternal survival, fertility rates have been validated in all states. We must learn from and sustain these gains beyond maternal, new-born and child health. The states must be congratulated for their achievements.

Moving forward, such initiatives within the national Health Mission will help in strengthening secondary care services and integrate primary and higher services. The Health and Wellness Centres would be a key platform for such integration.

I am also glad to note that multi-sectoral convergence was an active focus area of this CRM, since health relies on multiple other determinants and it is important for all sectors to work together.

States should use this report to take action on specific, contextual challenges for effective implementation to reach the goal of Universal Health Coverage.

I would like to convey my appreciation to all the team members who undertook this mammoth exercise and helped prepare this report. I am sure it has been an enriching experience to all involved and I am also sure the observations and recommendations will help move the mission forward.

(Ashwini Kumar Choubey)

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Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

Dated : 21st July, 2020

FOREWORD

It is a great pleasure to write a foreword for the Common Review Mission (CRM), which is unique to the National Health Mission.

National Health Mission (NHM) has many creditable features and CRM is a distinctive characteristic. Organized annually with multiple teams, each with over fifteen technical experts, the CRM report captures the pooled insights of many public health practitioners and researchers. The report of the 13th CRM is no exception.

It is heartening to note the many successes recorded across the ten Terms of Reference. Efforts such as Ayushman Bharat Health and Wellness Centres, Poshan Abhiyaan, Mission Indradhanush and Aspirational districts have demonstrated gains in reaching last mile populations, which would have been more difficult without the strong public health systems to which contribution of the integrated approach on mission mode of NHM has been substantial.

Besides the impressive progress in certain areas, implementation challenges have been highlighted in several areas by the CRM teams, especially, governance and equity in coverage, are highlighted.

The success we have achieved in maternal, child new-born and child health need to now be replicated for communicable and non-communicable diseases. The challenge before us now is to creatively use the structures and service delivery platforms already in place to strengthen an expanded range of services and public health actions.

The multiple stakeholders involved in the Common Review Mission bring valuable perspectives to the task and we are grateful for their insights.

It is my sincere hope that States pursue these successes further and leverage the NHM to improve their public health systems at district and sub district levels.

(Preeti Sudan)

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अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)
Additional Secretary & Mission Director (NHM)

The 13'h Common Review Mission (CRM) marks nearly a decade and half since the launch of the National Rural Health Mission. It is encouraging to see from the report that the vision of universality, equity and affordability continue to guide the States in the implementation of National Health Mission (NHM).

Apart from improvements in key indicators, the areas where efforts and investments were made, have shown impressive gains. Oven the past few years, multiple components were included in NHM, including the Urban Health Mission. The test of health systems strengthening is the ability to perform well on existing activities and absorb newer intervention components. NHM has withstood that test well.

The report highlights that a focus on continuum of care and quality of services require expedited attention. Public health functions particularly in urban areas also need focus. Use of technology in improving access, quality and accountability, are areas that need further attention.

The involvement of stakeholders from States, academic institutions, research agency, civil society and development partners, in this exercise brings multiple perspectives to bear on implementation assessment. Their involvement enriches this exercise and enables the CRM to serve as a useful sharing and learning platform.

I hope that States now use these findings as an input to programme planning as they work towards implementing the goal of Universal Health Coverage

(Vandana Gurnani)

Abbreviations

AAA	ASHA, ANM and Anganwadi	ANC	Antenatal Care
AB	Ayushmaan Bharat	ANCDR	Annual New Case Detection Rate
ABER	Annual Blood Examination Rate	ANM	Auxiliary Nurse Midwifery
ABS	ASHA Benefit Scheme	ANMMCH	Anugrah Narayan Magadh Medical College
ABSULS	ASHA based Surveillance for Leprosy Suspects	ANMOL	Auxiliary Nurse Midwifery Online
ACSM	Advocacy Communication & Social Mobilization	ANMTC	Auxiliary Nurse Midwifery Training Centre
		APHC	Additional Primary Health Centres
ACT	Artesunate Combination Therapy	API	Annual Parasitic Index
AEFI	Adverse Effect Following Immunization	APL	Above Poverty Line
AERB	Atomic Energy Regulatory Board Certification	APMSIDC	Andhra Pradesh Medical Services & Infrastructure Development Corporation
AES	Acute Encephalitis Syndrome	ARI	Acute Respiratory Infections
AFB	Acid Fast Bacilli	ARSH	Adolescents Reproductive & Sexual Health
AFHC	Adolescent Friendly Health Clinics		
AH	Adolescent Health	ART	Anti-Retroviral Therapy
AHD	Adolescent Health Day	ARV	Anti-Rabies Vaccine
AIDS	Acquired Immune Deficiency Syndrome	ASHA	Accredited Social Health Activists
AIIMS	All India Institute of Medical Sciences	ASV	Anti-snake venom
ALS	Advanced Life Support Ambulances	ATI	Administrative Training Institute
AMB	Anemia Mukt Bharat	AVD	Alternate Vaccine Delivery
AMC	Annual Maintenance Cost	AWC	Anganwadi Centres
AMO	Assistant Medical Officers	AWW	Anganwadi Workers
AMR	Anti-Microbial Resistance	AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy
AMTSL	Active Management of Third Stage of Labour		
		B.Sc.	Bachelor of Science

BAC	Block ASHA Coordinators	CBMWTF	Common Bio-medical Waste Treatment Facility
BAMS	Bachelors of Ayurvedic Medicine and Surgery	CBNAAT	Cartridge- Based Nucleic Acid Amplification Test
BCC	Behaviour Change Communication	CBWTF	Common bio-medical waste treatment and disposal facility
BCG	Bacillus Calmette–Guérin	CCCH	Certificate Course in Community Health
BCM	Block Community Mobilisers	CDAC	Centre for Development of Advanced Computing
BCPM	Block Community Process Manager	CDO	Chief Development Officer
BCTU	Blood collection and Transport Unit	CDPO	Child Development Project Officer (CDPO)
BER	Beyond Economic Repair	CDR	Child Death Review
BERA	Brainstem-evoked response audiometry	CEA	Clinical Establishment Act
BLS	Basic Life Support Ambulance	CEMoNC	Comprehensive Emergency Obstetric and New-born care
BME	Biomedical Engineer	CFMS	Centralised Funds Management System
BMGF	Bill & Melinda Gates Foundation	CFN	Certificate in Food and Nutrition
BMMP	Biomedical Equipment Maintenance and Management program	CGHS	Central Government Health Scheme
BMO	Block Medical Officer	CH	Child Health
BMW	Bio Medical Waste	CHC	Community Health Centre
BMWM	Bio Medical Waste Management	CHD	Congenital Heart Disease
BOR	Bed Occupancy Rate	CHO	Community Health Officers
BP	Blood Pressure	CIG	Certificate in Guidance
BPHC	Block Primary Health Centre	CLD	Central Leprosy Division
BPL	Below Poverty Line	CMC	Comprehensive Maintenance Contract
BPM	Block Program Manager	CMCHIS	Chief Minister's Comprehensive Health Insurance Scheme
BPMU	Block Program Management Unit	CMHA	Central Mental Health Authority
BSBY	Bhamashah Sisthya Beema Yojana	CMHIS	Chief Minister's Comprehensive Health Insurance Scheme
BSKY	Biju Sisthya Kalyan Yojana	CMHO	Chief Medical Health Officer
BSU	Blood Storage Unit	CMO	Chief Medical Officer
BTT	Block Training Team	CMTC	Child Malnutrition Treatment Center
CAC	Comprehensive Abortion Care	COPD	Chronic Obstructive Pulmonary Disease
CAH	Community Action for Health	COTPA	Cigarettes and Other Tobacco Products Act 2003
CARE	Cooperative for Assistance and Relief Everywhere	CP	Community Processes
CAS	Computer Application Software	CPCH	
CATS	Centralised Ambulance and Trauma Services	CPD	Continuing Professional Development
CBAC	Community Based Assessment Checklist		
CBE	Community Based Event		

CPHC	Comprehensive Primary Health Care		DMHP	District Mental Health Programme
CPMU	Central Project Management Unit		DMMU	District Mobile Medical Unit
CPS	College of Physician and Surgeon		DMO	District Malaria Officer
CPT	Clotrimazole Preventive Therapy		DNB	Diplomate of National Board
CQSC	Central Quality Supervisory Committee		DOTS	Directly observed treatment, short-course
CRM	Common Review Mission		DPC	District Planning Coordinator
CSR	Corporate Social Responsibility		DPHL	District Public Health Laboratory
CSSD	Central Sterile Supply Department		DPM	District Programme Manager
CSW	Commercial Sex Workers		DPMU	District Programme Management Unit
CT	Computed Tomography		DPT	Diphtheria-Pertussis-Tetanus
CTD	Central TB Division		DQAC	District Quality Assurance Committee
CTF	Common Treatment Facility		DQAMO	District Quality Assurance Medical Officer
CUG	Closed User group		DQAU	District Quality Assurance Unit
CXR	Chest X-Ray		DRG	District Resource Group
DACP	Dynamic Assured Career Progression		DRTB	Drug Resistance TB
DAK	Delhi Aarogya Kosh		DSSSB	Delhi Subordinate Services Selection Board
DAMAN	Durgama Anchalare Malaria Nirakaran		DST	Drug Sensitivity Test
DAPCU	District AIDS Prevention and Control Unit		DTC	District Tuberculosis Centre
DBT	Direct Benefit Transfer		DTCC	District Tobacco Control Cell
DCC	District Counselling Center		DTO	District Tuberculosis Officer
DCM	District Community Mobiliser		DVDMS	Drugs and Vaccines Distribution Management Systems
DDMS	Drug Distribution Management System		DWH	District Women Hospital
DDT	Dichloro Diphenyl Trichloroethane		EAG	Empoared Action Group
DDW	District Drug warehouse		EBF	Exclusive Breastfeeding
DEIC	District Early Intervention Centre		ECCE	Early Childhood Care and Education
DEO	Data Entry Operator		ECD	Early childhood Development
DGHS	Director General of Health Services		ECG	Electro Cardiography
DH	District Hospital		ECP	Emergency Contraceptive Pills
DHAP	District Health Action Plan		ECRC	Emergency Care and Recovery Centre
DHQ	District Headquarter		EDD	Expected Delivery Date
DHS	District Health Society		EDL	Essential Drug List
DJB	Delhi Jal Board		EGSA	Extended Gram Swaraj Abhiyan
DLO	District Leprosy Officer		EHR	Electronic Health Record
DM	District Magistrate		EHS	Electronic Health Services
DMC	Designated Microscopic Centre		ELISA	Enzyme-linked Immune Sorbent Assay
DMCHO	District Maternal and Child Health Officer			
DMF	District Mineral Fund			

EMRI	Emergency Management and Research Institute		GH	Government Hospital
EMS	Emergency Medical Services		GIS	Geographic Information System
EMT	Emergency Medical Technicians		GKS	Gao Kalyan samitis
EMTC	Elimination of Mother to Child Transmission		GMD	Growth Monitoring Device
ENBC	Essential New-born Care		GNM	General Nursing Midwifery
ENT	Ear Nose Throat		GOI	Government of India
EPTB	Extrapulmonary TB		GPS	Global Positioning System
EQAS	External Quality Assurance Standards		GRS	Grievance Redressal System
ERCP	Emergency endoscopic retrograde cholangiopancreatography		GSA	Gram Swaraj Abhiyan
ERIG	Equine Rabies Immunoglobulin		HBNC	Home Based New-born Care
ESB	Ensuring Spacing at Birth		HBPNC	Home Based Post Natal Care
ESI	Employees' State Insurance		HBV	Hepatitis B Virus
ESRD	End Stage Renal Disease		HBYC	Home Based Care for Young Child
ETP	Effluent Treatment Plan		HCF	Health Care Facility
e-VIN	Electronic Vaccine Intelligence Network		HCM	Hot Cooked Meals
FBNC	Facility Based Neonatal Care		HCT	Health Care Technology
FDC	Fixed Dose Combinations		HCV	Hepatitis C Virus
FDI	Free Diagnostics Initiative		HCW	Health Care Workers
FDS	Fixed Day sterilization		HDU	High Dependency Unit
FDSI	Free Drug Service Initiative		HIE	Hypoxic-ischemic encephalopathy
FEFO	First Expiry First Out		HIV	Human Resource Information Management System
FGD	Focussed Group Discussions		HLFPPT	Hindustan Latex Family Planning Promotion Trust
FICTC	Facility Integrated Counselling and Testing Center		HMIS	Health Management Information System
FIFO	First In First Out		HPD	High Priority Districts
FLC	Focused Leprosy Campaign		HR	Human Resource
FLW	Frontline Workers		HRH	Human Resource for Health
FMG	Financial Management Group		HRIMS	Human Resource Information Management System
FP	Family Planning		HRP	High Risk Pregnancy
FPLMIS	Family Planning Logistic Management Information System		HSC	Health Sub-Centre
FRU	First Referral Unit		HTN	Hyperattention
FSW	Female Sex Workers		HUD	Housing and Urban Development
GAK	Gram Arogya Kendra		HWC	Health and Wellness Centre
GDMO	General Duty Medical Officer		ICDS	Integrated Child Development Scheme
			ICTC	Integrated Counselling and Testing Centre

ICU	Intensive Care Unit		IUD	Intra Uterine Device
IDD	Iron Deficiency Disorder		IV	Intravenous
IDSP	Integrated Disease Surveillance Project		IWD	International Women's Day
IDU	Injectable Drug Users		IYCF	Infant and Young Child Feeding
IEC	Information Education Communication		JDS	Jeevan Deep Samiti
IFA	Iron Folic Acid		JE	Japanese Encephalitis
IGIMS	Indira Gandhi Institute of Medical Sciences		JHPIEGO	Johns Hopkins Program for International Education in Gynaecology and Obstetrics
IGNOU	Indira Gandhi National Open University		JIPMER	Jawaharlal Institute of Postgraduate Medical Education and Research
IHIP	Integrated heath Information platform		JNIMS	Jawaharlal Nehru Institute of Medical Sciences
IIPH	Indian Institute of Public Health			
IIPHG	Indian Institute of Public Health, Gandhinagar		JSAC	Jharkhand Space Applications Center
			JSSK	Janani Sisthya Suraksha Karyakaram
IIPS	International Institute for Population Sciences		JSY	Janani Suraksha Yojna
IKDRC	Institute of Kidney Diseases and Research Centre		KGMU	King George Medical University
			KKS	Khushion Ki Sawari
ILA	Incremental Learning Approach		KOI	Key Output Indicators
ILC	Innovation and Learning Centre		KPI	Key Performance Indicators
ILR	Ice Line Refrigerator		KTPL	Kirloskar Technology Private Ltd
IMI	Intensified Mission Indradhanush		KTS	Kala-azar Technical Supervisors
IMNCI	Integrated Management of New-born and Childhood Illness		LBW	Low Birth Weight
			LCDC	Leprosy Case Detection Campaign
IMR	Infant Mortality Rate		LF	Lymphatic Filariasis
INAP	Indian New-born Action Plan		LHMC	Lady Harding Medical College
INC	Indian Nursing Council		LHV	Lady Health Visitor
INH	Isoniazid		LIMS	Laboratory Information Management System
INR	Indian National Rupees			
IOL	Intra Ocular Lens		LLIN	Long Lasting Insecticide Nets
IPC	Inter Personal Skills		LPA	Line Probe Assay
IPD	In Patient Department		LPG	Liquified Petroleum Gas
IPHS	Indian Public Health Standards		LR	Labour Room
IPV	Inactivated Polio Vaccine		LSAS	Life Saving Anaesthetic Skills
IQC	Internal Quality Control		LT	Laboratory Technician
IRL	Intermediate Reference laboratory		MAA	Mother Absolute Affection
IRS	Indoor Residual Spray		MAM	Moderate Acute Malnutrition
ISO	International Organization for Standardization		MAS	Mahila Aarogya Samiti
IUCD	Intra Uterine Copper Device			

MBBS	Bachelor of Medicine and Bachelor of Surgery
MCB	Mother Circuit Board
MCD	Municipal Corporation of Delhi
MCH	Maternal and Child Health
MCHN	Maternal, Child Health Nutrition Day
MCP	Mother and Child Protection
MCR	Microcellular Rubber
MCTS	Mother and Child Tracking Systems
MCW	Maternity, Child and Welfare Centre
MDA	Mass Drug Administration
MDG	Millennium Development Goals
MDR	Maternal Death Review
MDSR	Maternal Death Surveillance and Response
MDT	Multi Drug Therapy
MEPMA	Mission for Elimination of Poverty in Municipal Area
MERM	Medication Event and Monitor Reminder
MGCA	Mentoring Group for Community Action
MH	Maternal Health
MHIP	Mizo Hmeicchhia Insuihhawm Pawl
MHS	Menstrual Hygiene Scheme
MHT	Mobile Health Team
MHU	Mobile Health Unit
MIS	Management Information System
MLA	Member of Legislative Assembly
MLHP	Mid-Level Health Care Providers
MMJAA	MukhyaMantri Jan Arogya Abhiyan
MMR	Maternal Mortality Ratio
MMU	Medical Mobile Unit
MNH	Maternal and Neonatal Health
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
MP	Member of Parliament
MPA	MedroxyProgesterone Acetate
MPH	Master of Public Health

MPHW	Multi-Purpose Health Worker
MPV	Mission Parivar Vikas
	Multi-Purpose Worker
MR	Measles Rubella
MRI	Magnetic Resonance Imaging
MSF	Medecins Sans Frontieres
MTP	Medical Termination of Pregnancy
MUP	Mizo Upa Pawl
MVA	Manual Vacuum Aspiration
NABL	National Accreditation Board for Testing and Calibration Laboratories
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NAQS	National Quality Assurance Standards
NAS	National Ambulance Services
NBCC	New Born Care Corner
NBE	National Board of Examinations
NBSU	New Born Sick Unit
NCD	Non- Communicable Disease
NCDC	National Centre for Disease Control
NDMC	New Delhi Municipal Council
NEIGRIHMS	North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences
NERRC	Regional Resource Centre for North Eastern States
NFHS	National Family Health Survey
NGCP	National Goitre Control Programme
NGO	Non-Government Organisation
NHAI	National Highways Authority of India
NHM	National Health Mission
NHSRC	National Health Systems Resource Centre
NIC	National Informatics Centre
NICU	New-born Intensive Care Unit
NIDDCP	National Iodine Deficiency Disorder Control Programme
NIHFW	National Institute of Health and Family Welfare
NIN	National Institute of Nutrition

NIOS	National Institute of Open Schooling		NVBDCP	National Vector Borne Disease Control Programme
NIPI	National Iron Plus Initiative		NVHCP	National Viral Hepatitis Control Program
NITI	National Institution for Transforming India		OBGY	Obstetrics & Gynaecology
NLEP	National Leprosy Eradication Programme		OC	Oral Contraceptives
NMEP	National Malaria Elimination Plan		ODF	Open Defecation
NMHP	National Mental Health Programme		OGTT	Oral Glucose Tolerance Test
NMR	Neonatal Mortality Rate		OMHS	Odisha Medical & Health Services
NOC	No Objection Certificate		OOPE	Out of Pocket Expenditure
NOHP	National Oral Health Programme		OPD	Out Patient Department
NPCB	National Programme for Control of Blindness		OPV	Oral Polio Vaccine
NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke		ORS	Oral Rehydration Solution
			OSCC	One Stop Crisis Centres
			OT	Operation Theatre
NPHCE	National Programme for Health care of Elderly		PAIUCD	Post Abortion Intra Uterine Copper Device
NPPC	National Programme for Palliative Care		PALS	PL-HIV ART Linkage System
NPPCD	National Programme for Prevention and Control of Deafness		PAP	Papanicolaou
			PBS	Population based screening
NPPCF	National Programme for Prevention and Control of Fluorosis		PCC	Pollution Control Committee
			PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
NPPMBI	National Programme for Prevention & Management of Burn Injuries		PCV	Pneumococcal Conjugate vaccine
NPY	Nikshay Poshan Yojanan		PDCA	Plan Do Check Act
NQAP	National Quality Assurance Program		PEP	Post exposure prophylaxis
NQAS	National Quality Assurance Standards		PFMS	Public Fund Management System
NRC	Nutritional Rehabilitation Centre		PG	Post Graduate
NRCP	National Rabies Control Programme		PGDHQM	Post Graduate Diploma in Healthcare Quality Management
NRHM	National Rural Health Mission			
NSP	National Strategic Plan		PGIMER	Postgraduate Institute of Medical Education and Research
NSSK	Navjat Sishu Suraksha Karyakaram			
NSSO	National Sample Survey Organisation		PHACO	Phacoemulsification
NSV	Non-Scalpel Vasectomy		PHC	Primary Health Centre
NTCP	National Tobacco Control Programme		PHFI	Public Health Foundation of India
NTCC	National Tobacco Control Cell		PHI	Peripheral Health Institution
NTEP	National Tuberculosis Elimination Programme		PHMC	Public Health Management Cadre
			PHN	Public Health Nurses
NUHM	National Urban Health Mission		PICME	Pregnancy and Infant Cohort Monitoring and Evaluation
NULM	National Urban Livelihoods Mission			

PICU	Paediatric Intensive Care Unit		QI	Quality Improvement
PIH	Pregnancy Induced Hypertension		RBD-1969	Registration of Births and Deaths Act, 1969
PIP	Programme Implementation Plan		RBS	Random Blood Sugar
PKDL	Postkala-azar leishmaniasis		RBSK	Rashtriya Bal Sisthya Karyakaram
PLA	Participatory Learning and Action		RBTC	Regional Blood Transfusion Centre
PLHIV	People Living With HIV/AIDS		RCH	Reproductive and Child Health
PLP	Performance linked payments		RCS	Reconstructive Surgery
PMCH	Patna Medical College and Hospital		RCT	Root Canal Treatment
PMJAY	Pradhan Mantri Jan Aarogya Yojana		RDK	Rapid Diagnostic Kits
PMJJBY	Pradhan Mantri Jeevan Jyoti Bima Yojana		RDT	Rapid Diagnostic Test
PMMVY	Pradhan Mantri Matru Vandana Yojana		RFID	Radio Frequency Identification
PMNDP	Pradhan Mantri National Dialysis Program		RHFWTC	Regional Health and Family Welfare Training Centres
PMSBY	Pradhan Mantri Suraksha Bima Yojana		RHS	Rural Health Statistics
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan		RI	Routine Immunization
PMSYMY	Pradhan Mantri Shram-Yogi Maandhan Yojana		RIHFW	Regional Institute of Health and Family Welfare
PMTCT	Prevention to Mother to child transmission		RIMS	Rajendra Institute of Medical Sciences
PNC	Post Natal Care		RIO	Regional Institutes of Ophthalmology
POC	Point of Care		RKS	Rogi Kalyan Samiti
POSHAN	Prime Minister's Overreaching Scheme for Holistic Nourishment		RKSK	Rastriya Kishor Sisthya Karyakram
PPE	Personal Protective Equipment		RLTRI	Regional Leprosy Training and Research Institute
PPIUCD	Postpartum intrauterine contraceptive devices		RMC	Respectful Maternity Care
PPP	Public Private Partnership		RMNCH+A	Reproductive, Maternal, neonatal, child and Adolescent Health
PPPBI	Pilot Programme for Prevention of Burn Injuries		RMO	Resident Medical Officer
			RNA	Ribonucleic acid
PPTCT	Prevention of Parent to Child Transmission		RNTCP	Revised National Tuberculosis Control Program
PRI	Panchayat Raj Institution		ROP	Record of Proceedings
PSC	Program Study Centres		RRT	Rapid Response Team
PSS	Patient satisfaction surveys		RTA	Road Traffic Accident
PTK	Pregnancy testing kits		RTI	Road Traffic Injuries
PUHC	Primary Urban Health Centres		RTO	Regional Transport Office
PREGNANT WOMEN	Pregnant Women		SAM	Severe Acute Malnutrition
QA	Quality Assurance		SBA	Skill Birth Attendant

SC	Sub-Centres	STP	Sewage Treatment Plant
SCD	Sickle cell disease	SUMAN	Surakshit Matritva Aashwasan
SDG	Sustainable Development Goals	TAEI	Trauma Accident and Emergency Care Initiative
SDH	Sub Divisional Hospitals	TBHV	TB Health Visitor
SHC	Sub-Health Centres	TCC	Tobacco Cessation Centres
SHG	Self Help Group	TFR	Total Fertility Rate
SHS	State Health Society	THR	Take Home Rations
SICS	Small-Incision Cataract Surgery	TIMS	Training Management Information System
SIHFW	State Institute of Health & Family Welfare	TISS	TATA Institute of Social Science
SIMS	Strategic Information Management System	TLD	Thermoluminescent dosimeter
		TMIS	Training Management Information System
SJH	Safdarjung Hospital	TNMSC	Training Management Information System
SKMCH	Sri Krishna Medical College and Hospital	TNPSC	Tamil Nadu Public Service Commission
SLAC	Sparsh Leprosy Awareness Campaign	TNULM	Tamil Nadu Urban Livelihood mission
SLEC	Sparsh Leprosy Elimination Campaign	TOT	Training of Trainers
SMC	Surat Municipal Corporation	TT	Tetanus Toxoid
SMHA	State Mental Health Authority	TU	Tuberculosis Unit
SN	Staff Nurse	UCHC	Urban Community Health Centre
SNCU	Special New-born Care Unit	UDST	Universal Drug Susceptibility. Testing
SNO	State Nodal Officer	UHC	Universal Health Coverage
SNP	Supplementary Nutrition Programme	UHIS	Universal Health Insurance Scheme
SOHC	State Oral Health Cell	UHND	Urban Health Nutrition Day
SOP	Standard Operating Procedure	UHSND	Urban Health, Sanitation and Nutrition Day
SPCB	State Pollution Control Board	UID	Urban Immunization Day
SPM	State Programme Manager	ULB	Urban Local Body
SPMU	State Programme Management Unit	UNDP	United Nations Development Programme
SQAC	State Quality Assurance Committee	UNFPA	United Nations Population Fund
SQAU	State Quality Assurance Unit	UNICEF	United Nations International Children's Emergency Fund
SRG	State Resource Group		
SRS	Sample Registration System	UPHC	Urban Primary Health Centre
SSH	Sentinel Surveillance Hospitals	UPT	Urine Pregnancy Test
SSS	Swachh Sisth And Sarvatra	URI	Upper Respiratory Infections
STCC	State Tobacco Control Cell	URR	Urea Reduction Ratio
STG	Standard Treatment Guidelines	USAID	United States Agency for International Development
STI	Sexually Transmitted Infections		
STK	Spot Testing Kits	USG	Ultrasonography
STLS	Senior TB Laboratory Supervisor		

VA	Verbal Autopsy	VL	Visceral Leishmania
VBD	Vector Borne Disease	WASH	Water, Sanitation and Hygiene
VDRL	Venereal Disease Research Laboratory	WCD	Women and Child Development
VHC	Village Health Committee	WEDS	Women's Economic Development Society
VHND	Village Health Nutrition Day	WHO	World Health Organization
VHNSD	Village Health, Sanitation and Nutrition Day	WHV	Women Health Volunteers
VHSNC	Village Health Sanitation and Nutritional Committee	WIFS	Weekly Iron Folic Supplementation program
VI	Visually Impaired	WKS	Ward Kalyan Samiti
VIA	Visual Inspection with Acetic acid	YMA	Young Mizo Association

Synthesis Report: 13th Common Review Mission

The 13th Common Review Mission covering 16 states was undertaken from 16th October 2019 to 23rd October 2019. The 16 states/ UTsincluded: Andhra Pradesh, Chhattisgarh, Delhi, Gujarat, Jharkhand, Madhya Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Rajasthan, Tamil Nadu, Uttarakhand, Uttar Pradesh and Bihar. The 16 teams comprised of officials from Ministry of Health and Family Welfare, other central ministries and NITI Aayog, public health experts from various public health institutions, officials from development partners and representatives of civil society.

The Terms of Reference (ToR) of the CRM spanned ten over arching areas. In keeping with the increasing number of interventions and the multiple components within each intervention, the areas of review or key questions for each sub topic, have multiplied many fold since the Common Review Missions conducted in the early years. As convergence with other sectors expands, this CRM also included an assessment of Poshan Abhiyaan, with representatives from the Ministry of Women and Child Development participating in every team.

The CRM reports and interprets findings from the states to improve the understanding of implementation challenges and proposes programmatic and policy recommendations. This document thus serves as an important knowledge resource enabling comparative assessments of practice across several domain areas within and across districts and states. The CRM covers a wide range of interventions; some of these were implemented since the launch of the National Rural Health Mission (NRHM) in 2005, and several newer components were added over the years in response to the emerging epidemiologic and demographic transitions and disease burden.

The findings in this report demonstrate that most states have either overcome or are actively addressing the challenges highlighted in the early CRM reports. It is clear that all states have institutionalized practices that in the early CRM years were limited to a very few selected states. Most progress on this front is noticed in the areas related to maternal, new-born and child health.

Across states, and in all thematic areas reviewed in the NHM, significant variations were observed within states and even within districts. This indicates that even after fifteen years of implementation, processes of planning and monitoring including ensuring standardization of key processes still need strengthening.

In the past Common Review Mission, successive reports reiterated the criticality of addressing social and environmental determinants for improved health outcomes, and recommended strengthening action on convergent action with related government schemes and departments. Poshan Abhiyaan is a scheme that represents such convergence for addressing malnutrition, and representation from the Department of Women and Child (DWCD) ensured that nutrition interventions were assessed through a lens of multisectoral convergence. Mission Indradhanush also highlights the importance of convergent action between various departments. Multisectoral convergence at district and sub district levels, show significant promise indicating that when there are shared operational strategies and goals across all levels, progress is possible.

The NHM has evolved from the few components increasingly complex with multiple components, and while divergences have been captured, the emphasis of the report on a few key areas is noticed depending upon the expertise of the team.

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Review of each component or packages of components was undertaken, to assess relevance and contribution to key outcomes and assess effectiveness in moving various districts and states towards UHC and achievements of the NHP, 2017 goals.

We need to better understand the factors underlying the seemingly stagnant progress for some components. Data from large scale surveys and HMIS while important are often not sufficient to provide solutions to sub-par performance in some areas. The need for research across various programmatic areas is important. Resources, it is also important to consider de-implementation of components which are no longer relevant implemented as "legacy programs".

The issue of HR shortages has remained a persistent and predominant challenge in all CRM reports. Such HR challenges often nullify the investments made in other spheres.

Two of the ten domains of this CRM pertain to control of Non-Communicable Diseases (TOR3) Communicable diseases (TOR 4). Both these include a plethora of programmes, for which details are available in the summary and in the detailed report. Each of these programmes has a different provenance, with some being initiated for secondary care and now extending to primary and community level, and others being limited to secondary care. Some of the programmes have been in place for over two decades and some initiated recently. Some of these, such as fluorosis and iodine deficiency programmes, appear to be stand-alone interventions, with little horizontal or vertical integration.

India is undergoing an epidemiological transition, with the burden of disease shifting towards NCDs. Nonetheless, communicable diseases, including chronic communicable diseases such as TB and leprosy, continue to pose a challenge and cause significant morbidity and mortality. Overall findings indicate that the health system needs strengthening in terms of public health action.

For programmes like the National Tuberculosis Elimination Programme, well defined and comprehensive strategies are in place but for IDSP which is critical to early detection

and containment of outbreaks, little attention and supervision beyond the SSO and DSO are observed. There is little by way of sub-district structures for any disease surveillance. Nonetheless, over the years, progress has been made in attempting to rationalize resources, both financial and human and in looking for synergies between programmes. Much more needs to be done to operationalize such strategies at state and district levels. A dialogue with state and district programme managers responsible for various programmes is a starting point to communicate the need and benefits of integration and obtain their inputs on how this can be done without diluting individual programme strategies and affecting outcomes. This is a key challenge for the NHM, and must be considered in any redesign efforts.

The first chapter deals with the implementation of the Health and Wellness Centres. Findings demonstrate the direct links between a functional and robust health system and the ability to introduce newer packages of services, and increased use of the little used Sub Health Centre.

In the area of RMNCHA there are several areas where remarkable improvements have been made particularly for reduction in mortality. Stagnation in some areas is ensured. As NHM approaches its 15th year landmark a need for redesign in clear and it is hoped that this report provides a starting point.

RMNCHA: improvements and stagnation: New-born and Child health, despite progress in mortality reductions continues to need attention in certain areas like breastfeeding, care of sick newborns, and CDRs.

The ASHA programme while continuing to be critical for the health system, needs a serious re-look. ASHAs are the face of the NHM, but persistent issues such as training quality, limited supervision, leading to skill gaps and divergence in performance, and delayed payments, affect the ability of the ASHA to collectively deliver the outcomes expected. Going forward, reforms for the ASHA programme must be undertaken for duration and quality of training, improved support and supervision, defined tasks, and assurance of payment.

TOR 1:
Comprehensive Primary Health Care through Health & Wellness Centres

In the nearly 18 months since the launch of the first Ayushman Bharat -Health and Wellness Centre, states have made significant efforts to operationalize HWCs in strengthening primary health care teams in SHC and PHC -HWC (by posting a Community Health Officer/ Mid-Level Health Provider at the SHC level and filling vacancies at PHC level), multiskilling and capacity building of primary healthcare teams, enabling an expanded range of medicines and diagnostics, infrastructural upgradation/branding, ensuring availability of IT infrastructure such as tablets and desktops, use of CPHC – IT application, establishing telemedicine/ platforms, undertaking activities related to health promotion and wellness, and introducing performance linked payments. So far 22,362 (as on Oct 15th, 2019) HWCs have been operationalized against the target of 40,000 by the end of FY 2019-20., and an overall target of 1,50,000 by December 2022.

KEY OBSERVATIONS

Planning and Operationalization

1. Of the sixteen states visited, fifteen had initiated operationalization of Health and Wellness Centres to provide Comprehensive Primary Health Care (CPHC) and are likely to achieve the target for FY 19-20. Delhi has a strategy of delivering CPHC in urban areas through Mohalla Clinics, created for a population of 10,000, but supported by the state.

2. Gujarat, Meghalaya, Uttar Pradesh, Odisha and Andhra Pradesh had developed annual plans, with implementation strategies to upgrade all primary healthcare facilities to HWCs by December 2022. In Jharkhand, the gap in meeting targets was on account of training inadequate number of CHOs.

3. States have prioritized upgrading rural and urban Primary Health Centres to HWCs on account of better infrastructure and relatively lower levels of investment in human resources, in comparison to SHCs however additional incestments in creating new infrastructure will be required. Andhra Pradesh, Odisha, Gujarat, Tamil Nadu have operationalized over 60-70% of their PHCs to HWC. Limiting factors to PHC being converted to HWC include a high proportion of vacancies

States have prioritized upgrading rural and urban Primary Health Centres to HWCs on account of better infrastructure and relatively lower levels of investment in human resources, in comparison to SHCs however additional incestments in creating new infrastructure will be required.

of MBBS Medical officer at PHCs as seen in Odisha, Uttar Pradesh and Bihar. A mismatch in number of primary health care facilities as per population norms, was noted as a constraint in Jharkhand.

4. In an effort to meet the target, in Chhattisgarh, Assistant Medical Officers, who are the CHO equivalent are posted in rotation to SHC from their parent SHC, bi-weekly, making daily ambulatory care services, planned community interactions, and supervision of the SHC team difficult. In Bihar also, 43 CHOs are allocated to 86 SHC-HWCs in an attempt to operationalize higher number of SHC-HWCs to meet the state's target.

Programme Management

1. Given that this is a new programme and also a flagship effort, states have set up dedicated programme management teams at state and district levels. There was progress observed in terms of understanding and ownership of the initiative compared to the 12th CRM. Development partners were supporting the state and district program management in Jharkhand, Odisha, Meghalaya and Uttar Pradesh. However, challenges regarding coordination with different programmes and lack of in house capacity building is a concern in these states.

2. States are yet to evolve a robust mechanism for monitoring. In Odisha, the medical college at Mayurbhanj has adopted one block and ten HWCs for capacity building, monitoring and supervision.

Infrastructure

1. Infrastructural challenges both in terms of absolute shortage and poorly maintained buddings was observed across states. Most HWCs were functioning in government buildings, with adequate space in Meghalaya, Mizoram, Nagaland, Odisha and Uttarakhand. External branding was completed in most visited facilities. In a few facilities in Gujarat, Madhya Pradesh, Andhra Pradesh, Nagaland and Uttar Pradesh, space constraint was reported. Land acquisition and administrative process delays were reported in Dahod district (Gujarat) and Gumla (Jharkhand) further delaying new constructions.

2. In Manipur and Nagaland, non-availability of staff quarters was reported to affect staff retention. In Nagaland, village councils had made some arrangements for CHOs to support their accommodation, but these were not found to be adequate.

3. Irregular water supply was reported in HWCs in Meghalaya and electricity back up was not available in most SHC-HWCs visited. Availability of space with privacy for examination was available across SHC-HWCs.

Human Resources

Certificate course in Community Health-

1. All states, except Tamil Nadu, are training a BSc/GNM nurse or Ayurveda candidate in the six-month Certificate Program in Community Health (CPCH). In Tamil Nadu,

the Village Health Nurse (MPW-F) posted at an SHC is trained in a one year course and an additional VHN is posted at sub centers. The team of two trained VHNs is currently providing services at SHC-HWCs.

2. Andhra Pradesh, Chhattisgarh, Meghalaya, Mizoram, Nagaland, Odisha, Uttar Pradesh and Uttarakhand) have included only nurses (BSc or GNM) for training under CPCH. Odisha recruited Ayurveda practitioners early on, but based on experience, has now decided to recruit only nurses as CHOs. Even where Ayurveda practitioners are being trained as CHOs, (Gujarat, Bihar, Jharkhand and Uttarakhand they are fewer in number.

3. Most states have enrolled candidates through open recruitment after an entrance examination except in Rajasthan, Jharkhand and Meghalaya, where in-service candidates were directly enrolled in initial batches of CPCH. However subsequently candidates are being enrolled through open recruitment. Two clear strategies thus emerge: one, a preferential selection of nurses, and second, using open market recruitment rather than have in service candidates apply for these positions to eliminate attrition of nurses from HWC. The latter is being used largely because of resultant shortages.

4. Adequate number of Program Study Centres (PSC) which are either medical, nursing colleges or district hospitals were available to roll out CPCH were available in most states. Availability and understanding of program counsellors regarding the course varied across PSC within and between states.

5. Wide variations in the quality of counselors, their orientation, and work responsibilities, was noted in Jharkhand and Chhattisgarh. In Gujarat, CHOs expressed concerns about lack of handholding support during practical skill training at community level in PHCs and SHCs and also during their clinical postings in district hospitals because of inadequate supportive supervision.

Community Health Officers

6. Only Odisha has planned to develop a cadre for CHOs and create a post of staff nurses at SHC-HWCs, so that they follow the career progression pathway of staff nurses. In Uttar Pradesh, attrition of CHOs, has prompted the state to consider planning for career progression plan for better retention.

7. Additional trainings of CHOs after their posting at SHC-HWC were undertaken in Gujarat- (Yoga, Arogya Samanvay (mediation, ayurvedic medicines), and Rajasthan (NCD and Yoga).

8. Posting of CHOs was based on the preference of CHOs in Jharkhand and Gujarat, which is a well known strategy for retention. In Nagaland, posting in non-home districts in Nagaland is a major challenge in retention.

9. Reports from Jharkhand, Gujarat and Nagaland raise concerns about irrational use of medicine by CHOs. This indicates the need for regular monitoring of CPCH training and regular mentoring of CHOs as well as better coordination with PHC MO.

Two clear strategies thus emerge: one, a preferential selection of nurses, and second, using open market recruitment rather than have in service candidates apply for these positions to eliminate attrition of nurses from HWC.

ASHA as a member of the Primary Health Care Team at the HWC-SHC

10. The active role played by the ASHA as an integral part of the Primary Health Care team at HWC-SHC was apparent across states. ASHAs across most states are involved in mobilizing community members for wellness activities. The newest activity added to the ASHA's portfolio is the use of the Community Based Assessment checklist for population enumeration and risk assessment to be used as a measure of health education and expanding her subgroups to women beyond the child bearing age and men

11. ASHAs were maintaining follow up records for those on treatment for non-communicable diseases (NCD), only in Andhra Pradesh, Gujarat, Jharkhand, Madhya Pradesh. Lack of clarity among ASHAs about CBAC form was reported from Bihar, Meghalaya and Nagaland. However, in states with a high work-load for reproductive, new-born, and child health activities, gaps in ASHA selection, and increasing working hours for existing hours to take the load of NCD is beginning to be apparent. In Tamil Nadu, the state has recruited a Women Health Volunteers (WHV) at the level of the SHC-HWC to undertake outreach activities in the villages.

The Primary Health Care team at HWC-SHC and PHC

12. As specified in the Guidelines a three-member team i.e. 1 CHO, 2 MPWs (both Female or one male and one female) and ASHAs, was available in most states, except UP (one CHO and one MPW-F). Gaps in understanding of respective roles and responsibilities was limited between team members, resulting in task duplication and compromising effective service delivery were seen.

13. Capacity building of team members in newer packages was limited in duration and quality, leading to gaps in understanding of various members of the team in most states. Reduction in number of days of training and limited hands on training was reported in Andhra Pradesh, Gujarat, Odisha

14. The PHC Medical Officer is expected to serve as the leader for all SHCs in the coverage area, with the PHC serving as the first point of referral. HR shortage at PHCs was reported in Bihar, Jharkhand, Odisha, Uttar Pradesh, Rajasthan and Madhya Pradesh. In Gumla, (Jharkhand), 12 out of 13 PHCs were nonfunctional on account of non-availability of HR.

15. In Odisha, MBBS MO was visiting PHC twice/thrice a week. In Khandwa (Madhya Pradesh), the MO was visiting PHC only two days a week. Shortage of LTs was reported in Madhya Pradesh and Jharkhand.

16. Steps to address shortfall was reported from Bihar as recruitment of 330 full time MOs was done against the 500 vacant positions at APHC and UPHCs.

17. Tamil Nadu has posted an additional staff nurse at PHCs for providing NCD screening and for follow up services.

Medicines and Diagnostics

1. Most states had revised the state Essential Drug List to ensure supplies at SHC-HWC and PHC, except Bihar and Jharkhand.

2. Medicines for hypertension and diabetes were being dispensed by CHOs at SHC-HWCs in Andhra Pradesh, Manipur, Gujarat, Meghalaya, Nagaland, Uttar Pradesh, Uttarakhand, Odisha and Tamil Nadu (by trained VHNs). In Rajasthan, antihypertensive and antidiabetic medicines were available, but these were not being dispensed due to limited guidance from the state

3. In Andhra Pradesh, vending machine for dispensing medicines was installed at SHC-HWCs as a part of e-sub Centre initiative, but challenges in dispensing were observed due to irregular internet connectivity.

4. Adequate availability of medicines was reported at SHC-HWCs in Gujarat, Andhra Pradesh, Uttar Pradesh, Tamil Nadu and Odisha while stock out of essential medicines was reported in SHC-HWCs in Chhattisgarh and Mizoram.

5. Limited knowledge and practice of standard treatment protocols was observed among Medical Officers in Gujarat and Madhya Pradesh,

6. DVDMS was functional till PHC level in most states except Nagaland and Mizoram.

7. SHC-HWCs are expected to provide at least 7 essential diagnostic tests at SHC-HWCs and 19 tests at PHC-HWC either directly or through use of hub and spoke model. Basic point of care diagnostics were available in Meghalaya, Uttar Pradesh, Tamil Nadu, Rajasthan, Odisha, Gujarat, Andhra Pradesh and Jharkhand. At the level of PHCs, point of care diagnostic tests were available in most facilities. Shortage of Lab technicians was reported to be a challenge in providing expanded rang of diagnostic services at PHCs in Bihar and Madhya Pradesh. Hub and spoke model (in house, with hub at PHC/CHC/DH) was functional in Madhya Pradesh and Tamil Nadu and had facilitated expanding the diagnostic services.

Service Delivery

Community Awareness of HWC

1. Community awareness regarding HWCs and the services offered varies across states. In Gujarat, Meghalaya and Nagaland and Uttar Pradesh, community members were aware about the HWC, CHOs and availability of the expanded range of services for NCDs. However, in Odisha, Rajasthan Jharkhand, and Mizoram, awareness about HWCs and expanded range of services was low.

2. Display of IEC material, citizen charter was observed in most HWCs visited except in Bihar. In Rajasthan, the display also included display of information regarding referral facility location and details.

Wellness and Health Promotion:

1. Wellness activities, such as Yoga sessions were being organized in HWCs at Andhra Pradesh, Gujarat, Gumla in Jharkhand and Madhya Pradesh. Celebration of Health days was organized at HWCs in Meghalaya, during which activities are planned to promote healthy life style, viz. sports activities for adolescents, screening camps for service providers, role plays etc.

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2. In most states, open spaces around HWC was utilized for conducting wellness activities including Yoga sessions. Space for wellness activities was reported to be a constraint in few HWCs v.i.z, Andhra Pradesh, Meghalaya, Odisha and urban areas in Madhya Pradesh.

Expanded range of services at HWC

1. Perhaps the most significant change reported across HWCs was the consistent availability of a service provider at the SHC-HWC on all working days. As OPD services were available at SHC-HWCs, on six days a week, increased service utilization was reported. An average daily OPD of 10-20 was reported at SHC-HWCs across states.

2. HWCs are envisioned to provide integrated service delivery for 12 service packages. At this stage of implementation, HWCs in all states are expected to provide at least the first seven service packages. In Bihar and Jharkhand, the services at HWCs remain RCH centric, which, while critical, need to be expanded.

3. Involvement of CHOs in providing RMNCH+A services was variable. In Meghalaya, delivery services were started after upgradation of SHC to HWC while in Mizoram, Uttar Pradesh and Jharkhand, involvement of CHO was minimal in providing ANC, RI and FP services.

4. Across all states MPWs-F have been allocated RCH related work and CHOs were providing OPD services and NCD services. In Tamil Nadu, one VHN is providing outreach services, mostly RCH related, while second VHN is providing OPD services. The outreach services for NCD, viz- risk assessment, screening and follow up are provided by Woman Health Volunteers.

5. CHOs were attending the VHNDs and VHSNCs Meghalaya and Gujarat. In Gujarat, good coordination was observed between RBSK team and SHC-HWC team, facilitating the integration of service delivery. In Meghalaya, CHOs were also undertaking home visits for NCD and TB cases. Patient support groups for NCDs were reported to be functional in Tamil Nadu and Gujarat (Dahod).

6. Additional service packages have been rolled out in few states. Home based palliative care services, elderly care, screening of Mental Health and basic Oral Health care has been initiated at HWCs in state of Manipur. Outreach camps for mental health and oral health have also been organized by SHC and PHC-HWC team. In Tamil Nadu, home based palliative care is being provided by staff nurse at block level and mental Health counselling services were available through toll free no. 104.

Continuum of care

1. Good coordination between SHC-HWC and its linked PHC team was observed in Gujarat, Meghalaya, and Tamil Nadu, facilitating forward and backward referral linkages. In Meghalaya, medicines for NCDs are prescribed by HWC-PHC, MO-MBBS for a period of 30 days. Staff members at HWC-SHCs follow-up with diagnosed NCD patients especially living far-off from health facilities and mobilise them to visit HWC-PHC for follow-up care. CHOs at HWC-SHC are regularly in

contact with MOs through telephone for referral patients, follow-up care of referred cases and loss to follow-up patients.

2. In most states, limited engagement of PHC-MOs was reported in supporting SHC-HWCs. Lack of commensurate strengthening of linked facilities such as PHCs and secondary care facilities has affected continuum of care in states.

Teleconsultation at PHC-HWCs

1. Facility for teleconsultation with specialists was available in rural PHC-HWCs in Meghalaya and at SHC, & UPHC-HWCs in Andhra Pradesh. In Meghalaya, the hub was established at DH, In Andhra Pradesh and Jharkhand the states have partnered with a private hospital. In Jharkhand PHCs, telemedicine clinics and MO consultation clinics were running in parallel, with patients in PHCs being asked to opt for telemedicine or face to face consultation.

2. In Meghalaya, tele-consultation set up has been installed at headquarters (DH/MCH) and initiated in RiBhoi district, but services are disrupted due to intermittent internet connectivity, power failure, dysfunctional desktop and camera, lack of coordination/time from specialists in MCH, etc.

3. In Bihar, UP, Gujarat and Jharkhand, plans for establishing telemedicine facilities are at various stages of maturity.

4. Tele-consultation at SHC-HWC level with PHC-MO was currently available in the form of call to PHC-MO in most states except AP, where 287 SHC-HWCs are linked to Dhanush and World Health Partners. However, Multipara monitor and noninvasive Hemoglobinometer linked with the tele-consultation device at e-SCs was not calibrated affecting the quality of services. Issues were also reported with internet connectivity affecting the uploading of data and dispensation of medicine via drug vending machine after tele-consultation.

Reporting and Recording System:

1. Given that these are early years of the implementation, information regarding service delivery is entered in registers and in IT applications in most states.

2. Most SHC-HWCs had one functional tablet (with MPW-F in Bihar, Jharkhand, Meghalaya and with CHO in Uttar Pradesh, Uttarakhand, Odisha). In Tamil Nadu, each VHN had a tablet and a laptop was available at the facility. In Gujarat, MPW-F had a smartphone, while a few CHOs were also provided with smartphones. In Andhra Pradesh, CHOs were provided tablet under e-SHC initiative and tablets with MPW-F. ASHAs were provided with smartphones only in Meghalaya, although they were not being used.

3. Regarding IT applications for HWC, most states have implemented CPHC-NCD IT application, although the pace of roll out was slow, on account of limited availability of tablets and lack of training. CPHC-NCD application was being used in visited SHC-HWCs in Jharkhand, Meghalaya, Nagaland, Uttar Pradesh, Odisha, and Uttarakhand. ANMOL application was being used by MPW-F in Jharkhand and Odisha. In Gujarat, a state specific application, TechoPlus is being used for recording RCH and NCD related service delivery. In Tamil Nadu also a state specific

UHC application is being used by VHNs (MPW) to enter the OPD information in centers where UHC pilot of the state is being implemented, while RCH related data is being entered in state specific- PICME application.

4. At the time of visit, CPHC-NCD application was not being used in visited SHC-HWCs in Andhra Pradesh, Bihar, Rajasthan, Mizoram, Chhattisgarh, Manipur and MP. At the level of PHC, MO portal was being used only in Odisha and Meghalaya.

5. Challenges in using the IT application included issues with creating ANMOL ID (Jharkhand), irregular internet connectivity (Meghalaya, Mizoram, Nagaland and Uttarakhand) and issue of synchronization of data in CPHC-NCD IT app (Meghalaya).

6. The envisioned use of CPHC-IT application to support service providers in decision making and facilitating continuum of care across levels is yet to take place. In most states, multiple registers were being maintained but the key outcome of being able to ensure treatment adherence and early recognition of complications in the case of Hypertension and Diabetes was not yet achieved.

Financing

1. CHOS are provided with a blended payment – Fixed payments and Performance linked payments (PLP). Disbursal of PLP had been initiated in Odisha, Uttar Pradesh, Gujarat and Rajasthan. CHOs reported receiving timely salary and incentive in Gujarat and Rajasthan. In other states, challenges were reported in streamlining the process of performance monitoring with involvement of PHC-MO, block and district team. Limited clarity regarding PLP among CHOs and program managers (Jharkhand) and insufficient funds with states (Nagaland, Meghalaya) were reported to be the reasons for not initiating the process. Delays in salary (Nagaland) and PLP (Uttar Pradesh) was also reported by CHOs.

RECOMMENDATIONS

1. States have made rapid advances in implementation of CPHC through HWCs. Given the huge paradigm shift in re-organizing service delivery, and the significant change management needed, the challenges discussed above are in many ways, to be expected at this stage of implementation. In the last 18 months of HWC implementation, most states understandably prioritized conversion of the SHC/ PHC/ UPHCs which needed minimal additional investment for HR and infrastructure. The larger effort required to strengthen health facilities with poor infrastructure and inadequate HR now requires states to undertake district wise planning taking into account disease burden, infrastructure, finances and human resources and prepare a district wise roadmap for delivery of CPHC services. This is an immediate action. Based on such district plans, a state vision to achieve the goals of Ayushman Bharat-Health and Wellness Centres needs to be crafted. This should serve to plan, implement, and monitor the delivery of CPHC.

2. Findings from states have demonstrated effective service delivery when the HWC-SHC is supported actively for capacity building, planning and logistics, and referral by its parent PHC. Strategic block/sector saturation (upgrading all SHCs and PHCs in a block) should be undertaken to ensure support to the teams at SHC-HWC.

The larger effort required to strengthen health facilities with poor infrastructure and inadequate HR now requires states to undertake district wise planning taking into account disease burden, infrastructure, finances and human resources and prepare a district wise roadmap for delivery of CPHC services.

States therefore need to map all PHCs and linked SHCs to prioritize upgradation of PHCs and all linked SHCs as a "HWC primary health care unit".

3. Primary healthcare teams require orientation and ongoing handholding on CPHC as a whole and particularly on specific sub components, such as re-organising service delivery, adding newer service packages, while continuing to focus on existing service packages, and ensure wellness and health promotion activities. This requires role clarity among team members for coordinated service delivery. One strategy would be to institutionalize the weekly calendar at all HWC (part of the CHO Induction Module) with a schedule of OPD and community outreach by CHOs, MPW-F and MPW-M; with clear roles and responsibilities.

4. Service utilization at HWCs is largely dependent on uninterrupted availability of medicines and diagnostics. This improves the credibility of the centre and builds trust in the public health system. As the disease burden shifts to chronic diseases, the need for secondary prevention assumes importance. States need to ensure that systems such as DVDMS are operationalized up to the lowest levels, and that no stock outs for any condition treated at the HWC level are minimized by improving logistics for procurement and distribution and allowing flexibility in local purchase at district levels.

5. Continuum of care to link community, primary and secondary care is a key requirement. When service packages were limited to MCH, this was enabled, albeit at a suboptimal level through manual registers and in some cases IT applications. The ambitious vision of delivering 12 packages of services over time, requires a robust IT infrastructure. All states need to expedite action on the procurement, distribution, training in IT along with continuous handholding of the team in using the IT application. Duplication of data entry into the registers and manual entry and the ensuing workload, would be reduced substantially by strengthening the infrastructure. This would also support the process of teleconsultation and tele-health.

6. The Community Health Officer at the HWC-SHC level is a new entrant in the system. The quality of CPHC delivered through HWC hinges upon the functioning of the CHO as a service provider and leader of the PHC team. Findings demonstrate weaknesses in most states across the processes of right selection, ensuring training quality for theory and practicum during the six month training, on the job mentoring after posting, and ensuring that skills and competencies are updated. States need to undertake diagnostic assessments to identify specific problems so that commensurate solutions could be designed. Apart from robust selection processes, a two pronged approach of building capacities of counsellors at Program Study Centres to train CHOs for their future role at SHC- HWCs and training of PHC and Block MOs in providing on the job mentoring for CHOs needs to be adopted. Use of digital technology can be explored to create telementoring platforms. High quality training of CHOs cannot take place just by focusing on the six month training. Given the varied nature and quality of in service training of the candidates being trained as CHOs, ongoing intensive hand holding and mentoring through blended mechanisms after they are posted in the SHC is critical to avoid the issues of poor quality service delivery as highlighted by the findings.

All states need to expedite action on the procurement, distribution, training in IT along with continuous handholding of the team in using the IT application.

7. The introduction of performance linked payments (PLP)to the SHC-HWC team was intended to instill team spirit, strengthen quality of services and enhance accountability for population health outcomes. There is an urgent need to orient PHC, block and district team on the processes of performance measurement and timely disbursal of PLP and team based incentives. The component of the CHO salary that is linked to performance also needs to be strengthened to sustain motivation.

8. Since the delivery of CPHC involves re-organizing service delivery and includes multiple new components, states need to establish a robust monitoring mechanism for regular review of service delivery as per standard protocols and to assess the coverage of services. Strong programme management teams and wide network of partners drawn from academic institutes like medical colleges and school of public health and civil society are key to build such processes.

9. Health Promotion and Wellness activities need to be institutionalized in all HWCs, with an emphasis on maintaining the balance between preventive and promotive and curative care. CHO and other members of the HWC team posted in SHC required strong orientation, mentoring support and motivation through visits and online discussions on the benefits of wellness and community engagement. These activities need to be closely monitored, and synergized with communication efforts, so that wellness activities are seen by the community as linked to overall health status and not become a ritual, devoid of the larger health context.

TOR 2:
Reproductive, Maternal New-born, Child and Adolescent Health

The 13th CRM visit showed an overall improvement for all components of the RMNCHA program in all states. Improvements in infrastructure availability, access to medicines and diagnostics, better trained HR, technical resources and an assured referral mechanism was reported by the states. Several innovations have been described across states for maternal health- and other long-standing programme components of RMNCHA.

Maternal Health

All states continue to focus on maternal health initiatives, leading to decline in MMRs in all states visited in the CRM. Out of the 16 CRM states visited, Tamil Nadu has already achieved the SDG target of less than 70 per 100,000 live births. A key strategy adopted for MMR reduction is the timely identification, and regular follow up of women who are potentially at high risk. States such as Delhi, Andhra Pradesh, Gujarat, Manipur, where tracking of HRP is being undertaken rigorously, likely accounting for the reduction in MMR seen, in contrast to states such as Bihar, Chhattisgarh, Jharkhand, Mizoram, Uttarakhand. The provision of Respectful Maternity Care particularly related to privacy and birth companion (PrasavSakhi in Andhra Pradesh, Bihar, Gujarat, Rajasthan, MP and Tamil Nadu) during labour, improved monitoring systems for tracking high risk cases (Techno + in Gujarat) and 1st trimester registration (PICME in Tamil Nadu) and availability of SBA trained staff at delivery points (Gujarat, Mizoram, Uttarakhand, Tamil Nadu, Odisha) was observed

KEY OBSERVATIONS

1. Increase in ANC coverage is noted, especially with the launch of Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA), in Andhra Pradesh, Gujarat, Delhi, Rajasthan and Tamil Nadu. However, Chhattisgarh, Jharkhand, Mizoram and Uttar Pradesh reported sub-optimal coverage as well as quality of ANC services.

2. Free diet, free medicines and free transport were mostly available, and some states have drop back facility in place such as 'TalliBidda

The provision of Respectful Maternity Care particularly related to privacy and birth companion (PrasavSakhi in Andhra Pradesh, Bihar, Gujarat, Rajasthan, MP and Tamil Nadu) during labour, improved monitoring systems for tracking high risk cases (Techno + in Gujarat) and 1st trimester registration (PICME in Tamil Nadu) and availability of SBA trained staff at delivery points (Gujarat, Mizoram, Uttarakhand, Tamil Nadu, Odisha) was observed

Express' in Andhra Pradesh, 'Khilkhilahat Express' in Gujarat and 'MAMTA Vahan' in Jharkhand.

3. Institutional deliveries are high in most states. In Uttarakhand, Uttar Pradesh, Jharkhand, Meghalaya and Nagaland, home deliveries were reported from the visited districts.

4. Novel Initiatives like *"Maa Gruha"* were functional in Odisha, wherein pregnant women from tribal and inaccessible areas are provided accommodation and medical care at the facility, one week prior to Estimated Date of Delivery (EDD).

5. Well-equipped labour rooms with Birth Companion and Respectful Maternity Care (RMC) were observed in Andhra Pradesh, Bihar, Tamil Nadu, Gujarat, Rajasthan,and Madhya Pradesh, although RMC during Antenatal and postnatal period needs to be strengthened in all states. Chhattisgarh, Manipur, Meghalaya, Mizoram, Nagaland, Odishaand Uttar Pradesh also had well equipped labour rooms. The quality of services in labour rooms requires focus in Chhattisgarh, Manipur, Meghalaya and Rajasthan.

6. The labour room staff were found to be trained in Skilled Birth Attendant (SBA) or DAKSHTA in almost all states, except Bihar, Uttarakhand, Jharkhand, Nagaland and Manipur.

7. Quality of ANC services in terms of range of services provided, counselling on diet and family planning, etc. continue to be areas in which most states lag.

8. Identification of high-risk pregnancies and line listing is limited mainly to anaemia detection. States like Gujarat are successfully tracking high risk pregnant women for an expanded range of conditions, using digital technology.

9. Timely reporting of Maternal Deaths and Maternal Death Reviews were being undertaken in Andhra Pradesh, Gujarat, Tamil Nadu and Delhi.

10. Revised MCP cards were available at most facilities, but staff met with in Uttar Pradesh, Jharkhand and Manipur, were not conversant with all aspects of the card.

11. Referral and drop back services remain an issue, especially in Uttarakhand, Bihar, MP, Manipur and Mizoram.

12. Bottlenecks in providing midwifery/ obstetric care services in Rajasthan, Chhattisgarh, Manipur, Mizoram and Uttar Pradesh ranged from ANM shortages, poorly trained staff and a lack of specialists. Lack of Blood Bank/Blood Storage facilities was a challenge to making First Referral Units (FRUs) operational in Bihar, Jharkhand, Manipur, Mizoram, Uttar Pradesh and Rajasthan.

13. High rates of caesarean sections were observed in states with high institutional delivery, particularly in Andhra Pradesh and Tamil Nadu, and this is an area requiring attention.

14. The 48-hours stay post-delivery was not implemented in almost all the states visited, with consequences for early newborn and post-partum morbidity and mortality.

RECOMMENDATIONS

1. Actions to improve the quality of care for all processes related to pregnancy, delivery and postpartum care need to be urgently undertaken. Orientation of all

staff on Respectful Maternity Care is universally required.

2. The first action to planning maternity services is to enable universal Line listing of pregnant women, and the identification, management and follow-up of High-Risk Pregnant women. This needs to be ensured at outreach and at all levels of healthcare facilities.

3. Trainings related to CEmONC, SBA, NSSK & Dakshata for various cadres as appropriate, need to be scaled up on priority to ensure skilled service providers at all levels- MPWs and Medical Officers

4. States should recognize the importance of skill labs as an effective mechanism to build skills and competencies and enable establishment with priority to Aspirational and High priority districts.

5. Time bound action plan for establishment of hybrid HDU/ICU at District hospital level and operationalizing FRU for assured CEmONC services need to be prioritized.

6. Protocols at LR and other places should be pasted at eye levels. The IEC/BCC material must be printed in local/regional language for easy understanding and practice.

7. Non rotational posting of staff nurses to be implemented for ensuring presence of skilled nurses in labor room. Also HR to be deployed rationally at delivery points for effective service delivery.

8. More advocacy and recognition is required to involve private practitioners in the PMSMA.

9. Capacity building of service providers for regular reporting and review of MDSR/CDR is urgently needed. District Collectors need to be sensitized for conducting review and improving interdepartmental coordination and convergence.

States should recognize the importance of skill labs as an effective mechanism to build skills and competencies and enable establishment with priority to Aspirational and High priority districts.

Family Planning

The impact of policies such as enabling access to contraceptives in the kits of ASHAs, a focus on expanding the basket of choices in the Mission Parivar Vikas Yojana, and other population stabilization programs has increased the range and reach of contraceptive methods at all levels and reduced unmet need. In most states availability and use of newer contraceptives-Antara and Chhaya was noted.

KEY OBSERVATIONS

1. Awareness regarding the need and various methods of family planning was found to be good in the states visited, with knowledge of beneficiaries on the newer contraceptives was low in Andhra Pradesh, Manipur and Madhya Pradesh.

2. Uptake of injectable contraceptives under Antara Program has improved in several states like Bihar, Delhi, Odisha, Jharkhand, Meghalaya, Rajasthan and Tamil Nadu, although high dropout rates were observed. However, the Mission ParivarVikas (MPV) focus states of Jharkhand, Chhattisgarh, Rajasthan and Uttar Pradesh reported lower uptake.

3. IUD insertions are being carried out at all levels in Manipur, Delhi, Odisha, Tamil Nadu but was low in Andhra Pradesh and Jharkhand.

4. PPIUCD insertion rate has picked up pace in Delhi, Tamil Nadu, Uttarakhand, Andhra Pradesh, Odisha, Madhya Pradesh and Rajasthan, although high expulsion rates indicate the need for regular refresher trainings and follow up. Very low PPIUCD rateswere seen in Bihar, Jharkhand, Meghalaya and Nagaland.

5. Preference of beneficiaries for terminal methods over spacing methods remains persistent in states. Nonetheless, despite availability of trained HR, sterilisation services are mostly being offered at DH level only in most states. Fixed day sterilisation approach is being followed in Uttarakhand but not in Mizoram and Nagaland.

6. Acceptance rates for male sterilization was low in all states as has been reported in all past CRMs.

7. Post-partum FP services (sterilisation and PPIUCD) is being done only at DH level in Manipur (camp mode only), Meghalaya and Mizoram.

8. Comprehensive Abortion Care (CAC) services are provided both at CHC and DH in Tamil Nadu and Uttar Pradesh while only at DH level in Jharkhand, Mizoram, Madhya Pradesh and Uttar Pradesh. MTP was being done at both DH and CHC in Chhattisgarh and Delhi.

9. Family Planning Logistics Management Information System (FP-LMIS) has been rolled out in Bihar, Delhi, Gujarat and Madhya Pradesh. In Meghalaya, FP-LMIS has been extended upto the PHC level.

10. Non-availability of FP commodities in Chhattisgarh, Mizoram, Nagaland and Uttar Pradesh, an area of concern given the rates of unmet need.

11. Training and orientation of ASHAs and ANM on family planning services was good in almost all CRM states except Chhattisgarh, Meghalaya, Manipur, and Gujarat, likely affecting uptake and continuation of contraception.

RECOMMENDATIONS

1. Frontline workers need training in using Eligible Couples Register/RCH register /portal to follow up with those who require contraceptive services. ASHA orientation should be organized via monthly meetings on newer contraceptives like Antara and Chhaya in order to generate demand for these contraceptives in the field.

2. Proper planning, monitoring and follow up is required while implementing family planning services at the community level.

3. Supply of FP drugs, IUCDs, Newer contraceptives & use of LMIS software are areas in which selected states need to pay greater attention.

4. Community awareness on gender sensitization related to son preference needs improvement.

5. Quality and access to MTP and CAC services needs to be improved.

Adolescent Health

Adolescents are an important focus under RMNCHA program, with the Rashtirya Kishor Swasthya Karyakram (RKSK) being the flagship strategy for adolescent programming. Nonetheless, findings indicate that the elements of the RKSK could not be quite appropriate in meeting the needs of adolescents and preparing them for healthy adulthood. Currently, there are 7495 Adolescent Friendly Health Clinics (AFHCs) in the country with 2,20,000 Peer Educators, across states.

KEY OBSERVATIONS

1. The Adolescent Friendly Health Clinics (AFHCs), though functional in some states, were mostly underutilized, necessitating a reconsideration of their need and configuration.

2. AFHCs were operational in Delhi, Gujarat, Jharkhand, Meghalaya, Manipur, Mizoram, Odisha, Tamil Nadu, Uttar Pradesh and Uttarakhand, while were found to be non-functional in Bihar.

3. Awareness and knowledge amongst adolescents about common health problems and knowledge about facilities for adolescents such as AFHCs was suboptimal in most states.

4. Under the Weekly Iron Folic Acid Supplementation (WIFS) initiative, states like Bihar, Jharkhand, Manipur, Tamil Nadu, Meghalaya, Rajasthan and Uttar Pradesh are providing WIFS- IFA tablets to adolescents.

5. School based component for Weekly Iron Folic Acid Supplementation (WIFS) has reportedly gathered pace in many states, but lack of interdepartmental coordination between the Departments of Health, Education and WCD has resulted in poor reporting under WIFS program.

6. Menstrual Hygiene Scheme (MHS) is being implemented in many states visited but lags in Chhattisgarh, Jharkhand, Manipur and Nagaland. A consistent finding from the field visits was poor quality of sanitary napkins and its skewed distribution.

7. Roll out of RKSK in terms of AFHC establishment, Peer Educator identification and selection, and training, was not seen in Chhattisgarh and Nagaland.

8. Delhi conducts Test, Teach and Treat (T3 camps) for detection of anemia in schools and colleges.

9. In Jharkhand, Ekjut Foundation and Centre for Catalytic for Change (C3) was found doing excellent work in creating awareness on RKSK in the community.

10. Substance abuse among adolescents was reported in a few states like Uttarakhand, Mizoram, Manipur and Meghalaya. Drug de-addiction treatment centers are functional in some CHCs in Manipur.

RECOMMENDATIONS

1. States should focus on creating awareness in the community and other fora on Adolescent health care needs and services available in Adolescent Friendly Health Clinics.

2. States should strengthen their referral networks in promptly providing Adolescent Friendly Health Services (AFHS) thereby reducing access barriers.

3. States should take steps for training of HR and enable clarity in roles and responsibilities for effective implementation of RKSK at facility level.

4. Overall across states the RKSK need to be strengthened with improved understanding of context, reach, needs and cultural variations to improve outcomes.

NEONATAL HEALTH

Newborn and child health are the two key pillars of RMNCHA. Infant Mortality Rate in India has shown a steady decline from 42 per 1000 live births in 2012 to 33 per 1000 live births in 2017 (SRS 2017). Similarly, Neonatal Mortality Rate has declined significantly from 31 (SRS 2011) to 23 (SRS 2017), as a result of a high level of commitment to rolling out NHM initiatives for improving neonatal health in all states.

Improvements in home and community level care behaviours for early and exclusive breast-feeding practices, Kangaroo Mother Care (KMC), and complementary feeding were noted. While the role of the ASHA in providing Home Based Newborn Care was variable in states, most reports indicate that improved training, mentoring and support are needed to sustain the early successes of the programme, particularly in states with high new-born mortality. States have also invested in infrastructure to provide critical care services to the new-bornsand infants.

KEY OBSERVATIONS

1. Community awareness about early and exclusive breastfeeding was found satisfactory, however early initiation of breastfeeding (within one hour) was found to be optimal only in a few states, viz. Bihar, Gujarat, Mizoram, MP, Nagaland and Odisha, indicating the need to improve facility based practices to improve early initiation of breastfeeding.

2. Birth Dose vaccination was being given in many states like Delhi, Gujarat, Madhya Pradesh, Manipur, Mizoram and Odisha, but gaps were noticed in Andhra Pradesh. In Chhattisgarh, where deliveries continued to take place at some SHCs, the birth does of the vaccines were missed.

3. Kangaroo Mother Care (KMC) practices varied across states. While well-established KMC corners were seen in Bihar and Delhi, states like Chhattisgarh, Jharkhand, MP, Odisha, Tamil Nadu, Meghalaya and Uttarakhand, practiced KMC only for Low Birth Weight babies.

4. Home-Based Newborn Care (HBNC) program by ASHAs needs improvement in most states, except Madhya Pradesh and Uttar Pradesh. This was due to lack of adequate mentoring & supervisory support by ASHA facilitators and block/district level officials, where large vacancies exist. Weighing of newborn, assessment about breast feeding, screening for any danger signs were not being conducted routinely and at several places mothers could not recall ASHA visits for HBNC.

5. New Born Care Corner (NBCC) and New Born Stabilization Unit (NBSU) were

established at most delivery points in Andhra Pradesh, Chhattisgarh, Gujarat, Madhya Pradesh, Manipur, Mizoram, Tamil Nadu, Uttar Pradesh, Uttarakhand but their utilisation rates varied. The functionality of NBSU was low in Bihar, Madhya Pradesh, Mizoram, Odisha, Andhra Pradesh and Nagaland, while they were non-available in Jharkhand.

6. Well-equipped and appropriately staffed Special New-born Care Units (SNCU), were established in most of the states – Bihar, Chhattisgarh, Delhi, Gujarat, Jharkhand, Madhya Pradesh, Meghalaya (West Garo Hills), Mizoram (Aizawl East), Odisha, Rajasthan, Tamil Nadu and Uttar Pradesh. SNCU and NRC were not found in the visited districts in Manipur. Online reporting was in place at Jharkhand, Tamil Nadu, Uttar Pradesh and Uttarakhand.

RECOMMENDATIONS

1. Awareness about the benefits of early and exclusive breastfeeding practices needs to be communicated effectively and reinforced for service providers, mothers, families and the community.

2. Service delivery for HBNC by ASHAs, related to the timings of visits, quality of counselling of mothers about danger signs, diet etc. needs to be strengthened by provision of refresher training to and regular mentoring by ASHA Facilitators/ANMs/MOs.

3. Regular follow-up of pre-term, LBWs and facility discharged new-born needs to be undertaken in the home and through outreach and monitored closely.

4. KMC practices for low birth babies need to be promoted..

5. Functional NBCC with in-built radiant warmer should be made available in all labour rooms with safe electric supply.

6. Capacity building of the medical doctors, nursing and other staff about the protocols and guidelines to utilize New Born Stabilisation Unit(NBSU) should be undertaken.

Capacity building of the medical doctors, nursing and other staff about the protocols and guidelines to utilize New Born Stabilisation Unit(NBSU) should be undertaken.

CHILD HEALTH

The key components of child health programme implemented through the National Health Mission, are home, outreach, and facility based care for the young child, encompassing management of childhood illnesses, particularly Acute Respiratory Illnesses (ARI), Diarrhoea, Sepsis, immunization through routine immunization programmes as well as though focused efforts such as Mission Indra Dhanush, micronutrient supplementation programmes, the Rashtriya Bal Swasthya Karyakram (RBSK), and a focused effort to improve child under nutrition through convergent action with the Department of Women and Child Development, i.ePoshan Abhiyaan. For the first time, every state CRM team also included representatives from DWCD and Poshan Abhiyaan was examined through the lens of multisectoral convergence between Departments of Health and Departments of Women and Child Development.

KEY OBSERVATIONS

1. Overall immunization coverage showed improvement. Special initiatives taken by states have helped achieve coverage rates of about 85- 90%. These include 'Model Immunization Corner' in Bihar, 'Tikakaran Nimantran Patrika' in Delhi and convergence with rural development programs like Gram Swaraj and Extended Gram Swaraj Abhiyan in Madhya Pradesh.

2. Electronic Vaccine Intelligence Network (eVIN) was found functional in Chhattisgarh, Gujarat, Jharkhand, Odisha and Manipur.

3. Alternate Vaccine Delivery systems are in place in Chhattisgarh, Gujarat, Uttar Pradesh, Mizoram and Manipur but needs to be strengthened in Madhya Pradesh.

4. Newer vaccines like Rota Virus were incorporated in immunization schedule of states like Jharkhand, Delhi, Madhya Pradesh and Odisha.

5. Nutritional Rehabilitation Centers were observed to be well functional in Gujarat and Odisha, while low community referral to NRC was reported in Uttarakhand. A model for effective linkage between facility and community-based management of malnutrition in the form of Malnutrition Treatment Centres (MTC) being managed by MSF (Medecins Sans Frontieres) was found in Jharkhand, which could be examined in more detail for scaling up.

6. Infant & Young Child Feeding (IYCF) programme has been initiated in all the states, but awareness about complementary infant and young feeding practices in several states was found to be low. Nonetheless, community based events like Upari Aahar Abhyas Diwas (UAAD), Annaprashan Diwas, Godbharai have strengthened complementary Feeding Practices in Bihar, Manipur, Mizoram and Rajasthan.

7. Gaps were found in the universalization of Supplementary Nutrition Practices (SNP) and training of ASHAs on Early Childhood Care and Education (ECCE) in Bihar and Uttar Pradesh.

8. Home Based Young Child care (HBYC), a relatively recent initiative, for improving home based care of the child under two years through increasing home visits by ASHAs, was reported to have been initiated in Manipur, whereas training is underway in Bihar, Mizoram and Madhya Pradesh.

9. The RBSK, with its focus of the four Ds: defects, delays, disability and deficiency, was observed to be functioning well in Gujarat, Tamil Nadu, Uttar Pradesh and Uttarakhand while limited screening under RBSK was seen in Jharkhand, Madhya Pradesh, Manipur and Nagaland. In Gujarat, the Sub-Center HWC worked closely with RBSK team so that referrals and follow for children were the responsibility of the Primary Health Care team, a practice that needs to be scaled up in all states with functional HWCs.

10. Though the screening for birth defects under RBSK has improved, the facility linkages with NRC, DEICs and other referral centres, were found weak in all the states visited. RBSK is not functional in Delhi, however, a state scheme called "Chacha Nehru School Health Yojana" was available for medical care of all paediatric illnesses.

11. DEICs were established in many states visited but they were found to be functional in Andhra Pradesh, Bihar, Meghalaya, Uttar Pradesh and Uttarakhand. No DEICs were found in Chhattisgarh, Jharkhand and Madhya Pradesh.

12. In Gujarat, Odisha and Bihar, child death reporting and facility-based review were being conducted. Child death reporting was reported from Chhattisgarh, while very poor reporting for child death review in Jharkhand.

RECOMMENDATIONS

1. Immediate measures need to be taken to scale up Home based Young child care in all states.

2. Capacity building of AWW/ANM for Infant and young child feeding (IYCF) and Mother's Absolute Affection (MAA) to be done with regular monitoring by ASHA/ Medical officer or District nodal officer.

3. Assured procurement of GMDs, induction training of AWWs/ANMs/ASHAs to use them and reporting of the growth monitoring data both in MCP card and in ICDS-CAS need to be ensured. Mothers should also be oriented about the various sections of MCP card and its importance.

4. Capacity building of ANM, ASHA, etc. regarding all the component of immunization starting from cold chain maintenance, open vial policy, AVD, EVIN and Storage of vaccines to be done.

5. RBSK Screening and its linkage to DEIC and NRC need strengthening. Adequate follow-up of screened and referred children needs to be ensured.

6. SAM/MAM children need to be monitored both in the facilities and in the communities.

7. Child death reporting and review to be strengthened across the country.

TOR 3:
Addressing Non-Communicable Diseases

A plethora of programmes are covered in this section, ranging from the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), mental health, elderly care, palliative care, blindness control, burns management, and programmes for fluorosis and iodine deficiency. Other than the NPCDCS programme, where a beginning has been made, there is little attempt at ensuring a care continuum and a two way referral for these programmes across community and outreach components and facility based care.

NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CARDIOVASCULAR DISEASES AND STROKE (NPCDCS)

The National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) was launched a decade ago, to prevent and control major Non Communicable Diseases, with a focus on establishing Non-Communicable Disease (NCD) clinics at CHC and DH levels and opportunistic screening at PHCs and SHCs. In 2016, the MOHFW launched the Universal Screening, prevention, and management of common Non-Communicable Disease to bring services close to community.

KEY OBSERVATIONS

Screening

1. The status of implementation of the population-based screening for common NCDs was found to be variable across states and across all components: duration and quality of training, completion and verification of the risk assessment checklists, ASHA payment for screening related actions, availability of glucometer strips, and above all community interventions to improve understanding of the importance of screening, and the prevention and control of NCDs.

2. Even among the five diseases for which population based screening has been initiated, cervical cancer screening at PHC levels is yet to take off in most states and requires immediate attention. Even for oral and breast cancers, screening was limited only to those who complained of symptoms, defeating its very purpose.

3. Population enumeration has been initiated in most states, however not much has been reported on line listing of the target population and status of family folders. All the states reported of CBAC completion being done by ASHAs, except for Nagaland and Delhi. CBAC completion was not being done in the community universally; and it was observed that in some facilities individuals were assessed and scored for risk factors only when they came to the health facilities to get screened.

4. In Andhra Pradesh, incomplete CBAC forms were observed, flagging the need for sustained training. Field findings also indicate a need to build the capacity of front line workers to understand the multifaceted uses of CBAC – beyond just risk assessment, i.e. its use of a tool to promote awareness and prioritize individuals for screening.

5. Madhya Pradesh is currently undertaking NCD screening in a campaign mode and male MPWs are designated as Community NCD worker by State andare involved in screening of the target population, Delhi, continues to undertake opportunistic screening in facilities. In Andhra Pradesh's urban slum areas MePMA workers in Mahila Arogya Samitis were involved actively in mobilizing women to be screened for NCDs

6. Cervical Cancer screening is limited to opportunistic screening, and even here only Andhra Pradesh and Tamil Nadu reported screening at PHC levels, using VIA. In Gujarat, cervical cancer screening was undertaken at CHC and above using PAP smear, Madhya Pradesh reported screening for cancer at the secondary level i.e. District Hospitals.

7. Supply of consumables was not streamlined especially in procurement and supply of glucose strips. In Chhattisgarh, the glucometers showed inaccurate readings and thus effecting the screening exercise. Calibration of equipment was not being reported by any facilities.

Capacity Building

8. The National Guidelines on Prevention, Screening and Control of common Non-Communicable Diseases strongly emphasizes the need to provide information and training to the Health workforce, to help them acquire the skills, knowledge and attitude thus making them competent to undertake programme related activities. While moststates reported that training on NCDs was completed for the health care workforce; however in Uttar Pradesh, Nagaland and Madhya Pradesh, the training duration was shortened thus leading to content overload. Bihar reported completion of training of District Nodal Officers on NCDs, and is yet to initiate the training of sub district health workforce including ASHAs and MPW/ANMs.

9. Field findings also indicate a need of refresher training for frontline workforce on recording and reporting formats including CBAC.

Community awareness for prevention of NCDs

1. Promoting healthy behaviours to effect lifestyle behaviour changes, is critical for prevention and control of chronic diseases. The state findings indicate a need to increase focus on community awareness in order to increase coverage with screening programmes. Overall community awareness on NCDs and associated risk factors was limited to Hypertension and Diabetes and even this was found suboptimal across the states. Community awareness regarding cancers was observed only in few states and was more in Urban areas than rural areas.

2. In Tamil Nadu, Rajasthan, Nagaland, Madhya Pradesh and Delhi, CRM teams observed that the IEC material was adequately present and well displayed at the facilities. From community's perception, IEC material with more pictorial representation was identified as more useful and preferred over text heavy posters. In Uttar Pradesh, IEC material was displayed at the district level facilities, but not at the facilities below. Overall findings from state indicates a need to focus on strengthening of IEC activities.

Treatment and management of complications

1. The credibility of the Universal Screening initiative for NCDs rests on the availability of essential medicine and diagnostics for NCDs across the health care facilities. Availability of antihypertensive and antidiabetic medicines was reported in most states like Andhra Pradesh, Delhi, Gujarat, Nagaland, Uttarakhand and Uttar Pradesh. In Andhra Pradesh, Nagaland, Uttar Pradesh and Uttarakhand, anti-hypertensives and anti-diabetic medicines are also available up to the level of Health and Wellness centre – SHC/PHC and CHC.

2. Most states are currently dispensing NCD medicines for a period of 5-10 days, repeatedly noted as a barrier to treatment adherence and increasing OOPE. However, in Delhi the medicines are being provided to NCD patients for a period of one month. In Gujarat, it was observed that prescription practices of antihypertensive are neither uniform throughout facilities nor according to guidelines at many places. Despite the existence of policies in most states to dispense medicines for one month, medicine shortages at peripheral facilities dictate dispensing for shorter durations.

3. Continuum of care is essential for Non-Communicable Diseases' management and control; however, referral and follow up mechanisms were weak across the states. None of the states reported back referral of identified NCD patients undergoing treatment at higher health care facilities.

4. Patients being screened at primary level are being referred to either CHC or DH, but there is no mechanism to follow up on these identified NCD cases. Referral cards/ diaries which also act as a tool for follow up, were either not observed or not used properly for strengthening follow up mechanism. In most of the districts, follow up of identified NCD patients for hypertension and diabetes are not driven by health workers at the primary level or from facilities, but self-driven by patients.

5. Lack of follow up mechanisms for positively diagnosed cases has emerged a critical challenge, and in absence of records for identified cases it is difficult for the service providers to follow up for treatment compliance.

In Andhra Pradesh, Nagaland, Uttar Pradesh and Uttarakhand, anti-hypertensives and anti-diabetic medicines are also available up to the level of Health and Wellness centre – SHC/PHC and CHC.

6. Human Resource shortages in NCD cells at district and state levels service delivery at the secondary level of health care facilities constrain continuum of care. In states like Andhra Pradesh, Gujarat and Odisha, adequate manpower was reported at the NCDs clinics but was being either underutilized or deployed to other NHM initiatives, thus hampering the functioning of NCD clinics. In other states, NCD cells were significantly understaffed.

RECOMMENDATIONS

1. States should expedite training for all cadres on a priority basis. States should ensure the joint training of ASHAs and ANM/MPWs of respective SHCs to better converge activities, and achieve programme goals.

2. For states, where the training for front-line functionaries has been conducted for a shorter duration, a refresher should be planned, with a focus on health promotion, reporting & recording, and follow up of patients to ensure treatment and lifestyle management.

3. State and district should ensure that the trained personnel are being utilized for NCD services and not being deployed to other departments,

4. Role and responsibilities of ASHAs and ANM/MPWs in health promotional activities to be discussed during monthly meetings by the block level officials and supervised in the field.

5. Involvement of community- based platforms like VHSNC/MAS/PRI/ULB/SHGs to be ensured for health promotion and screening activities.

6. Diagnostics availability to be ensured at SHC, PHCs and also at secondary care facilities to maintain continuum of care after screening.

7. Availability of medicines to be ensured across levels of facilities especially SHCs to reduce out of pocket expenditure. Clear guidelines to be communicated to block level officials and service providers regarding medicine prescription and dispensation.

8. States should also strengthen reporting and recording mechanism to ensure the follow up of positively diagnosed individuals.

NATIONAL ORAL HEALTH PROGRAMME (NOHP)

Government of India launched NOHP to provide integrated, comprehensive oral health care in the existing health care facilities with the objective to improve the determinants of oral health, to reduce morbidity from oral diseases, to integrate oral health promotion and preventive services with general health care system, and to encourage Promotion of Public Private Partnerships (PPP) model for achieving better oral health. The Organizational Structure of the NOHP constitutes of a National Oral Health Cell comprising of Technical and Administrative personnel, a State Oral Health Cell (SOHC) which works in liaising with the State NCD cell existing for other NCD programs, and a District Oral Health Cell.

States should also strengthen reporting and recording mechanism to ensure the follow up of positively diagnosed individuals.

KEY OBSERVATIONS:

1. Community level awareness regarding National Health Oral program was low in most states. Community awareness of oral health care services available in public health facilities was low, and high OOPE for dental treatment was reported.

2. The Rashtriya Bal Swasthya Karyakram's efforts in oral health screening of children however, had letter to improved understanding of oral health care, and referral for dental services.

3. NOHP services were functional at the DH level except in Bihar where the services are being compromised due to unavailability of dental chairs and in Uttarakhand where dental units are unutilized because of unavailability of dentist. In most of the states, service provision below the DH level is not adequate.

4. In states like Meghalaya, Bihar, Odisha sufficient dental chairs were not available in accordance with the number of dentists.

5. IEC materials were well displayed in few states like Meghalaya, Tamil Nadu and Uttarakhand.

6. Dental services available in the most of the states are limited to oral prophylaxis, tooth extraction, routine filling, and RCT. Only Tamil Nadu was providing services related to dentures in public health facilities.

7. In Nagaland, even DH and CHC level, the services were not free of cost and patients were being charged due to unavailability of logistics and consumables.

RECOMMENDATIONS:

1. Primary care services for oral health needs to be strengthened in all states.

2. The mismatch between human resources and equipment needs to be addressed in all states to ensure effective implementation of National Oral Health Program.

3. Community awareness needs to be strengthened to improve the demand generation and thus optimizing the utilization of services at the public health facilities. Community outreach activities can be used to increase community awareness on preventive and promotive care.

NATIONAL TOBACCO CONTROL PROGRAMME (NTCP)

Government of India launched the National Tobacco Control Programme (NTCP) in 2007-08, with the aim to (i) create awareness about the harmful effects of tobacco consumption, (ii) reduce the production and supply of tobacco products, (iii) ensure effective implementation of the provisions under "The Cigarettes and Other Tobacco Products Act, 2003" (COTPA) (iv) help the people quit tobacco use, and (v) facilitate implementation of strategies for prevention and control of tobacco advocated by WHO Framework Convention of Tobacco Control.

The Ministry of Health and Family Welfare has also started National Tobacco Quit Line to provide tobacco cessation counselling services to the community through a

toll-free number and has launched a pan-India, "m-cessation" initiative to reach out to tobacco users who are willing to quit tobacco use and to support them towards successful quitting through text-messaging via mobile phones.

KEY OBSERVATIONS

1. IEC materials and signages were well displayed at the facilities, however compliance to COTPA rules was not observed at all places.

2. Tobacco Cessation Centres are established and functional in Gujarat, Jharkhand, Mizoram and Uttarakhand; while the Nicotine Replacement Therapy was reported available only in two state of Uttarakhand and Uttar Pradesh.

3. High consumption of tobacco was reported in the state of Meghalaya and Nagaland. In most of the states, Community awareness on tobacco use and its health hazards is minimal.

4. Most of the states reported "no smoking" signboards being in place and well displayed at the health facilities. However, contact details of designated officer for reporting the violations was not mentioned in the signboards in all states.

RECOMMENDATIONS

1. States need to strengthen the intersect oral convergence activities and collaborate with PRI and NGOs to generate community awareness and ensure compliance to COTPA rules.

2. Service providers including frontline workforce could also be trained on COTPA to ensure effective implementation of the act.

3. Implementation of COTPA needs to be strengthened and counselling for tobacco de-addiction needs to be initiated.

4. All states need to ensure availability of functional Tobacco Cessation Centre at district level and also to support the pharmacological therapy by ensuring regular supply for Nicotine Replacement Therapy.

5. Special emphasis needs to be given to increase awareness activities in schools and colleges.

6. Standardized anti-tobacco signage could be displayed at the Health facilities and public places in the community.

NATIONAL MENTAL HEALTH PROGRAMME (NMHP)

The Government of India has launched the National Mental Health Programme (NMHP) in 1982, with the objectives to (i) ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population; (ii) encourage the application of mental health knowledge in general healthcare and in social development; and (iii) promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

Under this Programme, the Government is supporting implementation of the District Mental Health Programme (DMHP) in 517 districts of the country for detection, management and treatment of mental disorders/ illness. Further, The Mental Health Care Act 2017 was passed on 7 April 2017 and came into force from July 7, 2018. The law was described in its opening paragraph as "An Act to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto. The Mental Healthcare Act, 2017 also provides that the appropriate Government shall take all measures to ensure that the Government Officials including police officers and other officers of the Government are given periodic sensitization and awareness training.

KEY OBSERVATIONS:

1. NMHP has been partially implemented across the districts, where services are available at the district level, but implementation at the sub district level and below is sub optimal.

2. Central Mental Health Authority (CMHA) & State Mental Health Authority (SMHA) are meant for regulation & co-ordination of mental health services under the central & state governments respectively. These need to be constituted and made active across all states.

3. Outreach activities were reported from Chhattisgarh, Madhya Pradesh, Manipur and Uttar Pradesh, where state is undertaking fixed day clinics or conducting awareness sessions as a part of National Mental Health Programme.

4. Notable achievement was observed in form of functional District Counselling Centres at the DH level, and also suicide prevention helpline which was functional in most of the states.

5. Community awareness on Mental Health programme was reported low across the states. However, states like Delhi, and Manipur reported undertaking activities to generate awareness in the community.

6. High OOPE on mental health care was reported from several state reports.

7. High incidence of alcohol consumption and substance abuse were reported in few states, however there were no deaddiction services reported to address these issues.

8. Frontline workers are not yet actively involved in Mental Health related services, and few states reported their involvement in mobilizing the community for fixed day clinics. FLWs have not been oriented/trained on Mental Health related services so far in most states.

RECOMMENDATIONS

1. Strong IEC campaign is required to increase the awareness within the community on mental health conditions, and the services available in the health care facilities.

2. State could strengthen the coordination activities at state and district level between Mental Health division and other divisions like NCD cell, Drug de-addiction centres, Tobacco control cell to improve the coverage and provision of services in a holistic approach.

3. Linkages with Primary level facilities need to be developed to enable improved access to Mental Health services and facilitate continuum of care.

4. State needs to strengthen the existing DCCs to also follow up on identified individuals seeking services at these centres, and develop linkages to enable primary level facilities to provide counselling services to these identified individuals in the community, thus reducing the patient hardship and OOPE incurred in travelling to higher level facilities.

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS AND VISUAL IMPAIRMENT (NPCB&VI)

National Programme for Control of Blindness and Visual Impairment (NPCB & VI) was launched in 1976 with the goal of reducing the prevalence of blindness to 0.3% by 2020. Main objectives of the programme are to reduce avoidable blindness; develop and strengthen the strategy of NPCB for "Eye Health for All" and prevention of visual impairment; strengthening and up-gradation of Regional Institutes of Ophthalmology (RIOs) and partners like Medical College, DH/ SDH, Vision Centres, NGO Eye Hospitals; strengthening existing infrastructure facilities and developing additional human resources, enhance community awareness on preventive measures and expand research for prevention of blindness and visual impairment.

KEY OBSERVATIONS:

1. In all the states, Cataract surgeries are being conducted, however a backlog in the targets has been reported in Odisha, Mizoram, Manipur, Delhi and Jharkhand. Gujarat has effectively used NGO and private sector to address backlog of cataract surgeries in state.

2. School eye screening camps and screening of eye problems are being conducted in all the states. In Delhi and Tamil Nadu, Diabetic Retinopathy Screening Camps are being organised. Distribution of free spectacles was found to be poor in few states.

3. In Tamil Nadu, Tele Imaging, has been introduced to screen babies for Retinopathy of Prematurity. In Gujarat, a project to reduce blindness from Diabetic retinopathy has been started.

4. In most states, community awareness about program is poor as people with eye problems are visiting private providers incurring out of pocket expenditure (OOPE). In Nagaland where awareness was good as local churches were being used as a platform to spread awareness related to eye care and services available at the health care facilities.

5. Andhra Pradesh has launched Dr. Y S R Kantivelugu Programme for providing comprehensive eye care at no cost to prevent cases of blindness in the state.

Andhra Pradesh has launched Dr. Y S R Kantivelugu Programme for providing comprehensive eye care at no cost to prevent cases of blindness in the state.

The main objective of this initiative is to provide comprehensive and sustainable Universal Eye Care to all the people in the state by conducting eye screening and provision of appropriate interventions like distribution of Spectacles, Surgeries in case of Cataract, Glaucoma, Retinopathy, corneal disorders etc in a phased manner.

RECOMMENDATIONS

1. District level team should know the burden of cataract, glaucoma and other major eye diseases which would help them to create a road map for identification and treatment.

2. Operation Theatres (OT) at the DH/ SDH should be well equipped as per the norms. The position of ophthalmic Assistants should be filled at the block level facilities.

3. Orientation of ASHAs and MPW/ANMs in the program should be done and the performance of the programme needs to be regularly reviewed.

4. Outreach camps should be planned with a view to create awareness among the community and expansion of eye care coverage.

NATIONAL PROGRAM FOR PREVENTION AND CONTROL OF DEAFNESS (NPPCD)

National Programme for Prevention and Control of Deafness (NPPCD) was launched in year 2006-07 with an key objective to prevent avoidable hearing loss on account of disease or injury, enable early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness, medically rehabilitate persons of all age groups, suffering with deafness, strengthen the existing inter-sectoral linkages for continuity of the rehabilitation programme and develop institutional capacity for ear care services by providing support for equipment and material and training personnel.

KEY OBSERVATIONS:

1. NPPCD related services are currently limited to District Hospitals, and the cases from facilities at block and below are being referred to DH. In Nagaland, only Otitis Media cases were being treated at the DH, while for any other ear related conditions, patients were directly referred to Kohima or Dimapur.

2. Community awareness on the programme and knowledge regarding availability of services at the government facilities was poor. Frontline functionaries working at the level of community and facility also lack knowledge and awareness on the programme components and services available.

3. Linkage between NPPCD and RBSK programme for identification and referral of Congenital Deafness/ Hearing problems in neonates, infants/ Under five children was found in all states except Bihar, Chhattisgarh and Delhi where it was poor. Cochlear Implants are being carried out at Tamil Nadu and Gujarat.

4. Under NPPCD, there is provision for rehabilitation of hearing and hearing aid supply. This activity is being undertaken in collaboration with the Ministry of Social Justice & Empowerment. In Tamil Nadu, free hearing aids being provided under CMHIS (Chief Minister's Comprehensive Health Insurance Scheme) while in Uttar Pradesh it is provided by Divyank Kalyan Vibhag. In Uttarakhand and Mizoram hearing aids are not being supplied from State to the facilities.

RECOMMENDATIONS

1. Orientation of field levels workers (ASHA, ANM etc.) along with the primary and secondary level facility staff on NPPCD is needed for early detection and timely referral of common Ear problems.

2. Rational placement of Human Resource including audiologist to be ensured for early detection of hearing problems.

3. Awareness camps could be conducted involving NGOs, SHGs etc. and referral linkages to DH must be improved for better access of the community. IEC campaigns are required to create awareness among the community members.

4. Supply of essential consumables such as hearing aid needs to be streamlined in order to provide ensured services.

NATIONAL PROGRAMME FOR HEALTH CARE OF ELDERLY (NPHCE)

National Programme for Health Care of Elderly (NPHCE)was launched in 2010 with an objective to provide dedicated health care facilities to the senior citizens (>60 year of age).

The programme aims to provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an Ageing population; create a new "architecture" for Ageing; and build a framework to create an enabling environment for "a Society for all Ages". It also promotes the concept of Active and Healthy Ageing. One of the objective of the programme is also to strengthen the convergence between various departments i.e. National health Mission, AYUSH and Ministry of Social Justice and Empowerment.

KEY OBSERVATIONS:

1. The field findings reflected state specific mechanisms, where most states were delivering elderly care services as one of the routine services through daily OPD, while in Delhi, Manipur and Uttarakhand facility based services were being delivered through fixed day clinics. Few states are also undertaking integrated elderly care services at the NCD clinics functional at the secondary levels.

2. Overall community awareness on elderly care services was reported low in all states,. Elderly care services are currently limited to secondary level care in most states.

3. In Delhi, facilitation for elderly care includes provision of separate queue at the OPD and at dispensing counters, and OPD services on Sundays as well, to encourage

care seeking when the crowds for routine OPD for others are much less. This was seen in Nagaland and Odisha too.

4. Most states do have a functional ten bedded elderly ward at the level of District Hospital, except Gujarat, Meghalaya and selected districts of Madhya Pradesh and Jharkhand. In Nagaland a five bedded elderly ward is available but was not functional. Also in Bihar and Mizoram, ten bedded wards were in place but not functional due to unavailability of HR and administrative reasons respectively.

5. It was observed that the programme management unit at district level below is not strong and states are yet to evolve a robust management and monitoring mechanism of the programme. Human Resource shortfall was reported from most states.

6. Training of service providers was reported to be low across the districts, and field findings indicated a need for refresher training of those who had undergone orientation training at the time of joining.

7. Tamil Nadu reported Health insurance schemes like CMHIS and PMJAY being merged to facilitate provision of a common insurance benefit for elderly; and an Old age pension scheme of Rs. 1,000 per month provided by the Department of Social Welfare.

RECOMMENDATIONS

1. States should expedite the training and refresher trainings of the workforce on NPCE guidelines to better understand the needs of elderly and delivery quality of care.

2. State could strengthen its capacity by making Elderly care wards functional at the district hospitals, and linking the elderly care clinics with the NCD clinics at the CHC and DH.

3. Comprehensive NCD services- Existing HR under different programs to be rationally used to deliver a wide range of services.

4. Basic drugs need to be made available for reducing out of pocket expenditure. All mercury BP machines are to be replaced by digital ones.

5. Geriatric OPD, indoor, lab, physiotherapy unit to be made functional at all DH. Biweekly OPD and rehabilitation should be made available at CHC. Equipment to be made available

6. Health care facilities should be made elderly friendly and provisions of hand rails and elderly friendly toilets should also be made available. A provision of separate queue in OPDs and diagnostics and at the medicine dispensing counters could be preferred to prioritize the elderly.

7. Linkages of AYUSH should be done at the district level and those AYUSH doctors placed in remote areas should also be trained in elderly care.

8. Physiotherapy units should be near to the elderly care ward or Physiotherapist should periodically visit the elderly ward and provide services. If these options are not possible then a support could be made available in the facility to facilitate the movement of the elderly patients to the unit.

9. Integrated consultation facility can be set-up, where multispecialty consultation happens at one place, and elderly need not to move from one place to another.

NATIONAL PROGRAMME FOR PALLIATIVE CARE (NPPC)

Government of India launched National Programme for Palliative care (NPPC) in 2012 with a goal to ensure availability and accessibility of rational, quality pain relief and palliative care to the needy, as an integral part of Health Care at all levels, in alignment with the community requirements.

The key objectives of NPPC are to (i) improve the capacity of service providers to provide palliative care, (ii) refine the legal and regulatory systems and support implementation and ensure access and availability of opioids while maintaining measures for preventing diversion and misuse, (iii) promote behaviour change in the community and (iv) ensure continuous progress towards the vision of the programme.

KEY OBSERVATIONS:

1. NPPC implementation was reported in nascent stage in most of the states. While in most of the states, the programme functionality is limited to District Hospitals, states like Meghalaya, Chhattisgarh, Jharkhand, Mizoram, Nagaland are yet to implement the programme.

2. Palliative care services where rolled out, are limited to District Hospitals at present. Procedures like Ryle's tube insertion, catheterization and ascites tapping are available at the DH, but are underutilized either due to unavailability of skilled personnel or lack of awareness in the community regarding services available at the health facilities. Manipur is the only state which reported a ten bedded ward at DH level, and two bedded ward at 2 CHCs and 2 PHCs have been established and are being utilized.

3. Most service providers were not trained on Palliative care, and those trained also requested for a reorientation on the programme guidelines.

4. Manipur reported a high community awareness and engagement regarding palliative care services. At the level of community, regular awareness camps are organized by CHOs, and CHOs' involvement in delivering Palliative care services was well appreciated in the community.

RECOMMENDATIONS

1. States can plan and develop comprehensive plan to develop referral linkages between primary and secondary level, to spread awareness in the community regarding existing services and increase utilization of services across the levels of care.

2. States could organize orientation of service providers including frontline workers on palliative care services.

3. Awareness and orientation on home-based palliative care to be undertaken in the community. Care giver's support needs to be strengthened by routing home visits and training of care givers.

Manipur reported a high community awareness and engagement regarding palliative care services. At the level of community, regular awareness camps are organized by CHOs, and CHOs' involvement in delivering Palliative care services was well appreciated in the community.

4. Follow up mechanism to be developed to ensure treatment compliance and supporting the care givers of the patients.

NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF FLUOROSIS (NPPCF)

National Programme for Prevention and Control of Fluorosis (NPPCF) was launched in 2008-09 with an aim to prevent and control Fluorosis cases in the country. The programme has an objective to collect, assess and use the baseline survey data of fluorosis of Ministry of Drinking Water and Sanitation; Comprehensive management of fluorosis in the selected areas; and Capacity building for prevention, diagnosis and management of fluorosis cases.

KEY OBSERVATIONS:

1. In most states, National program of prevention and control of fluorosis is yet to be operationalised effectively to yield better results from the field.

2. In Chhattisgarh and Madhya Pradesh, screening activities of fluorosis was conducted, and visible deformities identified but physiotherapy services were not provided. Stock out of calcium tablets was also reported in Chhattisgarh.

3. In Madhya Pradesh, Andhra Pradesh and Rajasthan, fluorosis screening was undertaken but no further activities were undertaken.

RECOMMENDATIONS

1. Community level awareness can be strengthened and proactive measures to be undertaken for programmes implementation in the endemic districts.

2. IEC activities to be planned to disseminate information on fluorosis, its prevention and on use of vitamin D, Calcium supplements, to minimize the impact of fluorosis.

3. Regular review at district level and at State level needs to be institutionalized.

4. Defluorination plants are to be installed in fluorosis affected areas.

5. In fluorosis affected areas, the focus on prevention and control of fluorosis should also cover the community and primary level of health care services. Community engagement through platforms such as VHSNC and MAS should also be improved for better planning and monitoring.

NATIONAL IODINE DEFICIENCY DISORDERS CONTROL PROGRAMME (NIDDCP)

National Goitre Control Programme (NGCP) was launched in 1962 which was later renamed as National Iodine Deficiency Disorders Control Programme (NIDCP) with a view of wide spectrum of Iodine Deficiency Disorders like mental and physical retardation, deaf mutism, cretinism, still births, abortions etc. The goal of the programme is to bring the prevalence of IDD to below 5% in the country and ensure 100% consumption of adequately iodate salt (15ppm) at the household level.

KEY OBSERVATIONS:

1. Overall community awareness on consumption of iodised salt was average. In Gujarat and Nagaland, communities were observed to be well aware and informed on benefits of iodized salt; while in a few states the community did not have enough knowledge about IDD and its consequences.

2. In Nagaland, it was observed that even Salt traders are involved in the planning to ensure that only iodised salt is made available to the community. Meghalaya and Manipur also reported that the community using mainly iodised salt in their cooking.

3. Salt testing is being carried out in few states, and Delhi, Jharkhand, Manipur and Mizoram reported of Salt Testing Kits being provided to ASHAs; in U.P., although the STKs were provided to ASHAs, due to lack in clarity on its usage, they were underutilized. Delhi also reported stock out of the kits during the time of visit. Bihar, Meghalaya and Uttarakhand reported that STKs not being available with ASHAs during the visit. In Tamil Nadu, STKs were available at the Sub Health Centre level.

RECOMMENDATIONS

1. State need to streamline the availability of salt testing kits with ASHAs and at the facility level, where needed.

2. Proactive measures could be undertaken for monitoring and the implementation of the programme in the districts.

3. Community based fora like VHSNC and MAS could also be utilized in generating the awareness in the community on benefits of iodised salt and also methods of cooking to avoid loss of iodine in food.

NATIONAL PROGRAMME FOR PREVENTION and MANAGEMENT OF BURN INJURIES (NPPMBI)

The National Programme for Prevention and Management of Burn Injuries (NPPMBI) was launched in year 2014, with the key objectives to reduce incidence, mortality, morbidity and disability due to burn injuries, improve awareness among community including vulnerable groups, establish adequate infrastructural facility and to carry out research for assessing behavioural, social and other determinants of Burn Injuries in our country for effective need based program planning for Burn Injuries, monitoring and subsequent evaluation.

KEY OBSERVATIONS:

1. At present, provision for emergency and trauma services at primary health care levels is limited. At the community level, individuals were reported to be seeking care for trauma related services from private practitioners and thus incurring Out of pocket expenditure.

2. Most states reported that at the PHC and CHC levels services spanned stabilization including suturing and splints, with patients are being referred to DH and higher centres for further management.

3. Emergency care services at the higher level were found suboptimal either due to unavailability or non-functionality of resources or underutilization where available. In most states, a separate burn ward was not available, and where available was being utilized as post-operative care ward. Also, it was observed that triaging and zoning was not reported in most facilities.

4. Across the states, it was observed that facility-based ambulances and 108 services were being used for the referral of the emergency cases. Bihar reported utilizing 102 services for transferring of patients seeking emergency care. While referral transport services were available and functional at facilities, Tamil Nadu also reported building capacity of 108 staff including the drivers, to be functional as first responders for emergency and trauma cases.

5. Tamil Nadu has set up an Accident and Emergency Care Initiative (TAEI), which is functional across the facilities and providing comprehensive services for emergency care.

6. Overall reporting and recording mechanism was found weak for emergency and trauma care services. No separate record/statistics of emergency care were being maintained across the facilities in many states.

RECOMMENDATIONS

1. Emergency care services need to be strengthened and organized across the levels of care, to ensure the availability of services at the primary level of care. Availability of comprehensive emergency care would not only ensure timely intervention but would also reduce the out of pocket expenditure being incurred on emergency care services.

2. States need to ensure availability of adequate Human resources and skilled personnel for emergency care services at the facilities. This would also ensure optimal utilization of infrastructure, where available.

3. The underutilized resources also reflected the general status of training of service providers on emergency and trauma care. It is therefore recommended that the state could train the primary care workforce on emergency care and build their skills and ability to be functional as first responders in case of emergency. State could also expedite the capacity building exercise to ensure training of Casualty Medical Officers on "Emergency Care Management".

4. State should expedite the implementation of triage protocols across facilities delivering emergency care facilities, to prioritize patients requiring urgent intervention. A strong triaging mechanism would not only recognize the severity and urgency, but would also help in ensuring timely intervention for emergency care.

5. Referral linkages can be strengthened to ensure timely referral to appropriate facilities, depending on the severity of the condition.

6. Periodic monitoring of ambulance utilization and deployment at district as well as state level should be undertaken to make the efficient /optimal utilization of public resources.

TOR 4:
Addressing Communicable Diseases

KEY OBSERVATIONS

INTEGRATED DISEASE SURVEILLANCE PROGRAM (IDSP)

1. Surveillance through decentralized reporting and laboratory-based IT enabled techniques are being undertaken through the IDSP across the country. The programme monitors disease trends, detects and responds to outbreaks in early rising phase through trained Rapid Response Team (RRTs). During the CRM visit it was found that epidemiological data analysis, forecasting, preparedness and mitigation activities for disease outbreaksin several states were found to be weak.

2. Timely filling of forms and weekly IDSP was reporting observed in states such as Andhra Pradesh, Bihar, Manipur, Meghalaya, Mizoram, Rajasthan, Tamil Nadu, but gaps in reporting were seen in Jharkhand, Odisha, Uttar Pradesh, Uttarakhand and NE states (due to poor internet connectivity and difficult terrains).

3. Early warning signals were reported by facilities in Delhi, Jharkhand, Madhya Pradesh, Manipur and Rajasthan, whereas the same was found weak in Andhra Pradesh and Bihar.

4. District Public Health Laboratories were present in Bihar and Gujarat while they were not established in Delhi. Meghalaya is dependent on laboratories outside the state for diagnosis of emerging and re-emerging infectious diseases.

5. Regular reporting on the IDSP portal was seen in Delhi, Gujarat, Madhya Pradesh, Odisha and Tamil Nadu.

6. Constitution of Rapid Response Teams (RRTs) was not uniform across all visited CRM states. RRTs have been constituted uptoDH in Delhi and Tamil Nadu and till block/PHC level in Gujarat, Odisha, Rajasthan and Uttar Pradesh.

7. Forecasting and trend analysis was satisfactory at Nagaland, Rajasthan, while no effective epidemiological analysis of data collected was noted in Jharkhand, Manipur, Meghalaya and Mizoram.

8. Training on the Integrated Health Information Platform (IHIP) have been initiated in Bihar, Delhi, Jharkhand, Madhya Pradesh, Manipur, Odisha, Rajasthan, Uttar Pradesh but not in Gujarat.

9. Human resources under IDSP is an area of concern in majority of the states. The post of Epidemiologist was found vacant in Bihar, Chhattisgarh, Delhi and Gujarat whereas that of District Data managers was not filled in Gujarat, Bihar and Uttar Pradesh. Other crucial positions like Entomologist, Veterinary and Training consultants were vacantat several places.

10. Quality of training under IDSP needs to be strengthened as limited understanding of the programme among the key functionaries was observed. Trainings has been undertaken for staff in Bihar, Delhi, Madhya Pradesh and Tamil Nadu, whereas no orientation has been done in other states like Meghalaya, Mizoram, Nagaland and Uttarakhand.

11. Community awareness regarding Malaria, Dengue and Chikungunya was found optimal but for others such as Leprosy, JE, Kala- Azar was found to be low in most of the states visited. Even among the frontline workers- ASHAs & ANMs, knowledge on various communicable diseases and their surveillance mechanism was found sub-optimal in the states of Bihar, Nagaland and Uttar Pradesh.

12. Other gaps like incorrect data entry, weak or negligible reporting of early warning signals (EWS) and non-reporting by private hospitals on the IDSP portal were noted across all the states.

RECOMMENDATIONS

1. States to sanction/fill in the key vacant posts at the earliest to ensure proper forecasting of early warning signals, epidemiological data analysis and adequate preparedness to deal with any impending outbreaks.

2. Laboratory diagnoses of common outbreak prone diseases like Dengue, Cholera, Scrub Typhus, Leptospirosis etc. needs to be strengthened under IDSP.

3. States need to establish Integrated Public Health Laboratory at each District Hospital.

4. Strengthen recording, reporting and feedback mechanisms to the blocks and all HCFs for taking appropriate action as per the forecast with special focus on seasonal trends.

NATIONAL TUBERCULOSIS ELIMINATION PROGRAM (NTEP)

1. Community awareness about TB and testing centres was satisfactory in Meghalaya, Mizoram, Nagaland, Tamil Nadu and Uttar Pradesh whereas its was observed to be sub-optimal in Andhra Pradesh.

2. Sputum smear microscopy is being conducted across the states but the examination rate is lower than norms in Chhattisgarh, Madhya Pradesh and Nagaland.

3. DOTS was being implemented and both MDR and non-MDR TB cases treated in Andhra Pradesh, Bihar, Chhattisgarh, Delhi, Gujarat, Odisha and Rajasthan, while in Mizoram new drug regimen was not being given to MDR TB patients.

4. CBNAAT was functional in facilities visited in Andhra Pradesh, Delhi, Gujarat and Jharkhand, however its utilization rate varied across the country. Tamil Nadu and Meghalaya reported >90% utilization while Chhattisgarh, Manipur, Mizoram, Nagaland, Rajasthan and Uttarakhand had not utilised them to optimum capacity.

5. Nikshay Poshan Yojana (NPY) is being implemented in almost all states except Meghalaya. A limited number of notified beneficiaries (40-50%) were being paid through DBT in Bihar, Delhi, Gujarat, Jharkhand, Odisha, Rajasthan and Uttar Pradesh, with over 90% in Tamil Nadu. There were issues of timely disbursement of incentive due to lack of bank account of beneficiaries and lack of awareness amongst beneficiaries on utilisation of funds received under NPY.

6. All TB patients are being tested for Diabetes and HIV co-morbidity in Delhi, Tamil Nadu, Odisha and Uttar Pradesh.

7. Sub optimal INH prophylaxis among PLHIV was seen in Rajasthan and Mizoram.

8. Delays in recruitment of State and District level key positions was observed in Bihar, Madhya Pradesh and Manipur hampering programme monitoring.

9. No death audit is being conducted under the NTEP in most states visited.

10. Low notification from private sector was reportedfrom several states.

RECOMMENDATIONS

1 IEC/ Intensified Advocacy Communication & Social Mobilisation (ACSM) activities on generating community awareness on newer activities under the program such as Nikshay Poshan Yojana, usage of funds received thereof and the latest diagnostic and treatment facilities available at public health facilities needs to be done.

2 Sputum collection and transport of samples across facilities should be systematized, especially in hard to reach areas, with adequate provisioning of equipment/ boxes to carry the collected samples. Also, cross-checking of sputum samples needs to be performed.

3 Death audit under NTEP needs to be initiated.

4 Active Case Finding campaign in high risk areas needs to be taken up as well.

5 Notification from private sector needs to be strengthened.

NATIONAL LEPROSY ERADICATION PROGRAMME

1. Community awareness on signs and symptoms of the disease, mode of spread and its complications was satisfactory in most states, but reported to be low in Mizoram and Uttar Pradesh.

DOTS was being implemented and both MDR and non-MDR TB cases treated in Andhra Pradesh, Bihar, Chhattisgarh, Delhi, Gujarat, Odisha and Rajasthan, while in Mizoram new drug regimen was not being given to MDR TB patients.

Death audit under NTEP needs to be initiated.

2. Health Workers had satisfactory knowledge of leprosy case detection in most places, while training/refresher training for Leprosy is required in Bihar, Chhattisgarh, Gujarat, Mizoram, Odisha, Tamil Nadu.

3. Drugs for leprosy are available in majority of the states without interruption, namely, Bihar, Delhi, Gujarat, Uttar Pradesh, Andhra Pradesh (at CHC and DH level), while gaps in supply were noted in Chhattisgarh.

4. Leprosy Case Detection Campaign (LCDC) for house to house screening for leprosy was being undertaken in most states- Andhra Pradesh, Bihar, Delhi, Gujarat, Jharkhand, Madhya Pradesh, Meghalaya and Odisha.LCDC could not be conductedin Manipur due to lack of funds.

5. Sparsh Leprosy Awareness Campaign (SLAC) was being carried out in Andhra Pradesh, Bihar, Delhi, Jharkhand and Manipur. This initiative has helped to significantly reduce the national average of Grade-2-Disability (G2D) to 2.25%. However, Meghalaya and Biharreported a G2D rate of >3%, which indicates need to intensify the LCDC in these states.

6. ASHA Based Surveillance for Leprosy Suspect (ABSULS) was being carried out in Andhra Pradesh, Chhattisgarh, Delhi, Gujarat, Jharkhand, Odisha where these peripheral health workers were actively involved in active and passive case detection along with appropriate referral of leprosy cases. ABSULS was not being undertaken in Uttar Pradesh and Manipur.

7. Gujarat has been able to demonstrate significant decline in leprosy prevalence over the years, including elimination from six districts, though the disease is still endemic in districts visited. The state has institutionalised camp-based approach for reconstructive surgeries at District Hospital level.

8. There was no visibility of Leprosy program in Rajasthan, where no case of Leprosy has been identified in last seven years. No active case finding was being conducted in the community by PHCs in Odisha and Rajasthan.

9. Disability Prevention & Medical Rehabilitation services need to be implemented more effectively in most states including Bihar, Delhi and Uttar Pradesh.

10. High Grade 2 Disability (G2D) rate was reported from Bihar and Chhattisgarh, indicating high transmission and delayed detection of cases.

11. MCR footwear & self-care kits are available in Gujarat (at PHC level), Odisha (at CHC level and above) and Uttar Pradesh. Gaps in distribution of MCR footwear as against the requirement were observed in Chhattisgarh, Jharkhand and Manipur.

12. Disability Pension of Rs.1500 per month is being given at Virudhunagar district in Tamil Nadu.

13. Partnering with development partners (Damien Foundation-India) for case management of leprosy and associated disability was observed in Jharkhand, which assisted in timely case management.

RECOMMENDATIONS

1. IEC/BCC for leprosy needs to be strengthened in urban slums with focus on early diagnosis and treatment and increase leprosy notification by community.

2. Urgent measures are required to avoid delayed detection and high transmission of leprosy cases. Focus to detect leprosy patients with grade 2 disability is needed.

3. Disability prevention and medical rehabilitation services need to be implemented more stringently in some states like Bihar and Chhattisgarh. Also, active collaboration with rehabilitation centres, government facilities and NGOs is needed in all the states to ensure proper management of the identified cases.

4. Gaps in demand, supply and utilization of MCR footwear need to be addressed.

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAM (NVBDCP)

1. Awareness in community on spread and control of Vector Borne Diseases (VBD) was fair in Delhi, Meghalaya, Tamil Nadu, Uttarakhand but not in Nagaland and Uttar Pradesh. Besides, awareness on Malaria, dengue, chikungunya was better than other VBDs such as JE, Kala-Azar and Chikungunya in the community as well as healthcare staff in most of the states visited.

2. Integrated vector management by source reduction, use of Personal Protective Equipment (PPE), anti-adult measures, larvicidal measures and community engagement activities were being conducted at varied levels across States. For instance, '10 Hafte, 10 Baje 10 Minute' campaign for Dengue prevention in Delhi and DAMAN programme (Durgama Anchalare Malaria Nirakaran) in Odisha were being done.

3. In several states, active surveillance of Malaria was weak. Bihar, Chhattisgarh and Meghalaya are yet to declare malaria as a notifiable disease.

4. Improvement in surveillance with greater involvement of ASHAs has helped reduce ABER in Manipur, which is nearing certification of elimination status for Malaria. Active screening and testing of symptomatic cases was nearly absent in Bihar, Uttarakhand and Nagaland.

5. Malaria Elimination Committee and Malaria Elimination task force were constituted in states like Manipur but were not formed in Uttar Pradesh.

6. RDT kits and anti-malarial drugs were available at all level of HCFs in AP, Mizoram, Odisha, Madhya Pradesh, Uttar Pradesh and Uttarakhand, whereas its availability was suboptimal in Chhattisgarh, Gujarat and Rajasthan.

7. Record of M1 and M4 forms were being maintained in AP and Odisha while lack of awareness on these was seen in Uttarakhand.

8. Negligible/poor surveillance activities were observed in Bihar and Uttarakhand.

9. Usage of LLINs was seen in Andhra Pradesh (in endemic and tribal areas), Gujarat (only for ANC cases), Manipur (all the districts had micro action plan for distribution), Meghalaya, Nagaland and Odisha.

10. A good practice to contain malaria cases was seen in Nagaland, where surveillance workers submitted tour programme in advance so that the Malaria Technical Supervisor could track their movement.

11. Similarly, in Odisha, Long-Lasting Insecticidal Nets (LLINs) were being distributed in residential schools of Kandhamal. At, Mayurbhanj, ASHAs were found ringing bells at night 8:00 PM as reminder to use the LLINs and also made home visits to monitor the use of LLINs.

   Malaria microscopy was not being done even at the level of DH (only kit based rapid testing) in Bihar. Also, drug compliance during MDA needs to be monitored, as despite 12 MDA rounds over a period of 15 years, none of the districts have cleared Transmission Assessment Survey (TAS) in Bihar state Sentinel Surveillance Hospitals (SSHs) have been identified in Gujarat, Jharkhand, Tamil Nadu and Uttar Pradesh

12. Mass Drug Administration (MDA) for Lymphatic Filariasis were reported from Gujarat and Jharkhand.

13. In Bihar, which is endemic for Kala-azar, preventive activities for kala -azar, such as Indoor residual spraying (IRS) & IEC/BCC activities, curative activities like active case finding, drug treatment at identified treatment centres along with payment of wage loss compensation as per NHM & Mukhyamantri Kala-azar Rahat Yojana were being carried out.

14. Despite availability of JE vaccination and intense IEC activities deaths due to JE were reported in Manipur.

15. Community in Nagaland pooled its resources to procure test kits for Scrub typhus due to high burden of disease, as they are not supplied under IDSP due to shortage of funds.

16. The programme is hampered by the vacancies in crucial posts in certain states, for example, post of District VBD Control Officer in Delhi andentomologist under SVBCP in Manipur. National Filaria Control Unit has also relatively high vacancy in Uttar Pradesh.

RECOMMENDATIONS

1. Case-based surveillance and Sub-Centre wise stratification needs to be done as per NVBDCP guidelines.

2. Integrated vector management action plan (Micro and Macro) should be made available at all the levels, especially in endemic regions.

3. Entomological monitoring is required to be strengthened with increased coordination and cross checking of entomological surveillance and vector control measures.

4. Entomological Surveillance data should to be used for management of VBDs.

5. State of Bihar needs to intensify surveillance activities for Kala Azar in 458 blocks and hotspot villages of Saran, Siwan and Gopalganj to reduce case load. Also, key vacant posts such as VBD consultant in Gopalganj and KTS posts must be filled up on urgent basis.

NATIONAL AIDS CONTROL PROGRAM

1. Awareness regarding HIV and its transmission was good in the community in most of the states.

2. HIV screening for all TB and ANC cases is being done with referral of HIV positive cases to appropriate facility in Andhra Pradesh, Delhi, Gujarat, Jharkhand, Madhya Pradesh, Manipur, Mizoram, Nagaland, Odisha, Rajasthan and Tamil Nadu.

3. ICTC facility and Link ART centre were available at DH in Andhra Pradesh, Delhi, Gujarat, Jharkhand, MP, Manipur, Mizoram, Nagaland, Rajasthan, Tamil Nadu and Uttar Pradesh. Few of these states also had the service at SDH level.

4. ICTC infrastructure facilities and HR were found to be inadequate in Chhattisgarh, to provide confidential and quality counselling services.

5. The online integrated PALS portal (PLHIV -ART Linkage System) was found functional in Delhi, but is not linked with HMIS portal.

6. In Odisha, "MadhuBau Pension Yojna" is being run by the State government to financially support HIV positive cases.

RECOMMENDATIONS

1. SOPs for infection prevention control and needle stick injuries need to be in place at all health facilities along with orientation and training of HCWs.

2. RBSK teams need to make efforts to educate adolescents about HIV, STIs and RTI.

3. Partner notification and treatment needs further promotion.

NATIONAL VIRUS HEPATITIS CONTROL PROGRAM

1. The programme is picking up pace in several states like Gujarat, UP, Bihar, Madhya Pradesh, Odisha and Delhi, has started in phases in Nagaland and is yet to be implemented fully in Chhattisgarh and Rajasthan.

2. Screening of ANCs for Hepatitis is being undertaken in several states visited, including North Eastern states of Manipur, Meghalaya and Mizoram.

3. The practice of Zero dose immunization for Hepatitis B for all institutional deliveries is being done in majority of the states.

4. HBsAg screening at primary care level was performed through Rapid Diagnostic Kits while that for Hepatitis C, E was being done by referral tertiary hospitals.

5. Hepatitis B vaccination of health workers has been done at Jharkhand, Odisha, Tamil Nadu.

6. Model Treatment Centre/treatment Centres have been proposed at Madhya Pradesh and Odisha.

7. While sustained availability of kits was an issue at health facilities in Delhi, large procurement of HCV RNA test kits as well as antiviral drugs with very little utilization in Manipur, needs attention.

8. Auto-disposable (AD)/Reuse Prevention (RUP) syringes are used in most states except Mizoram and Rajasthan.

9. The Viral Hepatitis Management Units were formed in Manipur and Odisha.

ICTC facility and Link ART centre were available at DH in Andhra Pradesh, Delhi, Gujarat, Jharkhand, MP, Manipur, Mizoram, Nagaland, Rajasthan, Tamil Nadu and Uttar Pradesh. Few of these states also had the service at SDH level.

Screening of ANCs for Hepatitis is being undertaken in several states visited, including North Eastern states of Manipur, Meghalaya and Mizoram.

RECOMMENDATIONS

1. Model Treatment Centres (wherever proposed) should be made functional. Trainings for management, lab diagnosis of viral hepatitis and using National Viral Hepatitis Control Program - Management Information System (NVHCP-MIS) Portal is needed before operationalizing these treatment centres.

2. Stock should be taken of Case load versus HCV RNA test kits available as well as Antiviral drugs procured versus those lying unused.

NATIONAL RABIES CONTROL PROGRAM

1. Community knowledge on post exposure prophylaxis on rabies was satisfactory in Andhra Pradesh, Delhi, Gujarat, Manipur and Tamil Nadu but was limited in Jharkhand and Nagaland.

2. Programme was well implemented with good IEC on management of dog/animal bite in several states such as Andhra Pradesh, Gujarat, Manipur, Mizoram or not running well in others like Bihar and Nagaland.

3. ARV was available in facilities at all levels in Gujarat, Manipur and Tamil Nadu, while in Delhi, Odisha, Uttar Pradesh only Tetanus Toxoid Injection is being given at primary care level for animal bites, and thereafter patients are referred to higher centres for ARV.

4. Adequate stock of Anti-Rabies Vaccine was available at all health facilities in MP, Manipur, Rajasthan, Uttar Pradesh whereas shortage of ARV was noted in Chhattisgarh, Jharkhand, Delhi, Meghalaya, Mizoram, Nagaland and Uttarakhand, leading to OOPE. At Jharkhand, ARV is being locally purchased under Ayushman Bharat- PMJAY Scheme.

5. Animal bite register is maintained in the health facilities at Manipur, Mizoram and Uttarakhand but missing in Gujarat, MP, Nagaland, Odisha, Rajasthan and Uttar Pradesh.

6. Awareness of NRCP amongst programme staff was low in most states, except Gujarat and Manipur.

RECOMMENDATIONS

1. Sensitization of community on services provided by health facilities in case of animal bite.

2. Control on population of stray/wild animals to reduce the risk of Rabies.

TOR 5:
National Urban Health Mission

All state reports note that the institutional structures created to support implementation of NUHM in the states, are in place. Functionality of various programs in NUHM also demonstrate considerable improvement in the CRM states. The teams further observed that urban primary healthcare facilities are functional in most states visited, though further strengthening is required through augmentation of numbers of UPHCs so as to expand coverage particularly to reach the marginalized. UPHCs are being converted into Health and Wellness Centres (UPHC-HWCs) in order to deliver comprehensive primary healthcare. The infrastructure is adequate in the majority of the states visited, with around 60-65% of facilities functioning in government buildings. Programme Management Units are mostly in place. Convergence of NUHM with various National Health Programmes and also inter-sectoral convergence has improved in several states, though partnerships with Medical Colleges still need strengthening. This CRM report highlights several innovations in primary health care delivery across states, as a means to improve access and coverage. Nonetheless several weaknesses in areas such as continuum of care, follow up and referral and multisectoral convergence have been highlighted.

KEY OBSERVATIONS

Planning and Mapping

1. Mapping in the context of urban health pertains to health facilities and urban slums. Considerable progress in the sixteen states visited by the CRM teams was seen in both areas. In Andhra Pradesh, Nagaland and Uttarakhand only 70% of both facility and urban slum mapping,is complete. Bihar has completed facility mapping, but slum mapping has not yet been initiated.

2. Vulnerability assessment mapping to identify those most in need of urban health services, is reported to be complete in some states but not in several others. In Jharkhand, the VA tool for ward level and ASHAs has been prepared but the training is pending, while in Uttar Pradesh vulnerability assessment has not yet been initiated. In Delhi with the longest standing urban health programme, low use of VA as a tool limits the success of several other innovative measures to deliver health services to marginalized urban populations.

Convergence

1. The delivery of Urban Health services necessitates effective convergence with Urban Local Bodies particularly for action on social and environmental determinants. A few states demonstrated functional linkages with ULBs. A good practice related to convergence was reported from Odisha where the Bhubaneswar Municipal Corporation, enabled infrastructure development in several UPHCs, and supported the Mahila Arogya Samitis in developing hygiene and sanitation facilities. In Mizoram, construction of community toilets has been done through involvement of ULBs.

2. Convergence with women's self-help groups and the ICDS programme was a significant success in AP, in enabling reach and coverage and addressing social determinants.

3. A convergent model on nutrition was adopted in Tamil Nadu, with co-location of PHCs and Anganwadi Centres.

Community Processes

ASHA

1. In most states,about 85% to 100% ASHA have been selected against the target. In Madhya Pradesh, Meghalaya, and Uttar Pradeshonly 70-80% ASHAs were in place. The number of urban ASHAs and ASHA-population ratio was found low in Uttar Pradesh, creating significant gaps in community-based interventions in several areas. Tamil Nadu has no ASHA. Urban Health Nurses (UHN) provide the designated services at UPHC and during UHND, but gaps in other community level interventions which are performed by ASHAs in other states, is noted as a gap.

2. The performance of urban ASHAs was satisfactory in Andhra Pradesh, Bihar and Gujarat as could be gauged by community awareness and trust in ASHAs. In Odisha, the ASHAs use "Swasthya Kantha" (health wall) as a communication tool to disseminate information on health and sanitation within the community. One unique role of ASHAs in Manipur, besides working as a health worker, is that of Social Activist, where they form part of a movement called "Meira Paibi", a vigil against alcoholism and hooliganism

3. Bihar, Jharkhand, Manipur and Uttar Pradesh need to strengthen the training of ASHAs in order to equip them to perform the functions expected of them.

4. Andhra Pradesh does not follow the NHM guideline of performance-based incentives to ASHAs, instead monthly fixed incentives are provided to them.

Mahila Arogya Samitis (MAS)

1. Overall, around 75-80 % MAS formation has been observed across the states. Tamil Nadu and Uttarakhand do not have MAS in place as yet. Tamil Nadu engages women's Self-Help Groups (SHGs) in urban areas to perform functions similar to MAS.

2. The functioning of MAS was satisfactory in Andhra Pradesh, Bihar, Chhattisgarh, Gujarat, Madhya Pradesh, Manipur, Odisha, Rajasthan, Nagaland, Mizoram and Uttar Pradesh. In Odisha, MAS have their own letter head through which communications are sent to ULB to carry ut civic functions. High attrition rate among MAS was observed in Meghalaya. MAS funds remain under-utilized in most of the states.

3. As an innovative step towards motivating the MAS members in Odisha, 20% of the best performing MAS are provided with an additional incentive of Rs.3000.

Service Delivery

1. Urban areas are characterized by multiple service providers, and while some states have streamlined the service delivery, others have not had much success. In Tamil Nadu, health services are provided by State health department, 11 municipal corporations (MCs) and 75 municipalities. States such as Delhi have an array of stakeholders providing primary and secondary health services, which include the State Health Department, Municipal Corporation of Delhi (MCD), New Delhi Municipal Council (NDMC), CGHS, Railways, ESI, as well as 364 facilities providing AYUSH services.

2. Outreach services through UHNDs for services similar to VHNDs and Special Outreach sessions which entail the visit of a specialist on particular days were found to be conducted regularly in Rajasthan, Mizoram, Meghalaya and Uttar Pradesh. Shortage of ANMs has meant that UHND are not being conducted in Bihar. In Meghalaya, there is difficulty in hiring specialist doctors for attending special outreach camps.

3. Urban Primary Health Centres have been converted into Health and Wellness Centres (HWCs) for provision of Comprehensive Primary Health Care in Bihar (95%), Gujarat (51%), Andhra Pradesh (100% eUPHCs), Meghalaya (25%) and also in Mizoram, Madhya Pradesh, Nagaland, Odisha and Rajasthan. Ayushman Bharat – Health and Wellness CentersScheme has not been implemented in Delhi. HWC Branding with display of IEC materials was found in Bihar, Gujarat, Manipur and Meghalaya.

4. While UPHCs generally cater to a population of 50,000, some states have established facilities at a lower level to reduce population coverage and improve access to basic primary health care. In Rajasthan and Uttar Pradesh,health kiosks serve this function. Jharkhand has started "Atal Clinics", which are structures equivalent to health kiosks, providing only curative services at present. The "Mohalla Clinics" in Delhi are an initiative of the state government to provide curative and diagnostic services for smaller populations.

5. For access to specialist care and other services, too states have introduced innovations. Tamil Nadu has started Urban Polyclinics under NUHM for providing fixed day specialist OPD services during evenings. Similarly, "AMA Clinics" in Odisha provide services of Medicine, Physiotherapist and Nutritionist in UPHC as part of Geriatric Clinic. Urban Vision Centres "Sunetra Clinic" have also been rolled out in Odisha as part of the Universal Eye Health Programme of the State Government.

6. Most States have functional primary health facilities, except Madhya Pradesh, where only around 50% of the approved facilities were operationalised. The primary health infrastructure is adequate in most of the states, with approximately 60-65% of facilities functioning in government buildings and the remaining in rented premises. The majority of UPHCs in Delhi, Meghalaya and Uttarakhand are functioning in rented buildings.

7. In Uttar Pradesh, due to rapid urbanization, there is a shortage of facilities with respect to the population that is being catered to. Only 42% fund released for civil works was utilised by Andhra Pradesh during 2018-19.

Human Resources

1. Programme management Units at state, district and city level have been established and strengthened in most of the states visited. Approximately 80% programme management staff are in position at various PMUs.

2. Approximately 75% of clinical and paramedical personnel are in position. In Gujarat, 75- 90% of the key service delivery posts are filled, against those sanctioned. Adequate HR in line with NUHM guidelines was found in Meghalaya. Public health managers were appointed in Jharkhand, Odisha and Rajasthan.

3. It is naïve to expect good quality delivery of urban health services, with shortage of HR in all states. Bihar, Jharkhand, and Madhya Pradesh report more than 50% vacant positions of Medical Officers. Rajasthan reports 80% vacancies for Staff Nurse, Laboratory Technicians and Pharmacistsin UPHCs. In Chhattisgarh, urban health facilities are under-staffed and clinical services are being augmented through deputing AMOs and AYUSH practitioners. The Corporations in Tamil Nadu have not filled up most of the vacant positions of Health Officials/Workers.

Range of Services

1. UPHC-HWCs and are providing primary services –to slum and non-slum populations. Outpatient care for general ailments, maternal and child health conditions, NCDs, including day care for emergencies and minor procedures is provided. ANMs supported by ASHA provide ANC, PNC, Family Planning and Immunization services on a regular basis.

2. Several states have extended the OPD timings of urban facilities in order to improve access of urban community to the UPHCs. OPD services in dual shifts (morning and evening) are provided in Jharkhand and Rajasthan. eUPHCs in Andhra Pradesh are functioning throughout the year. In UP, services are now also provided on Sundays. 24x7 UPHCs are functional in a few facilities in Tamil Nadu, Chhattisgarh, Odishaand Madhya Pradesh.

3. A few states are also providing specialist services at UPHCs. Fixed day specialist services with support of Government Medical College are being provided in Chhattisgarh and Tamil Nadu. In Tamil Nadu, medical colleges are also involved with Skill Lab trainings. Specialist services in cardiology, endocrinology, orthopaedics / rheumatology and general medicine are being provided through Tele consultation in e-UPHCs in Andhra Pradesh.

UPHC-HWCs and are providing primary services –to slum and non-slum populations. Outpatient care for general ailments, maternal and child health conditions, NCDs, including day care for emergencies and minor procedures is provided.

4. Wellness activities such as yoga are being conducted in Chhattisgarh, Gujarat, Manipur, Odisha and Mizoram. In Chhattisgarh, as an innovative step "Wellness beyond Yoga" has been started through "Zumba Classes" along with Yoga classes at selected urban health centres, to improve overall wellness of urban population, irrespective of their age. Limited wellness activities are however taking place in UPHC-HWCs in Bihar, Meghalaya, and Rajasthan due to lack of space in rented building and for want of yoga teachers.

5. Diagnostic services are being provided in-house in almost all the UPHCs, except Bihar, due to lack of lab technicians.

Quality

1. Facility timings,Citizen Charter, EDL and IEC were on display in most facilities visited. Almost all states are implementing the Free Drugs and Diagnostics Initiative. Centralized Procurement of Drugs is done through e-Aushadhi; a web-based application is being done in Andhra Pradesh, Gujarat and "Jan Aushadhi" in Nagaland. Besides this, Delhi has "Delhi Arogya Kosh" and "Delhi Arogya Nidhi" Schemes to reduce OOPE on diagnostic services and free treatment is provided to BPL accident victims in private hospitals.

2. Adherence to Biomedical Waste Management (BMW) was satisfactory in most states except in Uttar Pradesh, Nagaland, and Bihar.

3. State and District Quality Assurance Committees have been constituted and quality initiatives such as Kayakalp and NQAS are being implemented well in Delhi, Gujarat and Nagaland. These states have functional infection control committees and service provision is satisfactory. Gujarat has devised a ''Mission NQAS 151'' for FY 2019-20 and UPHCs have been integrated into the ''MeraAspataal'' App.

4. Focus on quality measures however, is required to be reinforced in Meghalaya, as none of the UPHCs assessed for Kayakalp programme could qualify for Kayakalp. In Bihar and RajasthanQuality Assurance programmes at urban health facilities need to be strengthened.

RogiKalyanSamities

1. Most states visited had formed the Rogi Kalyan Samitis (RKS) at UPHCs, though account opening for a few is still pending. RKS have not been formed in Andhra Pradesh, Delhi, Madhya Pradesh, Meghalaya and Uttarakhand. The implications of non-functional RKS or not having RKS are that facilities are deprived of untied funds and are not able to accept financial awards such as Kayakalp, in addition of course to monitoring service quality and ensuring accountability.

2. Utilisation of funds under RKS was low, especially in Bihar, Jharkhand, UP and Manipur, Bihar, and Rajasthan. In some states this was on account of delays is fund releases to the RKS

Public Private Partnerships

1. Andhra Pradesh has started 243 e-UPHCs utilizing a digital platform, in a PPP mode, which enables patients to access any linked facility. Uttar Pradesh is also initiating the use of digital platform through e-UPHCs in certain of its urban health facilities.

In Chhattisgarh, as an innovative step "Wellness beyond Yoga" has been started through "Zumba Classes" along with Yoga classes at selected urban health centres, to improve overall wellness of urban population, irrespective of their age.

2. In Odisha, 25 UPHCs under NUHM are managed by NGOs under PPP initiative. Rajasthan is operating 30 UPHCs in PPP mode. Urban PHCs at Dehradun in Uttarakhand have been contracted out to different NGOs in PPP mode, since June 2019. However, the contract was only for six months and the provision of urban health services is uncertain beyond October 2019.

3. Chhattisgarh has signed a MOU with TATA Trust NGO to develop Electronic Health Services (EHS) and model immunization room at Urban Health Centres.

4. Tamil Nadu has started Urban Polyclinics providing specialists OPD clinic in a single roof at fixed timings by hiring specialists. As part of innovations, a Social Protection Scheme by the name "Dr. YSR Aarogyasri Scheme" is being run by Andhra Pradesh for providing end to end cashless services to BPL beneficiaries as identified by Civil Supplies department for 1059 procedures.

RECOMMENDATIONS

1. NUHM is intended to benefit the poor and marginalized populations. Mapping of such populations, and their access to facilities is the first step in planning such services. This is an exercise that needs to be undertaken not just once, but periodically updated, particularly given the rapid rates of urbanization and the proliferation of non-notified slums. States need to prioritize the vulnerability mapping and make it a regular feature of planning exercises. Engaging the MAS and ULB in such mapping and planning would be a strategic way of enhancing the involvement of both structures in NUHM.

2. Planning for additional infrastructure/creation of UPHCs needs to be based on mapping and the use of GIS to ensure access to slum and slum like areas.

3. Multisectoral convergence efforts need to be speeded up. This requires active engagement with There is a need to strengthen convergence with ULBs and other concerned departments to develop a strategy for addressing issues of housing, water, sanitation, nutrition, and supporting the delivery of high quality urban primary health care. Such multi sectoral convergence would need appropriate institutional mechanisms with the convening ability to call upon various departments to deliver the requisite services which have an impact on health, and the health department should be able to then focus on the goals of providing health care to the vulnerable.

4. The state and Corporation should ensure filling up vacancies in order to have requisite staff to deliver high quality, comprehensive services. The state should also plan to ensure rational deployment of HR in all categories,

5. Programme management staff need to be oriented to the new guidelines particularly related to Comprehensive Primary Health Care delivery through Health and Wellness Centres, needed to build the capacity of NUHM functionaries in the state, district and sub-district levels. A time bound road map needs to be developed for the same.

6. Most states have converted Urban Primary Health Centres to Health and Wellness Centres, with a little additional effort. The focus should now be on delivering the additional range of services, starting with care for non-communicable diseases.

Planning for additional infrastructure/ creation of UPHCs needs to be based on mapping and the use of GIS to ensure access to slum and slum like areas.

Both hypertension and diabetes rank high in urban prevalence. For the UPHC to undertake population enumeration, completing the Community Based Assessment check list, screening and leading wellness activities, would all be powerful ways of drawing people to the public health system, building trust, reducing patient hardship in terms of travel and costs of care.

7. All UPHCs need to also provide the full range of RMNCAH services. State should develop a mechanism to review the POSHAN Abhiyan in coordination with WCD.

8. Referral Mechanism needs to be strengthened by developing linkages with higher centres, especially in cases of emergency.

9. Special Outreach (need based) and UHNDs should be planned in urban slums. Develop calendar of UHND sessions for slum areas. Strengthen coordination among ANMs, ASHAs and MAS members through regular meetings.

10. MAS functionality needs to be improved by ensuring effective supervision so that the potential of the women's groups in addressing social and environmental determinants seen in some states can be scaled up in all others. The factors for success reported from Uttar Pradesh, Chhattisgarh and Odisha, appear to be linkages with existing SHG programmes such as NULM, including for income generation, capacity building to negotiate with ULB and other urban governance actors, effective supervisory support from the UPHC, so that MAS feel that there is an institutional structure, a role in community based outreach services, of which they are a part and are able to adequately express community health needs, and ensure that untied funds are released in a timely manner.

11. Gaps in ASHA selection need to be filled and training of all ASHAs be expedited. The roles of ASHA in outreach activities, social mobilization and follow up particularly in vulnerable areas are to be specially emphasized. The fact that most UPHCs in urban areas have been transformed to UHCW, and that the burden of chronic diseases is high, states should ensure that the ASHAs are trained in the NCD module. This will ensure that follow up care to the poor for chronic diseases is addressed. This level of planning and support for the ASHA required strengthening of support structures and training systems.

12. States should prioritize accreditation of urban facilities under Kayakalp and NQAS initiatives. The urban health nodal officers in states and districts along with CMO and Medical Officers should be part of Quality Assurance Committees.

13. Leveraging partnerships with NGOs, CSR projects and Private Sector should be considered as a way to enhance service coverage and strengthen linkages. CSR collaboration should be explored, especially in the metro cities. Partnerships with the private sector to contract out services or contract in services of private practitioners into urban public health facilities should be explored for underserved areas. However the contracts should be crafted with clear responsibilities of both parties, time bound deliverables, measurable outcomes, and timely fund releases.

14. Financial documentation at UPHC and UCHC should be reviewed and audited regularly as per norms. A system of separate audit of RKS of the CHCs and PHCs under NUHM needs to be developed on priority.

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TOR 6:
Community Processes and Gender

Over the past 15 years, with nearly 10,00,000 ASHAs responding to local health needs and playing a critical role in improving access to care, the ASHA programme has become one of the most important components of National Health Mission. Findings from all sixteen states underscore the instrumental role played by ASHAs and the strong rapport between ASHAs and their communities. Under Ayushman Bharat, ASHAs are considered a key member of primary health care team in Health and Wellness Centers and are expected to play a key role in ensuring continuum of care given their strategic positioned at the community level and with strong linkages to health system. The findings from most states also indicate that ASHAs are actively undertaking new tasks at field level as part of universal screening of NCDs.

Community based platforms of VHSNCs and MAS have been created across all states, with formation of 5.4 L VHSNCs (95% against the target of 5.7 L VSHNCs) and 77,003 MAS (86% against the target of 89,446). However, limited investments in capacity building and handholding of members of both institutions, and lack of a link to the larger local self-government institution have affected their functioning and potential to fulfil the mandate of community level planning to address social determinants and ensure accountability.

Key Observations

ASHA

1. States have achieved over 90% selection in rural areas in all visited states (except Tamil Nadu with 81% selection, in its tribal areas to which the ASHA programme is limited). However these numbers mask inter district and intra district gaps. Reports from Sirohi (Rajasthan), Gumla (Jharkhand) and Kiphre (Nagaland) highlight several left-out villages/areas.

2. In urban areas, shortfall was noted in ASHA selection in states of Bihar (with 50% selection), Jharkhand (with 55%), Uttar Pradesh (with 77% selection), AP and Nagaland (with 82% selection) and Meghalaya (with 84% selection). Attrition rate of ASHAs was within the range of 1- 4% as reported from states of AP, Delhi, Gujarat, Meghalaya and Nagaland.

3. Thirteen out of sixteen visited states have completed training of over 95% rural ASHAs in all four rounds of Module 6 and 7. Pace of ASHA training in Rounds 3& 4 was reported to be slow in Andhra Pradesh, Bihar, and UP. Delay in training of newly selected ASHAs was reported from Manipur and Meghalaya. For urban ASHAs training in Module 6 &7 has been completed only in Delhi (since state has launched the ASHA programme in 2009). Among other states, AP has reported good progress with over 90% urban ASHAs being trained up to round 3 while training in Module 6 and 7 is yet to start in Mizoram, Uttar Pradesh, Bihar and Jharkhand (Gumla district).

4. Training of ASHAs on common NCDs has been undertaken in Gujarat, Jharkhand, Uttar Pradesh, Mizoram and Meghalaya while in Andhra Pradesh only one day orientation was reported. With regards to Home Based Young Child Care (HBYC), training of district trainers is underway in AP and UP and training for ASHAs has begun in Odisha, Mizoram and Meghalaya.

5. Organization of training is affected by factors such as attrition of trainers in Bihar, Meghalaya and Nagaland; lack of adequate infrastructure in Nagaland and Meghalaya and adhoc planning in Gujarat and Nagaland.

6. Dedicated ASHA programme staff at state and district level has been created in 15 out of 16 states (except Tamil Nadu). At block level, this has been set up in eight states of Bihar, Chhattisgarh, Jharkhand, MP, Nagaland, Rajasthan, Uttar Pradesh and Uttarakhand.

7. ASHA facilitators, selected from among the group of ASHAs, are in place in Bihar, Chhattisgarh, Gujarat, Jharkhand, MP, Manipur, Meghalaya, Mizoram, Odisha, UP and UK.

8. Limited capacities of the support structures in providing mentoring support to ASHAs was reported from Andhra Pradesh, Bihar, Gujarat, Meghalaya and Mizoram. Despite training of ASHAs and their engagement in new tasks under HWCs, limited coordination between CP and CPHC teams was noted in Gujarat and Meghalaya.

9. Medicine and HBNC kits have been provided to ASHAs in all states but timely replenishment to address stockout continues to be a persistent, unresolved challenge in most visited states.

10. Grievance redressal committees have been set up in AP, Delhi, Jharkhand (present at state level and in West Singhbum), Manipur, Odisha, and UP. However, the committees were not found to be fully functional in AP and Manipur while in Odisha and AP, ASHAs were not aware about the grievance redressal committees. Alternate mechanisms to address grievances of ASHAs were also documented Eg- toll free number 104 used in Jharkhand, grievances being directly submitted to district nodal officers in Manipur and Madhya Pradesh and use of complaint boxes /grievance registers for ASHAs in Meghalaya.

11. Monthly incentive earned by the ASHAs ranged from Rs. 1700 in Meghalaya and Uttarakhand to Rs. 10,000 in Andhra Pradesh. In addition, seven of the visited states (Andhra Pradesh, Delhi, Gujarat, Odisha, Meghalaya, Chhattisgarh, Uttarakhand and Rajasthan – ICDS) provide incentives to ASHAs from state funds.

12. Timely payment of ASHA incentives was reported from states of Andhra Pradesh, Delhi, Gujarat, Jharkhand, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh. Delays in payments of ASHA incentives were reported from Manipur, Mizoram, Meghalaya and Nagaland. In Meghalaya, backlog of payments of rural ASHAs was observed since 2013-2016, with varied range for different incentives while in Manipur delays were up to 6 months. In Nagaland, community members shared that they provide money to ASHAs for JSY services to support them since the incentive payment is often delayed which is returned by ASHAs after receipt of incentive.

13. As part of the ASHA benefit package. Extension of life insurance, accidental insurance and pension benefits were extended to eligible ASHAs and ASHA facilitators by enrolment under Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY) and Pradhan Mantri Shram Yogi Maandhan Yojana (PMSYMY). However, enrolment has not begun in AP and was reported to be slow in Bihar, Gujarat, Jharkhand, Odisha, Meghalaya, Nagaland and UP. States of AP, Bihar, Jharkhand, Meghalaya and Odisha also continue to support ASHAs through existing state specific schemes in. Maternity benefits are provided to ASHAs in Odisha, Meghalaya and Delhi.

14. Rest rooms for ASHAs at high case load facilities were reported only in Bihar, Delhi, Jharkhand, Odisha and Meghalaya. No rest rooms were available in AP, Gujarat, MP, Rajasthan and UP. However, ASHAs in Surat district of Gujarat reported that comfortable spaces have been earmarked for their use in few health facilities and in Bahraich district of UP, 15 ASHA rooms have been developed through CSR support.

15. Overall findings reflect high levels of functionality of ASHAs with regards to improving access to services related to maternal, newborn and child health, communicable diseases and to some extent non communicable diseases. In most states, ASHAs had good technical knowledge and skills related to routine RMNCH+A except for reports from Manipur, Gujarat and UP. highlight limited understanding and role of ASHAs in identification of danger signs of pregnancy and follow up of SNCU discharged newborns respectively. In UP, ASHAs have limited coverage of marginalized population and they had limited understanding of marginalization and vulnerability

16. In areas where HWCs have been operationalized, ASHAs have started undertaking additional tasks such as filling of Community Based Assessment checklist, counselling on risk factors for NCDs and mobilising for NCD screening. Findings from AP showed that ASHAs maintain follow up records for NCD patients while finding from Gujarat indicated that ASHAs required additional support to perform new tasks. State of Tamil Nadu has engaged Women Health Volunteers (WHV) at the level of the sub centre selected from Self-Help Groups for follow up of Non-Communicable Diseases.

Village Health Sanitation and Nutrition Committee

1. Of the 16 states visited, fourteen states have constituted VHSNCs at revenue village level. Andhra Pradesh and Bihar are the only two states which have VHSNCs at Gram Panchayat level. Restructuring of VHSNCs has been completed in all states

Overall findings reflect high levels of functionality of ASHAs with regards to improving access to services related to maternal, newborn and child health, communicable diseases and to some extent non communicable diseases.

except in Andhra Pradesh, Bihar, Gujarat and Tamil Nadu. ASHAs are currently not reported to be a member secretary of VHSNCs in AP, Bihar, Gujarat and in Nagaland for VHSNCs under HWCs.

2. With regards to capacity building of VHSNCs, only Mizoram reported training of VHSNCs recently i.e, in 2018. Such limited investment in training of VHSNCs, has translated in low levels of functionality of VHSNCs across almost all visited states.

3. Irregular fund release was noted in states of AP, Manipur, Meghalaya and Nagaland which hampered the functioning of VHSNCs. In Rajasthan the untied fund was released with the instruction to spend it on Yoga Day.

4. Regular VHSNC meetings are held in states of Gujarat, Manipur, Mizoram, Meghalaya and Rajasthan while active participation of VHSNC members was reported from Odisha, Nagaland and Meghalaya.

5. Of the states visited, roll out ofVISHWAS campaign was observed only from four states i.e, Meghalaya, Mizoram, Jharkhand and Odisha.

6. Community Action for Health activities have been reported from selected districts in Madhya Pradesh, Meghalaya and Rajasthan

Rogi Kalyan Samitis

1. RKS constitution as per guidelines has been reported from Andhra Pradesh, Madhya Pradesh, Bihar, Mizoram, Manipur, Rajasthan and UP but in absence to training of RKS members, the RKS has not emerged as an effective community-based platform at heath facility level Regular meetings were reported from the states of Andhra Pradesh, Mizoram and Manipur. However, participation of PRI was noted to be low in Mizoram, MP and Rajasthan, where RKS was being managed mainly by office bearers at the visited health facilities.

Gender

- Ensuring that the health system is sensitive and responsive towards gender based and sexual violence was a low priority across all visited states. Even the measures required to safeguard female health workers, who constitute a high proportion of the workforce, have not been taken. This is evident from sporadic efforts being made to create safe rest rooms for ASHAs at health care facilities in most states and no or partial implementation of VISHAKHA guidelines at all levels.

- Reports from Andhra Pradesh, Gujarat and Madhya Pradesh indicate that ASHAs and ANMs were sensitizing the community regarding gender-based violence and discrimination. In Gujarat, they encouraged women to call 108 Abhyam helpline in Dahod in any such crisis.

- Protocols for treatment and management of sexual violence cases were found in place only in four of the 16 states (Andhra Pradesh, Gujarat, Tamil Nadu and Nagaland). However, gaps were noted in implementation at facility level in Dahod district of Gujarat. Training of service providers in such protocols has been conducted only in Jharkhand while no training was reported from Meghalaya, TamilNadu, Nagaland and Mizoram,

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1. One Stop Crisis Centres (OSCCs) for domestic and sexual violence were reported to be functional only in few districts like Dahod district of Gujarat, Mayurbhanj district of Odisha, in Nagaland and in Tamil Nadu. In Meghalaya, OSCC was established by Women's Economic Development Society (WEDS) which is a registered NG while in Nagaland the OSCC is linked with women Helpline 181and the Family Counselling centre. VISHAKHA guideline has been implemented only in Tamil Nadu.

2. Violations of PCPNDT act were reported to be common in Tamil Nadu and Manipur. In Tamil Nadu, increased monitoring and inspections was reported with regards to PCPNDT act. State has also proactively brought clinics providing genetic counseling clinics and Assisted Reproductive Technologies under the purview PCPNDT Act,

RECOMMENDATIONS

1. As the ASHA programme transitions into the next phase, where ASHAs take on more complex tasks requiring another set of skills and necessitating close coordination with the health systems, it is essential that the core components of the programme are strengthened. This would mean ensuring *timely, skill based and quality training, eliminating stock outs of equipment / medicines, timely payments, safe working conditions with rest rooms at all high case load government health facilities and stringent grievance redressal mechanisms.*

2. Role of support structures also needs to evolve at a commensurate pace by regular training on supportive supervision for newer tasks and working as a team with CPHC nodal officers at all levels. In the current context of primary health care where new tasks are being allocated to ASHAs, there is an urgent need to revise and institutionalize the performance monitoring system for ASHAs.

3. Most states have either completed or are near completion for selection of rural ASHAs. However, gap in terms of areas that have been left out while setting target for ASHAs is a major area of concern since the residents of these remote, underserved/hidden areas, are also the most vulnerable and difficult areas. It is recommended that detailed mapping should be done to identify and prioritize selection of ASHAs in such areas.

4. Selection status in urban areas has been relatively poor owing to inability to select a suitable candidate and/or high attrition due to better employment opportunities. Such findings warrant the need for a comprehensive review and, if required a revamp of the existing programme design to address the health needs of the urban poor.

5. Though the training structures for ASHAs are well established, mechanism to manage the attrition of trainers and strengthen the infrastructure for quality training on a regular basis needs to be created. ASHA certification can be utilized as an opportunity to standardize and strengthen the quality of all training components for ASHAs.

6. Given the requirement of refresher training along training in new skill areas, this could prove to be a significant logistic challenge. States should invest in building

the platform of PHC monthly meetings for capacity building of ASHAs on a regular basis as per the guidelines.

7. Despite several initiatives to streamline payments of ASHAs, delays still persist especially in areas where either banking services are limited or fund flow to districts is not regular. Such delays, after 15 years of roll out of programme are not-acceptable and require immediate intervention of the state and district administrators.

8. Health systems readiness to provide sensitive and high quality services to victims of sexual offences and even to provide a safe working environment to our women health care providers and community health workers needs strengthening. Systemic review and time bound plan need to be developed by states to address this gap.

9. Community based platforms of VHSNCs, RKS and MAS, are yet to evolve as avenues where the voices of the community in planning and monitoring for service delivery, accountability mechanisms and addressing social determinants on health. Efforts are needed at all levels to build capacities of these platforms and for providing handholding support. Better integration with decentralized structures such as PRIs and ULBs need to be explored.

TOR 7:
Quality Improvement

Delivery of quality health services is critical to achieving universal health coverage. National quality and patient safety strategies encompass a range of interventions targeted at different levels of health facility. The focus of interventions supported by the NHM rests on strengthening health facilities to provide high quality health care. The key components reviewed in the CRM during facility visits were the progress of implementation related to certification underNational Quality Assurance Standards (NQAS), LAqshya and KayaKalp. Feedback systems such as Mera Aspatal were also analysed.

NQAS provides an objective framework of quality measures for administrators, programme managers, district managers, and service providers to promote safety, efficiency, timeliness and equity in delivery healthcare that is patient centric. National Quality Assurance Program (NQAP) has laid out a systematic process for building both institutional and clinical capabilities in delivering the same. In comparison to previous years, this years' experience reflects remarkable progress, both in terms of effort and outcomes. The numbers of state and nationally certified health facilities have increased significantly. While the number of nationally certified health facilities have increased from 224 in March 19 to 536 by late 2019 and , the number of state quality certified facilities have risen from 503 to 941 during the same period.

About 114 facilities were certified under Laqshya. This certification is intended to improve the quality of services in the labour room and maternity OT. This ensures high quality intrapartum, immediate postpartum and early newborn care.

Kayakalp enables incentivization for health facilities, which demonstrate excellence in upkeep, infection control, waste management, support services, hygiene & sanitation and cleanliness for all levels of facility, including Health& Wellness centres Number of facilities participating under Kayakalp has increased from 750 in year 2015-16 to over

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26,000 facilities in Year 2018-19. Number of facilities getting Kayakalp awards has also increased from 97 in the year 2015-16 to 4820 in the year 2018-19 which includes 395 District Hospitals, 1140 Sub-divisional hospitals/Community Health Centres, 2723 Primary Health Centres and 562 Urban Health facilities.

KEY OBSERVATIONS

Across states, there was significant reporting of people's trust in public health facilities with most people who were interviewed reporting satisfaction with the quality of care and services provided, with a few complaints related to staff behaviour in few facilities. Most states had established State Quality Assurance Committee (SQAC) and District Quality Assurance Committee (DQAC). In terms of functionality, as reflected by regular meetings, only Delhi, Odisha and Tamil Nadu, reported regular meetings of SQAC and DQAC. Quality teams have been formed and are functional at the district hospital level, but are yet to be operationalized at lower levels, correlating well with the number of facilities at sub district levels that are being readied for certification. In the 16 states visited, facilities had been certified (Break up), indicating that scaling up of this effort is critical to ensure that health care facilities are equipped to deliver high quality facilities.

NQAS Certification

1. Most states had made significant progress in terms of number of health facilities being certified as part of the NQAS. However the picture is widely divergent across states. While Andhra Pradesh leads other states with 67 facilities certified, the states of Bihar, Jharkhand, Manipur and Nagaland have no NQAS certified facility. One common finding across all visited states and UTs is the slow pace of implementation of quality assurance programmes in health care facilities in urban areas.

2. All states had a pool of assessors in place but were not utilized in supporting quality improvement, particularly in their own states.

3. In terms of staffing while state teams are in place in all states, however, only Andhra Pradesh, Haryana, Delhi, Gujarat, Rajasthan Tamil Nadu, Uttar Pradesh, and Uttarakhand have district personnel in place to manage quality improvement processes.

LaQshya Certification

1. Although LaQshya Certification is limited to the labour room and maternity OT, the pace of certification is slow in most states, with Delhi, Jharkhand, Manipur, Meghalaya, Mizoram and Nagaland not having a single LaQshya certified facility.

Kayakalp

1. The states of Mizoram, Gujarat and Delhihave made significant progress under Kayakalp. However the pace of progress in Bihar, Uttar Pradesh, Madhya Pradesh and Jharkhand is extremely low.

2. While there is active participation of facilities from DH to PHC, in the Kayakalp scheme, the rates of participation of UPHCs/PHCs are still low in most states.

Safety Protocols and SoPs

1. Adherence to six steps of hand washing was observed in all states.

2. The staff handling biomedical waste were provided with Personal Protective Equipment (PPE) in most states except in Bihar, Chhattisgarh and Odisha. In most states visited, staff was not vaccinated for Hepatitis B and Tetanus Toxoid except in the states of Jharkhand and Tamil Nadu. Gaps in fire safety trainings and disaster preparedness were reported from several states.

3. Standard Operating Procedures for care were available and implemented in the states of Andhra Pradesh, Madhya Pradesh, Odisha, Tamil Nadu and Uttar Pradesh only.

4. Most visited health facilities had basic amenities for patients like separate toilets for men and women, running water, sitting arrangements, etc.

Biomedical Waste Management

1. Common Bio-medical Waste Treatment Facility was available in all States except Mizoram. In most of the visited States, working staff did not have knowledge about latest BMW rules 2016 (as amended) exceptin Delhi, Gujarat and Tamil Nadu, leading to non-adherence to the BMW management protocols.

2. Though colour coded bins were available in all the states mixing of waste was observed in Andhra Pradesh, Bihar, Nagaland, Odisha and Uttarakhand.

3. While pre-treatment of laboratory and highly infectious waste was practiced in all states, however liquid waste management (ETP/STP) was not in place in any state. This has implications for contamination of water sources.

1. Audi Prescription Audits, Death Audits, Maternal Death audit and Child Death Audits were not done anywhere except, Andhra Pradesh, Chhattisgarh, Meghalaya, Odisha and Tamil Nadu.

2. Facility staff were not aware of Quality tools and workplace management techniques such as Plan-Do-Check-Act (PDCA), Mistake Proofing, Pareto analysis, except in Odisha, Rajasthan and Tamil Nadu.

3. Reporting and recording of Key Performance Indicators was practiced in Andhra Pradesh and Tamil Nadu only.

Mera Aspataal

1. Integration of District Hospitals under Mera-Aspataal has been completed in most states however integration with lower level facilities is yet to happen. However, it is disappointing to note that the data recorded through Patient Satisfaction tools or MeraAspataal portal were not analysed and used for quality improvements in facilities.

Statutory and Regulatory Compliances

1. While compliance to statutory requirements, in respect of some of the following: Authorization for BMW, AERB authorization for radiology set-up, and blood bank licenses were seen in a few states , no state had implemented all of the requisite statutory compliances.

RECOMMENDATIONS

1. Setting up the institutional framework to undertake quality certification as a key process towards assured patient centric services in health facilities is critical. States must ensure adequate staffing, establish and monitor functionality of quality assurance committees at state and district levels, so that improvements of quality are reflected in positive population outcomes.

2. Almost all states have substantial numbers of NQA internal assessors and external assessors and also quality trained professionals, who have been specifically trained using NHM support. The states need to leverage the considerable investments made in these professionals by deputing them to undertake continual assessment and gap-closure action. Provision of adequate transport costs is required in areas of difficult terrain. Experienced personnel could be tasked with a mentoring role in guiding health facilities in meeting and sustaining the NQAS norms and certification.

3. The pace of scaling up of NQAS and LaQshya certification continues to be slow. States can build momentum by learning from the experience gained in NQAS implementation to get other health facilities certified. A strategic action plan to phase the certification process based on facility readiness needs to be devised by districts and states.

4. Most facilities have SOPs in place for clinical and administrative processes and sub-processes, but are not being followed in day to day practice. Adherence to SOPs needs supportive supervision and mentoring, and states need to identify mechanisms to enable this to take place. This would also go a long way in sustaining gains made during NQAS certification.

5. Awareness on various dimensions of patient safety be it infection control, antimicrobial resistance, drug safety, safe surgery, patient fall is low. QA Committees at state level should develop local strategies to implement National Patient Safety Implementation Framework, which was launched by the Ministry of Health & Family Welfare in April 2018.

6. Poor behaviour of the staff being was reported in some states, leading to fear of poor quality services. Training ofmedical and paramedical staff to build soft communication skills and provide respectful care would go a long way in improving the public perception about government health facilities.

7. In order to obtain and act upon patient feedback, tools such as Mera-Aspataal need to be utilized at facilities below the District Hospitals in all states, regardless of whether it is outpatient or inpatient care that is being provided.

8. Training of staff on Bio-medical waste management rules 2016 (as amended) and

strong linkages of peripheral health facilities with the Common bio-medical waste treatment and disposal facility (CBWTF) for timely transport, treatment and disposal of waste as recommended by BMW Rule 2016 and Central Pollution Control Board guidelines.

9. Practice of medical audit needs to be introduced at all level of facilities for continually improving the quality of care. Initially, a beginning could be made by introducing the prescription audit and death audits. Later clinical audit could be started against simple criteria. After the audit mechanism progresses and gets embedded in the hospital functioning, higher level criteria could be introduced for the audit.

10. SQACs should monitor compliances to following regulatory and statutory requirements Authorization from the competent authority under BMW Rules, including NOC for fire safety at health facilities, License for Blood Bank/ Blood Storage Unit, Electrical Safety Audit, Licence for operating lifts (if installed), and AERB Authorisation

11. SQACs and DQACs are required to put a system in the place where all healthcare facilities capture, measure and report the Key Performance Indicators (KPI).

12. States need to consider inclusion of Health & Wellness Centres in the Kayakalp scheme, in rural and urban areas.

13. All health facilities need to be integrated in the 'Mera-Aspataal' portal and user feed-back needs to be analysed for addressing concerns of the patients and their attendants. Kayakalp score of DH level facilities should allocate 15% weightage to the cleanliness element.

14. Facilities which were designated Kayakalp"winners" should be prioritized for NQAS certification, as their level of preparedness could be better than others.

15. All states are required to ensure that every facility undergoes at least one peer level assessment in a year.

16. Ensuring sustenance of the gains achieved after attainment of Kayakalp Awards through periodic monitoring and supportive supervision is necessary.

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Postnatal Care

Antenatal Checkup

First Visit

At All Visits

SERVICE PROVISION DURING CHECK UPs

Length Scale

TOR 8:
Human Resources for Health

Human resources are an integral part of the health system. Over the last fourteen years NHM has invested substantially in adding HR to state health systems. The content areas of this Tor are aimed at identifying best practices, existing bottlenecks and imbalances in states. The progress is reviewed on three parameters: Availability of Human Resources, Workforce Management and Capacity Building.

KEY OBSERVATIONS

Availability of Human Resources

Sanctioned Positions

1. In most states, sanctioned posts are not as per IPHS norms resulting in absolute shortages or irrational deployment. The consequences of shortages are reflected in gaps in service delivery. Thus for there is no sanctioned post of a dental surgeon at CHC level in Uttar Pradesh. Dental OPD is being conducted by a dental hygienist alone, thereby affecting the range and quality of services. Unavailability of sanctioned posts as per standards has also resulted in irrational deployment of existing staff. For example, some states have posted ANMs at CHCs and District Hospitals to compensate for shortage of staff nurses. This, in turn, hampers service availability at Sub Health Centres (SHCs) and Primary Health Centres (PHCs).

Recruitment Process

1. Delays in recruitments across all cadres was reported across states leading to unfilled vacancies. Major reasons cited for this include pending court cases, administrative issues such as involvement of different stakeholders, absence of a separate specialist cadre, centralised recruitment process leading to time overruns, low salaries and remoteness of health facilities.

2. Vacancies, were observed for regular cadre and contractual staff, in case of Specialists, Medical Officers (MBBS), ANMs, Staff Nurses as well as other paramedical and programme management staff. Inadequate staffing leads to overburdened

Human resources, resulting in attrition. Also poor employment opportunities and other associated factors in home states causes migration of skilled workforce to other states in search of employment as seen in Chhattisgarh.

3. Many states have devised in-house strategies to address HR concerns such as - Uttar Pradesh, Bihar, Jharkhand, Rajasthan, Madhya Pradesh and Uttarakhand have engaged HR agencies to support and assist them in large scale recruitment of contractual HR on time. Similarly, Nagaland has adopted a simple recruitment process under NHM, where in the state is able to fill almost all vacant posts, except specialists, within three months.

4. Other Strategies such as absorbing NHM employees in regular cadre in Tamil Nadu and giving preference/weightage to NHM employee during recruitment under regular cadre in Uttar Pradesh, AP, Mizoram and Rajasthan have also been adopted to attract and retain HR.

5. Initiatives are also being taken by some states for ensuring availability of medical officers and specialists such as walk-in-interviews (in Odisha, Nagaland, Uttar Pradesh, Gujarat, Madhya Pradesh), engaging specialists through bidding process (in Uttar Pradesh, Uttarakhand, Jharkhand),using District Mineral Fund (DMF) and corpus fund for bidding process in Odisha, and empanelling part-time specialists through state initiated scheme 'CM Setu' in Gujarat.

6. Despite the continuing effort,challenges pertaining to recruitment and retention of skilled HR remain. The data on recruitment carried out through the empanelled agency in Uttar Pradesh shows that joining letter was issued only against 47% of the posts advertised; while the number of persons who joined the system was even lower. The specialists hired through bidding process primarily consist of retired government doctors. In Gujarat, attrition rates among empanelled specialists and contractual NHM specialists is high. There is a need to further explore the possible reasons.

Quality Concerns

1. Competency-based skill tests have been initiated for recruitment of frontline workers, staff nurses and paramedical staff in Gujarat, Madhya Pradesh, Odisha and Jharkhand to ensure optimum quality recruitments.

2. Uneven distribution and irrational postings, of the health workforce is a challenge especially in hilly states such as Manipur, Meghalaya, Mizoram, Nagaland. This leads to subpar quality of service delivery.

3. At the community level, absenteeism of staff from the health facilities was highlighted as one of the major challenges in availing the services at public facilities in some states. These issues are leading to significant financial burden to the families and a decrease in health-seeking behaviour amongst the communities.

Workforce Management

Comprehensive HR Policy

1. A comprehensive HR policy, that can help the state and districts managers perform functions at different levels in a coordinated and synergistic manner, is in place

in Madhya Pradesh, Odisha, Tamil Nadu and Nagaland. Among other states, Uttar Pradesh is in the process of finalizing the HR policy

Retention and Distribution of HR

2. Retention of HR at all levels especially- medical officers and specialists is a challenge in most states. Major reasons cited during interactions with staff are disparity in the remuneration& working hours, delay in release of salaries and incentives, unavailability of basic amenities and staff quarter, lack of security at workplace, lack of recognition for good work and lack of career progression.

3. To attract and retain HR in rural and remote areas, states have adopted several strategies. For e.g. Nagaland, has categorized the state into A, B, C categories and higher compensation is paid to staff in category C districts (most difficult). Similarly,states like Tamil Nadu and Odisha are providing some weightage of rural/ tribal area postingsor of a fixed duration posting in public health facilities, in the PG entrance examination to MBBS doctors. In Uttarakhand, the Medical Officer in charge working in 24-hour shifts gets an incentive of INR 1000 per duty.

4. Moreover, Tamil Nadu and Odisha have devisedcareer progression pathways for the NHM staff for long-term retention. In Odisha, the state has introduced Dynamic Assured Career Progression(DACP) Scheme for Medical Officers providing them with three assured promotions i.e., after 7 years, 14 years and 21 years of service counted from the direct entry level.

HRMIS (Human Resource Management Information System)

4. Delhi, Gujarat, Odisha, Tamil Nadu have implemented HRIS (Human Resource Information System) which captures staff data and is linked with salary, generation of payslips, managing transfers, posting staff, and has a leave management module for service delivery and program management. In Rajasthan, the state has developed (CHRIS) Computerized Human Resource Management System to capture the data of NHM contractual staff and now is in the process of developing another Human Resource Information System (HRIS) with NIC for the regular staff. Meghalaya has also initiated implementation of HRMIS.

Rationalization of Human resources

5. There was a felt need of salary rationalization of staff working under different programmes in many states. For e.g. High attrition of service delivery staff was reported in Delhi due to the difference in salaries between the staff in the same cadre working under different national programmes. Disparities between regular and NHM staff not only in terms of salary but also in work load was noticed in some states like Nagaland.

6. In Uttar Pradesh, the district ROP has segregated the NHM-HR under different programmes both in service delivery and under program management.

Performance Appraisal

7. Annual performance appraisal of NHM staff is carried outin Gujarat and Madhya Pradesh and appears to be more structured as compared to other states. However,

To attract and retain HR in rural and remote areas, states have adopted several strategies. For e.g.Nagaland, has categorized the state into A, B, C categories and higher compensation is paid to staff in category C districts (most difficult). Similarly,states like Tamil Nadu andOdisha are providing some weightage of rural/tribal area postingsor of a fixed duration posting in public health facilities, in the PG entrance examination to MBBS doctors. In Uttarakhand, the Medical Officer in charge working in 24-hour shifts gets an incentive of INR 1000 per duty.

minimum performance benchmark has not been implemented in any of the states visited.

Capacity Building

Orientation and Training Schedules

8. Few States such as Manipur, Mizoram, Odisha and Tamil Nadu organize orientation training for newly recruited staff. However, most states still do not prioritize induction training programmes, resulting in inefficient use of available Human Resources and reduced productivity.

9. Monthly training plan is developed at State and District level for both regular and contractual staff in states of Andhra Pradesh, Odisha, Tamil Nadu and Gujarat but yearly training calendar and plan were not charted out in most states.

Training infrastructure and other resources

10. Lack of proper infrastructure hinders quality training. In states like Mizoram and Nagaland, there is no training site at the district level. There is also a limited pool of trainers available in the state. The dilution of training content and reduction in number of days was noticed in Nagaland resulting in substandard quality of training delivery as evidenced from participant feedback.

11. Leveraging resources from development partners for the training of service delivery staff was seen in Bihar. The quality of teaching and training conducted for the health workforce of Odisha, Tamil Nadu and Andhra Pradesh was well reflected in the knowledge, attitude and practice of the healthcare delivery staff.

5. However, the training conducted for service delivery staff of Nagaland, Chhattisgarh, Delhi, Mizoram, Gujarat and Jharkhand was ad-hoc and inadequate. Training institutes such as Institute of Public Health in Jharkhand are not functioning optimally.

6. Training Management Information System (TIMS) has been integrated with HRIS in Odisha; but in Rajasthan there is lack of interoperability between TMIS and CHRIS.

RECOMMENDATIONS

1. Addressing gaps in availability of HR, against the IPHS norms in most states needs to be addressed urgently. Since the number of posts sanctioned in many of the facilities were developed prior to IPHS, these were mostly on ad-hoc basis or programme specific. It is important that states create the sanctioned number of posts as per IPHS norms.

2. Necessary measures to fast track the recruitment process needs to be taken. States must also ensure availability of required infrastructure and enabling working environment prior to recruitment or posting of HR to the health facilities.

3. Training of Medical Officers by initiating and enrolling them in DNB/CPS courses or other courses is required to build competencies and at least partially meet

Leveraging resources from development partners for the training of service delivery staff was seen in Bihar.

the gap occasioned bya scarcity of specialists and to provide career progression opportunities. States could also explore the engagement of private practitioners to strengthen secondary care services.

4. A robust HR policy must be developed by all the states including the entirety of HR lifecycle. It is also essential to set-up an HR management cell. The cell should be responsible for coordinating with various programmes and manage HR functions - from planning, recruitment, and management till exit. Appropriate personnel for this cell can be identified from the existing pool of staff..

5. All states should have a separate specialist cadre so that the PG doctors get entry in the system at a higher rank and salary. NHM provides flexibility in order to ensure availability of all type of specialists in public facilities as per IPHS. The "you quote we pay" scheme can be explored to the fullest and other initiatives such as CM Setu adopted by Gujarat can be evaluated to assess its adequacy in recruitment of specialists.

6. States must have an integrated HRMIS, capturing details of all regular and contractual staff. Comprehensive, real time data on HRH can also help the states in dealing with issues related to irrational deployment.

7. The TMIS/Training module should be integrated with HRMIS. The system must have provision to generate salary slip, linked to transfer and posting, record performance of staff, and skill gaps so as to enable states to plan for need based training modules.

8. Apart from implementing HRMIS, it is essential that HRIS is used as a planning and monitoring tool by the planners, decision makers, HR managers and programme officers.

9. Improved retention strategies should be adopted by states to sustain skilled HR, especially in remote and rural areas. Monetary and non-monetary incentives that have been successfully adopted by other states such as timely release of salary and incentives, fixed tenure posting, linking experience of remote/ difficult/ tribal areas to post graduate entrance, providing suitable working and living conditions, support for continued learning, recognition for good work should be explored.

10. Rationale utilization of funds through proper planning for recruitment purpose (new staff/filling vacant position). This is the only way to scale up National programmes, staff satisfaction by dividing work-load, better work culture, and distribution of responsibilities.

▶   States need to devise ways for timely and appropriate recognition of its healthcare staff, especially frontline workers to keep them motivated.

DISTRICT HOSPITAL KIPHIRE

FLOOR-WISE HOSPITAL FACILITIES

GROUND FLOOR

1. EMERGENCY / CASUALTY
2. LABORATORY
3. X-RAY
4. ULTRASOUND
5. BLOOD BANK
6. CBNAAT
7. CSSD
8. SAMPLE COLLECTION ROOM

1ST FLOOR

1. FEMALE WARD
2. MATERNITY WARD
3. LABOUR ROOM
4. NBSU
5. OPERATION THEATRE

2ND FLOOR (YOU ARE HERE)

1. OPD REGISTRATION AND RECEPTION
2. MALE WARD
3. PAEDIATRIC WARD

3RD FLOOR

1. CONFERENCE HALL
2. LINEN ROOM / STORE

Hosp. No - 8131857572
DAK AMBULANCE No - 124A

MONTH	OPD	EMERG
MAR 19	698	296
April	634	260
MAY	590	340
JUNE	470	238
JULY	651	270
AUG	729	369
SEPT	425 HG-1207	26
OCT		

TOR 9:
Governance, Finance and Accountability

KEY OBSERVATIONS

1. Institutional Structures for Programme Management include State and district Health Missions (DHM) and State and District Health Societies. These platforms of governance are functional in almost all states. The State Health Societies, chaired by the Mission Director, meet regularly in most states. However, review meetings of State Health Missions (SHM) and District Health Societies (DHS) are irregular in some states. The role of state and district health missions in playing a supervisory / lead role in providing direction to enable effective implementation and monitoring for health outcomes action needs strengthening in most states.

2. Institutional structures at block level still remain a weak link and the capacity of Block program managers to implement and follow up various programs is suboptimal. Their orientation to emerging public health issues needs to be strengthened to facilitate functions of support, supervision, reporting, and analysis. With the transformation of PHC and SHC to Health and Wellness Centres, the Block Programme Management Units will need to be strengthened, in terms of number of staff and in their capacities to undertake a range of functions spanning leadership, clinical and public health actions, including multisectoral convergence.

3. NHM has greatly expanded its component interventions but despite attempts at integration, both vertically and horizontally there is considerable fragmentation in implementation, largely because of limited awareness of programme managers and service providers at district and block levels. This was observed in all states.

4. Supportive supervision, a key component of effective implementation is not being undertaken in its true spirit and form, in any state. It needs strengthening in terms of scheduling, action planning, feedback and effecting changes based on state and district review and monitoring reports. There are no structured reports of monitoring visits are being submitted in many states, and even where reports are submitted, follow up for corrective actions remains a weak area.

5. District planning, a key tenet of the NHM, does not figure as an important activity. Involvement of districts and block in the planning process is limited to preparing budget sheets in Bihar, Chhattisgarh, Gujarat and MP. In some states like Jharkhand,

district officials have not been trained in district planning. Even where districts do prepare their health action plans, feedback and adequate funding from state PIPs appears missing.

6. Rogi Kalyan Samitis have been formed in all states. However, the lack of regular meetings compromises functionality. The functionality of RKS in terms of identifying the priorities of the hospital, planning of resources, appropriate expenditure for ensuring quality patient care services etc. needs improvement.

7. Among the core components of the Grievance Redressal System, Help desks and Call Centres have largely been established in the States. The call volume for grievances are low, in most states reflecting insufficient public awareness or interest. AP, Bihar, and Rajasthan had implemented time bound grievance redressal system for effective and assured resolution.

8. Availability of computers and internet connectivity was not an issue in most of the states visited except a few like Meghalaya, Orissa and Uttarakhand. In Uttarakhand, staff reported using their personal phone data package for official purposes, the bills of which had to be borne by the staff themselves.

9. Proper recording and reporting of key data was a weak area across many states. Analysis and feedback of routine monitoring data is also inadequate, reflecting the need to strengthen capacity in this area, to improve planning and implementation.

10. Though Tablets/Smartphones have been given to ASHAs and ANMs in most states, issues related to the quality and training were seen everywhere. Tele-consultation is being attempted in some states. AP appears to be ahead of the rest in this area.

11. There are multiple legal provisions to facilitate improved access and attain equitable population health outcomes through strengthening public health functions. No state visited had undertaken a review of actions related to the various legal provisions. Inadequate or poor awareness on various health related Acts is largely because there is no organized training program for service providers to orient them on these legal provisions. In many states, service providers in health facilities were not trained in medico legal protocols.

12. For e.g. only 5 out of 16 states have adopted CEA. Proper enforcement of PCPNDT Act was observed in 3 out of 16 states. Even in cases such as COTPA, MTP Act, POSH, etc, service providers were unclear about all the provisions of the law and their responsibilities in relation to reviewing and implementing these.

13. Medico legal Protocols for Rape/Sexual violence – Lack of training of health care providers on the protocol aspects of examination, consent, treatment, counselling and police intimation was observed in most states.

14. With respect to the Disabilities Act, most programme managers and states/facilities are not aware of the provisions of the Act and in many states the certificate is being issued at the district hospitals level only.

15. HIV/AIDS Act is yet to be implemented by the states. State rules need to be passed and institutional set up needs to be put in place such as having an Ombudsman and Complaints Officer at facility level.

16. Mental Health Care Act – Two years after the enactment of this Act, around 10 states are yet to set up authorities for the proper implementation of the rules under the new legislation. The Act mandates that states have a functional authority within nine months of the law coming into force, but most of the States have missed the deadline. Several states are also yet to draft the rules of the Act.

RECOMMENDATIONS

1. DHS to be more accountable for planning, implementation and outcomes for various programs. Every state needs to prioritise decentralized planning. State plan should take into account the District Health Action Plans. This would also reduce fragmentation between programmes and enable a systems approach to planning and implementation, improving health outcomes.

2. Supportive supervision needs to be strengthened with use of structured templates for planning, supervision and monitoring and creation of appropriate feedback mechanisms.

3. Given the increasing emphasis on partnerships with the private sector for secondary and tertiary care , states should prioritize adopting/adapting the CEA or its core principles, including those that have a pre-existing legislation. States that have adopted the CEA need to notify state rules, constitute and notify councils of Clinical Establishments, notify registration authorities in districts and initiate process of registration.

4. The guidelines for implementation of States must ensure strict monitoring and compliance with the provisions of the PCPNDT Act. I t has been seen that if a state enforces the act strictly, then people seeking sex selective foeticide, move to neighbouring states for the services. This underscores the point that all states need to implement the act equally strictly across the country, in order to realise the objectives of the law. States can confer and share best practices with one another.

5. The MTP Act has recently been amended and the States must organise training workshops to orient relevant health care providers on provisions of the latest MTP Act and Rules, especially on provisions related to consent of the woman, extended periods of time limits and forms to be maintained. Training on protocols for medical termination of pregnancy is required, and supplies of medical abortion medication needs to be ensured with requisite training.

6. Ensuring training and implementation of medico-legal protocols for survivors of sexual violence. Every district hospital should have dedicated rooms with examining and counselling facilities supported by adequately trained staff for victims of sexual violence, domestic violence etc. MOs and gynaecologists should be trained in medico-legal protocols for examination, treatment, psychosocial intervention, consent requirements etc. States should do periodic audits of the forms, formats and 'chain of custody' of samples. This is essential for ensuring compliance with the protocols.

7. Written policy on sexual harassment at the workplace and trainings and workshops need to comply to the POSH Act.

Health Care Financing

KEY OBSERVATIONS

1. Key goals of the NHM are ensuring universal access to health care and that OOPE on health is minimized. In most states visited this time, as per NSSO data, OOPE exceeds 50 % of total health expenditure. Gujarat is the only State with OOPE under 50 percent. In Andhra Pradesh, Bihar, and Uttar Pradesh, share of OOPE exceeds 70 percent of total health expenditure.

2. Among all the CRM states visited, the utilisation of NHM funds has reduced between 2015-16 and 2017-18, only exceptions being Delhi, Nagaland, Tamil Nadu and Uttarakhand. As per 2017-18 estimates, states with very high utilisation include Uttarakhand, Tamil Nadu and Andhra Pradesh where the utilisation exceeds 90%. On the other hand, Manipur and Nagaland have utilisation rates less than 80%

3. With the use of PFMS the beneficiaries under various programmes like JSY, JSSK, ASHA, NTEP (erstwhile; RNTCP) etc. are getting their money through DBT. However, issues with opening of bank accounts were noticed in many states which has led to fewer beneficiaries obtaining entitlements.

4. IT initiatives such as e-vittapravaha in Madhya Pradesh, ASHA Soft and OJAS (Online JSY, Rajshree and Subhalaxmi) Payment System in Rajasthan and application of e-Janani in Bihar have simplified fund flow process in these states.

5. The availability of finance personnel is not seen as a problem barring in few states that had vacant positions of finance staff. Rather capacity building of finance personnel was seen as one of the important requirements as observed in the states of Andhra Pradesh, Gujarat, Meghalaya, Nagaland, Mizoram and Uttar Pradesh.

6. Most of the states reported less than optimum utilisation of NHM funds. Multiple reasons were identified- some of them were procedural and some were due to inefficiencies of the system. Procedural delay can be due to the late release of funds from Treasury to State (Uttar Pradesh) or non-submission of utilisation certificate for the outsourced work given by NHM (Bihar and Delhi) or parking of funds at the District/State level (Nagaland and Meghalaya). On the other hand, the inefficiencies of the system affect fund absorption when there is- dearth of health personnel (Chhattisgarh), lack of information about routine activities at the district level due to lack of planning (Jharkhand, Uttarakhand, Nagaland and Mizoram) or distribution of funds to peripheral units uniformly without analysing the utilization pattern (Bihar).

7. Delay in fund disbursal from the State treasury to State Health Societies (SHS) continues to be a major problem in many states such as- Andhra Pradesh, Chhattisgarh, Jharkhand, Manipur, Nagaland, Mizoram, Tamil Nadu and Uttar Pradesh, adversely impacting implementation of various health programs.

8. Overall, there has been an improvement over previous years, on delays in payment to ASHA or JSY beneficiaries except in states of Manipur, Nagaland and Meghalaya where irregularities in payment of ASHA incentives and in Meghalaya and in Uttar Pradesh where delay in payment to JSY beneficiaries was found.

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9. Differential financing related to the allocation of an additional 30% fund for High Priority Districts was not taking place in Andhra Pradesh and Tamil Nadu

10. Measures to ensure fund accountability of fund was seen across states, with some variations. Statutory Audit was already submitted in the States of AP, Gujarat and MP. On the other hand, in Chhattisgarh, Jharkhand, Manipur and Nagaland the audit process was not complete. Account keeping practices, especially at the facility levels, vary across the States. In AP, Gujarat and Madhya Pradesh books of Accounts have been maintained at all levels but in Chhattisgarh, Meghalaya, Nagaland and Mizoram gaps in accounting systems at the facility level were noted.

11. Regular meetings of RogiKalyan Samiti (RKS) to decide expenditure at the facility level was not held in most of the States. There were instances of non-utilisation of untied fund allocated for RKS. The accounting system for most RKS was not satisfactory. Apart from untied fund, user charge was another important source of revenue for RKS as seen in Uttarakhand. Utilisation of user fees at facility level has led to under-utilisation of the seed money from GOI, reducing allocations in the subsequent year. Thus, user fees, which reflect OOPE borne by patients visiting the facility, appear to be substituting the grants being given by the government.

RECOMMENDATIONS

1. All entitlements under JSY, JSSK, PMSMA, PMMVY should be assured at all levels. Public displays related to entitlements under various schemes need to be prominent. This should be coupled with awareness generation among service providers. States also need to address delays in timely payments to staff and to the ASHAs.

2. There is an urgent need to reduce delays in fund transfer from State Treasury to State Health Society and also for the fund transfer to facilities. States should also ensure the timely release of RoP approvals and funds to the Districts.

3. There is a need to explore an alternate route for the transfer of the fund to reduce delay in fund transactions in states like Nagaland where banking facilities are not well developed. States could consider utilizing the postal services for banking facilities in areas where there are gaps in the banking system.

4. The financial performance of Districts and Blocks needs to be monitored on a regular interval.

5. The age-wise advance register should be prepared at all levels for monitoring and settlement of advance outstanding.

6. States and districts should review the use of RKS funds regularly, and RKS need to be held accountable for ensuring timely resolution of issues in the health facility, that are within their mandate.

7. Differential financing should be followed strictly in all states, with high priority districts (HPD) receiving the allocation of the 30% additional funds.

8. Capacity building of finance staff at State and Regional levels should be undertaken at regular intervals and accounting system at the facilities need to be improved.

9. Finance and Accounts wings at district level must be integrated. All the accountants could be placed under the District Accounts Manager with rational distribution of work.

TOR 10:
Access and Equity

This ToR encompasses several strategies related to improvements in access to services with a focus on equity, implemented in the National Health Mission. Hitherto these were dealt with in separate terms of reference. The areas covered include Infrastructure, Ambulances/Referral Transport, Mobile Medical Units and Medicines, including Blood and Blood Products, Dialysis Services, Diagnostics and Equipment Management, and strengthening of Secondary care in District Hospitals.

Overall, the infrastructure of public health facilities at all levels, from SHCs to DHs, was found satisfactory in most states visited. Kayakalp and the launch of Ayushman -Bharat -Health and Wellness Centres, with support to transform SCs/PHCs into HWCs have been two catalysing factors in enabling improvements in infrastructure. Investments in the early years of NRHM and NUHM, demonstrate that "time to care" approach to health services has improved in most states. Infrastructure with regard to residential facilities, needs improvement, and would serve as a mechanism to ensure staff retention in hard to reach areas. Ambulance and Referral transport services were found functional in many states such as AP, UP, Uttarakhand, TN, Delhi, MP, Gujarat, and Odisha. State specific innovations such as Bike Ambulance (in Odisha), Khilkhilahat express for pregnant women (in Gujarat) and Feeder Ambulance for pregnant women in hard to reach areas (in AP) have proved to be beneficial and has potential for replicability. However, issues such as delays in availability of services in difficult geographies like NE states and in other hard-to-reach areas in other states are areas of concern. Mobile Medical Units, in several states are a useful adjunct to expanding access and coverage for services ranging from ANC to Cataract screening, with wide variation in reach and performance.

Improvements in the availability of medicines and diagnostics was noted in all states. Community interaction in Odisha, AP, TN showed negligible OOPE on medicines, diagnostics, and transport. However, ensuring uninterrupted availability of essential medicines and access to diagnostic services, continues to face challenges, and is an area for states to focus on, if the goal of Universal Health Coverage is to be achieved. In most states, issues of timely renewal of license, blood equipment availability & maintenance, operationalization of Blood Storage Units and availability of blood component separator unit persist. An important component of service delivery is to

ensure that equipment management and maintenance is ensured for full functionality. The Biomedical Equipment Maintenance and Management program (BMMP), launched in 2015, still requires strengthening in most states. The Atomic Energy Regulatory Board Certification (AERB) program, related to ensuring radiation safety, is yet to gain momentum in all the states.

Strengthening District Hospitals as nodal training centres for capacity building of Human Resources and to conduct Diplomate in National Board (DNB) and College of Physicians and Surgeons(CPS) courses, were seen in Odisha and Uttarakhand. By virtue of investments in District hospitals, all district hospitals in the districts visited were empanelled under the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), enabling mobilization of additional resources in the public hospitals.

KEY OBSERVATIONS

Infrastructure

1. Since the launch of NHM there has been a steady improvement in availability and functionality of public health infrastructure, but state and district variations are common. State reports from demonstrate that almost 50% of states have established health care facilities to meet the Indian Public Health Standards (IPHS). However, a shortfall of 44% is reported from urban areas, with nearly 50% facilities in urban areas of Jharkhand, M.P. and U.P functioning out of rented buildings. Access to services and time to care approach remains a challenge especially in hilly and tribal areas. While all visited facilities had functional Operation Theatres, Labour rooms and Laboratories as required, a significant proportion were functioning with insufficient infrastructure.

2. State reports also show deficiencies in assured access to emergency services, at the level of District Hospitals (DHs), resulting in increased OOPE. Key factors highlighted include HR shortfalls, lack of equipment, and poor design.

3. The reported number of OPDs and IPDs in most facilities has increased over the previous years, but the 75th NSSO survey shows that utilization of government healthcare facilities is lower than 50% except in Manipur, Mizoram, Meghalaya, Odisha and Tamil Nadu.So far as surgical services are concerned, even better performing states such as Tamil Nadu have (8.8/1000) and Andhra Pradesh (3.08/1000) are not able to utilize the available infrastructure to provide surgical services as compared to smaller states like Delhi and Mizoram where usage is much higher at 20.46/1000 and 10.87/1000 respectively. Lower use is possibly due to one or several of the following: irrational distribution of HR, lack of assured critical care services (emergency, HDU/ICU, blood banks/blood storage units), poor support services (manifolds, CSSD & mechanized laundry), lack of Annual Maintenance Contracts for equipment maintenance, and non-availability of medicines and diagnostics.

4. The utilization of available infrastructure is limited to services under RMNCH+A and a few services related to other programs. Even the designated FRUs are not able to provide assured surgical services as they either lack blood storage units or dedicated emergency units.

5. Physical access to health care has improved with a concomitant improvement in health infrastructure. This is mainly due to addition of government buildings in the states of Uttar Pradesh, Madhya Pradesh and Gujarat. Of the 16 states visited, eight have achieved infrastructure as per IPHS population norms for DH, 13 states for CHCs, 8 states for PHCs and 9 states for HSCs. However, shortfall of facilities is reported in almost all states. Almost all states have increased the number of Urban PHCs functioning in government buildings and states like A.P., Gujarat, Manipur, Mizoram, Nagaland and Odisha have all Urban PHCs functional in govt. buildings. Andhra Pradesh, Delhi, and Rajasthan have achieved the target of UPHCs as per the population norms.

6. The status of construction of health infrastructure varied across states. Manipur and Uttar Pradesh reported good completion rate as on March 2019. Relatively poor completion rate was reported in Madhya Pradesh and Tamil Nadu due to the absence of monitoring mechanisms to regulate construction work leading to escalation of overall cost. Delays in handing over the constructed buildings was observed in Odisha and Tamil Nadu.

7. Lack of adherence to statutory provisions like National Building Codes, AERB, Fire safety norms, and provisions for disaster management were noted across most states. Most facilities did not have disabled friendly amenities- a significant lacunae in patient centered quality care. not have disabled friendly structures.

8. Availability of electricity and safe drinking water is still a challenge in some HSCs located in remote areas of Madhya Pradesh, Manipur and Meghalaya.

RECOMMENDATIONS

Infrastructure

1. States need to undertake a district wise assessment of facilities and develop a time bound action plan to improve infrastructure needed to deliver the appropriate services with quality, in accordance with the IPHS. In urban areas, state action plans for infrastructure strengthening/creation, should necessarily engage urban local bodies.

2. To avoid construction delays, which have become ubiquitous, states should undertake close monitoring on a frequent basis, and enforce penalty clauses for timely completion of work and handover of facilities.

3. While planning for hospital construction, layout designs should be aligned with standard designs for various facilities and service areas. Organizing capacity building workshop for engineers and doctors on hospital planning is a key step in this process.

4. State should empanel/ appoint in-house team of hospital planners, architects and public health professionals for planning design and construction public health facilities.

5. Active engagement of RKS with appropriate capacity building is required so that they are involved in the planning and upkeep of infrastructure.

Access to Medicines Blood & Blood Products, & Diagnostics

Accessibility to affordable and quality drugs is essential for the meaningful roll-out of the UHC (Universal Health Coverage). Several studies have shown that expenditure on medicines in India accounts for about 50 to 80 percent of the total cost of treatment. In fact, 65% of the Indian population lacks regular access to essential medicines and the expenditure on health is the second most common cause for rural indebtedness and is responsible for 2% shift from APL to BPL every year.

'Free Drug Service Initiative' (FDSI) was launched under NHM in 2015 to improve accessibility to quality essential drugs at the public health facilities. NHM scope under FDSI is not only limited to procurement of drugs but also to setup/strengthen systems of procurement, quality assurance, IT backed supply chain management like Drugs and Vaccines Distribution Management Systems (DVDMS), warehousing, prescription audit, training and dissemination of Standard Treatment Guidelines.

All the states visited for CRM were found to have undertaken significant efforts to ensure availability of free drugs at public health facilities and have a dedicated system for procurement and supply of drugs and consumables. Penetration of DVDMS and availability of drugs as per EDL at all level of health facilities was, however, an area of concern in the states that needs attention.

Newer initiatives such as Pradhan Mantri National Dialysis Program (PMNDP) for provision of free dialysis services has already been launched in 34 states and UTs, via in-house as well as PPP mode and out of 16 CRM states visited, 14 were found providing free of cost dialysis services to BPL patients.

To ensure the accessibility of comprehensive healthcare in public health facilities by providing quality diagnostic and imaging services to all patients MoHFW implemented National Free Diagnostic Initiative guidelines. All CRM states except Mizoram have implemented the NHM- Free Diagnostics Services.

NHM launched the program on Biomedical equipment management and maintenance program (BMMP) in 2015. BMMP has been implemented in 30 States/UTs, of which 24 States/UTs have implemented in PPP mode and 6 States/UTs have implemented through in-house mode. Implementation of this program has helped in providing assured quality diagnostics services in public health facilities, thereby reducing the cost of care and improving the quality of care for poor patients in CRM states. The centralized toll-free numbers and real-time dashboard are available where the program has already been implemented via PPP mode.

To rapidly strengthen public health facility safety in terms of diagnostic radiology and equip public health facilities to address concerns related to radiation safety unaided, NHM has emphasized Atomic Energy Regulatory Board (AERB) safety guidelines. Out of 36 States/UTs across India, only 4 states (Assam, Kerala, Uttar Pradesh and Tripura) have implemented Atomic Energy Regulatory Board Program for obtaining "License of Operation" for Public Health Facilities while tender is in progress for 2 states (Arunachal Pradesh and Maharashtra). The compliance to AERB licensing in 16 states visited during CRM is less than 5%. As per the AERB radiation protection rules 2004, no diagnostic X-ray equipment should be operated for patient diagnosis unless License of Operation is obtained from the competent authority. Infrastructure

was found inadequate in most of the visited health facilities across the country. The machine operators were unaware of radiation safety norms.

KEY OBSERVATIONS

Access to Medicines

1. While the Free Drug Service Initiative (FDSI) has been implemented in all 16 CRM states,availability of free drugs to the public remains a major concern, except in Tamil Nadu and Rajasthan.

2. Processes for procurement in the form of a centralized Procurement Agency, has been established in most states, except Chhattisgarh.

3. Drugs and Vaccine Distribution Management System (DVDMS) was initiated in most of the states except Mizoram and Nagaland. Most states were using eVIN for cold chain logistics.

4. District Drug warehouse (DDW) for storage of medicines has been operationalised in most of the states visited.

5. Availability of all essential medicines at different level of health facilities, mainly of NCDs- HTN and DM-2 at HWCs has been observed in most of the states.

6. Essential Drug List (EDL), though formulated by all states, has not been disseminated to all public health facilities and service providers.

7. High OOPE on drugs was observed in Bihar, Uttarakhand, Nagaland, Mizoram and Jharkhand.

8. Frequent stock outs/ non-availability of medicines was reported in the states of Bihar, Chhattisgarh, Delhi, Gujarat, Uttar Pradesh, Mizoram, Jharkhand, Manipur and Meghalaya.

9. Mechanisms for Quality control and Quality Assurance, and empanelment with NABL Accredited testing Laboratories for Quality control of drugs has not been universally undertaken. Delays in receipt of quality testing reports of drugs was observed in many states.

10. Except for the states of Andhra Pradesh, Uttar Pradesh, Odisha, Tamil Nadu and Meghalaya, prescription audits were not being undertaken.

11. Standard Treatment Guidelines (STGs) are available in most of the states but adherence to the same remains a major concern everywhere

Essential Drug List (EDL), though formulated by all states, has not been disseminated to all public health facilities and service providers.

RECOMMENDATIONS

Procurement of Drugs

1. Central and independent Procurement Agency/body for all kinds of purchases and rate contracting of drugs and consumables.

2. Evidence based demand generation with use of technology would go a long way in strengthening the cost-effective procurement system.

3. Local Purchase of medicines should be undertaken only for emergency requirements.

Inventory management of Drugs

4. There is a need develop proper infrastructure for better storage facility and stacking of drugs at appropriate temperature within the health facilities and also at drug warehouses.

5. EDL needs to be reviewed annually through an institutional mechanism.

6. Service providers to be aware of EDL and the status of availability of drugs at their respective facility.

7. Availability of drugs at the warehouses and the health facilities to be ensured by the state to improve access and reduce OOPEs on drugs. Also, buffer stocks of essential drugs and supplies at the health facilities and drug warehouses to be maintained.

8. Warehouses should supply of drugs as per demand to the health facilities (Pull system), not pushing down the ones that have been received.

9. Ensure establishment of a mechanism for managing near expiry drugs at the health facilities and drug warehouses (First Expiry First Out – FEFO).

10. List of availability of commonly used critical drugs should be displayed at the facilities.

Quality Testing of Drugs

11. Sufficient numbers of NABL accredited labs need to be empanelled for the quality testing

12. Internal and external Quality Assurance mechanism to be ensured.

13. Samples from each batch should be tested in the drug warehouse before releasing to HCFs.

14. Facilities should be encouraged to report Adverse Drug Events on web-portal of Pharmacovigilance Programme of India.

Drugs and Vaccine Distribution Management System (DVDMS)

15. IT enabled supply chain management system should be implemented health facility wise, extending upto Health & Wellness Centres (HWCs).

16. Real time supply management system should be developed to get actual information of drug stock at the facility level.

17. All parallel software need to be integrated with the DVDMS.

Logistics of drugs

18. Further planning of District Drug warehouses should be based on geographical mapping, factoring into the number of health facilities, distances etc. to minimize

the logistics cost, lead time of stock replenishment and fast mobilisation of the stock in emergency situations.

Prescription Audit

19. Prescription audit practice needs strengthening and internalisation at all level of health facilities. IEC and BCC measures for changing prescription-writing behaviour of the doctors and educating patients for explaining benefits of generic drugs is needed.

Standard Treatment Guidelines (STGs)

20. Though majority of the states have developed Standard Treatment Guideline (STGs), their usage in investigation, treatment, follow-up and over-all management of patients is missing. The states could create an institutional mechanism for periodical revision of developed STGs and promoting its usage at the health facilities, including engagement of non-government sector.

Access to Diagnostics

1. All CRM states except Mizoram have implemented the NHM- Free Diagnostics Services. Bihar, Chhattisgarh, Rajasthan, Tamil Nadu, Madhya Pradesh, Gujarat and Uttarakhand provide laboratory services through in-house strengthening. Andhra Pradesh, Delhi, Jharkhand, Manipur, Meghalaya, Odisha and Uttar Pradesh on the other hand, partner with the private sector, to provide access to laboratory services.

2. Andhra Pradesh, Delhi, Jharkhand, Madhya Pradesh, Odisha, Rajasthan and UP have outsourced CT services. Andhra Pradesh, Meghalaya, Odisha, Rajasthan, UP and Uttarakhand have outsourced the Tele-radiology services for X-ray reporting.

3. The number of tests which are provided free of cost to patients are variable in the CRM states due to state policies and availability of resources like Equipment, HR and Consumables, some states have outsourced only higher level of tests .

4. It was observed in some CRM states that NHM notified diagnostics tests were not available free of cost to all the beneficiaries who visited public health facilities and some fees was collected for specific categories of tests from the patients, adding This can significantly add to out-of-pocket expenditure.

5. In many CRM states, there are no fixed policies or common exercises for External Quality Assurance Scheme (EQAS) and Internal Quality Control (IQC) in the state. Most facilities are not using any mechanism for quality assurance and it was observed by the CRM team that the maximum number of facilities was not having any Standard Operating Procedures (SOP).

6. In some facilities of the CRM states, it was noted that radiology equipment such as X-ray machines were lying idle due to lack of trained technicians to operate them and most of the radiation facilities are not AERB certified.

7. BMMP

8. Gujarat, Tamil Nadu and Delhi have an in-house system for biomedical equipment maintenance and management. Andhra Pradesh, Chhattisgarh, Jharkhand, Madhya Pradesh, Mizoram, Manipur, Meghalaya, Nagaland, Odisha, Rajasthan and Uttar Pradesh haveimplemented Biomedical Equipment Maintenance and Management program in PPP model.Bihar and Uttarakhand use the conventional method of engaging AMC/CMC with the vendor.

9. Implementation of BMMP programs in most of the CRM states/UTs has shortened the turnaround time to repair the equipment in the CRM states. However, in most of the states the registration of complaints for equipment maintenance through online or Toll free number is either delayed or not properly registered.

10. Corrective maintenance, preventive maintenance, calibration, user training, Toll-free number-based complaint logging, a website-based summary on all the medical equipment till the level of district hospital were made available after the initiation of the BMMP program. Above mentioned features are common to 11 states/UT which implemented the program via PPP mode.

11. In Nagaland and Manipur, staff in the public health facilities were unaware about the key aspects of the BMMP program and responsibilities of service providers.

12. In few of the CRM states, there is no robust monitoring framework since the beginning of the rollout of the BMMP by state. State-level meetings are conducted rarely where state program nodal officer and service provider representatives participate.

13. Most of the States/UT where the CRM team visited observed that X-ray machines/ Radiation facilities were without license from AERB.

14. TLD badges, PPE for radiation safety and IEC regarding radiation safety were found missing in many visited facilities by the CRM team.

15. Lead aprons were not used during X-ray exposure and instead were found crumpling in shelves.

16. Absence of lead door, control room and Mobile Protective Barrier was observed.

RECOMMENDATIONS

1. Nodal Officers at State& district level needs to be identified for managing and ensuring availability ofdiagnostics, equipment maintenance, dialysis, AERB certification etc.

2. The hospital In-Charges (I/C) and Managers should be sensitized to oversee the functioning of these equipment and services through a defined checklist while taking daily rounds.

3. States could plan to initiate a laboratory information system which is linked with electronic health record (EHR) for all laboratories.

4. To ensure competency among laboratory and other diagnostic services induction and refresher trainings need to be organized for laboratory supervisors/Managers/ Radiographers and technicians.

5. Awareness among community and even service providers needs to be organized about the free diagnostic, dialysis and equipment maintenance program.

6. It is suggested to develop a clear strategy and institute monitoring mechanisms for PPP to avoid irrational utilization of services. Prescriptions of 'individual/single tests' in PPP should be monitored closely by the State.

7. Devise a system to verify the assets which are physically available in the facility against the BMMP dashboard at least once in every month.

8. The service provider could be advised to synchronize calibration schedules with NQAS assessment, renewal of license for blood bank or renewal of AERB registration etc.

9. Diagnostic X-ray equipment should not be operated for patient diagnosis unless License of Operation is obtained from the competent authority.

10. States could prioritize for up-gradation/development of infrastructure based on the essential needs and explore by self (using e-lora site) or through empaneled agencies obtain AERB clearance for radiological units.

11. Training could be imparted to radiology technicians for effective usage of radiology equipment.

12. Units should always be operated from the control room or standing behind the Mobile Protective Barrier (1.5 mm lead equivalent) or fixed protective barrier (such as a wall).

13. States needs to display warning signage for pregnant ladies entering the X-ray room and IEC for radiation safety has to be appropriately displayed at each health facility.

DH STRENGTHENING

A well-resourced District Hospital provides secondary health care which includes a range of curative, preventive, promotive, rehabilitative and palliative care services to the community within the district. Strengthening District Hospitals for assured and comprehensive secondary care services and developing it as hub for pre-service and in- service training is one of the focused activities of MoHFW. GoI guidelines on 'District Hospital Strengthening' were disseminated in 2017. Establishing multispecialty care at DHs as per Indian Public Health Standards (IPHS) with assured critical care services (emergency, functional OTs, SNCU, NICU, PICU, Obstetric and general HDUs and ICUs etc.) and developing it as knowledge hub for initiating medical (DNB/CPS), paramedical and nursing courses are some of the core activities under DH strengthening.

During 13th CRM, implementation of District Hospital Strengthening guidelines, PM-JAY and initiation of medical/paramedical/nursing courses were reviewed in 16 states.

KEY OBSERVATIONS

1. Critical care services including emergency surgical services are either limited or unavailable in district hospitals across all states visited. As per provisions of

DH strengthening guidelines, RKS of district hospitals are empowered to hire specialists for strengthening their specialties and running courses. Though, none of the states visited had utilized this provision.

2. Very few states are utilizing their district hospitals for training needs of their service providers.

3. Although, 232 seats in 142 District Hospitals across 14 states in the country have been accredited for DNB programme, but in the states visited for CRM, 84 seats in 58 District Hospitals across 6 states were found accredited for DNB programme. CPS has been initiated only in Madhya Pradesh and Odisha.

4. Most of the district hospitals visited are running ANM/GNM courses. Some states like Odisha are also planning to initiate BSC courses in GNM schools. However, none of the states had any defined plan for initiating para-medical courses in the DHs.

5. TMIS portal is not being used in any state adequately for deciding training load and posting of trained personnel at various levels of health facilities except in Odisha.

6. Post-training follow-up, supportive supervision and mentoring remains a weak area.

7. States like Delhi, Gujarat and Jharkhand had their district hospitals empanelled under PMJAY. Also, Arogya Mitras were available at empanelled hospitals in MP and Manipur.

RECOMMENDATIONS

1. Clinical care at secondary level facilities need strengthening in terms of quality of care, expanded spectrum of inpatient services and increased range of diagnostics services.

2. Comprehensive district wise roadmap after assessing the training need of various service providers along with its linkages with service delivery plan at all levels of health facilities needs to be drawn in consultation with State and District Programme Officers.

3. High focus states like UP, Bihar and Jharkhand can ensure availability of trained manpower by strengthening their DHs and accelerating initiation of medical/paramedical and nursing courses.

4. Priority action is needed for converting nursing schools into nursing colleges. Opening of new ANM schools also need to be restricted as focus of states should be on initiating 4 year nursing programs as per INC.

5. In lieu of shortage of specialists, MBBS doctors could be trained to handle emergency and other critical areas like HDUs, SNCUs, PICUs, NICUs, ICUs etc.

6. States should also think about initiating post basic nursing programs in their DHs. This will ensure provision of trained manpower in critical care areas.

7. PMJAY empanelled Hospitals attached to teaching institutions (medical, PG and DNB courses) are entitled for 10 per cent higher packages. States should utilize this low hanging fruit and develop their district hospitals as knowledge hubs.

8. Accreditation under NQAS is approved for getting gold certification under PMJAY, so, states need to accelerate the accreditation process for all DH and SDH.

1. *Access to Dialysis services* MoHFW launched Pradhan Mantri National Dialysis Program (PMNDP) in 2016. Hemodialysis services under PMNDP are currently available at district hospital level in 465 Districts in 798 Centres deploying 4727 machines as on 31st October 2019 (Source: DVDMS/monthly reports). Furthermore, PMNDP has already been rolled out in 34 States/UTs and is in implementation phase in 02 States. Hemo-dialysis services are available in 20 States/UTs through PPP Mode whereas 14 States/UT are providing services through In-house mode. PMNDP is supported by National Health Mission and is providing free of cost services to BPL patients. CRM teams found dialysis services were implemented at 88% CRM states i.e. in 14 out of visited 16 States/UTs and dialysis services are being provided free of cost to BPL patients in most of the visited States/UTs. Ten CRM states namely Andhra Pradesh, Delhi, Jharkhand, Odisha, Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Uttarakhand and Gujarat are operating on PPP mode for dialysis services; whereas 25% states namely Manipur, Tamil Nadu, Mizoram, Nagaland are providing dialysis services by In-house mode. PMNDP is under-implementation in 2 CRM states i.e. in Meghalaya and Chhattisgarh.

2. Adequate space (120sq.ft. space) was available for performing dialysis at most of the dialysis centres except in Rajasthan for proper functioning.

3. Community awareness regarding the National Dialysis Program was found excellent in most CRM States/UTs.

4. Dialysis services are not free for patients in Bihar and tendering is in process in order to make dialysis services free to BPL patients.

5. Availability of Nephrologist (fortnightly visit) was a key concern in most of the facilities visited by the CRM teams.

6. Dialysis services are not being provided to positive patients at some dialysis centres like SDH, Dahod, Gujarat and DH, Khandwa, Madhya Pradesh; are not taking seropositive patients whereas in Nagaland, HIV +ve patients are not getting dialysis services despite high prevalence of HIV in Nagaland.

7. Issues with seepage, water logging in the dialysis unit were observed at DH, Chhindwara, Madhya Pradesh which is a source of microbial growth and increases chances of infection.

8. In Meghalaya, the PMNDP is yet to be implemented since the tender to outsource the dialysis services has failed three times.

9. Records regarding quality of dialysis service delivery (Kt/V or URR record) were available except in Nagaland.

Availability of Nephrologist (fortnightly visit) was a key concern in most of the facilities visited by the CRM teams.

RECOMMENDATIONS

1. Dialysis services should be provided free of cost to all BPL patients free of cost for reducing OOPEs.

2. Availability of Nephrologist, visit on fortnightly basis, must be assured at every dialysis centre with immediate effect.

3. The dialysis centres should be providing adequate space as defined in the guideline for all dialysis patients with isolation rooms and separate equipments for seropositive patients.

4. Records to evaluate the quality of dialysis service delivery (Kt/V or URR record) should be maintained. Also, performance of microbial testing, water testing etc. on regular basis.

5. National Dialysis Program Dashboard to be created and maintained for monitoring and evaluation purposes.

6. Measures should be taken to reduce waiting time for patients availing dialysis services.

7. Sharing of monthly progress report on PMNDP by all Nodal Officers with MoHFW.

8. IEC and social awareness camps for free dialysis services for BPL patients could be appropriately displayed at each health facility for proper utilization.

BLOOD BANK/ BLOOD STORAGE UNIT

Assured blood transfusion services are critical in reducing mortality and morbidity. 'National Blood Policy' was launched in 2007 to reiterate the Government's commitment to provide safe and adequate quantity of blood, blood components and blood products. Under this, only licensed blood banks are allowed to collect, process, store and transport blood and blood components. State Drug Controllers are authorized to approve blood banks and blood storage units. Sale or purchase of blood/blood products otherwise is strictly prohibited.

Moreover, crucial policy decisions such as setting up Blood Bank in every District Hospital and a BSU at FRUs and other secondary care facilities were taken by the GOI to reduce or prevent untimely deaths that occurred due to lack of availability of blood.

13[th]CRM noted most of the DHs have blood banks with adequately maintained infrastructure and requisite equipment's. However, licensing of the same is still a matter of concern. Despite relaxing the norms for setting up of blood storage units, availability of approved and operational blood storage units was found to be inadequate in most of the CRM visited states. One of the major reasons for the same is inadequate linkages and ownership by the mother blood banks.

Recently in 2016, GOI also launched e-Raktakosh- a centralized Blood Bank Management system to connect, digitize and streamline the work flow of blood banks across the nation. During 13th CRM, only three states viz. Delhi, Jharkhand and Madhya Pradesh were found to have e-Raktakosh implemented.

Many other issues were notices in states such as inadequate calibration and maintenance of blood bank equipment, unavailability of blood component separation unit and lack of effluent treatment plans that need priority attention to ensure round the clock supply of safe and secure blood and blood components in all the health facilities.

KEY OBSERVATIONS

Collection of blood

1. Collection of blood was occurring in both ways (voluntary and replacement donation) in most of the visited states except AP, Mizoram, Nagaland and TN where it only was voluntary.

Availability of services

2. Availability of blood services have seen improvement in most States/UTs however in 06 States (Nagaland, Mizoram, Meghalaya, Uttar Pradesh, Rajasthan and Bihar) availability of blood has been reported as a concern.

3. Though mother blood banks were functional in most of the states visited however, they did not meet the requirement of BSUs at peripheral first referral units (FRUs), except in AP & TN.

4. Poor linkages between mother blood banks and dependent blood storage units remained a serious concern in providing emergency maternal care. Reported maternal deaths of severely anemic women in the states of Jharkhand, Rajasthan and Uttarakhand could have been prevented with proper coordination between the BBs and BSUs.

5. Blood Component separation units were functional in the states of Delhi, Jharkhand, Madhya Pradesh and Tamil Nadu.

Accessibility of services

6. Free blood service to BPL patients and JSSK beneficiaries was reported in most of the states except in the states of Chhattisgarh, Gujarat and Manipur

7. Access to safe blood continues to be limited especially in rural areas of states like Uttar Pradesh, Rajasthan, Uttarakhand, Jharkhand, Bihar, Chhattisgarh and North East. Relatively better access to blood services was reported in AP, Delhi, MP, Odisha and TN.

8. Statutory and Regulatory Compliances Blood banks in the states of AP, Delhi, Jharkhand, Manipur and Nagaland had license in place

9. Blood bank equipment were not found calibrated in most of the states visited except UP.

10. Liquid waste management system for discarding blood samples was not found functional in almost all the CRM states visited.

Blood bank management system

11. e-Raktkosh was functional in the states of Delhi, Jharkhand and Madhya Pradesh for effective management and monitoring of blood transfusion services.

12. None of the states reported blood transfusion reaction except Chhattisgarh.

Poor linkages between mother blood banks and dependent blood storage units remained a serious concern in providing emergency maternal care. Reported maternal deaths of severely anemic women in the states of Jharkhand, Rajasthan and Uttarakhand could have been prevented with proper coordination between the BBs and BSUs.

RECOMMENDATIONS

1. States need to develop a road a map with set timeline regarding establishment of BB/BSUs to ensure equitable and round the clock availability of blood in all the health facilities.

2. All the equipment in Blood bank/Blood storage units should be covered under equipment maintenance plan.

3. Blood Component separator units at BBs could be initiated for optimal utilization of Blood.

4. Proper implementation of Laboratory Information Management System for documentation of test results & monitoring, live availability of blood stock across all the district blood banks, blood group stock and list of blood donors registered with the blood banks.

5. Adopt appropriate liquid waste management system for discarding blood samples. Also, states must have a robust mechanism in place to monitor wastage of blood and blood products

6. Adopt appropriate liquid waste management system for discarding blood samples. Also, states must have a robust mechanism in place to monitor wastage of blood and blood products

7. Training and performance evaluation of the staff (EMTs, blood banks etc.) to be done regularly.

8. Should have a SOP in consonance with DCG(I) following safe blood practices

9. Collection of blood from regular (repeat) voluntary non remunerated blood donors should constitute the main source of blood supply. So, states should focus on IEC and social awareness.

10. Blood needs to be transported under proper cold chain maintenance from the linked mother blood bank to the Blood Storage Units (BSUs).

11. There is a need for supporting states in renewal of licenses and in roll out of online platforms (e.g. e-Raktkosh) for management of blood services.

12. Licensing &coordination with private blood banks is also required.

13. Voluntary donations to be promoted to meet the free blood bag requirements of the health facilities. Particularly for those who are brought to the health facility with emergency conditions.

14. Operationalization of Blood Storage Unit at FRUs is an urgent need for making FRUs functional.

15. Regular reporting of transfusion reactions (on its occurrence) by the clinicians

16. There is a need to enhance blood access through a structured network of centrally coordinated, efficient and self-sufficient blood transfusion service to ensure round the clock availability of blood.

AMBULANCE & REFERRAL SERVICES

Emergency Medical Services (EMS) is a critical component of any health system to ensure faster access to care, pre-hospital medical care, and medical transportation to patients/beneficiaries. EMS is not merely a transport service for moving a patient from one location to another. It connotes a patient who receives an appropriate medical care from trained professionals and is transported to the appropriate healthcare facility within reasonable period of time in an emergency so that he has a greater chance of survival.

Under NHM ,Dial 108 is predominantly an emergency response system, primarily designed to attend to patients of critical care, trauma and accident victims etc. It caters to transporting patients through Basic Life Support (BLS) and the Advanced Life Support Ambulances (ALS) in all kinds of medical emergencies. Currently 9344 ambulances are being supported under 108 emergency transport systems.(NHM MIS)10017 ambulances are operating as 102 patient transport (NHM MIS) .Along with that, 5484 empanelled vehicles are also being used in some States to provide transport to pregnant women and children e.g. Janani express in MP, Odisha, Mamta Vahan in Jharkhand, Nishchay Yan Prakalpa in West Bengal and Khushiyoki Sawari in Uttarakhand. (Source : NHM MIS).

In almost all CRM visited states, awareness and knowledge regarding ambulance and toll free number is known to the community people and also to ASHAs, ANM and other field staff. However the response time varied from state to state. The deployment of ambulances based on population norms or geographical location for a sparsely located community was not adequately followed by states. In most of the states there was inadequate supervision and review on technical parameters like infection prevention protocols, maintenance of vehicles, their response time, etc. None of the states has implemented Government of India guidelines or advisory for a monthly check by district supervisor.

KEY OBSERVATIONS

1. An overall improvement in ambulance service availability and accessibility was seen in all the states. Majority of the community had knowledge of 108 and 102 Ambulance services.

2. The availability of ambulance services were found good in states like Andhra Pradesh, Uttar Pradesh,Madhya Pradesh, Gujarat, Tamil Nadu and Delhi.

3. Talli Bidda Express in Andhra Pradesh, Mamta Vahan in Jharkhand and Jaccha Baccha Vahan/Bike ambulance in Madhya Pradesh are some of the special initiatives take by the states.

4. However, the timeliness of service, quality of training of EMTs, equipment maintenance varied across states. States like Bihar, Chhattisgarh, Uttrakhand, and Odisha reported delay in services and thus need improvement.

5. In states like Meghalaya, Mizoram and Nagaland the condition of the existing ambulances are poor. The vehicles are in dilapidated conditions and are majorly

used for transportation of drugs and vaccine from the drug warehouse to designated health facilities and as a transport vehicle for Medical Officers.

6. State like Manipur does not have provision of 102/108 at all, only 102 patient transport facility is available.

7. None of the visited states were getting ambulances checked/verified by the district level competent authority. Most of the equipment's in the ambulances were not being used , indicating that they were used as transport vehicle only and not for stabilizing patients.

RECOMMENDATIONS

1. Ambulance services in states should be organised in a way that there is universal access to the entire population through a systemic response mechanism particularly during emergencies.

2. Rational deployment of ambulances should be done. Location or point of deployment of ambulance should be determined both by the density of population as well as the time-to-care approach (access to health facility within 1 hour), as the case may be.

3. All ambulances should be analysed on a monthly basis on various performance indicators and utilization of vehicle like No. of calls received and no. of calls dropped,% and no. of dropped calls responded , Average response time per call with minimum and maximum duration of attendance, No. of trips and total kms travelled per day for each ambulance etc

4. Every month district anaesthetist or an authorized district nodal officer should check each ambulance in the district and give certification for operational status of all equipment, availability of drugs as per the list.

5. The log book should be properly maintained on a daily basis. The record should also indicate change of oils, tyres and other fittings requiring periodic replacement

6. Regular training of EMTs(6 weeks training for ALS, 4 weeks for BLS and 2 weeks for JSSK ambulances)for handling basic emergencies and life support while deployed in BLS and competent to resuscitate and handle emergencies like trauma, spinal injuries, coma, heart attacks, poisoning, snake bites etc. in ALS ambulances should be conducted.

7. Differential parameter for Capex and Opex should be worked out for any states, hilly terrain and smaller UTs with sparse population.

MOBILE MEDICAL UNITS

Healthcare service delivery through Mobile Medical Units (MMUs) under NHM is a key strategy to facilitate access to public health care at the doorstep particularly to people living in remote, difficult, under-served and unreached areas. Deployment of MMUs is based on a population norm with 1 MMU per 10 lakh population with a cap of 5 MMUs per district. However, further relaxation of norms is permissible on a case

to case basis, where patients served through existing MMUs exceeds 60 patients per day in plain areas and 30 patients per day in hilly areas. As on 30th September, 2019, 486 districts are equipped with Mobile medical units under NRHM and 28 with MMUs under NUHM. Total of 1599 MMUs under NRHM and 39 MMUs are operational under NUHM across nation

Though number of districts equipped with Mobile medical units have increased from 426 (31st March, 2013) to 486 districts (31st March, 2019) which is a positive effort by the states but on the other hand the states did not take adequate steps for operationalizing primary care health facilities in such areas. MMUs are temporary mode for providing outreach services in remote areas where public health facilities are not adequately functional. So, while deploying MMU states need to also plan for strengthening HWCs and PHCs in the area. During CRM visits, it was also found that there is variable performance of existing MMUs ranging from around 10- 25 trips and approximately 500-1500OPDs per month in different states of the country.

KEY OBSERVATIONS

1. MMUs were found functioning well in Gujarat, Jharkhand, Madhya Pradesh, Manipur and Odisha. Although, irrational deployment of these units was reported in Jharkhand.

2. Distribution of MMUs was not uniform in many districts of Andhra Pradesh, Bihar, Delhi and Mizoram.

3. MMUs provide their services as per monthly visit plan as reported in Gujarat, Jharkhand and Tamil Nadu.

4. Utilization of MMUs are variable in different states. Number of trips performed by MMUs ranges from 10 to 25 trips per month.

5. MMUs are primarily being used for minor ailments, ANC, PNC, Neonatal Care. However, Geriatric care given through MMUs in Jharkhand is admirable.

6. Health education and counselling services through MMUs are found limited.

7. Opportunistic screening is being done by MMUs in states as reported in Jharkhand state while estimations of Hb, Blood sugar are being performed in Gujarat, Madhya Pradesh, Nagaland and Odisha.

8. Diagnostic facilities through MMUs were found limited in most of the states. However, Hub and spoke model is utilized in Gujarat for diagnostic services in coordination with CHC.

9. Referral linkages with higher facilities was found inadequate in most of the states. It is reported specifically in Jharkhand and Nagaland.

10. The MMUs in difficult terrain halt during nights while providing services to hard to reach population as reported in Nagaland. Some of these are operationalized by multiple agencies like Multi Sector Development Plan of Department of Welfare for SC/ST & Minorities in North East District in Delhi, GVK in Gujarat, HLLFPPT in Meghalaya and Uttarakhand.

MMUs provide their services as per monthly visit plan as reported in Gujarat, Jharkhand and Tamil Nadu.

11. The MMU services needs availability of at least one Medical officer. However, half of required MOs were missing in the MMUs of Nagaland. Coordination in the staff was seen good in Gujarat and Jharkhand.

12. Old and damaged MMUs are reported in Jharkhand and Manipur.

RECOMMENDATIONS

1. Since MMUs are not the sustainable mode of assured service delivery. So, state needs to develop a comprehensive plan or road map with defined timeline to operationalize health and wellness centres and PHCs to provide assured preventive, promotive and curative health care services.

2. Rational distribution needs to be done of existing MMUs and required number of MMUs need to be provisioned as per requirement of the states.

3. In states where MMUs are showing remarkable performances, old and damaged MMUs need immediate repair and replacement to provide better service delivery.

4. In-service Training of MMU staff needs strengthening in most of the states.

5. Regular performance monitoring and evaluation need to be done to assess the status and functionality of existing MMUs in the states.

6. MMUs can also be utilized for Health education and generating awareness on communicable diseases.

7. Each MMU has on an average 1 MO, 1 Staff nurse, 1 LT, 1 Pharmacist and 1 driver

NATIONAL HEALTH MISSION
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