Ministry of Health & Family Welfare
Government of India

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

15th

COMMON REVIEW MISSION REPORT 2022

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सुधांश पंत
सचिव
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Secretary

सत्यमेव जयते

आज़ादी का अमृत महोत्सव

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

MESSAGE

Common Review Mission (CRM) is unique to the National Health Mission as an annual monitoring and review activity. CRM has its core strength in its structure, where State specific teams undertaking the field visits are a mix of policy makers, senior programme officials, public health experts, researchers, government officials from relevant Departments, representatives from Medical Colleges, NGOs, technical partners, civil society organizations and other technical experts. This allows pooled insights of experts to provide context specific and evidence-based recommendations to strengthen public health systems across the country.

The 15th CRM report serves as evidence of the collective commitment and relentless efforts of the diverse group of stakeholders dedicated to this cause. This comprehensive assessment covers 17 States and Union Territories and serves as a crucial resource for shaping the trajectory of our healthcare system. The CRM's focus on patient-centered care and the development of practical tools and checklists shows adaptability and a commitment to address evolving challenges.

By scrutinizing both outcomes and processes, the report offers a comprehensive view of public healthcare service delivery. The report highlights the commendable progress achieved over the years, demonstrating the significant impact of investments in healthcare access and outcomes.

Furthermore, the emphasis on health systems specific innovations and good practices underscores a forward-thinking approach to healthcare delivery.

I express my sincere gratitude to all the members of the CRM Team for their invaluable contributions. It is expected that States/UTs will take note of the 15th CRM report and initiate the necessary recommended actions.

Sudhansh Pant

Date : 14.11.23
Place : New Delhi

(Sudhansh Pant)

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MESSAGE

Ministry of Health and Family Welfare prioritizes monitoring and programme review as an important exercise, which enables our health systems to identify enablers and barriers towards effective programme implementation, thus acting accordingly to achieve expected health outcomes. The 15th Common Review Mission (CRM) is another significant step in this direction, and plays a vital role in assessing the impact of various programs and initiatives under the National Health Mission (NHM), guiding us towards more effective strategies and mid-course corrections.

Our commitment to the values of universality, equity, and affordability continues to be a guiding light as we navigate the evolving healthcare landscape. Over the several years, CRMs have been reflecting on field insights and significant improvement in overall service delivery across all domains of health systems strengthening.

The fifteenth CRM was a deep dive not only to understand the programme implementation within NHM, but to also capture the State/UT specific utilization of funds for government's recent initiatives under PM-ABHIM and FC XV health sector grants. The CRM report reflects on State/UT's efforts to provide comprehensive health care across primary and secondary levels of care. It also provides a clear picture on preparedness of systems towards implementation and roll out of recent interventions within NHM. I am confident that not only we will achieve the defined targets of National Health Policy 2017 to ensure better health outcomes, but the States will also be able to leverage this cross-learning activity to further strengthen their public health systems in both rural and urban areas.

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

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Message

Common Review Mission (CRM) has been a robust mechanism/exercise under National Health Mission to monitor the implementation of NHM strategies. Over the years CRM has played a critical role in reviewing the ongoing and newer initiatives of GoI to strengthen the health system. 15th CRM visited 17 States and UTs to provide an account of various initiatives being undertaken under NHM.

The multidisciplinary CRM teams comprising officials from MoHFW, NITI Aayog and other Central Ministers, State officials, public health experts from SHSRCs, academic institutions and representatives from, NGOs working in public health domain bring a holistic view of the functioning of public health system in India.

15th CRM report highlights various state specific interventions and good practices across the states/UTs and hence provides a good cross learning opportunity for other States & UTs to pilot and scale similar context specific interventions to achieve better performance and improved health outcomes.

The report reflects on how AB-HWCs are emerging as first port of call for community members, and this is being validated by substantial progress reported by states/UT in operationalizing these centres. Across the visited districts, the primary health care services are now visibly strengthened and are being offered closer to community at no cost. With this, community health workers have also evolved and ASHAs are now undertaking an expanded range of tasks to complement the efforts of Comprehensive Primary Health Care. Aligning with government's agenda to promote wellness, States/UTs have also showcased mechanisms to include yoga and other physical activities within AB-HWC, and also administering Annual Health Calendar to streamline health promotion across the communities. NHM efforts towards strengthening of secondary healthcare facilities and ensuring quality of care across the levels of care was also visible and showed progress in this direction.

Findings and recommendations outlined in this report will be highly useful to States/UTs to further improve the implementation of various ongoing National Health Programmes. I believe that the insights provided herein will contribute significantly to public health and policy implementation.

(Aradhana Patnaik)

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Foreword

The Common Review Mission (CRM), a robust mechanism conducted under the aegis of the Ministry of Health and Family Welfare (MoHFW), supported tirelessly by National Health Systems Resource Centre (NHSRC), holds paramount importance in our collective journey towards enhancing the effectiveness and impact of national health programs under the National Health Mission (NHM), and the pioneering Ayushman Bharat programme.

In its 15th iteration, the CRM covered 16 states and one Union Territory, providing a comprehensive view of the diverse healthcare scenarios across states/UT. The findings of CRM are captured across the levels of care i.e. primary and secondary level, and it also includes direct interactions with community members, thus making this an important exercise to understand the holistic perspectives on implementation and roll out of National Health programmes.

The critical insights generated through the CRM activities serve as a compass for refining strategies, identifying best practices, and addressing challenges. As we navigate through the outcomes of this assessment, I believe that the collaborative efforts showcased during the review will pave the way for transformative changes in our healthcare landscape.

I extend my heartfelt appreciation to every team member involved in this monumental undertaking for their unwavering commitment and hard work in compiling this report. The insights and recommendations from the 15th CRM will undoubtedly guide us in propelling NHM forward, ensuring that the trajectory of improvement remains steadfast.

We look forward to using the learnings and experiences from CRM towards establishing strong health systems and thus a resilient future for our nation.

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CONTENTS

LIST OF ABBREVIATIONS

A	
AAMC	Aam Aadmi Mohalla Clinic
AAPC	Aam Aadmi Poly Clinic
ABC	Always Better Control
ABHA	Ayushman Bharat Health Account
AB-HWCs	Ayushman Bharat Health and Wellness Centres
AB-SHWP	Ayushman Bharat- School Health & Wellness Programme
ACDR	Active Case Detection & Regular Surveillance
AEFI	Adverse Effect Following Immunization
AERB	Atomic Energy Regulatory Board
AFHC	Adolescent Friendly Health Clinic
AHU	Air Handling Unit
AIIMS	All India Institute of Medical Sciences
ALS	Advance Life Support
AMC	Annual Maintenance Contract
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
APHC	Additional Primary Health Centre
APL	Above Poverty Line
APMSDC	Andhra Pradesh Medical Service & Development corporation
ARS	Anti Rabies Serum
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker

B	
BCC	Behaviour Change Communication
BCM	Block Community Mobiliser
BCSU	Blood Component Separation Unit
BEMMP	Biomedical Equipment Maintenance and Management Program
BLS	Basic Life Support
BMGF	Bill & Melinda Gates Foundation
BMW	Bio Medical Waste
BOR	Bed Occupancy Rate
BPL	Below Poverty Line

C	
CAMC	Comprehensive Annual Maintenance Contract
CAPD	Continuous Ambulatory Peritoneal Dialysis
CBAC	Community Based Assessment Checklist
CBNAAT	Computer Based Nucleic Acid Amplification Test
CBWTF	Common Bio- Medical Waste Treatment Facility
CCH	Certificate Course on Community Health
CDR	Child Death Review
CDSR	Child Death Surveillance and Response
CEA	Clinical Establishment Act
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHC	Community Health Centre
CHOs	Community Health Officer
CLMC	Comprehensive Lactation Management Centres
CMC	Comprehensive Maintenance Contract
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disorder
COTPA	Cigarettes and Other Tobacco Products Act (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution)
CPHC	Comprehensive Primary Health Care
CRM	Common Review Mission
CSR	Corporate Social Responsibility
CT	Computed Tomography
D	
DMHP	District Mental Health Programme
DPHL	District Public Health Laboratory
DQAC	District Quality Assurance Committee
DQAU	District Quality Assurance Unit
DVDMS	Drug Vaccine Distribution & Management System
DVS	Drug & Vaccine Store
DBT	Direct Benefit Transfer
DEIC	District Early Intervention Centre
DGD	Delhi Government Dispensary
DH	District Hospital
DHAP	District Health Action Plan
DM	Diabetes Mellitus
DMC	Designated Microscopic Centre

E	
ECPs	Emergency Contraceptive Pills
ECRP	Emergency Covid Response Package
EDD	Expected Date of Delivery
EDL	Essential Drug List
ELISA	Enzyme Linked Immunosorbent Assay
EML	Essential Medicine List
EQAS	External Quality Assurance System
e-VIN	Electronic Vaccine Intelligence Network
F	
FBNC	Facility Based Newborn Care
FDDSI	Free Drugs and Diagnostics Services Initiative
FDI	Free Diagnostic Initiative
FDSI	Free Drug Service Initiative
FEFO	First Expired First Out
FHC	Family Health Centres
FP	Family Planning
FPLMIS	Family Planning Logistics Management Information System
FRU	First Referral Unit
FSN	Fast, Slow and Non-Moving
FY	Financial Year
G	
GDMO	General Duty Medical Officer
GDP	Gross Domestic Product
GeM	Government e Marketplace
GNM	General Nurse Midwife
GoI	Government of India
H	
HBNC	Home Based Newborn Care
HBYC	Home Based Care for Young Children
HCV	Hepatitis C Virus
HDU	High Dependency Unit
HIV	Human Immuno Deficiency Virus
HMIS	Health Management Information System

HPV	Human Papilloma Virus
HR	Human Resources
HRH	Human Resources for Health
HRMIS	Human Resource Management Information System
HRP	High Risk Pregnancy
HTN	Hypertension
HVAC	Heating, Ventilation and Air Conditioning
HWCs	Health & Wellness Centres
	I
ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centre
ICU	Intensive Care Unit
IDSP	Integrated Disease Surveillance Programme
IEC	Information Education Communication
IFA	Iron & Folic Acid
IHIP	Integrated Health Information Portal
ILR	Ice Lined Refrigerator
IPC	Infection Prevention and Control
IPD	In Patient Department
IPHL	Integrated Public Health Laboratory
IPHS	Indian Public Health Standards
IT	Information Technology
	J
JAS	Jan Arogya Samiti
JSSK	Janani Shishu Suraksha Karyakaram
JSY	Janani Suraksha Yojana
	K
KMC	Kangaroo Mother Care
	L
LAMA	Left Against Medical Advice
LASA	Look Alike Sound Alike
LCDC	Leprosy Case Detection Campaign
LDR	Labour, Delivery and Recovery
LLINs	Long Lasting Insecticidal Nets

LMIS	Laboratory Management Information System
LMU	Lactation Management Unit
LSU	Lactation Support Unit
LT	Laboratory Technician
	M
MAA	Mother's Absolute Affection
MAS	Mahila Arogya Samiti
MCD	Municipal Corporation of Delhi
MCH	Maternal and Child Health
MCP	Mother and Child Protection
MCR	Micro Cellular Rubber
MCW	Maternity and Child Wing
MDSR	Maternal Death Surveillance and Response
MDT	Multi Drug Therapy
MH	Maternity Home
MHCA	Mental Health Care Act
MHT	Mobile Health Team
MLC	Medico Legal Case
MLHP	Mid Level Healthcare Provider
MMUs	Mobile Medical Units
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MOT	Maternity Operation Theatre
MPCDSR	Maternal, Perinatal, Child Death Surveillance and Response
MPWs	Multipurpose Workers
MRI	Magnetic Resonance Imaging
MTM	Makkalai Thedi Maruthuvam
MTP	Medical Termination of Pregnancy
MVY	Mana Shakti Vikas Yojna
	N
NBCC	Newborn Care Corner
NCDs	Non-Communicable Diseases
NFHS	National Family Health Survey
NGOs	Non-Governmental Organisation
NHA	National Health Accounts
NHM	National Health Mission
NICU	Neonatal Intensive Care Unit

NIDDCP	National Iodine Deficiency Control Programme
NIHFW	National Institute of Health and Family Welfare
NLEP	National Leprosy Eradication Programme
NMHP	National Mental Health Programme
NMTI	National Midwifery Training Institute
NOHP	National Oral Health Programme
NPCBVI	National Programme for Control of Blindness and Vision Impairment
NP-NCD	National Programme for Prevention & Control of Non-Communicable Diseases
NPHCE	National Programme for Healthcare of Elderly
NPPC	National Programme for Palliative Care
NPPCF	National Programme for prevention and Control of Fluorosis
NPY	Nikshay Poshan Yojana
NQAS	National Quality Assurance Standards
NRC	Nutritional Rehabilitation Centre
NRCP	National Rabies Control Programme
NSSK	Navjat Shishu Suraksha Karyakaram
NSSO	National Sample Survey Office
NSV	Non-Scalpel Vasectomy
NTEP	National Tuberculosis Elimination Programme
NUHM	National Urban Health Mission
NVBDCP	National Vector-borne Disease Control Programme
NVHCP	National Viral Hepatitis Control Programme
	O
OEM	Original Equipment Manufacturer
OOPE	Out of Pocket Expenditure
OPD	Out Patient Department
OT	Operation Theatre
	P
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PCTS	Pregnant Women & Child Tracking System
PCV	Pneumococcal Conjugate Vaccine
PFMS	Public Financial Management System
PGIMER	Post Graduate Institute of Medical Education and Research
PHSC	Primary Health Sub Centre
PICME	Pregnancy and Infant Cohort Monitoring and Evaluation
PICU	Paediatric Intensive Care Unit

PIP	Programme Implementation Plan
PM-ABHIM	Pradhan Mantri Ayushman Bharat Health Infrastructure Mission
PM-CARES	Prime Minister's Citizen Assistance and Relief in Emergency Situations
PMJAY	Pradhan Mantri Jan Arogya Yojana
PMJJBY	PM Jeevan Jyoti Bima Yojna
PMNDP	Pradhan Mantri National Dialysis Programme
PMS	Progress Management System
PMSBY	Pradhan Mantri Suraksha Bima Yojana
PMSMA	Pradhan Mantri Surakshit Matritava Abhiyan
PMSYMY	Pradhan Mantri Shram Yogi Maan Dhan Yojna
PNC	Post Natal Care
POC	Point of Care
POCSO	Prevention of Children from Sexual Offenses Act
POSH	Prevention of Sexual Harassment
PPIUCD	Post Partum Intra Uterine Contraceptive Device
PPP	Public Private Partnership
PR&RD	Panchayati Raj & Rural Development
PRCs	Population Research Centres
PRI	Panchayati Raj Institutions
PRO	Public Relation Officer
PSA	Pressure Swing Adsorption Plant
	Q
QAS	Quality Assurance Standards
	R
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive and Child Health
RDK	Rapid Diagnostic Kit
RDT	Rapid Diagnostic Test
RHS	Rural Health Statistics
RI	Routine Immunisation
RKS	Rogi Kalyan Samiti
RKSK	Rashtriya Kishor Swasthya Karyakram
RMC	Respectful Maternity Care
RMDs	Rural Medical Dispensaries
RMNCH	Reproductive Maternal Newborn Child Health
RVV	Rotavirus Vaccine

S	
SAM	Severe Acute Malnutrition
SC	Scheduled Caste
SC-HWCs	Sub Centre Health & Wellness Centres
SDH	Sub District Hospital
SHCs	Sub Health Centres
SHGs	Self-Help Groups
SHP	School Health Programme
SHSRCs	State Health Systems Resource Centres
SIHFW	State Institute of Health and Family Welfare
SLAC	Sparsh Leprosy Awareness Campaign
SMTI	State Midwifery Training Institute
SN	Staff Nurse
SNA	Single Nodal Agency
SNCU	Special Newborn Care Unit
SOP	Standard Operating Procedure
SPHC	Seed Primary Health Centre
SQAC	State Quality Assurance Committee
SRS	Sample Registration System
ST	Scheduled Tribe
STEMI	ST Elevated Myocardial Infarction
STG	Standard Treatment Guidelines
SUMAN	Surakshit Matritva Aashwaswan
T	
TAEI	Tamil Nadu Accidental Emergency Initiative
TAT	Turn Around Time
TB	Tuberculosis
TCC	Tobacco cessation center
TLD	Translumniscence Dosimeters
T-MANAS	Tele Mental Health Assistance and Networking Across States
TMIS	Training Management Information System
TNMSC	Tamil Nadu Medical Supplies Corporation
ToR	Terms of Reference
TPT	Tuberculosis Preventive Treatment
TU	Tuberculosis Unit

U	
UCHC	Urban Community Health Centre
UHND	Urban Health and Nutrition Day
UHWC	Urban Health and Wellness Centre
UIP	Universal Immunisation Programme
UPHC	Urban Primary Health Centres
USG	Ultrasonography
UT	Union Territory
V	
VED	Vital Essential Desirable
VHC	Village Health Council
VHND	Village Health and Nutrition Day
VHN	Village Health Nurse
VHSNC	Village Health Sanitation and Nutrition Committee
VIA	Visual Inspection with Acetic Acid
W	
WCD	Women and Child Development
WHVs	Women Health Volunteers
WIFS	Weekly Iron and Folic Acid Supplementation

MANDATE & METHODOLOGY OF 15TH CRM

OVERVIEW

The National Health Mission (NHM) denotes a coordinated effort towards health systems' reforms in the country. Every year, the Common Review Mission (CRM) is organized by the Ministry of Health & Family Welfare (MoHFW) in various states to evaluate the effectiveness of several National programmes within the National Health Mission (NHM). Common Review Mission undertaken so far has provided valuable insights and understanding of the strategies which were successful and have led to several significant mid-course adjustments.

This year the CRM was organised between 4th Nov to 11th Nov 2022 in 17 States/UT namely Andhra Pradesh, Bihar, Chhattisgarh, Goa, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Meghalaya, Nagaland, Punjab, Rajasthan, Sikkim, Tamil Nadu, Telangana, Uttar Pradesh, and Delhi.

OBJECTIVES

The objectives of the CRM is to undertake a rapid assessment of implementation status of NHM and its key strategies and priority areas, analyse strengths and challenges with respect to health system strengthening, identify trends in progress of key indicators, particularly relating to coverage, equity, quality and affordability at state, district/ sub-district, and community level, document innovations and best practices, evaluate readiness of states to undertake implementation of new initiatives, review the progress and coordination mechanisms with various partners. Another focus of the CRM is to assess the implementation status of Ayushman Bharat-Health and Wellness Centres (AB-HWCs) and availability of expanded package of comprehensive primary healthcare services at these upgraded PHC- HWCs and SC-HWCs in the states.

TERMS OF REFERENCE OF THE 15TH CRM

The terms of reference (ToR) were designed to capture ground reality faced by public health care system in delivering the services, uptake of new initiatives, strengthening of existing programmes and State specific achievements and good practices taken up to meet the challenges. Information on demographic indicators, relevant Health Managements Information Systems (HMIS) data and district and state health profiles were made available to the CRM teams before the visit.

GEOGRAPHICAL COVERAGE OF 15TH CRM

The 15th CRM covered 16 states and one Union Territory. The States were Andhra Pradesh, Bihar, Chhattisgarh, Goa, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Meghalaya, Nagaland, Punjab, Rajasthan, Sikkim, Tamil Nadu, Telangana, Uttar Pradesh, and Delhi.

TEAM COMPOSITION

Each State was visited by a team of 14-16 members comprising a mix of the following:

1. Government Officials from
    a. Officials of the MoHFW, GoI.
    b. Representatives of State Governments (Health Secretary/Mission Director/ Director of Health).
    c. Regional Directors of Health & Family Welfare.
    d. Officers from other Central Ministries and NITI Aayog.
2. Public Health Experts from
    a. Non-official member of Mission Steering Group of NHM.
    b. Non-official member of Empowered Programme Committee of NHM.
3. Public Health Experts from the National Health Systems Resource Centre (NHSRC), National Institute of Health & Family Welfare (NIHFW), State Health Systems Resource Centres (SHSRCs), Public Health Foundation of India (PHFI), other credible academic institutions like Indian Institute of Health Managment Research, Tata Institute of social sciences (TISS), Post Graduate Institute of Medical Education and Research (PGIMER), Indian Institute of Public Health (IIPHs) including AIIMS.

4. Population Research Centres (PRCs).
5. Representatives from Development Partners
    a. World Health Organization (WHO).
    b. Norway India Partnership Initiative (NIPI).
    c. United Nations International Children's Emergency Fund (UNICEF).
    d. United Nations Population Fund (UNFPA).
    e. United States Agency for International Development (USAID).
    f. United Nations Development Programme (UNDP).
        a. Bill & Melinda Gates Foundation (BMGF).
        b. JHPIEGO
        c. PATH
6. Consultants from various divisions of the MoHFW.

METHODS

To conduct review of implementation of NHM programmes by the CRM teams along with critical analysis of secondary data collected at the national level and provided by the state.

Teams were provided background material like CRM Agenda, Terms of Reference, Guidelines, latest MIS Reports, Factsheets, Survey reports (RHS, SRS, NFHS, HMIS) etc. Other reference material included specific reports and studies for the state and districts, data collected from the state with respect to the ToRs, and relevant findings from the past CRM reports.

The CRM teams receive the briefings at the State and districts on progress made by them on all NHM programmes. Subsequently, field visits were conducted in selected districts for next three to four days. The interactions were planned to begin with the community and continued to examine service provision from Sub centres/HWCs onwards up to the district/state levels in rural and urban areas, on the principle of the continuum of care.

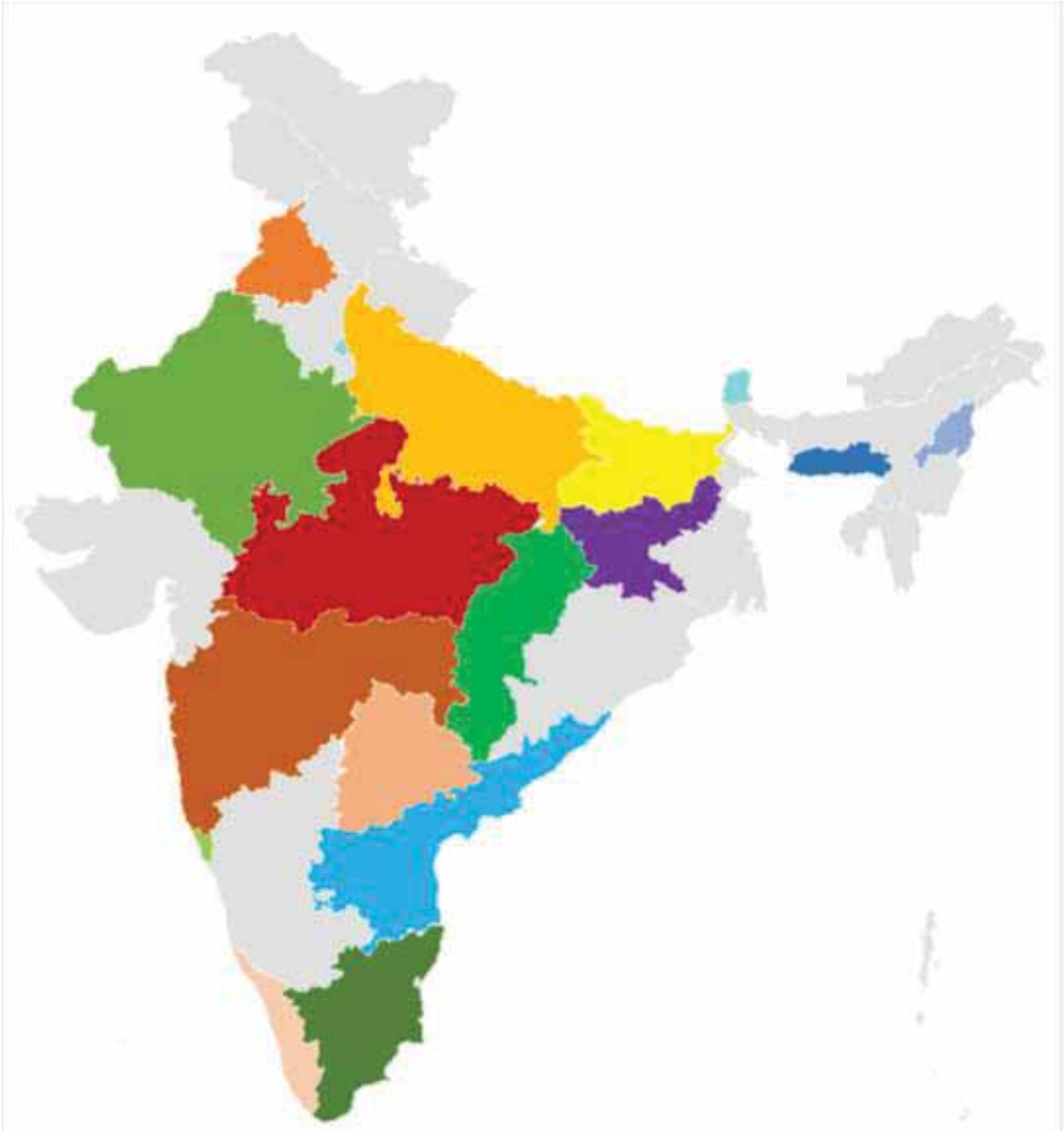
The facility visits were undertaken to DH/SDH, CHCs/ UCHCs (AB-HWCs), PHCs/UPHCs (AB-HWCs)/ Mohalla clinics (Delhi), and Sub Health Centres (SC-HWCs). Interview were held with ASHA, AWW, ANM, VHSNC/ MAS/JAS members, and community representatives, including beneficiaries and interaction with community in two villages/slums. Focus Group Discussions were held, one with ASHAs; one with community (SC/ST/underserved hamlet/slum) to assess reach and access of health services to these communities and their experiences and one with RKS representatives.

LIST OF STATES AND DISTRICTS VISITED IN 15TH CRM

State	District 1	District 2
Andhra Pradesh	Vizianagaram	Krishna
Bihar	Aurangabad	Bauxar
Chhattisgarh	Kondagaon	Surajpur
Delhi	South District	North-west District
Goa	North Goa	South Goa
Jharkhand	Garwah	Deoghar
Kerala	Wayanad	Thrissur
Madhya Pradesh	Sidhi	Singrauli

Maharashtra	Dhule	Washim
Meghalaya	Southwest Khasi Hills	Ribhoi
Nagaland	Mokokchung	Zunheboto
Punjab	Ferozpur	Rupnagar
Rajasthan	Jaisalmer	Kota
Sikkim	South district	East district
Tamil Nadu	Thoothukudi	Tiruvannamalai
Telangana	Asifabad	Suryapet
Uttar Pradesh	Chitrakoot	Maharajgang

GEOGRAPHICAL COVERAGE OF 15TH CRM



TOR-1 COMPREHENSIVE PRIMARY HEALTHCARE SERVICES

NATIONAL OVERVIEW

The National Health Policy, 2017, articulated an important change from very selective to comprehensive healthcare package which includes geriatric health care, palliative care and rehabilitative care services. The transition is envisioned through the establishment of Health and Wellness Centres. The policy also recommended the establishment of these Centres on geographical norms apart from population norms, while advocating a 'gate keeping mechanism' at primary level in a phased-manner, accompanied by an effective feedback and follow-up mechanism.

In February 2018, as the first step in the conversion of policy articulations to a budgetary commitment, the Government of India announced creation of 1,50,000 Health and Wellness Centres (HWCs) by December 2022, by upgrading existing Sub-Health Centres (SHCs) and Primary Health Centres (PHCs) to deliver Comprehensive Primary Health Care (CPHC). These AB-HWCs endeavour to provide CPHC closer to home with the principle being "time to care" to be no more than 30 minutes.

Also, newer initiatives like Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PMABHIM) and Fifteenth Finance Commission (FC-XV) health sector grants are providing additional resources to establish Urban Health and Wellness Centres (UHWCs) and Polyclinics in order to cater to community's differential healthcare needs and aspirations in urban areas.

The UHWCs would be the first port of call for individuals and families in urban areas and would be linked to the nearest UPHC-HWCs to enable decentralized delivery of primary health care services closer to people.

Over the past four years, the states have made substantial progress in operationalizing the AB-HWCs through essential inputs such as strengthening primary health care team at the SHC and PHC level (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, providing expanded range of medicines and diagnostics, upgrading infrastructure aligned with newer IT initiatives such as tablets and desktops, use of CPHC-IT and other applications, telemedicine/ information technology platforms, undertaking activities related to health and wellness promotion and introducing performance linked payments.

As of November 2022, at the time of 15th CRM visit, all States/UT cumulatively have operationalised 1,31,150 primary health facilities into Ayushman Bharat- Health and Wellness Centres. The country is on track to achieve the set target of 1.5 lakh AB-HWCs by December 2022. (Figure 1, 2).

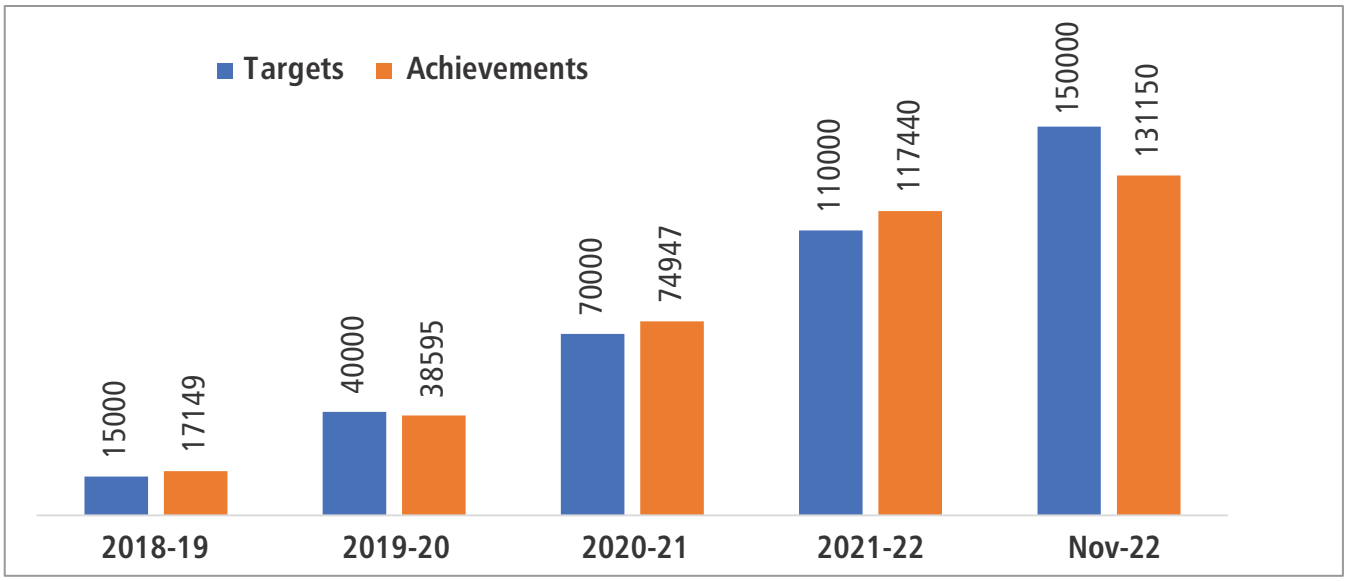


Figure 1: Status of achievement of AB-HWCs (Till Nov 2022)

KEY OBSERVATIONS

Operationalization of Ayushman Bharat - Health and Wellness Centres and delivery of 12 packages[1] of comprehensive primary health care services (CPHC) in urban and rural areas.

- Among the 17 states visited for the CRM, Andhra Pradesh, Chhattisgarh, Goa, Madhya Pradesh, Maharashtra, Meghalaya, Nagaland, Punjab, Sikkim and Telangana had achieved their targets prior to December 2022. The progress of the states was differential (See Fig 2). Nevertheless, the operationalization has been paced-well and the states were committed to achieving their targets. Delhi, is an exception, as the UT has not implemented the program.

- The states have adopted operationalization strategies suiting their context. For example, Rajasthan and Nagaland prioritized the upgradation of SHCs into AB-HWCs. Whereas, Goa has upgraded its Rural Medical Dispensaries into SHC-HWCs. Telangana has planned to upgrade all urban primary health centres as well as the Basti Dawa Khana (urban health clinics) into UPHC-HWCs and UHWCs respectively.

- Operationalization of HWCs in some states have been challenged due to delayed recruitment of the Community Health Officers (CHOs)/Mid-Level Health Providers (MLHPs) and/or Medical Officers as well as due to delay in branding the facilities. In Sikkim, the upgraded facilities were not recognised as HWCs due to the absence of branding. Whereas in Rajasthan, shortfall of CHOs with respect to the upgraded SHCs delayed their operationalization.

- The NCT of Delhi has an independent structure for providing primary and secondary level services. Primary healthcare is being delivered through the Aam Admi Mohalla Clinics (AAMC), Aam Aadmi Polyclinic (AAPC), Delhi Government Dispensary (DGD), Seed Primary Health Centre (SPHC), Maternity and Child Wing (MCW) and Maternity Home (MH). The AAMC, AAPC, DGD, SPHC are under the administration of the State, and the MCW and MH are under the administration of Municipal Corporation of Delhi (MCD).

INFRASTRUCTURE

- Most of the visited AB-HWCs were functioning in government buildings. They were found easily accessible by the community, except in parts of Bihar, Meghalaya and Telangana due to poor road conditions and transport connectivity.

- The infrastructure of the operationalized HWCs were differential across the states. HWCs (SHC/PHC) in Chhattisgarh, Maharashtra, Meghalaya, Nagaland, Rajasthan, Sikkim, Tamil Nadu and SHC-HWCs in Uttar Pradesh were found to have adequate infrastructure with dedicated spaces for registration, waiting area, OPD services, laboratory and diagnostic services, IEC corners, and spaces for wellness activities. Whereas, inadequacies in infrastructure were observed in Andhra Pradesh, Bihar, Goa, and Madhya Pradesh.

- Andhra Pradesh has rolled-out the Nadu-Nedu (before-after) scheme to strengthen the infrastructure of existing health facilities and revitalize the health care services offered at the government hospitals through a separate agency, namely the Andhra Pradesh Medical Services & Infrastructure Development Corporation (APMIDC). The key focus of the initiative is to ensure that necessary infrastructure is made available at all facilities in order to easily accommodate and offer comprehensive package of services.

[1] The 5/7 packages out of 12 added subsequently would be assessed only on those HWC established for more than 1 year.

- **Branding:** Most of the facilities had done the external branding of Ayushman Bharat - Health and Wellness Centres as per the guidelines, except in Bihar, Kerala, Madya Pradesh, Rajasthan, Telangana and Uttar Pradesh. Rural PHCs converted to AB-HWCs under the Nadu - Nedu initiative of Andhra Pradesh were not branded as per the norms.

- **Waiting areas:** The availability of waiting area at the facilities was varied across the states. Space constraints for the waiting areas were observed in Andhra Pradesh, Bihar, Goa, Madhya Pradesh and Uttar Pradesh.

- **Demarcated spaces (OPD, drug storage, laboratory):** The presence of dedicated spaces for OPD consultations, drug storage area and laboratory/ diagnostics area were observed to be differential across the states. For example, in Uttar Pradesh, the CHO's OPD was found outside the premises of the SHC-HWC. Dedicated spaces for the storage of medicines and laboratory services were not available in the facilities visited in Andhra Pradesh.

- **IEC materials and signages** in vernacular languages were appropriately displayed in OPD rooms and waiting areas across the facilities, except in Punjab. The Citizen charter was displayed across most of the facilities.

- **Power supply:** Regularity in power supply was a common concern. Power-backups were reported only in a few states like Maharashtra, Nagaland, and Sikkim, where solar panels were being used.

- **Water supply:** Availability of running water for domestic consumption was a concern in most of the facilities across the states. Provisions for safe drinking water were not available in Jharkhand, Madhya Pradesh, and Punjab.

- **Separate toilets:** Most of the HWCs lacked the availability of gender specific and/ or disabled friendly toilets. In Telangana, a facility reported having non-functional toilets for over four months.

- **Disabled friendly structures:** Availability of disabled friendly structures such as ramps, railings, wheelchair access, disabled-friendly toilets etc., were variable across the states. A few states like Chhattisgarh, Kerala, Rajasthan, Tamil Nadu were observed to have some of these structures.

- **Labour rooms:** Dedicated and well equipped labour rooms at PHC-HWCs were observed in Goa, Maharashtra, Meghalaya, Sikkim and Tamil Nadu. It was noted that a labour room in PHC-HWC of Goa had received State QAS certification.

- **Wellness area -** Availability of adequate spaces for conducting wellness sessions varied across the

states. Wellness areas were not available in Andhra Pradesh, Bihar and Goa. Whereas, in Sikkim, near by schools, community centers, and spaces near PHSCs were used for wellness activities.

- **Boundary wall -** Boundary wall was found in most of the facilities visited except in Bihar, Maharashtra, and Madhya Pradesh.
- **Complaint/Suggestion boxes** were found in Sikkim and Bihar within AB-HWC premises. However, the HWC teams were unaware of grievance redressal mechanisms.
- Availability of staff quarters was observed in Meghalaya.

HUMAN RESOURCES

Primary healthcare team at AB-HWCs

- In all the states, the primary healthcare team played a critical role in the provision of expanded range of essential package of services as a part of Comprehensive Primary Health Care (CPHC).
- In Nagaland, roughly 96.6% peripheral centres were successfully converted to AB-HWCs with CHO availability. Similarly, recruitment of CHOs was a priority agenda in Uttar Pradesh and approximately 75% of AB-HWCs were functional with CHOs.

- In Rajasthan, the recruitment of CHOs was affected due to a lag in the NHM recruitment cycle. Whereas in Bihar, a parallel integrated CHO course that directly positioned the CHOs in the SHCs was implemented to strengthen the functionality status of the AB-HWCs.
- In Jharkhand, CHOs were not posted regularly as they were also assigned other duties outside the AB-HWC such as teaching in Nursing courses which affected service provision. But in states like Chhattisgarh, Uttar Pradesh and Meghalaya, the CHOs are leading the primary care team and working with a proactive approach to provide promotive and preventive services to the community. Particularly in Meghalaya where the CHOs are known as MLHPs, were also providing teleconsultation services.
- States such as Sikkim and Telangana reported significant increase in footfalls at AB-HWCs with the engagement of CHOs.
- In Madhya Pradesh and Telangana, the sanctioned HR was not as per the Indian Public Health Standards (IPHS) norms.
- In Madhya Pradesh where cadre wise posts of Lab technician, Multi-Purpose Workers (MPWs), Pharmacists, Staff Nurses, General Duties Medical Officers (GDMOs) and Specialists are sanctioned; the State needs to facilitate the recruitment and posting of all these sanctioned human resources in a timely manner.
- In Chhattisgarh, PHC-HWCs were running without an MBBS Medical Officer and vacant ANM posts were also noted at several facilities.

Training

- Training of HR improves overall performance and encourages cooperation, as well as efficiency to improve the functionality of the AB-HWCs. Notwithstanding, the training status of the

primary healthcare team at the AB-HWCs varied across the states and was rolled out in an incremental manner.

- In Maharashtra, the CHOs received training on all essential services. In Sikkim, the MLHPs were additionally trained in Yoga and were conducting yoga and wellness activities in schools and communities. However, in Madhya Pradesh and Telangana, training on the expanded range of services was inconsistently provided to the HWC staff. In Rajasthan, training on the expanded range of services and refresher trainings were not being properly conducted on a regular basis resulting in inadequate skills across all major cadres.
- In Jharkhand, although CHOs were in position in AB-HWCs for two years, induction training was not provided to them.
- In Punjab, the CHOs had received training on the expanded package of services but the quality of training was observed to be lacking. Additionally, ASHAs and ANMs hadn't received any form of training in the past two years.
- Quality of training was also found to be an issue in Bihar, where poor team dynamics were observed in the SHC-HWCs, with CHOs and ANMs working in verticals and separate identified spaces. This was also the case in Uttar Pradesh, where inadequate interpersonal coordination was observed among the primary healthcare team.

PROGRAM IMPLEMENTATION AT PRIMARY LEVEL

Maternal health

- In majority of the states, service provision through the AB-HWCs, remained focused on RMNCHA^{+}. Notably in Telangana, major footfalls in the OPDs at the AB-HWCs was catering to RMNCHA^{+} services.

- The supply of MCP card was found to be an issue in several states. In Maharashtra, the MCP card was not supplied since the past 1 year in the Dhule District. In Meghalaya, MCP cards were not being filled during the HBNC Visits by ASHAs, and in Punjab, although most women had ownership of the MCP card, the details were missing.
- Early registration and tracking of pregnant women for 4 ANCs by ASHA required rigorous strengthening in Uttar Pradesh. Complete ANC (4 ANC visits) was found to be low in both the districts which was evident on examining the MCP cards.
- With high prevalence of anemia in states of Maharashtra and Madhya Pradesh, the services varied across the AB-HWCs. Although the CHOs in Madhya Pradesh provided iron-sucrose injection to the anaemic patients, the facilities in Maharashtra were out of IFA tablets.
- In terms of institutional deliveries, most women reported delivering in a healthcare facility in Punjab, which corresponded to the national survey findings. However, in Meghalaya, only 30% to 40% institutional deliveries were being conducted which is far below the national average. Roughly 15-20 deliveries per month were conducted in the APHCs visited in both the districts in Bihar.

- With respect to labour room protocols, respectable maternity care was observed in the APHCs in Bihar which were well-equipped and adequately managed by the staff nurses at the respective facilities. A fully equipped state QAS certified labour room for normal deliveries was also observed in an AB-HWC in South Goa. Though, no delivery was conducted in the past 3 months.
- In Maharashtra and Nagaland, the AB-HWCs did not have sufficient space for deliveries and had issues with use of partograph, Oxytocin storage, infection control mechanisms and maintenance of labor registers.
- High OOPE on delivery was noted during facility and community interactions in Bihar, Maharashtra, and Uttar Pradesh.
- Maternal Death review was being conducted regularly in Meghalaya and High-Risk Pregnancy registers were also maintained.
- The need to properly list high-risk pregnant women, provide counselling, birth preparedness and follow-up services was felt in Andhra Pradesh.
- A midwifery initiative that trains ANMs and staff nurses has been rolled out to improve maternal care services in Telangana by providing counselling to the pregnant mothers and inculcating their confidence in having normal deliveries. The initiative also triages high risk cases and facilitates appropriate and timely interventions by the specialists.
- Some issues with real-time data entry were recorded in Rajasthan.

UNIVERSAL IMMUNIZATION PROGRAM

- Immunization coverage varied across the states. ASHAs and ANMs actively mobilized the community members for immunization outreach camps. It was also being provided through VHNDs in all states.
- Vaccine handling was done properly by the AB-HWC teams. The practice of vaccination micro planning needed strengthening in most of the states.
- Birth dose was being provided across all states. Sikkim was the only state to include HPV vaccination for eligible girls (9- 14 years) in the immunization schedule.
- Under the Universal Immunization programme, district Kota of Rajasthan had started the new concept called 'Amavasya Tikakaran Programme' where vaccination was done on new moon day of every month for the migrant labour's children. This is because Amavasya Day is the only holiday for the migrant labourers.
- In Bihar, Model Immunization Corners were set up across the PHCs and CHCs to strengthen routine immunization within their catchment areas.
- Cold chain points were found at various facilities across the states. Ice Lined Refrigerators (ILRs) were functional in Maharashtra, Punjab, Delhi, Nagaland and Kerala. e-VIN was found functional with good ease and acceptance among the users across states. Entries were found up to date in most of the facilities.

CHILD HEALTH

- A major proportion of the population availed child health services at the AB-HWCs in Bihar.

All services delivered at the centres are recorded through the RCH portal. However, some patients continued to incur OOPE on drugs, diagnostics, and referral transport due to unavailability.

- Maternity and Child Welfare Centres in Delhi are effectively providing ANC, PNC, immunization services at the facility and the HBNC services through ASHA workers. A centre in Mongolpuri has also adopted 13 primary level schools under the school health programme, through which general health check-up is done at the schools. At least one school visit was undertaken once a week, where health screening was done, and iron tablets were provided.
- All 11 thematic areas of Ayushman Bharat School Health and Wellness programme (AB-SHWP) have been added to school curriculum by the Education Department in Jharkhand to promote health and wellness of school going children in the state.
- In Meghalaya, mothers are provided counselling services. IFA supplements were also available in the health facilities visited. Moreover, child deaths are recorded, and Child Death Review is also conducted in the state.
- Services related to HBNC was found to be compromised in Punjab, Madhya Pradesh, and Uttar Pradesh. In Punjab, although the ASHAs conducting postnatal visits were aware about the number and frequency of visits to be conducted, they were not measuring and recording the newborn's temperature and weight. In Uttar Pradesh, the HBNC visits conducted by the ASHAs were irregular which led to missing the sick new-borns. Also, routine anthropometric measurements for the babies/children visiting VHSND sites were missing, and growth monitoring is laggard despite the presence of equipment.
- In Goa, child health services at the primary level- SHC, HWCs, PHC, HWCs, UPHC and UHWC were not available. Mothers were not counselled or aware of KMC in some of the facilities visited.
- Some skill-based competencies essential to delivering effective child health care such as new-born resuscitation skills were found to be lacking among the AB-HWC staff in Madhya Pradesh and Meghalaya.
- Overall, child Health training and capacity building of ASHA/ANM/SN and MO along with strong supportive supervision and monitoring is needed in all the states.

FAMILY PLANNING

- The implementation of family planning program at the primary level was satisfactory across all states. ASHAs ensured the distribution of contraceptives within the community.
- The 'Basket of choice' for contraceptives was available across the facilities, except in Maharashtra. Acceptance of barrier methods and modern contraceptives was variable across the states. For example, acceptance of Antara (injectable contraceptive) was found to be limited in the states of Meghalaya and Maharashtra, whereas beneficiaries in Rajasthan preferred Antara over PPIUCD. Barrier methods were preferred in Nagaland and Uttar Pradesh. Knowledge and awareness of ASHAs/ frontline workers on the basket of choice as well as stock-out of contraceptives (e.g. Antara) were observed to influence the acceptance of contraceptive methods.
- States adopted different strategies for the provision of counselling services for family planning. In Goa, they services were provided to the beneficiaries in dedicated spaces by the FP counsellors. In Tamil Nadu, 'Family Planning Cards' were being used both for counselling and as an IEC booklet. However, these cards lacked information on Oral Contraceptive Pills (Mala D). In Nagaland, 'Saas Bahu Sammelans' were being organized.

- In Bihar and Telangana, PPIUCD insertions were reportedly not done due to the lack of confidence among the service providers. Sterilization services were not being provided in Goa, Nagaland and Maharashtra. The uptake of male sterilization procedures (NSV) was low across the states.
- The use of FPLMIS has been observed to be limited across states.

COMPREHENSIVE ABORTION CARE

- Comprehensive abortion care services were found to be lacking in several states. In Goa and Meghalaya, Comprehensive Abortion Care services were not provided at the AB-HWCs as MMA (combi pack, Mifepristone & misoprostol) was not available. Particularly in Goa, no beneficiary availed abortion services in the past one year at the visited facilities.
- In Uttar Pradesh, medical abortions are prevalent and abortion pills are readily available over the counter from pharmacies. The knowledge of Post Abortion Family Planning options was poor among ASHAs/ ANMs which reflected the need for strengthening Post-Abortion Family Planning services across all facilities.
- The primary healthcare teams at the AB-HWCs need to be trained on Comprehensive Abortion Care across all states.

RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK)

- The implementation of RBSK program at the primary level was satisfactory across the states. Their activities varied from state to state. For example, in Tamil Nadu, two RBSK teams were operational in a block, whereas in Nagaland, only one team functioned in a district.
- Development of micro-plan and screening were systematically done in Goa, Madhya Pradesh, Nagaland, Uttar Pradesh, and Tamil Nadu. The

Mobile Health Teams (MHT) were well trained. They conducted screening in Anganwadi Centres and schools in coordination with the AB-HWC teams. However, there is a need for periodic validation and maintenance of the equipment used for RBSK. RBSK nurses were doing School Children screening in Kerala

- Follow up of children referred to the higher facility was an area of concern. In Madhya Pradesh, it was reported that only 30% access a higher facility after a referral. In Uttar Pradesh, the referral documents were being handed over to the children while at the same time left undocumented by the team, thereby impairing future follow ups. In addition to this, weak linkages between the RBSK teams, AWCs and the healthcare providers affect the primary level activities.
- Regular outreach activities and integration of RBSK with RKSK are crucial to reach out to children and adolescents in school and community for addressing issues related to early marriage and high teenage pregnancies.

ADOLESCENT HEALTH

RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK)

Adolescent Friendly Health Clinics

- Adolescent Friendly Health Clinics in Andhra Pradesh and Maharashtra were providing

counselling and referral services to adolescents on Sexual Reproductive Health, Mental Health, Non-Communicable Disease as well as Dietary practices. However, in some centers in Maharashtra, only a male counsellor was present who provided counselling services to both male and female adolescents in a common room.

- In Telangana, these clinics were functional on Thursdays in both the districts as 'YUVA Clinics' in which counselling, ECPs distribution, etc., was done but no sanitary napkins were provided. In Meghalaya, these clinics were inconsistently present across the districts, and in Rajasthan, no counselling or promotional services were made available to adolescents.
- The Peer Education Programme was not implemented in majority of the states visited. In Punjab, Peer educators were not identified uniformly across both districts. In Andhra Pradesh, Peer Educators group has been formed in both the districts, but they did not have adequate knowledge and clarity about their roles. Peer educators placed under the RKSK in Meghalaya were playing an important role in preventing child marriages in some districts.

Menstrual Hygiene Scheme

- Limited data was collected on the Menstrual Hygiene Scheme in the visited states. Among them, good quality sanitary napkins were provided at school level to adolescent girls in both the districts in Andhra Pradesh by Department of Women and Child Development with the financial support from National Health Mission.
- In Meghalaya, Sanitary pads under the scheme were not available in any of the districts visited. However, awareness generation was undertaken in the schools and AWCs.

Weekly Iron and Folic Acid Supplementation (WIFS)

- WIFS tablets were available in schools in Bihar, Meghalaya, Nagaland, and Uttar Pradesh. In Bihar, sufficient stock of WIFS tablets was available and teachers were well-informed on the dosage and precautions of the tablets in a school in Aurangabad district. In Nagaland, WIFS tablets were being distributed in schools every Wednesday. The continuous supply of WIFS tablets was however hampered during vacations. Some resistance from parents in private schools towards use of WIFS was also observed. In addition to WIFS, deworming tablets were also distributed in the schools bi-annually. In Uttar Pradesh, RBSK team was visiting the schools. So, IFA tablets and Vitamin A & D were being distributed to the school-going children, however, non-school going children were left out.

School Health & Wellness Programme (under AB)

- The School Health & Wellness Programme was found to be under various stages of implementation in different states. In Bihar, the programme was being implemented across 14 districts covering 13,380 schools in the state whereas in Madhya Pradesh, the program was in an early phase of implementation and needed to ensure that the operational guidelines are adhered to in the visited districts.

- In Telangana, activities undertaken under the programme included taking physical measurements, providing first-aid, conducting medical camps for the purpose of regular routine check-up etc.
- In Meghalaya, School Health and Wellness Ambassadors were available in the schools visited in the Ri Bhoi district.

NATIONAL TUBERCULOSIS ELIMINATION PROGRAM (NTEP)

- The implementation of the National Tuberculosis Elimination Programme (NTEP) was satisfactory across the states. NTEP services at the primary healthcare facilities were robust in Delhi, Kerala, Jharkhand, Nagaland, Tamil Nadu, Telangana and Uttar Pradesh, whereas needs improvement in Sikkim, Madhya Pradesh and Punjab. NIKSHAY portal was used across the states, yet its implementation up to the SHC level has been variable. Nikshay Portal was not seen functional across all facilities in Sikkim.
- The primary healthcare team has been involved in varying degree. In Tamil Nadu, the MLHPs and Women Health Volunteers (WHVs) have been sensitized about screening and diagnosis of TB, however, other health staff have not been trained on recent updates. In Punjab, the TB suspected patients were being referred by CHOs for sputum examination to their respected DMCs. NIKSHAY Login IDs have been allocated to each HWC and medicine dispensation via CHO for TB patients is being done. In Telangana, the involvement and awareness of the primary healthcare team (ASHAs, CHOs, MO etc.) in sample collection and transportation, line listing and follow-up of TB patients, recording and reporting mechanisms were variable across the districts.
- Community level implementation varied from state to state. In Uttar Pradesh, community surveys and active case finding were being undertaken regularly for increasing the TB case notification. TB screening was also being conducted during Dastak and Non-Communicable Disease survey rounds. In Tamil Nadu, village-level TB forum has been created and the districts were actively involved in community sensitization and engagement activities through mike campaigns, IEC vans with distribution of fliers etc. Involvement of PRI members and their support for community mobilization for availing the NTEP services was observed.
- Screening and early monitoring of tuberculosis needed attention in the states of Rajasthan, Punjab and Meghalaya. Lack of bidirectional screening of the patients of TB for HIV and diabetes or vice versa was an area of concern in the visited states.
- None of the facilities visited in Bihar were identified as TB treatment centers and TB drugs were not available at the SHCs and APHCs. Patients were referred to TB Unit (TU) for medicines and follow up.
- Both CBNAAT and TruNAAT testing facilities were available in Nagaland. In Maharashtra, quality check mechanism for Tuberculosis diagnostics was also being done. Nikshay Poshan Yojana and Nikshay Mitra have been implemented well. Nikshay Mitra scheme is not implemented in Sikkim.

- Backlogs of DBT have not been reported in most states.

NATIONAL LEPROSY ERADICATION PROGRAM

- Nagaland and Kerala had no active leprosy cases. Particularly, Kerala had no reported cases in the past 7-9 years. However, in Madhya Pradesh, the presumptive rate of Leprosy was 0.009% and confirmation rate was 0.035%. Additionally, the programme was integrated with the state health system. In Uttar Pradesh, the prevalence rate of Leprosy is 0.39 per lakh population.

- In Delhi, the Leprosy Case Detection Campaign (LCDC) and Sparsh Leprosy Awareness Campaign (SLAC) are conducted every year at the district level. As a part of the LCDC, MOs, ANMs, ASHAs and male volunteers are being trained. The SLAC includes performing activities like Munadi, pamphlet distribution, banner display and health talks.

- In Rajasthan, active case detection campaign was about to begin as Type-II cases were continuing to be detected. Regardless, there was no dedicated Program Officer in position and ASHAs lacked knowledge on case detection as well as the programme.

- Active Case Detection and Regular Surveillance was also found to be a major challenge in Andhra Pradesh and Punjab. ASHAs involvement in these activities was also less due to incentive issues in Punjab.

- In Telangana, active cases were undergoing treatment. The ASHAs had adequate knowledge on the programme and ensured continuity of treatment. Referrals were made from the community to the facilities, but referral registers were not maintained properly.

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAM

- Services under the National Vector Borne Disease Control Program (NVBDCP) were being implemented differentially at the primary level across the states.

- In Maharashtra, lab technicians (LT) for conducting Malaria tests were deputed from nearby PHCs and tests were done on selective days of the week. Quality check mechanism for malarial diagnostics and Gambusia fish tanks were maintained in Maharashtra for the containment of larvae.

- In Uttar Pradesh, Rapid diagnostic tests (RDT) for malaria and dengue were available up to the SHC level and were utilized by the ANMs. Coordination committee meetings with other line departments were held in the visited districts. Surveillance activity has been conducted by the district health team; however, the primary health facilities (SHC/PHC) were unaware of the micro-plan and focused areas.

- Efforts for source reduction with the active involvement of community platforms was observed in Goa. Outbreaks of Dengue fever were reported in South Goa, Rajasthan, and Uttar Pradesh.

NATIONAL RABIES CONTROL PROGRAM

- In Goa, no Rabies cases were reported in past 3 years.

- In Rajasthan, Anti-Rabies Vaccine was available at the PHC level, however, some issues with the availability of Anti-Rabies Vaccine were observed in Nagaland.

- In Madhya Pradesh, the NRCP unit had adequate drugs and equipment and the staff had good knowledge regarding management protocol of Rabies. But there was a knowledge gap in health

providers regarding categorization, management, and reporting of animal bites in Rajasthan. Additionally, reporting and listing of these cases was also an issue in the state.

NATIONAL PROGRAM FOR CONTROL OF BLINDNESS AND VISUAL IMPAIRMENT

- In Maharashtra, regular cataract screening camps were arranged by all the health facilities. Diagnostic and correction of refractive error camp were also organized periodically. Glasses were provided to school children, 40+ year-old patients and post cataract patients.
- Although the screening programs were minimal in primary care, the activities conducted as part of the program included the distribution of plastic lens spectacles to students, cataract surgeries, distribution of free spectacles to old persons and Keratoplasty in Punjab.
- Screening activity was a challenge in Telangana, as no government/active involvement of NGOs for screening of cataract at the community or primary care facilities was observed in the state. CHOs/ANMs were not trained to screen cataract cases and the Snellen's chart was not available at the SCs, PHCs and UPHCs. Spectacles were also not being provided to the patients in either of the districts visited in Telangana and Kerala.

NATIONAL TOBACCO CONTROL PROGRAM

- In Punjab, eight villages in the Ferozepur district have been declared as tobacco-free villages.
- The consumption of smokeless tobacco was found to be very high in Nagaland. Active steps were taken by the state government for the prevention of sale of tobacco products in vicinity of schools. IEC material was adequately displayed at facilities and Nicotine de-addiction tablets were made available.
- In Maharashtra, Tobacco cessation center (TCC) was functional in all the visited facilities and No Smoking Policy was followed at the PHC. At primary care facilities, tobacco cessation awareness sessions were also conducted for OP and IP patients in Goa. However, in Telangana, no TCC were placed in either district. It was found that any plans to develop TCC were also not in the pipeline. Pharmacotherapy was also not witnessed in any of the visited facilities and counselling services to abate the use of tobacco were not available.
- In Andhra Pradesh, implementation of the program was not evidenced at the primary level as there was no screening records or records of any specialist visit to the areas visited.
- In Punjab and Madhya Pradesh, IEC pertaining to tobacco were suboptimal and not placed strategically.

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

- Under the NPCDCS, the implementation of the universal screening, prevention, and management of common NCDs were observed to be at different stages across the states.
- The states have initiated ASHA-led population based screening through the administration of the Community Based Assessment Checklist (CBAC) for the risk-assessment of all adults who are 30 years of age and above. The status of completion as well as periodical update were differential. The CBAC administration of the targeted population was reported to be still ongoing in Maharashtra and Uttar Pradesh.
- The pace of screening of individuals at the level of SHC was not commensurate with the CBAC

administration. Referral, follow up mechanisms and record-maintenance were not robust. NCD screening was generally limited to diabetes mellitus and hypertension. Screening for breast cancer and VIA for cervical cancer were limited across the states. Screening of common cancers at the facilities were not streamlined due to training gaps and lack of basic screening equipment.

- In Madhya Pradesh, e-Sanjeevani teleconsultation was also used for NPCDCS. Opportunistic screening conducted either at the facilities or in camp mode was variable. It was regular in few states (Chhattisgarh, Goa, Tamil Nadu, Telangana) and sporadic/limited in many others (Maharashtra, Meghalaya, Sikkim). It however, did not encompass common cancers across the states.
- Ayushman Bharat Health Account (ABHA) IDs of the individuals were created as a part of the NPCDCS program. However, needs more thrust to cover all its beneficiaries.
- Outreach NCD camps were being organized at facility level in Goa, Chhattisgarh, Kerala and Jharkhand. Diagnosed NCD patients were line listed and entered on NCD-CPHC portal. Though data was reflected in NCD portal, follow-up consultation from MO portal was found to be low in some states.
- The availability of NCD medicines and diagnostics at the SHC-HWC level are yet to be streamlined. In the absence of robust referral linkages between the SHC-HWCs with their linked PHCs coupled with the unavailability of medicines (especially for patients with co-morbidity), a large section of HTN and DM patients preferred going to private health facilities or higher level facilities for treatment and follow-up. As a result, beneficiaries reported incurring out-of-pocket expenditure on medicines. On the other hand, HWC-PHC and UPHC in Telangana had all medicines and even insulin for the treatment of diabetes under NPCDCS programme.
- Regular follow up of patients was being done by AB-HWC team members across the states, with a few exceptions. However, the use of CHPC-NCD application to monitor NCD care progress was limited. In Telangana, state specific forms were filled digitally for NCD screening, while ASHAs recorded the data in disease profile records and Village Health Records.
- Providers' awareness of the universal screening and NCD services reflected the community's awareness. There was a need for reorientation or refresher training, especially on the identification, management, and referral of three common cancers (e.g. Bihar, Maharashtra, Telangana). On the other hand, population based screening of diabetes and hypertension is being done extensively in Tamil Nadu under the MTM scheme. The scheme has enhanced the awareness of the community on common NCDs. The community recognises and demands these services from the Women Health Volunteers. Community's acceptance of the services was good.

NATIONAL PROGRAMME FOR HEALTHCARE OF ELDERLY (NPHCE)

- In Maharashtra, home based care was provided to elderly people at the primary level. There was availability of physiotherapist and related equipment in all visited facilities. As well, in Goa, elderly health-related classes are being conducted by the HWCs. Under Swayampurna Goa scheme,

various geriatric health camps, day-care centres, and counselling centres offer services to the geriatric population. Additionally, Andhra Pradesh and Kerala conduct health assessments based on clinical examination relating to vision, joints, hearing etc. for the elderly.

- The healthcare professionals in the CHC, PHC, and UPHC were not well familiarised with the program in Punjab and community awareness regarding services under NPHCE is also poor.
- Overall, the program has patchy implementation at the primary level.

NATIONAL PROGRAM FOR PALLIATIVE CARE (NPPC)

- The National Programme for Palliative Care (NPPC) was defunct at the primary level in most of the states.
- In Telangana, a dedicated mobile palliative care team consisting of Medical Officer, physiotherapist and staff nurse worked to provide home-based palliative care. Bed ridden, cancer patient, and the elderly were benefitted by these services. The team visited once in a two to three months' time. A separate palliative care register for such patients and regular follow up was maintained.
- Through Tamil Nadu's MTM scheme, a dedicated three-member team of Women Health Volunteer (WHV), Palliative Nurses and Physiotherapists worked in coordination with the MLHPs and VHNs.
- National Program for palliative care is part of Health & Wellness centers in Kerala.

NATIONAL MENTAL HEALTH PROGRAMME (NMHP)

- The implementation of the National Mental Health Programme at the primary level varied across the states. In Madhya Pradesh, the CHOs were yet to receive training in providing mental health services. In Punjab, mental health disorders were neither managed nor counselled at the level of PHCs and UPHCs.
- Recent initiative of Tele-MANAS has been established in a few states like Telangana. The toll-free number/landline were operational. Calls were managed by the counsellors and appropriately referred to higher level facilities. Yet, the community awareness on these numbers and services was rather low. Although, Tele MANAS still not rolled out in Sikkim, but as a first step T- MANAS cell was identified in the state, and order was issued for the same.
- Maharashtra has initiated the establishment of 'Man Shakti' Clinics for Mental health counselling

and screening at PHC-HWCs. The clinics were regularly visited by psychiatrist and team on a fixed day in a month. The state also organized stress management camps and psychiatric camps. ASHAs provided counselling to people with suicidal ideation or tendency under the 'Prerna Prakalp Program.' Community referral for mental illness cases were being done in Tamil Nadu. Psychiatrist were deputed on a weekly basis at UPHCs. Additionally, the state had launched "Mana Nala Vyazhan" (Mental Health Thursdays) at the Block PHC.

- Though the states have taken substantial efforts, the uptake of mental health services were poor due to the lack of public awareness, information and availability of medicines.

NATIONAL VIRAL HEPATITIS CONTROL PROGRAMME (NVHCP)

- The implementation of the Viral Hepatitis Control Programme has been differential. Routine HBsAg surveillance among all pregnant women during their ANC check-up were performed in most of the states.
- Delivery of Hepatitis C and Hepatitis B positive pregnant women were being ensured at Government institutions in Punjab. However, HBsAg kits and Anti HCV kits RDT kits were made available only at a few PHCs.
- Hepatitis B testing and IEC materials at the primary healthcare facilities were observed to be inadequate in Kota district of Rajasthan. Hepatitis B testing has not been included in the 15 tests performed at the PHC level by the State, and hence was unavailable. In Telangana, Hepatitis B immunoglobin was not available below the level of district hospital.
- In Goa, Hepatitis vaccination through the universal immunisation program was observed to be available on fixed days per week at the facilities. In Madhya Pradesh, viral load testing for Hepatitis B & C was found to be outsourced in the visited districts.
- Healthcare worker vaccination has been a major concern in Rupnagar district of Punjab. Hepatitis B vaccination details of healthcare workers were not maintained in Tamil Nadu.
- Punjab's state specific innovation (Mukh Mantri Punjab Hepatitis-C Relief Fund) promotes free drugs, base line tests and viral loads tests for all infected residents. Viral Hepatitis Portal has been implemented in government hospital, Suryapet district of Telangana.

NATIONAL ORAL HEALTH PROGRAM (NOHP)

- Implementation of the NOHP program at primary level has been limited or not initiated in several states such as Madhya Pradesh, Punjab, Rajasthan, Telangana, Tamil Nadu. It has been attributed to shortage of skilled providers, training and infrastructure. IEC materials for the programme were also inadequate. As a result, community awareness on oral hygiene practices and the services available under NOHP were poor.

NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF FLUOROSIS (NPPCF)

- The implementation of the prevention and control of fluorosis program has been found to be limited.
- In Maharashtra, Oral health screening camps for Fluorosis were organized. Water Samples were sent to Divisional Lab for the detection of Fluorides from all the visited facilities. The district has identified fluorosis effected areas and the water supplies have been demarcated. Whereas, in Punjab, the program is yet to be operationalized in the state. The community and healthcare workers were unaware of the program.

PROVISION OF EXPANDED RANGE OF SERVICES (COMMON OPHTHALMIC & ENT PROBLEMS, ORAL HEALTH, ELDERLY & PALLIATIVE CARE, EMERGENCY MEDICAL SERVICES & MENTAL HEALTH AILMENTS)

- The status of roll out of 12 expanded packages of services varied across states. Chhattisgarh and Sikkim were providing around 8 to 9 expanded range of services, while in Andhra Pradesh, Maharashtra, Punjab, and Rajasthan, 7/12 expanded range of services were provided.

- In some facilities of Bihar, Jharkhand, and Sikkim the services were still concentrated on RMNCHA^{+}.
- Kerala, Madhya Pradesh, and Meghalaya were unable to implement the expanded packages at AB-HWCs due to resource constraints.

AVAILABILITY OF DRUGS AND DIAGNOSTICS TESTS AS PER THE NORMS

- The mode of implementation of the Free Diagnostic Service Initiative varied across the states visited. It was observed that the scheme was implemented through an In-house mode in Nagaland, a Hybrid mode in Meghalaya and Punjab and PPP mode in Madhya Pradesh and Maharashtra.
- The number of drugs available at the AB-HWCs were according to the National EDL in Andhra Pradesh and Chhattisgarh. Cases of non-availability of drugs as per EDL were reported from Bihar, Goa, Maharashtra, Meghalaya, Nagaland, Punjab, Sikkim, Telangana, and Uttar Pradesh.

- Comprehensive diagnostics services were being provided with no user charges in Chhattisgarh and Telangana but lacking in Andhra Pradesh, Bihar, Maharashtra, Meghalaya, Nagaland, Tamil Nadu and Uttar Pradesh.
- Delhi had a free drug and diagnostic service scheme, being delivered through the Aam Aadmi Mohalla Clinics. Rajasthan, under the "Mukhyamantri Nishulka Dawa Yojana" provided majority of the drugs and diagnostics free of cost to the patients. Regardless, OPD/IPD patients paid nominal charges in Punjab to avail drugs and diagnostics and user charges for diagnostic services were applicable in the PHCs and UPHCs visited in Kerala.

- Patients in Bihar, Goa, Kerala, Maharashtra, Meghalaya, and Nagaland incurred high OOPE due to unavailability of essential medicines and diagnostic services at the AB-HWCs.
- In Bihar, Kerala, Nagaland and Sikkim, patients with Hypertension and Diabetes were provided medicines for 30 days duration, in Meghalaya for 15 days and Delhi for 5-7 days based on availability. Additionally, expired drugs were found in some facilities in Meghalaya.
- E-Aushadi was used in Andhra Pradesh, Bihar, Maharashtra, Punjab, Rajasthan and Telangana.

BIO-MEDICAL WASTE MANAGEMENT

- Bio-medical Waste Management was appropriately conducted in Andhra Pradesh and Delhi. In Andhra Pradesh, BMW was transported to the nearest PHCs from the SHCs and BMW from the UPHCs was finally disposed at the central biomedical waste treatment plant. In Delhi, the health facilities practiced biomedical waste onsite segregation. BMW hand over was done to a common biomedical waste facility run by a private agency.
- Adherence to biomedical waste management guidelines was present but limited in Jharkhand, Nagaland, Telangana, and Uttar Pradesh. Particularly, in Jharkhand, poor BMW Management and Infection Prevention Practices were observed, in Nagaland, there was no provision of Common Bio-Medical Waste Treatment Facility. In Telangana, biomedical waste was not collected frequently, in Uttar Pradesh, effluent treatment plants were not in place.
- In Rajasthan, bio medical waste management was not followed, and no temporary storage was available at the facilities. Liquid waste management was not done in either labour room or laboratory in the visited PHCs and HCs.

BIOMEDICAL EQUIPMENT MAINTENANCE AND MANAGEMENT PROGRAM (BMMP)

- Almost all the visited states have implemented the BMMP through the PPP mode. Tamil Nadu alone has implemented through in-house mode among the visited states.
- The programme implemented across the states has been robust. Challenges such as prolonged downtime of equipment at the primary level were observed in Nagaland, Uttar Pradesh and Punjab. This was attributed to poor coverage of the program till the primary level, improper calibration and maintenance, incomplete mapping of biomedical equipment and lack of services.
- Providers' awareness of the tollfree helpline and complaint registration process was satisfactory

BEST PRACTICES -CPHC

Andhra Pradesh

- **Friday - Dry day Concept:** This application is used to monitor and implement activities for prevention and control of Dengue and Chikungunya in coordination with the PR&RD and MA&UD Departments.
- **Vector Control and Hygiene APP:** is being used to monitor and capture low lying areas, garbage heaps, indoor and outdoor mosquito breeding places for effective management and control of growth of mosquitoes.
- Both the applications have been integrated with the ANM app.

Chhattisgarh

- **CM Haat Bazaar Yojana:** provides comprehensive health care services in the underserved areas, especially in tribal areas.

- **Mukhyamantri Bal Hridaya Suraksha Yojana or Chief Minister Child Heart Scheme for Children:** The state government is providing free treatment under Mukhyamantri Bal Hridaya Suraksha Yojana or Chief Minister Child Heart Scheme for Children who have heart ailments since 2008. This scheme covers children between the age 0-15 years. Under this scheme, the children from BPL and APL category gets free treatment in nearby hospitals whether the hospital is government aided or private. Till date, over 6,100 children in the state have taken leverage of scheme. The benefits under this scheme include the provision of up to Rs.1,30,000/- for routine heart procedures, up to Rs.1,50,000/- for complicated heart surgeries, and Rs.1,80,000 for valve replacement surgeries. The scheme also provides up to Rs.50,000/- for replacement of a heart stent. Extra financial assistance for complicated treatments including pacemaker, replacement of two heart stents will be provided, in addition to free follow-up services by hospital after treatment.

Madhya Pradesh

- **DASTAK Abhiyaan:** The program is an expansion of Intensified Diarrhea Control Fortnight to encompass overall child health through biannual community-based surveys in Madhya Pradesh.

- **DASTAK portal:** A data management portal to track child health and identify help management of malnourished and anemic children in the state.

Meghalaya

- **Chief Minister's Safe Motherhood Scheme:** The state launched this scheme to reduce maternal and infant mortality. Under the scheme dedicated transport vehicles are made available at PHCs & CHCs for transportation of pregnant women, with a greater focus on high-risk pregnancies, to the health facilities and drop back to home. Transit homes have been established under the scheme at PHCs, CHCs and other places nearby to PCHs & CHCs through NGOs for the stay of pregnant women and those accompanying them for institutional deliveries. Attendants were also being paid Rs 1000 as compensation for wage loss for accompanying the pregnant women. An award scheme has been implemented for the Village Councils/VHCs on accompanying pregnant women to promote the institutional delivery. In the state, 924 pregnant women availed services of Transit homes.

- **Rescue Mission:** The objective of the Mission is to rescue pregnant women from any complications during childbirth and even from probable death through following interventions:

  i. **Tracking pregnancies:** Early ANC registration, track every pregnant woman whose due date is within next 9 months and identify high-risk pregnancies.

  ii. **Anaemia & ANC:** Identify aneamic women in the 1st trimester and correct anemia by the 2nd trimester, ensure Td injection and counselling on nutrition.

  iii. **Safe Delivery:** Ensure that all high-risk pregnant women delivery at a health facility, facilitate transport and if households insist on home delivery, ensure presence of a SBA-trained ANM.

  iv. **Right to Birth Spacing:** Counsel all eligible couples on birth spacing and family planning method.

  v. **Reducing Teenage Pregnancies:** Counsel teenagers on safe sex and the risks of teenage pregnancy and work with schools.

  vi. **Activating DCL Model:** Activate VHCs in every village and SHGs to discuss maternal health issues.

Rajasthan

- **Mukhyamantri Nishulka Dawa Yojana:** The main aim of the initiative is to reduce OOPE of patients suffering from cancer, heart and kidney-related diseases, and other severe ailments. The scheme has two components - Free Medicines and Free diagnostic Tests.

Sikkim

- Sikkim is the only state to include **HPV vaccination for eligible girls (9- 14 years)** in the immunization schedule. HPV DNA testing lab has been established at UPHC Gangtok. Also, for HPV testing / VIA screening - positive cases are referred to DH Singtam for further diagnosis and treatment.

- Sikkim has established a **help-line for mental health services** with both toll free and landline functional number, which is widely displayed across health care facilities. State has also outsourced these services to NGOs for hiring "lay counsellors" with sociology background, who are trained by state on mental health. State has a supervisory role for this activity. Under the initiative, an assessment is done for beneficiaries followed by linking them to the DH for further interventions. Also, counselling is done for family members and caregivers for identified cases.

Tamil Nadu

Makkalai Thedi Maruthuvam (MTM) scheme: Launched in August 2021 to address the increasing burden due to non-communicable diseases in the state, the scheme is operationalized by a dedicated three-member team of Women Health Volunteers (WHV), Palliative Nurses and Physiotherapists, who work in coordination with the MLHPs and VHNs. The scheme envisages delivery of home-based NCD screening, palliative care and physiotherapy services. Drugs for Hypertension and Diabetes are provided as a measure to reduce the number of visits to a health facility and enhance adherence to the treatment regimen. Patients who are on Continuous Ambulatory Peritoneal Dialysis (CAPD) are also given PD bags at their homes.

Telangana

- **KCR Kit** was introduced in Telangana to promote institutional deliveries in the public health facilities in the state. The scheme includes financial assistance of Rs 12,000 for male-birth and Rs 13,000 for female-birth which is provided in three installments. The kit contains 16 essential newborn care items.

- **T-diagnostics** initiative in Asifabad, Telangana is a first of its kind in-house initiative where quality diagnostic services are provided free of cost to the public through Hub & Spoke model. It currently provides testing of 57 types of blood and urine samples for various health issues.

Kerala

- NCD Clinics in HWCs- Patients referred from community are being treated at PHCs.

- Growth monitoring of the children and early identification and referral of SAM children by the ASHAs with proper recording and reporting in portal.

RECOMMENDATIONS

- States are recommended to expedite the operationalization of the AB-HWCs as per commitments. States that have operationalized AB-HWCs need to ensure the AB-HWCs are as per the CPHC guidelines and meet all the functionality criteria of HWCs. Tribal and aspirational districts should be prioritised for operationalization.
- Most of the visited AB-HWCs had satisfactory infrastructure concerning demarcated spaces for OPD, drug storage, laboratory services, IEC corner and wellness areas. As per the CPHC principles, it is recommended that concerted efforts are made to ensure patient privacy as well as facility functionality with amenities such as power supply with power back-up, running and potable drinking water, gender specific toilets and disabled friendly structures.
- All states need to sanction HR as per IPHS norms. NHM recruitment cycle needs to be expedited in states where it is lagging and a dedicated CHO's recruitment needs to be completed in all HWC-SHCs. The recruitment and posting of all sanctioned HR in HWCs- SHCs and PHCs also needs to be facilitated in a timely manner.
- Under the CPHC guidelines, it is mandated that the primary healthcare teams at the HWC-PHC/UPHCs are led by an MBBS Medical Officer. Hence, facilities with vacant MO posts need to be prioritized for recruitments and positioning of a full time dedicated MBBS MO I/C.
- Training on the expanded range of services including refresher trainings were provided to the AB-HWC staff. States need to ensure that there are mechanisms in place to monitor the quality of training.
- Early registration of pregnant cases should be ensured and MCP cards provided to the beneficiaries and providers. These cards should be adequately maintained in terms of accuracy and completeness by the frontline health workers for identification and line-listing of pregnant women. Additionally, ANC should be strengthened in states where coverage is low.
- With respect to labour room protocols, respectful maternity care should be provided across all facilities. All labour and delivery points should be well-equipped with the required amenities. Institutional deliveries in the existing delivery points at HWC-PHC/UPHCs should be conducted as necessary to reduce OOPE on deliveries incurred from private institutions.
- Services related to HBNC and HBYC needs to be strengthened for timely identification and treatment of sick new-borns and children.
- The primary healthcare team at the AB-HWCs need to be trained on Comprehensive Abortion Care across all facilities.
- Coordination between RBSK and RKSK activities is recommended to ensure services to children in schools and communities.
- Community level implementation of NTEP needs to be strengthened to ensure community sensitization and active case findings. Capacity building of primary healthcare team in NTEP and NVBDCP is recommended.
- Active Case Detection and Regular Surveillance activities under the NLEP should be strengthened across all states.
- Outreach and screening activities done at the primary level to identify conditions related blindness and visual impairment needs strengthening. Distribution of free spectacles should be ensured among eligible beneficiaries.
- Implementation of the tobacco control programme at the primary level must be strengthened across all states with designated tobacco cessation counselling centres.

- Under the NPCDCS, the implementation of universal screening, prevention and management of common NCDs needs to be streamlined with a particular focus on the three common cancers.
- Screening for cancer needs strengthening across all states.
- Availability of medicines and diagnostics for common NCDs should be ensured to facilitate continuum of care. Drugs for Hypertension and Diabetes should be provided for a 30-day duration to maintain treatment adherence, reduce repeat/ multiple facility visits and thus reduce OOPE.
- Referral mechanisms and follow-up activities need to be strengthened.
- Tele MANAS activities needs to be expedited within defined timelines, to achieve expected outcomes. The programme was launched a month prior to CRM visits (October 2022), thus the implementation across states was in initial stage.
- Mental health services should be made available at the primary level across all states. Provider training and community awareness to improve the uptake of mental health services should be ensured.
- Implementation of FDDSI should be strengthened to assure free provisioning of drugs and diagnostics to all users accessing the AB-HWCs.
- High-volume low-cost diagnostic services should be provided in-house, while high-cost, low-volume services may be delivered through PPP mode. However, the focus should be on strengthening in-house capacities in both the cases.

STATE SPECIFIC FINDINGS ON CPHC

Andhra Pradesh

- HWC operationalization status in the state is 85% (as of the RHS 2021). It has 1,142 PHCs, 542 UPHCs and 10,032 SHCs out of which all PHCs and UPHCs and 8,351 SHCs have been converted to HWCs. Operationalization was under process in the remaining 1,681 SHCs.
- The operationalized HWCs had limited or no space for registration, waiting or wellness areas. Some SHCs also had issues with basic amenities such as water and electricity supply which made carrying out day-to-day activities a difficult task. All visited facilities needed to complete AB-HWC branding as per CPHC guidelines.
- PHCs and SHCs that were providing maternal health services, needed to properly list high-risk pregnant women, provide counselling, birth preparedness and follow-up services for the achievement of improved health outcomes.
- Vaccines are distributed from PHCs to SHCs based on due list submitted by ANM. However, supportive supervision plan for routine immunization needed to implemented.
- Family Planning orientation of staff nurses was very poor in both the districts and uptake of Family Planning methods is overall low. IEC related to Family Planning program needs to be strengthened.
- Adolescent Friendly Health Clinics (AFHCs) for counselling of adolescents on Sexual Reproductive Health, Mental Health, Non-Communicable Disease, Dietary practices etc was available.
- Peer Educators group has been formed in both the districts; however, they do not have adequate knowledge and clarity about their roles.
- Good quality Sanitary Napkins are provided at school level to adolescent girls in both the districts by Department of Women and Child Development with the fund support from National Health Mission.
- School Health and Wellness Ambassador Program needs a more focused approach.

- Distribution of 25.94 Lakhs of Long-Lasting Insecticide Treated Nets (LLINs) have been completed for Malaria control. IEC posters regarding vector borne disease control was found well-posted across the health facilities.
- All pregnant women were being tested for Hepatitis B. IEC material for Hepatitis B testing was found in some facilities but was mostly inadequate. Regardless, IEC for all healthcare services provided at the facilities need to be strengthened.
- Population-based screening has been initiated in district, and was found to be universal across facilities. ABHA IDs of the individuals was created as a part of the NPCDCS program, but needs thrust to cover all beneficiaries.
- Community members were happy with the services being provided to them. No OOPE was observed as members of the community visited were getting drugs and diagnostics free of cost.
- The distribution of spectacles through the Kanti Velugu and Avva Tatha program has been successful in the identification of individuals who need correction of vision.
- Dentists from the DH was visiting PHCs periodically for providing dental treatment. Documentation for the same needs to be improved as the facilities visited could not show any past dental treatment records.
- Implementation of the Tobacco Control program was not evidenced at the primary care level as there was no screening records or records of any specialist visit to the areas visited.
- Health assessment of the elderly was being conducted at primary level facilities based on complaints with which they present to ASHAs and ANMs, the first point of referral is thus the PHC.
- PHCs and UPHCs provided specialist services for Gynecology, Dental Surgery and Ophthalmology on specialized days. Expanded CPHC services at the SHCs were yet to be rolled out for Ophthalmology, Oral, ENT & Mental Health.
- The list of drugs & diagnostics available under Free Drugs Initiative and Free Diagnostics Services Initiative were well displayed. The SHCs were providing 67 drugs and 14 diagnostics, PHCs were providing 172 drugs and 19 diagnostics and UPHCs were providing 172 drugs 50 diagnostics.
- E-Aushadhi was used at all health facilities but real-time monitoring was lacking. Modern techniques like ABC analysis, VED analysis & FSN analysis was not being used for inventory control of drugs and diagnostics.
- At the SHCs, BMW was transported to the nearest PHCs. BMW from the UPHCs was finally disposed at the central biomedical waste treatment plant.
- "Friday - Dry day" concept: Application was being used to monitor and implement activities for prevention and control of Dengue and Chikungunya in coordination with the PR&RD and MA&UD Departments.
- No active surveillance activity in the community was noticed for Tuberculosis, Leprosy, Filariasis etc. Follow-up of patients with Leprosy, Hepatitis, Cancer, Filariasis etc. at the SHCs and PHCs was not being done.
- Cancer screening requires additional push at the HWC level and is recommended for prioritization.
- Continuity of care and identification of appropriate treatment options for geriatric patients is also needed.
- Flow of patient related data in case of upwards/ downwards referrals i.e., from secondary care to primary care and vice versa needs strengthening.

Bihar

- The state had not achieved their FY 2021-22 target for conversion of AB-HWCs.
- Majority of the health facilities had infrastructural inadequacies ranging from no waiting area, wellness space, boundary walls, regular water, and electricity supply. Branding as per the guidelines was not observed in most of the visited health facilities except the UPHCs.
- To facilitate the CHO recruitment process, Bihar had implemented a parallel integrated CHO course that directly positioned the CHOs in the SHCs.
- The visited APHCs were providing 24X7 delivery facilities managed by the staff nurses in both the district. The labour room was well-equipped and adequately maintained in both the districts. Roughly 15-20 deliveries per month were conducted in the APHCs.
- Majority of population availed RMCHA^{+} services at the health facilities that were recorded on the RCH portal. However, some patients availing these services were incurring OOPE on drugs, diagnostics, and referral transport due to unavailability.
- Family Planning commodities were provided at the HWCs, though, majority of drugs as well as pregnancy kits were not available with the ASHAs.
- In a school of Aurangabad district, sufficient stock of WIFS tablets was available. Teachers were well aware about the dosage and precautions of the tablets.
- School Health Program (SHP) under Ayushman Bharat was being implemented across 14 districts covering 13,380 schools in the state.
- Unfortunately, none of the visited facilities were identified as TB treatment centers.
- RDK was available for Dengue & Malaria across the visited facilities.
- Diagnostic facilities for Hep-B and Hep-C were observed at all facilities. Though, programmatic activity has not been observed. Hepatitis B vaccination has been completed for the facility staff across all Health care facilities and all pregnant mothers were being screened for Hepatitis B.
- NCD screening and medicines were available at HWCs. But no mechanism of follow-up or continuum of care was observed in both districts. The NPCDCS program needs to be successfully implemented.
- Population enumeration and Community Based Assessment Checklist (CBAC) forms were filled by the ASHAs, although, it was observed that the CBAC forms were incompletely filled and submitted. The entries of these forms in the portal were comparatively low. Therefore, CBAC forms should be checked by ANMs/CHOs and MOs.
- NCD kits were available with ASHAs in all the facilities visited. Screening of NCDs along with teleconsultations were done by the CHOs at SC-HWCs. At the APHC, there was no dedicated day for NCD screening, but opportunistic screening was being conducted. NCD drugs were provided to the patients for one month and sufficient drugs were available across the facilities.
- Screening for cervical cancer is not yet initiated as the training of the staff was pending.
- In most of the places, "no smoking" signboards were 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 leading to implementation gaps.
- Dedicated Elderly care OPDs and fixed day services were not available. Palliative care team for elderly care was also not initiated in both the districts.

- The maintenance of equipment was under PPP mode and dedicated tollfree number was available for registering complaint.
- There was lack of awareness on the expanded range of services among the CHOs and MOs.
- Patchy implementation of free drugs and diagnostics initiative was observed. According to the EDL, roughly 20 drugs were available at the SHC and 30 at the APHCs. Around 4 tests were conducted in SHCs, 10 in APHCs and 30 in UPHCs which is inadequate as per the norms.
- Most of the CHOs indented drugs through the e-Aushadhi portal. DVDMS is also implemented in both the districts.
- IEC material needs to be well displayed in all the facilities.

Chhattisgarh

- The State has operationalized 4814 (94%) AB-HWCs against the approval of 5115. Most of the visited HWCs had adequate infrastructure with water and electricity supply.
- CHOs, ANM and Mitanins (ASHAs) were well-versed in their role and responsibilities and the state was in the process of operationalization of 12 services in all HWCs. Currently, only 8 to 9 types of services were being provided by the facilities.
- Outreach activities were performed regularly through VHND and Health Melas.
- NCD screening was regularly conducted through peripheral health providers and in the health facilities which were visited. However, it is done in the camp mode and screening diseases like Oral Cancer and Breast Cancer is difficult in a camp setting.
- The line-listing of diagnosed cases of DM & HTN were maintained in a register. They were also entered in the NCD portal.
- Medicines are prescribed for a minimum of one month for common NCDs. Opportunistic screening for NCDs was being conducted by trained health staff in the NCD Clinics.
- Most of the SHC-HWCs were carrying out roughly 12 diagnostic tests. The diagnostic tests carried out in the PHC-HWC facilities varies from 14 to 18.
- Yoga and celebration of health days were regularly carried out in the visited facilities and records were maintained. However, attendance of the participants needs to be maintained.
- NLEP services were NM/NMS dependent.
- Though microscopes were available in health facilities, Malaria diagnosis was most commonly done by RDK.
- Software platforms like AB-HWC app, NCD portal, E-Sanjeevani, ANMOL were being used in the visited HWCs. The CHOs were being provided with tablets.
- IEC material was not well-displayed in the visited facilities and needs strengthening.

Delhi

- Delhi has a completely different set of nomenclature for its primary and secondary facilities funded by different sources. Primary healthcare in Delhi is being delivered through designated institutes namely: Aam Aadmi Mohalla Clinics (AAMC), Aam Aadmi Polyclinic (AAPC), Delhi Government Dispensary (DGD) and Seed Primary Health Centre (SPHC), Maternity and Child Wing (MCW) and Maternity Home (MH).
- AAMC, AAPC, DGD, SPHC were under the administration of state and MCW and MH fall under the administration of Municipal Corporation of Delhi (MCD). Delhi provides CPHC through Common Minimum Services Package being delivered through the above-mentioned institutes.
- The AAMCs provides Common Minimum Service Packages to an average population of 10,000. Geographic mapping of health facilities has been

done on a web-based portal and unserved/under-served populations identified. Delhi has 521 Mohalla Clinics as of November 2022. Delhi aspires to have 1000 Mohalla clinics, however, space was a constraint.

- Community members in the surrounding areas of the AAMC appreciated the services being provided by the clinic. The patients interviewed were largely satisfied with the curative services being given, especially the laboratory tests, for which they had to incur out of pocket expenses (OOPE) earlier. However, they informed that medicines for chronic conditions such as Diabetes and Hypertension were prescribed for just 5-7 days.
- There were no quality parameters developed for the AAMC. Therefore, accepted quality parameters may be developed for the AAMCs.
- National Health Programmes implementation is limited to NCD services under the NPCDCS program. Patients were being referred to other health system for linked services.
- Anti-TB and leprosy medicines were not provided from AAMCs.
- Any preventive, promotive and wellness and rehabilitative activities are also not being undertaken and only curative services were being offered.
- A total of 144 Essential drugs and all-important categories of drugs were available. Medicines were supplied monthly from the Delhi Govt dispensary/ Polyclinic to which the AAMC was attached.
- BMW guidelines in the AAMC were being followed. Outsourced to Biotech Solution, Waste from all the dispensary / Mohalla clinics are being collected and disposed.
- The Maternity Home (MH), Shakurpur was providing ANC, PNC, immunization services at the facility and also the HBNC services through ASHA workers. Delivery and immediate neonate care and PNC are provided to low-risk mothers. The intra-natal facility is open 24 hours. An adolescent clinic had also been demarcated but no services were being provided.
- Maternity and Child Welfare Centre, Mongolpuri was providing ANC, PNC, immunization services at the facility and also the HBNC services through ASHA workers. The facility has adopted 13 primary level schools under the school health programme, through which general health check-up is done at the schools. At least one school visit was undertaken once a week, where health screening was done, and Iron tablets were provided.
- Maternal and Child Wing (MCW), Mehrauli provides OPD services for common occurring illness, treatment of minor injuries, essential medicines, laboratory services, immunization services, family welfare activities, health education, family planning services, referral to higher centres and services under various national programme.
- Laboratory service at the MCW, Mehrauli provides around 23 laboratory tests in hybrid mode. Thyroid and HbA1C tests were being done through the private empanelled lab service provider (PPP mode) on chargeable basis. This was reimbursable to only Municipal corporation employees and other beneficiaries have to pay and avail the services leading OOPE.
- Vaccines are received from South district DVS monthly. Open vial policy was being practiced and entries made on e-VIN. It was updated by the CCH and Alternate CCH were trained in e-VIN. Stock was matching physically, in the registers and on e-VIN. Distribution register and stock register was updated till date.
- Contingency plan was available but there was shortage of contingency funds and extreme delay

in the transfer of funds to MCW since the last few months acting as a bottleneck for several activities.

- CUPHC, Mehrauli was providing OPD services for medical and dental curative care services. Lab services used were from the same lab of MCW, but Pharmacy was separate for these units.
- Seed Primary Urban Health Centre (SPUHC), Aya Nagar provides primary care to the underserved community nearby. Biomedical waste onsite segregation practice was followed in the facility and BMW was handed over to common biomedical waste facility for disposal.
- Delhi Government Dispensary, Rohini caters to an average of 350-400 patients per day. The centre provided ANC services, routine immunization services for children and pregnant women and TT for the general public, adolescent health services and outreach services. There was no separate OPD for NCDs, however, the centre provided opportunistic screening and curative treatment to the patients with Diabetes and Hypertension.
- Delhi Government Dispensary: Diagnostic tests currently performed at DGD Jonapur were Haemoglobin test; Urine R/M; Platelet count; Random blood sugar; COVID 19 Rapid antigen test.
- DGD, Chirag Dilli was providing clinical services which primarily focused more on ANC, immunization, basic services for common ailments and limited services related to disease control programs like NVBDCP, NTEP (DOTS centre), NLEP along with activities related to community awareness. The dispensary also has a provision of a specialized geriatric clinic every Thursday. Immunization services were available and ANMs maintain necessary registers including AEFI registers. ANCs check-ups were being undertaken in the dispensary and HRP registers were maintained. PMSMA was done on the 9th of every month. As per Free Diagnostic Initiatives (FDI), the PHC level facilities should provide 63 laboratory tests either through in house or PPP mode, but the visited facility was providing only COVID-19 testing. No other tests being provided, and all the patients were being referred to AAMC or District Hospital.
- Polyclinic, Sector 4 Rohini provides Ayurveda and Homeopathy OPD daily, and specialized OPDs for eye, ENT, orthopaedics, skin, and surgery are provided on designated days.
- At the primary level, in the Northwest district, the Mohalla clinic does not provide any services under national programmes. All spacing methods on Family planning services were provided in the MCW centre. Interval IUCD services were also provided in the centre. In DGD of Northwest district, Family planning commodities (Condoms) were provided in a box installed at the facility.
- Immunization services were being provided in the MCW DGD clinic, Northwest under UIP. Vaccines were kept in ILR, and deep freezer and the temperature was maintained. e-VIN was being used for vaccine supply chain management. The children under the age of one were not receiving the Pentavalent vaccine.
- e-VIN was operational in the facilities visited. The physical stock, recorded in the eVIN and the registers were matching. The cold chain handlers are trained on eVIN and they are well versed with vaccine handling and management principles and transactions to eVIN.
- There were no child deaths in the catchment area of the MCW and DGD, Northwest district in the last 6 months.
- The school health program was being implemented in the government and government aided schools in the state since 1979. WIFS tablets were being distributed in schools on every Wednesday. However, the continuous supply of WIFS tablets was hampered during vacations. There was

resistance from parents in private schools towards use of WIFS. Deworming tablets were being distributed in the schools bi-annually.

- Delhi has initiated to convert mobile Teams to fixed Teams, located in a Porta Cabin in a particular school premise. The apprehension, as it is expressed by one of the teachers that it may reduce the coverage of school children of other schools under the jurisdiction of the said team, until and unless, there was a robust schedule for the purpose with strong monitoring.
- National Tuberculosis Elimination Programme (NTEP): In Northwest and in South district, at the primary level, the Delhi Government Dispensary was a designated DOTS centre with a treatment provider who provides TB and drug-resistant TB treatment. The presumptive TB cases were referred to the Chest Clinic at the Baba Saheb Ambedkar (BSA) hospital by the treating physician where the diagnosis is done, and further management was done at primary level. The TB diagnostic centres were not present at the primary level in Delhi i.e. diagnosis is centralized, and presumptive cases have to travel to higher centres for diagnosis.
- Every year two campaigns were being conducted at the district level, Leprosy Case Detection Campaign (LCDC) and Sparsh Leprosy Awareness Campaign. Sparsh Leprosy Awareness Campaign (SLAC) was conducted during 30th January to 13th February every year. During this campaign, IEC/BCC activities like Munadi, pamphlet distribution, banner display and health talks were done. The 26 MO in charge, 183 ANMs and 758 ASHAs and male volunteers have been trained as a part of the Leprosy Case Detection Campaign 2022 conducted from 22nd August to 4th September 2022.
- At primary level, active case detection and regular surveillance was not present at the primary level. But awareness campaigns are conducted in the Northwest district conducting health promotion activities regarding the prevention of the Dengue, Chikungunya and Malaria through ASHAs during the pre-monsoon months.
- At DGD, no HIV testing was being done but MCW centre and MH, Shakarpur the HIV testing for pregnant women was being done but there was no provision of pre-test, post-test counselling, which was beyond protocol.
- At primary level, the DGD only conducts the opportunistic screening of patients for DM, HTN and common cancers like Breast and Oral cancers screening by the MO.

Goa

- There are 190 operationalized AB-HWCs in the state of Goa.
- The operationalized HWCs had limited or no space for registration, waiting or wellness areas. Some had issues with basic amenities such as water and electricity supply which made service provision and carrying out day-to-day activities a difficult task.
- ANC registration was made through ANM at the PHC, and SHC levels. Registration was done through the ANMOL app. All the ANM are trained for using the app and physical registers were also maintained.
- Labour room for normal deliveries was fully equipped at PHC, South Goa. However, no delivery was conducted in the last 3 months. PHC labour room has received State QAS certification.
- 32 tests were available in the PHC visited in South Goa, though, lack of robust supply chain mechanism of reagents led to underutilization of diagnostic equipment.
- High OOPE for beneficiaries due to unavailability of essential medicines and diagnostic services was observed in some facilities.

- Comprehensive Abortion Care services were not provided at HWCs as MMA (combi pack, Mifepristone & misoprostol) were not available. No ANM or staff nurses were trained for CAC.
- eVIN was found functional with good ease and acceptance among the users. Entries were found to be up to date.
- Child health services at the primary level- SHC, HWCs, PHC, HWCs, UPHC and UHWC were not available. Mothers were not counselled in the facilities visited in North Goa. Regardless, no child death was reported in the last 1 year.
- No Rabies case was reported in the state in last 3 years.
- Hepatitis vaccination through UIP on all fixed days per week was conducted at the facilities.
- Routine HBsAg surveillance was conducted among all pregnant women during their ANC check-up. No cases were reported in the last one year.
- Under National Vector-borne disease control Program, active and passive surveillance strategies were made to be carried out by MPWs at the field level. Treatment was available free of cost at all peripheral centres. Integrated vector control measures are being taken to prevent and control the cases. Strategies are based on pre-monsoon, monsoon, and post-monsoon decisions made during meetings with the DH collector. Source reduction by cleanliness drives in the community with the help of VHSNC, PRI, etc. is also being done.
- Opportunistic screening at all levels was conducted through weekly Lifestyle clinics.
- Outreach NCD Camps were conducted monthly under each health facility. Free drugs and diagnostics are provided in NCD Camps that focus on health promotion, early diagnosis, prompt initiation of treatment as well as screening for complications, and referrals to higher centres.
- Risk assessment by house-to-house activities to identify high risk suspects of DM, hypertension, anaemia etc. are also being done by community health workers.
- Free eye check-up camps and provision of free spectacles delivery followed by referral at SDH or DH for further management is done at the primary health facilities.
- Under the school health program, refractory error detection was carried out by the PHCs. At few PHCs, there were retina clinics to detect diabetic retinopathy and other injuries or infections monthly.
- Tobacco cessation awareness counselling sessions were conducted for OP and IP patients. COTPA act was implemented in the state.
- IEC and BCC activities were prominent at PHCs. IEC activities were also promoted through School Health Programs, PRI etc.
- Elderly health-related classes were being conducted by the PHCs and SHCs. Under Swayampurna Goa scheme, various geriatric health camps, day-care centres, and counselling centres offer services to the geriatric population. Geriatric queue and geriatric-friendly infrastructure (ramp) at the primary health facilities was observed.
- Essential pathology initiatives were made available at the HWCs and tests that are unavailable are supported by the 'Hub and Spoke' model with SDH and DH labs.
- Rural Medical Dispensary was a primary healthcare OPD facility in Goa. It is headed by MO who are deputed from the Primary health centres on rotation basis.
- The RMDs are now converted into HWCs. These centres act as a connecting link between community and the higher facilities. Their conversion into HWCs will help in further strengthening of the wellness component in the state.

Jharkhand

- Against the target of 3549 (3237 SHC-HWC, 998 PHC-HWC, 59 UPHC-HWC) of December 2022, the State of Jharkhand operationalized 1793 (49%) AB-HWCs inclusive of 1544 (47%) SHC-HWC, 192(54%) PHC-HWC and 57 (96%) UPHC.
- Branding was as per the CPHC guidelines in all the facilities visited. However, in some facilities there was no regular supply of electricity and water. Portable water was also an issue in some facilities. Separate toilets for male and females were however available.
- The delay in operationalization of AB-HWCs was associated with low pace of recruitment of CHOs and MOs which has also affected the rollout of expanded package of services in the primary healthcare facilities. Additionally, the CHOs recruited to AB-HWCs were given other duties such as teaching in nursing colleges which adversely affected the service provision in AB-HWC. Moreover, in Deoghar, although the CHOs were in position for two years, no induction training was provided to them.
- Service provision was focused on RMNCHA^{+}, and expanded range of services were not provided at the facilities.
- CHOs in Garhwa were provided tablets. However, CHOs in Deoghar were not. This impacted uniform reporting in the relevant applications. Although CHOs in Garhwa used e-Sanjeevani for service provision, specialists/ MOs at the Hub were not available on time which increased the waiting time during teleconsultations and led to loss of patients at the facility.
- Reporting in all the facilities was mostly paper-based. Lack of access to internet also prevented regular and real-time reporting on the e-Aushadhi portal. Additionally, the ANMs were not comfortable using digital platforms.
- Implementation of BMWM guidelines not seen uniformly at all HWCs. Poor Biomedical Waste Management and Infection Prevention Practices was observed.
- Regular wellness services such as Yoga were only observed in SHC, Deogarh where records were also duly maintained. In other facilities, wellness sessions were not conducted due to unavailability of yoga instructors.
- All 11 thematic areas of Ayushman Bharat School Health and Wellness programme (AB-SHWP) have been added to the school curriculum by Education department to promote health and wellness among school children.
- There were Health & Wellness Ambassadors in schools who provide age-appropriate learning for promotion of healthy behaviour after receiving training from the doctors. Interactive sessions with the students revealed they were well-informed on the concerned topics.
- IEC materials were displayed at all visited facilities.

Kerala

- Operationalisation of HWCs (Family Health Centres/ FHC) was in progress, however the expanded range of services needs to be strengthened. Branding of HWC PHCs was not done as per CPHC guidelines.
- Pregnant women prefer to go to private facilities/ tertiary care centers/Taluka/DH for even basic services like ANC. Recently, full ANC coverage declined from 90.1% (NFHS 4) to 78.6% (NFHS 5). MCP cards with incomplete entries were observed in the field.
- There was no service provision for labour delivery and new-born at PHC level in both districts, no deliveries were reported at PHCs in the state. Eligible couples were not being entered in RCH register at PHC level in Wayanad district.

Strengthening labour delivery services with new-born care at HWCs with the expanded range of services is needed.

- RMNCHA^{+} services needs to be strengthened with a particular focus on tribal communities.
- Family Planning commodities were available at the PHCs except ANTARA (Injectable contraceptives). Distribution of contraceptives was also being ensured by the ASHAs. Registers were being used to record service delivery for family planning. However, some inadequacies in reporting was observed.
- Well-maintained cold chain ice packs were correctly placed on the vaccine vials. ILRs were functional, VVM status was regularly checked. Open vial policy was being implemented and date/time was mentioned on the open vials. Health care providers were entering the data on e-VIN app.
- Under the National Programme for Healthcare of Elderly, health assessments were being conducted. However, free spectacles were not provided to the elderly patients. Physiotherapy units were not available in UPHCs and PHCs of visited districts of Thrissur.
- Home based palliative care activities were being delivered proactively in the community.
- Under NTEP, the percentage of presumptive TB patients referred for examination out of total OPD was available in most of the PHCs. Two patients have completed treatment in the catchment area of UPHC Gosayikunnu. The UPHCs Gosai Kunnu and Family Health Centre (FHC) vettilappara in the district of Thrissur were Designated Microscopy Centres (DMC).
- No Leprosy cases reported from the area during the last 7-9 years.
- HBsAg kits & Anti HCV kits RDT kits were available in PHCs. All pregnant women were tested for Hepatitis B. No positive cases found at PHC Mullankolly, District Wayanad.
- HWC-PHCs were screening common NCDs such as Hypertension and Diabetes. Suspected cases of Oral, Cervical, and Breast Cancer were being referred to SDH/Taluka hospital from the PHCs. Outreach camps for NCD screening were being conducted by CHOs in their respective areas. Drugs were sufficiently available for all NCDs. All medicines were free to all with a minimum supply of one month.
- Well maintained drug stores and labs with almost all tests (except microscopic) were available at UPHCs and turnaround time for pregnant women test was 60 minutes. Beneficiaries availed these reports by E health (SMS services). Sufficient availability of diagnostic tests in UPHCs and PHCs was observed with applicable user charges.
- Diagnostic tests were available at PHCs and UPHCs with user charges. The tests were performed through rapid card-based kits as well as the analysers. Diagnostic consumables and reagents were available adequately.
- The BMMP is implemented through PPP-mode in the State as per NHM guidelines. However, the equipment uptime as per NHM guidelines should be adhered to and needs to be monitored on a real time basis.
- The facilities have enrolled for External Quality Assurance Scheme as well as performs internal Quality control on a routine basis.

Nagaland

- 96.6% peripheral centers had been successfully converted to AB-HWCs (as per data shared by state), with availability of CHOs in most places. The HWCs were branded, neat, clean and well maintained. There was availability of space for wellness activities in most HWCs premises. However the area allocated to Wellness rooms is

very small. Some facilities also have solar panels installed for power backup and availability of running water is 24x7. Herbal gardens were also well maintained at HWCs. But the 12 packages of services are yet to be operationalized completely.

- Availability of medicines at HWC was adequate. Antihypertensive medicine like Amlodipine and Telmisartan were available however antidiabetic not available at Asukiqa HWC (Zunheboto) and stocked out at a few HWCs visited in Mokochung.
- IEC displayed adequately and appropriately. However most of the IEC material is printed in English.
- Teleconsultations were earlier being done through Naga Telehealth but since adoption of e-Sanjeevani, the IT systems are reporting problems and teleconsultation services have halted.
- Community interaction reflected that some prefer home delivery especially those living in remote areas or migrate to bigger cities like Kohima and Dimapur before EDD. There were many cases where deliveries of antenatal mothers are managed at home are attended by CHO/ANM. To promote safe home delivery, the state was distributing home delivery kit and providing home delivery incentive to SBA trained nurse @ Rs. 500/- per case.
- The overall infrastructure of labour rooms compromised protocols for delivery with the non-availability of LDR etc. Delivery points require strengthening with respect to skilled and trained HR. Simplified partograph was not filled universally in the state. However partographs filled at Akuluto was not a simplified partograph. PHC and staff were unable to fill partographs efficiently.
- Dakshata training have been provided in all districts. There are 110 MOs, 441 SN/ANMs & 55 CHOs trained in Dakshata across all the districts.
- Under SUMAN, 25 high case load facilities have been notified to provide free services for mothers and neonates.
- All children were appropriately immunized. One of the challenges reported by the state was that the immunization targets were much more as per census compared to the actual headcount survey for the state of Nagaland. As such, the percentage of coverage were low for the state. Regardless, ANMs and ASHAs need refresher/induction trainings with respect to immunization activities.
- There was a need for better trainings for the PHC/HWC/SC staff for timely and accurate data reporting on the RCH and HMIS portals every month at the block level.
- Non availability of IFA syrup for children under 5 years and Blue and Pink IFA for adolescents and children 5 to 10 years was noticed.
- Anaemia Mukt Bharat was a flagship programme and proper implementation depends on involvement of three important departments which are Health, Education, Women and Child Department. For achieving this, a mechanism needs to be established like regular meeting of these departments at State and district level. Review system also needs to be in-place to review and to understand challenges for example issue related to supply chain and reporting.
- There were no active leprosy cases in the primary health facilities visited.
- State needs to ensure availability of anti-rabies vaccines at peripheral health institutions.
- Separate days have been identified for elderly check-ups at the primary level.
- Free Drugs and Diagnostic Service Initiative was implemented in in-house mode. Number of test conducted at HWC level: 5, Number of test conducted at PHC level: 14-16, Average turnaround time is approximately 6 - 12 hours. In case of stock out of consumables e.g., strip for RBG, patients are charged user fees as they purchase it from outside (Mokochung). No EQAS

was done. Sample barcoding facility not available. Additionally, no radiology diagnostic services were available.

- BMMP was implemented in state through in-house mode. Few Biomedical equipment (BP Machine, Radiant warmer) were available of which some were non-functional.
- The consumption of smokeless tobacco was very high in the state. In this regard, active steps taken by the state government were not observed, except for prevention of sale of tobacco products in vicinity of schools. Nicotine de-addiction tablets were available at HWCs in Mokochung district. IEC material was adequately displayed at facilities.
- The NVBDC programme has its focus on Malaria and the disease is nearing elimination. Fogging, distribution of LLIN was undertaken which should be continued for elimination.
- Universal population-based screening was not being conducted at the primary level and only opportunistic screening was done for Hypertension and Diabetes Mellitus. As per national guidelines, universal population-based screening needs to be conducted by preparing line list of 30+ population and using CBAC forms by ASHAs.
- Palliative Care program and Mental Health program need to be implemented as services under these programs were not universally available.
- Colour-coded foot-operated bins with biohazard sign were found at all the facilities across the districts. However, there was no provision of common bio-Medical waste treatment facility in the state. Human resource handling BMW need to be appropriately trained in handling waste and required training.
- DVDMS has not been rolled out universally. Training of staff needs to be conducted for the use of DVDMS portal.

Madhya Pradesh

- The state has made significant progress in the operationalization of AB-HWCs. As of November 2022, a total of 10715 HWCs (103% of committed target) have been upgraded into AB-HWCs.
- However, the upgraded infrastructure needs strengthening to ensure patient-friendly amenities such as waiting areas, functional and gender-specific toilets, ramps and railings for wheelchair, visual and physical privacy for undertaking examination, and isolated area for drinking water. Branding was not done as per the norms.
- The sanctioned human resources at the AB-HWCs (SHC/PHC/UPHC) were not in alignment with the IPHS norms.
- Service delivery largely focused on maternal and child health, and for communicable diseases such as Malaria, Tuberculosis and Leprosy.
- Services under maternal health (e.g. Post-natal care), neonatal and child health (HBNC), Universal Immunization programme, Oral health, tobacco control, palliative care, and mental health need strengthening with adequate human resources, infrastructure and IEC materials.
- The state has rolled out DASTAK Abhiyaan and portal as an expansion of the Intensified Diarrhea Control Fortnight. It aims to encompass overall child health through bi-annual community-based surveys. The portal has been established to identify, track child health, and support the management of malnourished and anemic children.
- The Pradhan Mantri TB Mukta Abhiyan has been implemented in the visited districts. All AB-HWCs now function as Peripheral Health Institutions (PHI) for TB notification with individual NIKSHAY user ID and Password. Additionally, Patient-Provide Support Agency (PPSA) was available in all

52 districts. All TB patients (including drug resistant cases) were being provided with free pre-treatment evaluation and treatment.

- The implementation of NLEP though robust, with the presumptive rate being 0.009% and confirmation rate being 0.035%, was observed to lack integration with routine services.
- Screening and viral load testing of pregnant women during ANC and the healthcare workers were being done under the NVHCP in all facilities.
- Under the School Health Programme, health messengers have been appointed. Umang help center have been established and services were being provided by the SHP Counsellor. The schools have well-displayed Umang helpline numbers and IEC boards.
- An expanded range of services under CPHC were rolled out across the state. The status of implementation of various programmes was differential. Population based screening through CBAC has been administered to only 30% of the target group. However, screening of NCDs at the level of SHC-HWC has been done for the population assessed. E-Sanjeevani teleconsultation was being used from AB-HWC for NPCDCS programme. However, follow-up consultation was found limited.
- Involvement of the primary healthcare team on various health programmes such NLEP, NTCP, NMHP, NPPC needs to be strengthened.
- Shortage of ANMs, pharmacist and providers under various health programmes (e.g., RBSK, NOHP) were reported. Laboratory technicians, though available, were being under-utilized due to the presence of the PPP provider. Training needs and gaps in orienting primary healthcare team on CPHC, expanded package of services, quality assurance and patient safety initiatives, and use of HMIS have been observed.
- The State revises the Essential Medicines List (EML) every two years for each level facility. The last update was done in 2022.
- The state has established the 'MP-Aushadi' portal for indenting till the level of PHCs. A fixed grant (20% of budget on medicines) has been allocated and released for local purchase of medicines, while the rest is utilized for the central procurement of medicines.
- The availability of medicines as per the EML for SHC-HWC (i.e., 105) and PHC-HWC (i.e. 172) was a constraint. Only 30-40 essential medicines were available at the SHC-HWC, and 80-100 at the level of PHC-HWC. There was a shortage in the essential medicines pertaining to hypertension and diabetes due to which the patients visited DH to avail medicines. Also, MP-Aushadi was not being used at the PHCs due to the lack of pharmacists or training. A standard process of indenting at SHC-HWC and PHC-HWC from higher facilities or drug stores was not practiced. It was further challenged by poor record keeping.
- The state had notified the Free Diagnostic Service Initiative (FDSI) at all public health facilities. The FDSI program was being implemented in PPP mode. The HR and equipment were provided by the government, while services pertaining to maintenance, technical support and data systems were provided by the service providers. Low-cost, high-volume services were performed in-house, while high-cost tests were outsourced to the private provider.
- Teleconsultation services have been rolled out in the state. It is being done through a private service provider (i.e., GLocal) at rural areas. At UPHCs, it was being facilitated through e-Sanjeevani platform.
- Emergency mobilization of patients was an area of challenge, with the ambulance (108) turnaround time reportedly being close to one hour in one of the visited facilities.

Maharashtra

- The state has achieved AB-HWCs target for FY 2021-22. All the Primary Health Care facilities including Sub Health Centre, Primary Health Centre and Urban Primary Health Centre were operationalized as Ayushman Bharat Health & Wellness Centres.
- External Branding of HWC-SHC has been done as per guidelines. The facilities had adequate patient waiting area, space for Yoga/wellness activities within HWC or its premises.
- The areas needing improvement include availability of amenities (power and water supply, separate toilets), disabled friendly structures for accessing the facilities and display of updated IEC materials.
- In Dhule district, labour rooms were available at most of the primary healthcare facilities. Some of them even had oxygen concentrator installed under the PM CARES. HWC-SCs were also being utilized as delivery point.
- Overall, the facilities' upkeep was found to be satisfactory. The labour rooms, however, faced issues concerning patient privacy, security, and cleanliness.
- Most of the facilities provide seven out of twelve services from the expanded package delivered at the HWCs. Though the CHOs were trained in all services under the expanded package, the delay in the rollout of oral, eye, and ENT services has been attributed to the unavailability of basic screening equipment.
- There was a gap in the awareness amongst the service provider on the performance and team - based incentives. A monitoring system for facilitating the PBI or the TBI was lacking.
- The primary healthcare facilities provided basic services under RMNCHA^{+}, NCDs (hypertension and diabetes), and disease control programmes (NTEP, NLEP, NVDCP).
- Outreach services in Urban PHCs (UPHCs) mainly focused on maternal and child health.
- In Dhule district, the Maternal and Child Protection (MCP) card was not supplied for the past one year. Some of the photocopy cards in circulation were incomplete with no provision to record identified high risk pregnancy (HRP).
- There were observed shortcomings in the maintenance of labour room protocols in some facilities such as poor infection control, inadequate use of partographs, improper oxytocin storage, and poor maintenance of labour registers. Space constraints in the labour rooms were observed to compromise infection control and respectful maternity care.
- Prevalence of anaemia among women was reportedly high. However, the availability of IFA tablets was sub-optimal. Mobilizing pregnant tribal women to participate in ANC camps by the ASHAs was reportedly a challenge. Due to their beliefs as well as livelihood practices, their participation in the ANC camps has been poor. As a result, the healthcare providers continue to face constraints in addressing anaemia, misinformation, or lack of information on ANC, exclusive breast feeding and complementary feeding.
- The State has integrated the PMSMA with the State specific Manavshakti Vikas Yojana (MVY). Through the MVY, an additional financial top up of Rs 18,000 per camp session is provided by the state for each PHC. The integrated programme was being conducted twice a month on camp mode focusing on HRP and promotion of institutional deliveries. In-house and private specialists are being engaged during the camps. Pre-cooked meals are provided to the beneficiaries by the District Administration in collaboration with the ICDS department. Vehicles are deployed to pick up and drop back the beneficiaries requiring USG tests. The reports are usually furnished on the same day.

- High out of pocket expenditure on delivery was reported. Some of the reported concerns like unavailability of staff nurse at the PHC, referral to secondary level facilities and cost of frequent travel have been attributed to the high OOPE.
- All the HWC-SHCs provided routine immunization services. However, the processes such as preparation of micro-plans, maintenance of records, due lists of children with missed doses, or drop out cases, review mechanisms, data entry in HMIS and outreach sessions need to be strengthened.
- The awareness on family planning programme and modern contraceptive methods was lacking among the community member and the frontline workers of some facilities. FPLMIS was not used in the visited facilities.
- Under the RBSK programme, a total of 191 AWCs and 210 schools have been visited for screening the children during the FY 2022-23. From the AWCs, a total of 349 screened children were referred. Similarly, 24,045 children have been screened at school level, of which 1,683 have been referred to higher level facilities during 2022-23. A total 4 heart surgeries and 46 other types of surgeries have been performed under the programme.
- The implementation of the RKSK needs to be strengthened.
- Population-based screening was done for around 70-90 percent of the targeted population.
- While the MOs were trained in NCD services, the staff nurses and the ANMs were not adequately trained on their role in NCD care. Opportunistic screening needs to be strengthened.
- Shortage of NCD drugs and diagnostic products was a common concern at the HWC-SHC level facilities. The referral linkages between the SHC-HWCs and PHC-HWCs need to be strengthened. Post-treatment follow-up and downward referral has been observed to be limited.
- Shortcomings in NCD services along with medicine shortage, hypertensive and diabetic patients go to private health facility or higher-level government facilities for treatment and follow-up.
- The state has initiated the establishment of 'Mann Shakti' Clinics for mental health counselling and screening at the level of PHC-HWC, wherein a psychiatrist and team visit on a fixed day (2nd Thursday) of every month. The uptake has been relatively poor owing to the lack of public awareness and information. Counseling services on people with suicidal ideation were provided by the ASHAs under the 'Prerna Prakalp Program.' The ongoing mental health initiatives need to be supported with robust IEC activities and medicines.
- Elderly Home-based care has been initiated at the level of PHC-HWC.
- The biomedical equipment maintenance and management programme has been outsourced to a third-party provider. The service provider monitors the complaints through a software developed by them. The end-users and facility staff were aware of the provisions under the programme. The programme implementation has been observed to adhere to the state guidelines for BEMMP.
- Free Drug Service Initiative has been notified, and free drug entitlements were displayed at the facility in local language. E-Aushadi software was used for medicine forecasting and procurement. Drugs under the disease control programmes (HIV/AIDS, NTEP, NLEP and Malaria) were not supplied. Availability of medicines was not as per the EDL. High and prolonged stock outs were observed.
- Free Diagnostic Service Initiative has been implemented in a PPP mode. Through this arrangement, only 30 tests each at the SHC and

PHC level were provided. In HWC-SC, only seven point of care (POC) tests were performed.

- Though teleconsultation services have been rolled out, their uptake has been poor.
- The referral linkage between the SHC-HWCs and PHC-HWCs was observed to be lacking in some of the visited facilities. Linkages of primary healthcare facilities to secondary level facilities need to be strengthened.

Meghalaya

Operationalization of AB-HWC

- The state has targeted to operationalize all SHCs, PHCs and UPHCs in a phased-out manner by December 2023. Facility-wise operationalization targets for the FY 2021-22 were 354 SHCs, 114 PHCs, 19 UPHC, and 460 SHC, 115 PHC and 19 UPHCs for the FY 2022-23.
- Overall, the infrastructure at the primary healthcare facilities was adequate. They were branded as per the guidelines, have dedicated spaces for waiting area, laboratory and diagnostic services, delivery, and wellness activities. Erratic power supply coupled with lack of power backup, and lack of disabled friendly structures were the areas needing further improvement.
- The primary healthcare facilities were supported by a proactive team of providers led by the MLHPs at the SHC-HWC level and MOs at the PHC-HWCs. Staff quarters were available at the visited facilities.
- The facilities were largely providing services pertaining to RCH and Communicable diseases. The expanded package of services has been rolled out at the HWCs. However, the ANMs and ASHAs were yet to receive relevant training.
- Population based screening has been initiated by the ASHAs. However, screening at the facilities has been differential. Reasons that have been attributed to the variability include shortage in functional glucometer, glucometer strips, lack of services for screening of breast and cervical cancers, and variable opportunistic screening.
- Teleconsultation services have been rolled out through e-Sanjeevani platform and has been implemented through a hub and spoke model. The CHCs and the DH serve as the hubs and provide consultations as per the availability of the specialists.
- The availability of medicines at the SHC-HWCs was not as per the EML. Inventory management was an area of concern.
- The State was yet to expand the diagnostic services as per the GOI guidelines. Only 4 tests at the SHC-HWC and 14 tests at the PHC were being provided.
- To reduce the maternal and infant mortality, the State's 'Chief Minister Safe Motherhood Scheme' have rolled out dedicated transport vehicles, transit homes, attendant's wage loss compensation of Rs 1000 and an award scheme for the Village councils to promote institutional delivery. The intervention is crucial to improve the low rates of institutional deliveries (30-40%).
- Universal Immunization Programme (UIP) at the State needs further strengthening in terms of inputs and processes. Implementation issues include shortage of relevant human resources, high staff- turnover, lack of power back up, fund shortage, poor micro-planning, record keeping and beneficiaries tracking. Lack of awareness and apprehension among the community towards immunization have been reported.
- Availability of radiant warmers, skillsets like resuscitation training, and growth monitoring need to be strengthened at the level of PHCs.
- The uptake of modern contraceptive services and provision of comprehensive abortion care was limited.

- The free diagnostic service initiative has been implemented in the state through a hybrid mode. 51 different tests have been outsourced under FDSI to a private provider. However, the out-of- pocket expenditure on diagnostic services have been reported as the patients had to either avail services from private laboratories or travelled out of the district for the same. The PPP arrangement needs to be assessed and strengthened to ensure free and quality services at the public health facilities.
- Gross mismatch in the demand and supply of essential drugs, diagnostics, and equipment was observed at the level of HWC-PHC.
- The users of SHC-HWCs were referred to their linked PHCs or CHCs. However, follow-up mechanisms post-referral treatment need to be established.
- Irregularities in the release of Performance Based Incentives to the MLHPs were reported across the facilities.

Punjab

- As of November 2022, the state has operationalized 2,957 HWCs (SHC/PHC/UPHC) with 2,475 CHOs in place.
- Though the facilities had satisfactory infrastructure, the availability of basic amenities like safe drinking water, ramps for wheelchair access, power-back was an area of concern.
- The HWCs have rolled out 7-8 packages of services under CPHC. While the CHOs and the MOs have received training on the expanded package, the quality of training needs attention. The ASHAs and the ANMs have not received training in the last 2 years.
- The uptake of institutional delivery is high in the state. Improving community awareness on the importance of early registration, danger signs of pregnancy and need for spacing between births needs more focus. Providers' awareness on SUMAN, PMSMA and E-PMSMA initiatives needs to be reinforced.
- Immunization services were robust at the primary level and were being promoted as 'Mamta Diwas' during VHSND.
- ASHAs demonstrated knowledge gaps in family planning measures. The field findings corroborate the NFHS-5 report that only 14.8% and 25% health workers ever talked to female non-users about family planning in Ferozepur and Rupnagar districts respectively.
- Under the NTEP, the TB suspected patients were being referred by the CHOs for sputum examination to their respective DMCs. The allocation of Nikshay IDs to each HWC, and engaging CHOs for dispensing TB medicines are under process. However, in Rupnagar, the mapping of high-risk population and active case finding by ASHAs and MPHWs need attention. Case review on treatment by the MOs needs to be strengthened.
- Irregularities in ASHA incentives have affected the implementation of NLEP. Due to this, Active Case Detection and Regular Surveillance (ACDRS) have been affected.
- The implementation of the Viral Hepatitis Control Programme has been differential. Healthcare worker vaccination has been a major concern in Rupnagar district. The state specific innovation (Mukh Mantri Punjab Hepatitis-C Relief Fund) promotes free drugs, base line tests and viral loads tests for all infected residents.
- NCD services at the primary level must be strengthened. Screening of individuals administered with CBAC at the SHC and follow-up of referred cases at the PHC need to be streamlined.
- Mental health disorders were poorly managed at the primary level facilities (PHCs and UPHCs). Overall, the implementation of NMHP in the state needs focused actions.

- Implementation of NIDDCP, NOHP, NPPCF, NPHCE, NPPC were weak. As a result, community awareness with respect to these services was low.
- The Ferozepur district has initiated a new project known as 'SOHUM' for early detection and management of hearing loss in neonates. The RBSK nurse conducts the screening for congenital deafness or hearing issues in children underage-five in camp mode and were referred to the ENT specialist at the DH. The IEC materials for the same were displayed at both the primary and secondary level facilities.
- The state provides free diagnostic services and medicines to BPL, ANC/ pregnant women, and children. OPD and IPD users were required to pay nominal charges.
- In the state, free diagnostic service initiative was implemented in a hybrid mode. At the PHC 10-15 tests were being provided against the EDL (63) and at the SHC, 6 tests were being provided against the EDL (14). Overall, the implementation of FDSI needs to be strengthened, which includes implementing a LMIS and capacity building of laboratory technicians.
- For the free drug service initiative, the state has its own EML for each level of care facility. However, it needs to be updated and brought in alignment with the revised EML for HWCs. As of 2022, 56-74 drugs were dispensed at the PHC (out of 161) and 27-36 at the SHC (out of 61).
- The BMMP was being implemented in PPP mode. However, the downtime of critical equipment across the levels of care, including the radiant warmers at the PHCs was more than a month, over and above the formal agreement of 7 days or under.
- The State has a total of 33 MMUs under the NHM to service remote and far-off communities of Ferozepur district. Shortfall in skilled HR, equipment functionality and medicine availability challenge their operations.

Rajasthan

- Overall, the HWCs had adequate infrastructure. However, the branding was not as per the guidelines in the facilities visited.
- The State has prioritized the upgradation of SHCs into AB-HWCs and the recruitment and training of CHOs for the facilities.
- The centralized HR recruitment cycles tend to be prolonged and have caused delays in the posting of CHOs and MOs at the district and block levels. A vacancy of 31% of CHO and 62% of MOs against the sanctioned have been reported.
- Seven out of the twelve services under CPHC have been rolled out. However, the delivery of NCD services were limited to hypertension and diabetes. Training gaps in CHOs and ASHAs on the expanded packaged have been identified.
- Components of maternal health initiatives need more attention. For instance, under the JSY scheme, the beneficiaries were only provided with Daliya twice a day at the delivery point. The labour room digitalisation initiative namely the 'Prasav Watch' was supported by a development partner. However, the data entries were not done timely for real time monitoring.
- Kota has started a new concept under the immunization programme, namely the 'Amavasya Tikakaran Programme' where vaccinations were provided on the new moon day of each month for the children of migrant labourers. This has been arranged because the Amavasya Day is the only day-off for the migrant laborers.
- Type II leprosy cases have been reported in the state, due to which an active case detection campaign has been scheduled. There was a general lack of awareness on leprosy and case-finding among the ASHAs.

- The viral hepatitis control program (NVHCP) needs attention, especially in Kota district. Hepatitis B testing and IEC materials at the primary healthcare facilities were inadequate.
- Providers' awareness on the rabies control program (NRCP) needs improvement to facilitate identification and referral of patients needing Anti-rabies Serum (ARS).
- Most of the non-communicable disease control programmes such as NMHP, NOHP, NPCB+VI, NPHCE and NPPC were not being delivered at the primary level. Services under the NPCDCS included only hypertension and diabetes.
- The free drugs initiative has been facilitated under Rajasthan's 'Mukhyamantri Nishukla Dawa Yojana.' The initiative covers almost all EML medicines.
- E-Aushadhi has been established till the level of UPHC/PHCs for indenting and monitoring the consumption of medicines.
- The diagnostic services are being provided free of cost to all patients across the levels of care under the 'Mukhya Mantri Nishulka Janch Yojana.'
- BMMP has been implemented in PPP mode. Awareness on the programme and the toll-free helpline number was satisfactory among the providers.
- Biomedical waste Management at the PHCs and SHCs was an area of concern.

Sikkim

- The state has a total of 150 functional AB-HWCs, which includes 126 PHSC, 22 PHC and 2 UPHC. The status of implementation of CPHC through AB-HWCs was close to the target. However some facilities were yet to be categorized as AB-HWCs due to the absence of branding on the façade.
- The facilities in general had dedicated spaces for waiting area, laboratory / diagnostic services, labour room, IEC corners with displayed Citizen Charter and Health Calendars and for wellness activities. In the South district, wellness activities were organized in schools, community centers and spaces near the PHSCs due to space inadequacy at the facilities.
- Availability of basic amenities were differential. Almost all facilities had a good supply of potable drinking water, except in a few Centres of East district. Availability of separate or disabled toilets were subjected to space adequacy. Frequent interruption in the power supply were reported for which portable emergency lights or solar panels were being used as power-back up.
- MLHP and CHO positioned across all PHSC/HWC in both the districts visited. In urban areas, ASHA mapping was identified as an area of concern. The facility has 29 ASHAs, covering a population of 4000-8500 population with only 2 ASHA Facilitator. The ASHAs had the opinion that covering 8500+ population was difficult for them.
- The status of training varied across the districts. Training was conducted in Namchi district, while none were undertaken in the East district. Virtual mode of training on CPHC expanded package services that was provided to ASHAs and ANMs was reportedly ineffective owing to connectivity issues.
- In Sikkim, linkages of the primary healthcare facilities with secondary level facilities were yet to be established.
- The community awareness on the National Health Programmes and social security initiatives was low across the facilities. Health seeking behaviour needs attention. It was observed that community prefers to access the medical college over the existing primary and secondary health care facilities.
- NCD screening and control package has been implemented across all AB-HWCs, while

additional package with expanded range of services is yet to be initiated.

- The Urban HWCs have been providing all RMNCAH$^+$N, Communicable disease, NCD, Dental and Mental Health services. For NCD services, Opportunistic NCD screenings were not linked with CBAC forms.
- Sikkim is the only state to include HPV vaccination for eligible girls (9- 14 years) in the immunization schedule. Out of the total 1.14 lakh eligible women, a total of 2728 HPV testing was done so far. HPV DNA testing lab has been established at UPHC Gangtok.
- State has established a help line with both toll free and landline functional number, which was widely displayed across health care facilities. State has also outsourced these services to NGOs for hiring "lay counsellors" trained by the state on mental health. State has a supervisory role for this activity. Under the initiative, an assessment was done on the beneficiaries followed by linking them to the DH for further interventions. Also, counselling was done for family members and caregivers of identified cases.
- The State has its own software for stock keeping of medicine (True-PoS). The PHCs indent through the software while SHCs do physical indenting of drugs. PHCs have been provided with a desktop computer for stock entry. A month's supply of hypertension and diabetes medicines were given to patients as per the availability of medicines.
- A Common Bio- Medical Waste Treatment Facility (CBWTF) was not present in the State. All the health facilities have been given permission by the Pollution board for deep burials pits. In the rural areas, solid wastes were collected by the Gram panchayat vehicle, and red and yellow wastes were dumped in the deep burial pits after treatment. It was reported that attendants of some pregnant women took the placenta back to their native place. The practice needed to be discouraged through effective advocacy and IEC.

Tamil Nadu

- The state implemented the Universal Health Coverage programme as a pilot in 2017 and since then, has upgraded over 5,201 SCs, 1,381 PHCs, and 460 UPHCs into Health and Wellness Centres (HWCs). The State has operationalized a total of 7,042 (77%) HWCs and is committed to achieving the target of 9135 functional HWCs by March 2023.
- The HWCs were branded to the local context as per the guidelines. The facilities' premises had boundary walls which were decorated with attractive IEC paintings and ramps.
- Deliveries were not being conducted at the SHC-HWC level, whereas, the visited PHC-HWCs had designated and functional labour rooms.
- SHC-HWCs did not have a dedicated space for laboratory/ diagnostic services. Only 5 out of 14 labs tests mandated at the HWC-SC level were being performed.
- The State policy gives weightage for local candidates at the time of recruitment of MLHPs. One Health Inspector (MPW-Male) has been posted for every 3 SHC-HWCs, a Woman Health Volunteer (WHV) has been recently deputed under the Makkalai Thedi Maruthuvam (MTM) scheme for undertaking the screening of Diabetes and Hypertension in the community. ASHAs, however, have been recruited for the tribal regions.
- The state has 4,848 SHC-HWCs with a Mid-Level Health Provider (MLHP) and a Village Health Nurse to enable the provision of the expanded package of services. The MLHPs covered NCD services including eye, oral, dental, and mental health services, whereas the VHNs focused on outreach services under RMNCH$^+$.
- All delivery points visited were well equipped with NBCC and conducted more than 20 deliveries per month. For pregnant women living in-hard to reach areas of Jamnamaruthur block, birth waiting rooms

were made available. Both normal and high-risk pregnant women (HRP) were accommodated almost 14 days ahead of the expected date of delivery (EDD) in these rooms.

- Tracking of ANCs through the PICME portal was being done to ensure no ANC dropouts. The line list of ANC cases, especially identified HRP along with their EDD was available at the facility to facilitate preparedness and robust monitoring of ANCs and HRPs. However, community interaction revealed gaps such as missing out identified HRP from the line-list maintained by the VHNs, and thereby missing out notifying the concerned PW, who then had a bad obstetric history. Further, the details of the number of ANC visits maintained in ANC notebooks of pregnant women were not reflected in the MCP card.
- USGs were available at the PHC level and MOs were mentored by Ob-Gyn specialists in ultrasonography on a weekly basis. The SCs and the PHCs were SUMAN notified with identified volunteers. The documentation and upkeep of the facilities with essential supplies in the labour rooms were good. However, facilities with small labour rooms compromised patient privacy and infection prevention and control.
- The State organizes regular Maternity Picnics for pregnant women to become familiarized with the health systems and gain confidence to deliver at the government health facilities.
- In tribal blocks, high risk antenatal cases usually refused to visit higher level facilities when referred. Teenage pregnancies, being engaged in agriculture or spouse being away at work were some of the cited reasons.
- The immunization coverage was over 90% and in line with the immunization agenda 2030. The overall processes under the Universal Immunization Programme were robust. The functionality of e-VIN-based temperature loggers due to connectivity issues in certain blocks needs attention.
- Services under neonatal and child health were robust. Some facilities, however, kept healthy neonates in radiant warmers and separated them from their mothers immediately after delivery, and in some facilities, the NBCCs were outside the labour rooms.
- The uptake of family planning services in the state were differential. Low uptake of NSV, low acceptance of Antara, poor uptake of PPIUCD in tribal blocks and non-functionality of FPLMIS in a few facilities were identified.
- The activities under the RBSK have been robust. The teams comprised of 2 Medical officers, 1 staff nurse, 1 pharmacist, 1 sector health nurse and 1 driver. Each block has been assigned with two teams, who visited schools on weekdays and AWCs on Saturdays. In Tiruvannamalai, a mobile-based application has been developed for the teams to ensure the continuum of care for the children screened and identified by the RBSK team and treated by the DEIC team.
- Under RKSK, the PHC-MO caters to the complaints of the adolescents who accessed the facilities. Most cases were related to stress, sexual health-related issues, and menstrual disorders. At the UPHC in Thoothukudi, adolescents with mental health issues were cross-referred to the visiting psychiatrist. ICTC counsellors at all PHCs were engaged in adolescent health counselling. However, they had not been adequately trained in dealing with Adolescent Health Issues.
- Under the NTEP, the MLHPs and Women Health Volunteers (WHVs) have been sensitized about screening and diagnosis of TB, however, other health staff have not been trained on recent updates. TB - DM, HIV bidirectional screening coverage was found to be suboptimal. The utilization of health staff under the Directorate of Public Health for case finding activities under NTEP needs to improve. Vulnerability mapping exercise has not been carried out in the districts.

- Village-level TB forum has been created and the districts were actively involved in community sensitization and engagement activities through mike campaigns, IEC vans with distribution of fliers etc. Involvement of PRI members and their support for community mobilization for availing the NTEP services was observed. Two TB champions per block have been trained in community sensitization and mobilization activities during ACF campaigns.
- Several patients in the community reported high Out-of-pocket-expenditure (OOPE) for their diagnosis and treatment as they were unaware of the free services being offered by the public health system.
- In Tiruvannamalai UPHC, contacts of leprosy patients have not been given PEP. High percentage of multi-bacillary leprosy and Child leprosy rate of more than 10% was found for the past two years in Thoothukudi. The urban PHCs did not have access to the NIKUSTH portal.
- Under the viral hepatitis control programme, HbsAg testing was being done for all antenatal women. Hep B vaccination details of healthcare workers were unavailable.
- The Makkalai Thedi Maruthuvam (MTM) scheme was launched in August 2021 to address the increasing burden due to non-communicable diseases in the State. Operationalised by a dedicated three-member team of Women Health Volunteers (WHV), Palliative Nurses and Physiotherapists, who work in coordination with the MLHPs and VHNs. The scheme envisages delivery of home-based NCD screening, palliative care and physiotherapy services. Drugs for Hypertension and Diabetes were provided as a measure to reduce the number of visits to a health facility and enhance adherence to the treatment regimen. Patients who were on Continuous Ambulatory Peritoneal Dialysis (CAPD) were also ensured home delivery of PD bags.
- Population based screening of diabetes and hypertension was being done extensively under the MTM scheme. WHVs posted at 1 per SC carried out screening at the community level. However, NCD screening of the male population was limited due to their unavailability. Opportunistic screening for DM and HTN was being conducted at the primary level facilities. The MTM scheme has expanded the awareness of the community on common NCDs. The community recognises and also demands these services from the WHVs. Community's acceptance of the services was good.
- Patient support groups were formed at the SC level and IEC activities on lifestyle modifications were being conducted.
- Activities under the NPCB+VI were differential. Village-wise cataract screening was being conducted with the help of a mobile app in Thoothukudi HWC-SC. However, community-level screening activities and free services for visual impairment were being undertaken by NGOs in Tiruvannamalai.
- Community and primary level activities under the NOHP need to be strengthened. Anti-tobacco awareness and referral of users willing to quit tobacco to medical college were done in Thoothukudi.
- Geriatric Training of Physiotherapists, Medical officers, and District NCD programme officers has been conducted under the NPHCE. During community visits, elderly members not having the means to afford walking aids/hearing aids and incurred out-of-pocket expenditure for the same were identified. There is a need to institute measures to identify such beneficiaries to provide essential aids.
- Under the MTM scheme, home-based physiotherapy and palliative care services were being provided to the community. One physiotherapist and one Palliative Nurse posted at the Block level were undertaking house-to-house

visits using the MTM vehicles with necessary consumables and functional equipment according to the fixed tour programme. Similarly, a team at the UPHC level undertook home visits in the allotted sectors. Patients in need of specialized physiotherapy sessions were referred to the Block PHC which has a functional physiotherapy unit. The community were appreciative of the home visits by the physiotherapist and the palliative nurse.

- Primary level services under the DMHP were good. Community referrals of patients with suspected mental illness was being done by the frontline workers to the District Mental Health Team. Psychiatric drugs were available at the PHC level to facilitate drug delivery for the patients being referred back from the DH/Medical College. Facilities with the provider lacking training or drugs referred the patients to the DH for further treatment. Psychiatrists were being deputed from medical colleges to undertake weekly OPD at UPHCs. However the attendance in the OPD was hardly 2-3, and has scope for improvement to ensure optimal utilization of the Specialist's presence.
- IEC on mental health topics and mental well-being was being provided through the unique initiative of 'Mana Nala Vyazhan' (Mental Health Thursdays) at the Block PHC level. The awareness and visibility of the recently launched mental health helpline TeleMANAS in the community and among field-level workers was limited, with much scope for permeation.
- The BMMP has been implemented in the state through in-house mode. TNMSC has a policy of procurement of equipment with 3 years warranty plus 7 years of CAMC through OEM. All the equipment was well maintained, and timely preventive maintenance was done.
- The IDSP forms (P, S and L) were being filled, however, the validity, completeness and timeliness of reports were found to be inadequate. Reporting was being done on the Integrated Health Information Platform daily. However, training of staffs in filling the form needs attention.
- Under the Free drugs service initiative, the EML was displayed at each facility. All NCD drugs and consumables were available at the facilities. However, a delay in the supply of glucometers and strips in the urban areas. IT-enabled logistics & supply-chain systems were not in place in the primary health facilities, and manual indenting was practiced at all levels. Prescription audit mechanisms were not in place.
- Mobile Medical Units (MMUs) have been functioning in all the blocks of Tamil Nadu to cater to the underserved and inaccessible areas. A total of 415 MMUs have been deployed in the State, of which 20 are designated as Tribal MMUs. The tribal MMUs are operationalised through partner NGOs and are functional across 13 districts.
- The MMU team functions with a Medical Officer, Staff Nurse, Lab technician and Driver. Basic primary care services including ANC services, NCD screening and management and minor ailments were being provided by the MMU teams. IEC and counselling activities were also conducted by the MMU team along with screening for hemoglobinopathy traits among the tribal population.
- The frequency of the breakdown of the tribal MMU vehicle was reported to be high in Tiruvannamalai, which hindered the schedule of the MMU teams. The Tribal MMU team reported a delay in the supply of medicines from NHM. In such scenarios, the medicine supply was arranged from the PHC's stock which was later replenished when the tribal MMU team receives its supply.
- Under the free diagnostic service initiative, the state government has been providing free in-vitro diagnostic lab services to all the patients at each level of care. The number of tests available free of cost to patients is 5 at the SCs, 21 at the PHCs, and

58 at the DH level. However, it is not as per NHM recommendations.

- The laboratories were functional in all visited facilities. In the PHCs with a laboratory technician, tests for Haemoglobin, Blood group, Random blood sugar, HIV and Malaria (rapid/smear) were being conducted. In PHCs with no such provisions, patients were referred to the nearest Government facility and private facilities. As a result, the patients had to travel long distances for basic tests such as Haemoglobin and Blood Sugar while the ANC women travelled to CHCs for RPR and Blood group tests.
- The state has outsourced the bio-medical waste management, and all visited health facilities were linked with the treatment facility.

Telangana

- Most of the primary healthcare facilities in the state have been operationalized into Health and Wellness Centres. 99% of UPHCs has been upgraded to HWCs. The urban primary healthcare models in the state, namely the 'Basti Dawa Khana' have been now converted to UHWCs. 56% of the targeted UHWCs (218/390) have been achieved.
- The infrastructure of visited facilities was overall satisfactory. The facilities had a state-specific branding while only a few were branded as per AB-HWC guidelines.
- Some facilities in Singireddypallem faced severe shortage of power supply, water supply and had non-functional toilets. The facility's functionality and the providers' working conditions were compromised.
- The CHOs served as Mid-level health providers at the HWC-SHC. The State has six program study centres (PSC) with 16 counsellors for their training and certification.
- Access to public health facilities and consequent expenditure on medicines, diagnostics and referral transport is variable across the districts. In Suryapet district, the users incurred no out of pocket expenditure in availing primary healthcare facilities, but the users from Asifabad (tribal district) incurred high OOPE ranging from Rs 3000 to Rs 20000. The cited reasons were difficult terrain, poor internet/ network connectivity, lack of specialists at the facilities, and on transport to the higher facilities on referral.
- The primary healthcare facilities largely provide services under RMNCH+A and communicable diseases. Services under non-communicable disease control programs like NPPCF, NIDDCP, NOHP and NMHP were limited to initial screening.
- Some PHCs functioned as delivery point and conducted a monthly average of 10-15 deliveries. To promote early initiation of breast feeding, the case sheets were stamped in green, blue, and red, as per the time of initiating breastfeeding. Green stamp was used if breastfeeding was initiated in the delivery room, blue if initiated on the day of delivery in the postnatal ward, and red if breastfeeding was not initiated.
- The state has introduced KCR kit to promote institutional deliveries in public health facilities. It is an institutional cash transfer scheme (Rs 12,000 for male-birth and Rs 13,000 for female-birth) provided in three installments, while the Kit contains 16 essential newborn care items.
- The state has rolled out a Midwifery initiative to improve maternal care services. The initiative aims to improve counselling and awareness on alternate birthing positions, birthing exercises, partner involvement, inculcate confidence among expecting mothers in having normal deliveries and enable providers to triage high risk cases for appropriate and timely interventions by the specialists. Midwifery training is being provided

to ANMs and staff nurses for a duration of 6 weeks in 23 high risk conditions.

- To circumvent the shortage of gynecologists and radiologists in Asifabad district, the district administration constituted four scanning centers - one in DH and three in PHCs for identification and management of high-risk cases. The MO and team mobilize the ANC cases for scanning to the nearest center. Scanning is provided once a week, however arranged in such a way that pregnant women were assured a scan for each ANC visit. The reports were shared with the PHC team for birth planning.
- The state's RBSK implementation was robust. Each Mobile Health Team (MHT) under the RBSK comprise of 2 MOs, 1 Pharmacist and 1 ANM. The state has 300 mobile units conducting outreach sessions. Screening done at schools were referred to tertiary care centers in the state.
- The implementation of NTEP at the community level has been variable. Involvement and awareness of the primary healthcare team (ASHAs, CHOs, MO etc.) in sample collection and transportation, line listing and follow-up of TB patients, recording and reporting mechanisms were variable across the districts. NIKSHAY portal is yet to be implemented at the HWC-SHC level.
- The activities under the NPCB&VI were not commensurate with the identified need at the community level. There was no substantial involvement from the government or NGO partners for screening of cataract at the community and primary level facilities. CHOs and ANMs were not trained to screen, and Snellen's chart was not available at the SCs, PHCs and UPHCs.
- Insulin was available at PHC-HWCs and UPHCs for the treatment of diabetes under NPCDCS. The existing NCD services need to gradually expand to ensure the continuum of care and provision of all service components such as VIA for cervical cancer screening. The primary healthcare team needs to be trained to facilitate services under the NCD programme.
- Programmes on oral health, tobacco control and blindness were not robust in the state.
- Dedicated mobile palliative care teams comprising of MO, physiotherapist and staff nurse were operational in Suryapet district.
- Though the state has an operational toll -free number under the NMHP, awareness and mental services at the community level were relatively low.
- BMMP has been implemented in PPP mode and the services were linked to e-Upkaran. The implementation has been robust.
- The state's Free Drug Service Initiative (FDSI) is supported by the state's central procurement agency (TSMSIDC) and through Telangana Vaidya Vidhana Parishad (TVVP). Though the number of medicines available at the facility was not as per the EML (i.e., 15-20 at HWC-SHC and 40-45 HWC-PHC/UPHC), their supply has been consistent. Medicines were indented through the e-Aushadhi platform. Reported challenges included lack of refrigerator for TD vaccines and ARV medicines couple with lack of power-back up.
- Management of biomedical waste was an area of concern. Waste segregation and collection from delivery points were not practiced regularly.
- The link between the SHCs and the PHCs was facilitated by good coordination among the ASHAs, ANMs and the MLHPs with the MO i/c at the PHCs.
- Referrals to higher level facilities were facilitated through well-equipped 108 ambulances available at the HWC-PHCs. However, in Asifabad, availing ambulance services was a challenge due to lack of

network and connectivity issues. To facilitate the transportation of pregnant women and for ANC services, 'AVVAL ambulances' have been provided by the tribal department. The district has made arrangements for the users to allow inter-district travel from Asifabad to Mancherial without having to change the vehicle.

Uttar Pradesh

- The State has 14,201 (74%) functional AB-HWCs. The state plans to achieve the committed target of 19,424 by the end of December 2022. The shortfall in the availability of CHOs was cited as a key factor for the delay.
- Of the 603 functional UPHCs, 83% (506) have been operationalized as UPHC-HWCs. As of November 2022, 35% of MOs, 45% of staff nurses, 40% of Lab technicians and 25% of ANM positions for the urban primary health centers are vacant.
- The status of infrastructure at the HWCs was variable. Most the PHC-HWCs had earmarked space as wellness room. However, dedicated spaces for waiting, wellness area, and OPD as well as gender-specific toilets and disabled-friendly structures were not available at most of the SHC-HWCs. CHO's OPD was found outside the premises of one of the SHCs. Branding was not uniform across the facilities.
- The team dynamics at the SHC-HWC was poor, with the CHOs and ANMs working in-siloes. Poor interpersonal coordination among the primary health care teams (SHCs and PHCs) was an area of concern.
- The training status of the SHC-HWC team was variable. CHOs were trained in most of the modules except for TB, while the ASHAs and ANMs orientation towards NCD care was limited.
- Delays in the disbursement of CHOs' performance linked payment was reported while the ASHA's awareness regarding their incentives was limited.
- Components of maternal health services need strengthening. Early registration and tracking of pregnant women for ANCs needs attention, as complete ANC (4 visits) was low in the visited districts and MCP cards were partially filled. Line listing of pregnant women and high-risk pregnancy were not maintained by ASHAs and ANMs. Mobilization of pregnant women for PMSMA days also needs to be improved.
- Community awareness of RMNCH+A programs was not adequate. The users reportedly incurred high OOPE on ANC services at private facilities. In Chitrakoot district, users reportedly incurred no OOPE on transportation, medicines, and blood tests. However, the providers solicited informal payments at the facilities. Use of private facilities and home deliveries due to lack of awareness of public facilities were identified.
- Neonatal and child health services at the community level must be strengthened. HBNC visits, identification of low-birth weight (LBW), SAM children, sick babies and growth monitoring need to be reinforced and streamlined. Relevant orientation, refresher trainings and supervisory visits were mandatory.
- Gaps in routine immunization such as unavailability of immunization micro-plan, zero-dose vaccination and Hepatitis B vaccine at primary level facilities needs prompt redressal.
- Provision of family planning services were not robust at the level of SHC-HWCs, whereas was implemented satisfactorily with provisions such as FP counselling rooms, IEC materials, FPMIS and dedicated days to 'Khushaal Parivar Diwas' from the level of PHC and above.
- The primary health facility teams were unclear on the referral linkages and mechanisms.

- Though activities under the RBSK program are undertaken as per the requirement, the referral documents were being handed over to the children, there by impeding mechanisms of tracking children referred to higher level facilities. There is a need to strengthen the screening activities and providers' awareness of the same.
- Since the components of Anaemia Mukt Bharat had oversight from various providers, the implementation was fragmented due to the lack of coordination and ownership.
- NTEP has been implemented-well in the state. TB notification has increased with regular community surveys and active case finding. ASHAs were proactively involved in DOTs and adherence monitoring.
- The implementation of NLEP has been variable across the state. Information related to leprosy patients were not maintained at the SHCs and PHCs with suboptimal adherence monitoring and supervision of patients on treatment.
- The status of population-based screening has been differential in the state. Community awareness on NCD services provided at the HWCs was lacking. There was no defined mechanism for upward and downward referral of NCD patients from the primary level facilities.
- Other non-communicable disease programs like NMHP, NTCP, NPHCE, NPPC and NPCB+VI were either defunct or not implemented at the HWCs (SHC, PHC).
- Biomedical waste management has been outsourced in the state for the collection, transportation, and disposal of biomedical wastes till the level of CHCs and includes only two PHCs in the state. PHCs and SCs in general used deep burial pits. Adherence to biomedical waste management guidelines was limited and effluent treatment plants were not in place.
- Biomedical Equipment Maintenance and Management Program was implemented in PPP mode. However, the services provided focused on maintenance due to which repairs were delayed.
- Services provided by MMUs were suboptimal in Maharajganj district. The MMUs served in areas close to the SC-HWCs and not in remote or under-served areas.

COMMUNITY PROCESSES: FROM THE PERSPECTIVE OF EQUITY AND GENDER

National Overview

The ASHA programme, a key component of community processes has continuously evolved over the last decade and a half. The country currently has 9.83 Lakh ASHAs in position making it the world's largest community health worker programme. ASHAs have been widely acknowledged for their substantial contribution in improving access to care for community in areas ranging from RMNCHA^{+} to Communicable Diseases and which has now expanded to also include Non communicable diseases (NCD). ASHAs are also critical component of the Community platforms like Village Health and Sanitation Committees (VHSNC), Mahila Arogya Samiti (MAS) and Community Based Planning and Monitoring under National Health Mission.

With the launch of Ayushman Bharat Programme, the role of ASHAs has been expanded to provide NCD, Oral care, Eye care, Emergency care, Ear - nose- throat care, Mental Health care, elderly, and palliative care at the community level while retaining her social activist role. Her role is being strengthened in community mobilization, generating awareness, health promotion, home, and community-based interventions to support the delivery of comprehensive primary health care, by appropriate skill building, supportive supervision and established monitoring mechanisms.

Findings from the seventeen states and UTs highlight the crucial role played by the ASHAs at community level. The field findings revealed ASHAs are actively involved in undertaking their routine activities as well the newer roles that have been introduced under CPHC including population enumeration, CBAC administration for risk assessment, mobilizing community for NCDs screenings and referrals. Being an active member of the community level platforms, their contribution in implementing national or state initiatives at grassroot level is remarkable.

However, reports from states also highlighted some gaps pertaining to programme components that affect the functionality of ASHAs such as lack of orientation on newer roles, lack of a dedicated community processes support structures and grievance mechanisms for ASHAs. Given that ASHAs are expected to undertake newer roles in alignment with Government's approach towards delivery of comprehensive primary health care services to attain Universal Health Coverage, these essential components need to be strengthened on priority.

NATIONAL LEVEL FINDINGS-

Assess functionality of ASHA, VHSNC, MAS and JAS for their focus on equity, gender, people with disability, sociocultural and environmental determinants of health

KEY OBSERVATIONS

Selection of ASHAs

- Most of the states have selected ASHAs as per the target requirements. In rural areas, only four States of Bihar, Rajasthan, Telangana, and Uttar Pradesh reported lower number of in-position ASHAs than the national average of 96%. (Figure 3). Similarly, in urban areas, states of Bihar, Maharashtra, Telangana, and Uttar Pradesh reported lower proportion of in-position ASHAs than the national achievement of 89% (Figure 4).
- In Tamil Nadu, ASHAs are only deployed in tribal/ inaccessible areas. In other parts of the state,

Village Health Nurses (VHNs) are providing similar functions for maternal and child health (MCH) care. The State has engaged Women Health Volunteers (WHV) who receive performance-based incentives and are primarily engaged for follow up of Non-Communicable Diseases. Additional WHV were recruited under Makkalai Thedi Maruthuvam (MTM) scheme (2021) to undertake community- based NCD screening and delivery of free medicines at door step. Tamil Nadu has recruited one VHN and one WHV for a population of 5000 people. WHVs are selected amongst the local women of the region by the Tamil Nadu Women's Welfare Development Corporation.

- In most of the visited states, ASHA selection was through community participation, with the involvement of local bodies, i.e. panchayat and ULBs. In Jharkhand, ASHAs (Sahiya) were selected through 'public voting' in a transparent manner.
- In majority of the states, it was observed that the selection of ASHAs was in accordance with the recommended population norms in both urban and rural areas. However in Sikkim, the number of urban ASHAs were reported less as per the population norms which was highlighted as a challenge by ASHAs, as they were covering a catchment area for more than 8000 population per ASHA.
- Across all the visited states, ASHAs were found to be motivated, pro-active in undertaking their routine tasks and had adequate knowledge about the health care programs/initiatives/ schemes and were also actively mobilizing the community for seeking healthcare services.

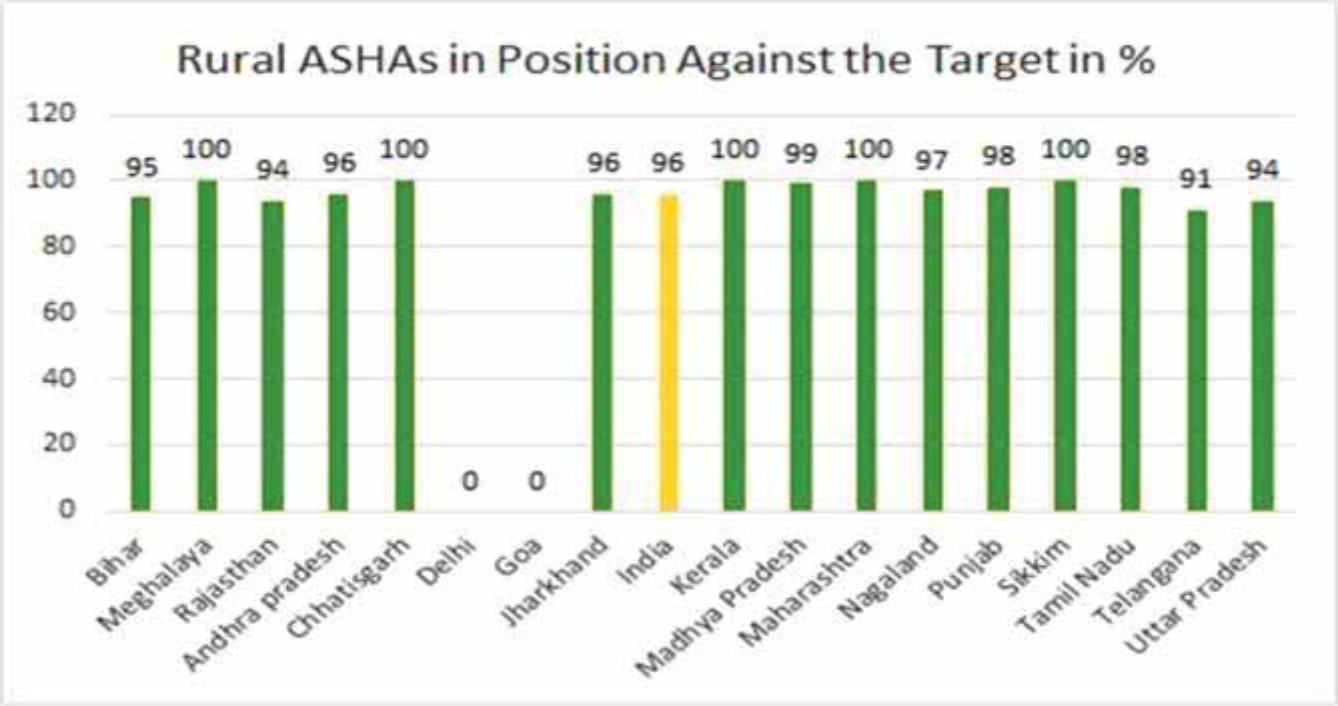


Figure 3: Status of ASHAs in rural areas

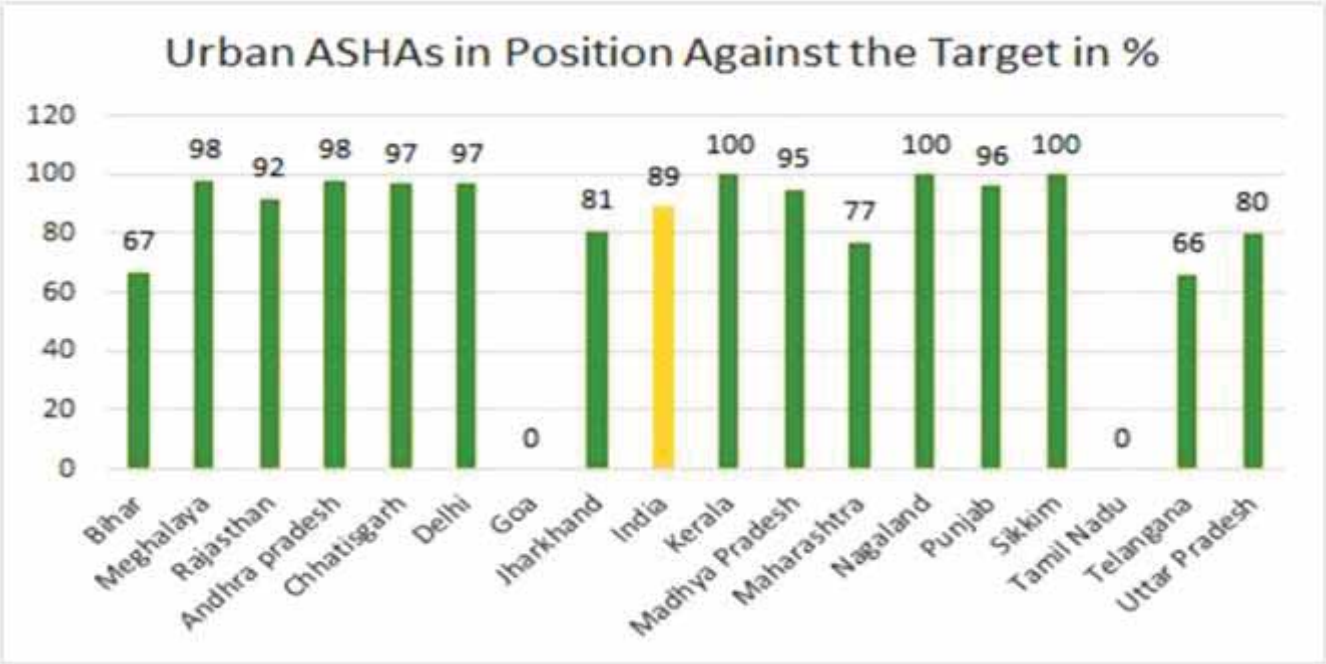


Figure 4: Status of ASHAs in urban areas

Training and Capacity Building of ASHAs (Induction, Module 6 and 7, NCD, HBYC, newer service packages of Oral, Eye, ENT, MNS, Elderly, Palliative and Emergency)

- Most of the visited states have completed the training of ASHAs in Module 6 & 7. However Telangana and Bihar states reported slow progress in completion of Module 6, 7 (round 4) trainings of ASHAs in rural areas. (Figure 5)

- In most of the states, in addition to Module 6 & 7, ASHAs were also trained on Home Based Care for Young Child (HBYC) and NCD. However, Nagaland reported lag in training of ASHAs on HBYC.

- Given that routine updating and skill building activities play an important role in building ASHAs' capacities in undertaking her routine work, it is important to ensure that refresher trainings are being conducted on a periodic basis. Refresher trainings were not reported as regular activity by states, except Kerala, where it was being done on an annual basis. In Meghalaya, newly ASHAs were not provided induction trainings, as mandated under national guidelines.

- The status of NCD training for ASHAs varied across states where although most of the states reported training completed, while in few states it was underway in selected districts. Despite of training being completed for NCDs, lack of orientation and clarity on community level activities like population enumeration and CBAC administration was observed uniformly across visited states.

- The trainings on comprehensive primary health care (CPHC) package of services such as Oral, eye, ENT, Emergency, elderly, palliative and MNS are ongoing in most of the visited states. In few states, ASHAs reported trainings being held on virtual mode were not very detailed and requested for in person training for better understanding and clarity.

- In Rajasthan, knowledge of ASHA on newer initiatives like PMSMA, MAA, NCD services was inadequate. Home visits by ASHAs were also not conducted regularly as per HBNC schedule.

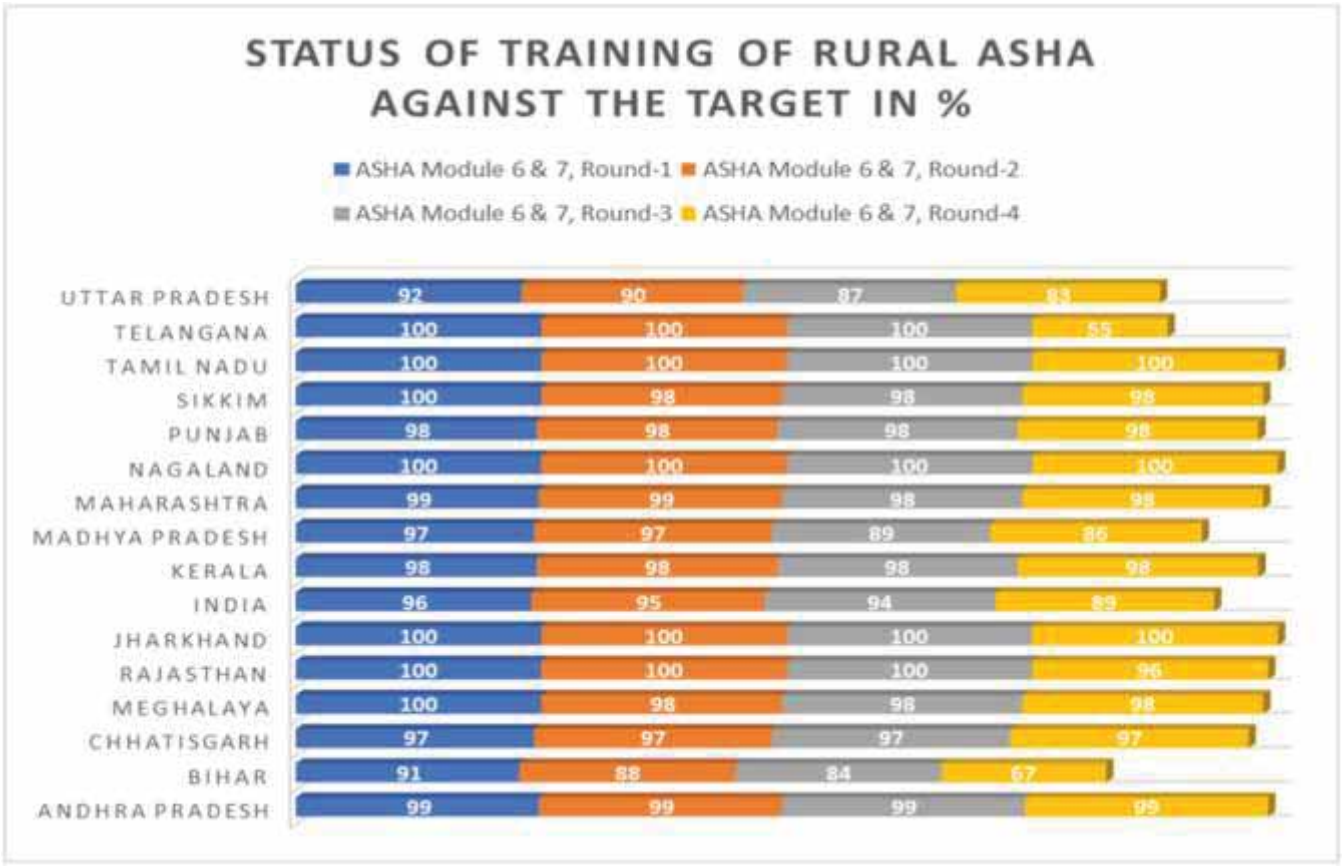


Figure 5: Training Status of ASHAs in rural areas

SUPPORT STRUCTURE AND SUPPORTIVE SUPERVISION

- A dedicated CP support systems comprising of state and district programme officers has been established in most of the visited States/UTs. ASHA facilitator (AF) was available in most of the states in rural areas, and they are the most important link in the providing handholding support to ASHAs. Maharashtra reported that ASHA facilitators were not oriented on the HBNC, HBYC, NCD and other expanded package services under CPHC.
- Most of the visited states have a dedicated support cadre in place at all four levels (State/ District/ Block & Sub-block), except for Maharashtra and Bihar where existing staff managed the programme at block level. UP has established the support structures at block level by positioning Block Community Mobilizers (BCMs).
- Some states such as Kerala, and Delhi have created a mix of dedicated and existing support structures setup in state programme management unit to support the ASHA programme.
- ASHAs are mapped for tribal areas in Kerala.
- It has been seen in most of the states like Delhi, Maharashtra, Kerala, Bihar and Madhya Pradesh, ANM has been providing the field level mentoring support to ASHAs. However, a poor coordination between ASHAs and ANMs was reported in Bihar.

ASHA INCENTIVES

Monetary Incentives:

- There were wide variations in the average ASHA incentives reported across States/UTs. The average monthly incentive earned by ASHAs ranged from Rs.6000 in Kerala to Rs. 10,000 in Andhra Pradesh.

- In addition to the NHM incentives, a number of states, including Andhra Pradesh, Bihar, Chhattisgarh, Delhi, Kerala, Rajasthan, Sikkim, and Uttar Pradesh, are providing incentives to ASHAs from their state funds. .
- Several states have developed their own online system for reporting of data and timely disbursement of incentives, where payments are made via DBT (Direct Beneficiary Transfer) directly to ASHA bank accounts.

Non-monetary Incentives: Social Security & Measures:

- As an additional measure to support the ASHA and recognize her work, selected states have included existing mechanism of social security benefits for ASHAs and AFs. Currently, ASHAs and ASHA facilitators are eligible for three social security schemes named as the Pradhan Mantri Jeevan Jyoti Beema Yojna (PMJJBY), the Pradhan Mantri Suraksha Bima Yojna (PMSBY), and the Pradhan Mantri Shram Yogi Maan Dhan Yojna (PMSYMY) along with state-specific social security schemes.

  The enrolment of ASHAs in social security schemes varied across states and which was related to awareness of the ASHAs regarding these schemes.

- In few states such as Delhi and Kerala, most of the ASHAs were aware and enrolled in the social security schemes PMJJBY, PMSBY, PMSYMY. However in Telangana and Andhra Pradesh, it was observed that despite awareness regarding the social security schemes (Aarogyasri and PMBSY) among ASHAs, majority of them were not enrolled in any of the schemes.
- ASHAs in Kerala have additionally been covered under the state specific social security scheme, which provides cover for accident, accidental death, and natural death.

IT Applications for Strengthening Payments

- Most of the visited states have reported use of IT applications to streamline ASHA payments. Jharkhand state is using the Sahiya Information Management App (SIMA) for real-time data entry, which aids in the timely payment of Sahiya (ASHA). Similarly in Delhi, timely and transparent disbursement of ASHA incentives is ensured through the web based portal.
- Meghalaya is using 'ASHA First' mobile application to ensure timely disbursement of incentives to the ASHAs. "Ashwin portal" is developed in Jharkhand to measure the performance, monitoring and disbursement of incentives to ASHAs and ASHA Facilitators.
- In Andhra Pradesh, ASHAs were using the "e-ASHA" app on their smartphones to ensure efficient service delivery to all beneficiaries in the state and timely reporting of the data.
- In Telangana, ASHAs and ANMs were using smart phones and tablets to enter the data on RCH, NCD and teleconsultation portal. Also, "ASHA Disease Profile app" was used for NCDs screening and annually maintain the disease profile of the community.

Safety measures and gender

- Most of the states have made provisions for the Grievance Redressal Mechanism for ASHAs to discuss issues related to their work or delayed payments.
- Few of states such as Maharashtra, Delhi, and UP have a well-established systematic Grievance Redressal System for ASHAs.
- In UP and Kerala, a dedicated grievance redressal committee has been constituted for resolving ASHA grievances. Whereas, in Jharkhand, ASHAs grievances are addressed on every 3rd Tuesday of the month which is celebrated as "Sahiya Divas".

Career Progression

- Creating career opportunities for the ASHA is another important avenue not just for recognition, but also to encourage a positive turnover and renewal of the ASHA from the programme and allowing newer selections to be made.
- In some of the states like Uttar Pradesh, Maharashtra, Andhra Pradesh, and Jharkhand had ASHA career progression pathways were in place.
- In Jharkhand, provisions have been made for ASHAs to fund 50% fees in case of ASHA register for an ANM/GNM courses and further receive preference in selection for jobs as ANM/GNM.
- Telangana state does not provide career progression option for ASHAs rather promote their education (who are below 8th standard) under Open Basic Education (OBE).

Village Health Sanitation and Nutrition Committee (VHSNC)

- Across India, approximately 5.5 Lakh VHSNCs were in place and 57% of them have been trained on the VHSNC guidelines (ASHA update, 2021). Constitution of VHSNCs is near completion in all states except Bihar, Telangana and Meghalaya which is reported less as compared to national average of 97%. (Figure 6,7)

- Among the visited states, mostly VHSNCs are constituted at revenue village level and have been formed as per the guidelines issued by MoHFW. However, meetings were found to be irregular and meeting minutes were unavailable in some states. This made it difficult to ascertain the output of the meetings and VHSNCs in general. In Madhya Pradesh, Gram Sabha Swasathya Tadarth Samiti' (GSSTS) were mostly non-functional, and meetings were not held regularly, neither they have documented the meeting minutes.
- In the state of Jharkhand, despite no trainings, status of VHSNC functioning was reported satisfactory. All VHSNC members were aware of their roles and responsibilities and were conducting regular meetings and maintaining the records. However, in majority of states, clarity amongst the members regarding their roles and responsibilities and utilization of untied funds was limited.
- Given the importance of trainings in building

capacities and orienting members regarding their roles, it is observed that only few states have completed the trainings of VHSNC members. In most of the visited states such as Meghalaya, Nagaland, Punjab, and Madhya Pradesh the pace of trainings was seen to be slow.

- Use of untied funds was also found to be unsatisfactory in most of the states. Some of the states such as Punjab, and Madhya Pradesh had reported that the untied funds have not been received in last two-three years.
- Most of the states reported utilizing the untied funds for emergency transport of pregnant women and conducting VHND meetings.

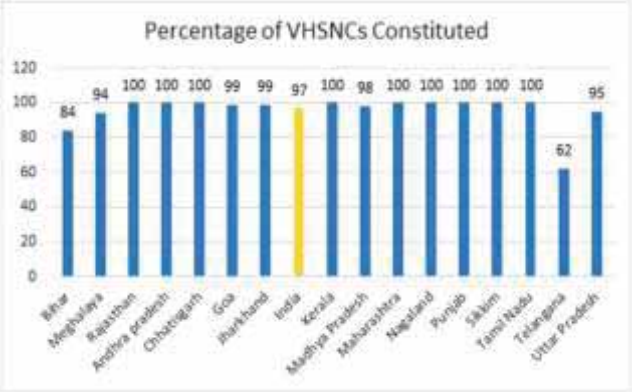


Figure 6: Status of VHSNCs constituted

Figure 7: Training status of VHSNCs

Mahila Arogya Samitis (MAS)

- Across India, 80,538 MAS have been constituted in the urban slum areas and 88% of them have been trained on MAS handbook. Out of 17 visited states, 7 States/ UTs (Kerala, Madhya Pradesh, Maharashtra, Nagaland, Telangana, and Uttar Pradesh) reported less MAS formation compared to National average. (Figure 8)
- In some of states visited, absence of Mahila Arogya Samitis (MAS) in urban areas was seen to be a major concern and in the states where MAS has been formed, it was either irregular in their meetings or were inactive. MAS members were also not oriented on their roles and responsibilities.
- Regular MAS meetings and record keeping have been reported from states of Madhya Pradesh, Jharkhand Andhra Pradesh and Delhi. However, in Telangana, meetings were not held since last one year.
- Tamil Nadu does not have Mahila Arogya Samitis (MAS) in place yet. Instead, the State engages women's Self-Help Groups (SHGs) and Women Health Volunteers (WHVs) in urban areas to perform functions similar to MAS especially for initiatives related to health promotion and disease prevention.
- In majority of the states, MAS members were neither oriented on their roles nor had received any training in last one year.
- The utilization of untied funds was optimum in most of the states except for Telangana.
- Major topics discussed during the MAS meetings were related to health and social challenges in community whereas in few states health related topics were not touched upon during these meetings.

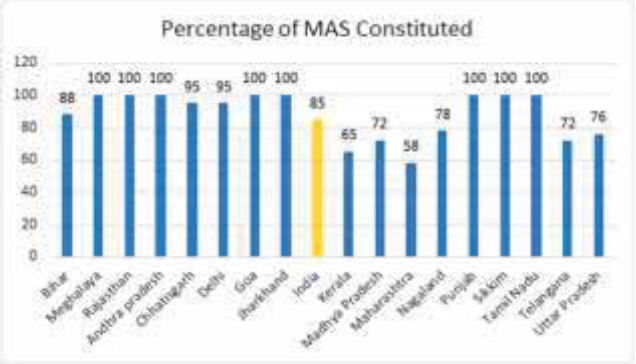


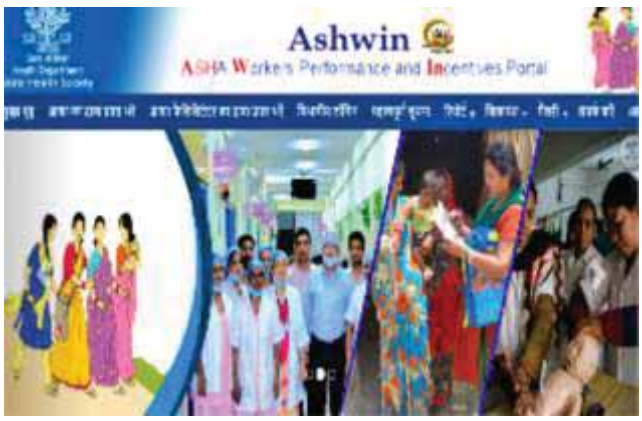
Figure 8: Status of MAS constitution

VILLAGE HEALTH NUTRITION DAYS/URBAN HEALTH NUTRITION DAYS (VHND/UHND)

- VHNDs and UHNDs were being conducted in all states to provide ANC and immunization services in rural and urban areas respectively. In most states, PRI involvement in VHNDs was limited. Additionally, there was little engagement or dialogue with the community in terms of organising these sessions at the village level.
- In most of the visited states, VHND/UHND sessions were conducted on a regular basis by ASHAs and ANMs at Aaganwadi centres. However in few of the states, a little involvement from VHSNC members was observed.
- In Sikkim, VHND were observed to be held on different days in different villages.
- The major activities during VHND/UHND are health education sessions, wellness activities, ANC, PNC, and NCD screenings.
- Some of the states have reported lack of coordination among AWW, ASHA, ANM during VHND in terms of activities and record sharing. Moreover, the sessions were not monitored by block/district officials or facility in-charge.

Rogi Kalyan Samitis (RKS)

- Rogi Kalyan Samities (RKS) were established under the National Health Mission (NHM) in health care facilities at the level of the PHC and above. The RKS were seen as a mechanism for promoting active public participation in health with the principle of decentralization and devolution of administrative and financial powers.
- With the launch of Ayushman Bharat, Primary Health Centres have been upgraded throughout the country as Health and Wellness Centres. The scope of services and responsibilities at the Primary Health Centre has also expanded. To improve and broaden its scope, the PHC Rogi Kalyan Samiti has been reformed as Jan Arogya Samiti- PHC (JAS-PHC). However, in some states RKS at PHC is still functioning.
- In most of the states and UTs such as Jharkhand, Delhi, Nagaland, Madhya Pradesh, Tamil Nadu, Chhattisgarh, Goa, and Sikkim, the RKS was in place and most of the states have reformed or initiated the process of constituting JAS at PHC-HWC as per the national guidelines. In Sikkim, at PHC level, it was observed that JAS and RKS are functional simultaneously as facilities are yet to receive directions from district to dissolve RKS. However, the frequency of meetings, record keeping, and utilization of untied funds was observed suboptimal in some of the states.
- In most of the states such as Tamil Nadu, Chhattisgarh, Delhi, and Madhya Pradesh, the RKS meetings were not held regularly, and members were unaware of their roles and responsibilities because none of them have received trainings or orientation so far.
- Utilization of funds under RKS needs attention in some of the visited states. In states like Madhya Pradesh and Chhattisgarh, RKS funds authorization and utilization were not in accordance with RKS guidelines. In Delhi, funds for last four RKS were



released between 2010 and 2016 and no other funds have been released after that because of poor utilization of existing funds.

- In most of the states, RKS/JAS untied funds were primarily used to purchase drugs and equipment, facility and ambulance repair and maintenance.

Jan Arogya Samitis- SHC-HWC

- Under Ayushman Bharat, the SHC level AB-HWCs, are provided Rs. 50,000 as united fund, enhancing the amount from Rs. 20,000 that was being provided to all SHCs earlier. This untied fund is expected to be used primarily for supporting the essential requirements for AB-HWC. A new committee called Jan Arogya Samiti (JAS) is to be established at the facility level such as SHC-HWC, PHC-HWC and UPHC-HWC, and also for UHWCs.
- Across all the visited states, JAS at SHC level were at a very nascent stage. In most of the states, the state specific guidelines and orders were in the process of being issued.
- Some states such as Uttar Pradesh, Punjab, Sikkim and Meghalaya have constituted JAS in most of the SHC-HWCs and were found to be functional with regular meetings being conducted and records were properly maintained.
- Since it is a newly formed committee, nearly all visited states are yet to initiate the trainings of JAS members.

LINKAGES OF VHSNC / MAS WITH PRI / ULB AND COMMUNITY ACTION FOR HEALTH

- Most of the states visited had issues pertaining to inter-sectoral coordination. In few states like Rajasthan and Madhya Pradesh, convergence was limited in respect to VHSNC/PRI and MAS/ULB and meetings were also not being held regularly. However in Sikkim, active involvement of PRIs and community ownership of public health facilities was observed during the field visits. Strong coordination across all primary healthcare providers (MLHPs, ANMs and ASHAs) was visible and evident.
- Good coordination among Panchayats, SHGs and ICDS department including ASHAs, ANMs, MAS & JAS was observed in Maharashtra.
- Community Action for health (CAH) mechanism was found to be completely absent in most of the visited states.

BEST PRACTICES

Bihar

- **Ashwin portal** has been developed to measure the performance, monitoring and disbursement of incentives and ASHA Facilitators. The portal is functional to ASHAs from December 2020.
- This online Incentive Payment System for ASHAs and ASHA Facilitators is a centralized system in which payments are made through DBT (Direct Beneficiary Transfer) in their bank accounts. This portal facilitates the filing of complaints and monthly community and institutional activities. It also helps in monitoring the work of ASHAs, their incentive disbursements, complaints and the dissemination of various orders and guidelines.

Andhra Pradesh

- Regular performance monitoring system - Under 'Gram Darshini' initiative, supportive supervision visits by District Level Officials were being undertaken to villages for monitoring activities under Health, Education and Nutrition.

Kerala

- **ASHAs - peer learning -** Every month during review meeting, ASHAs are given a topic related to any program or disease, etc. The ASHAs themselves read the topic for teaching others. In the meeting, any of the ASHAs are randomly asked to teach the given topic to all other ASHAs. This practice has led the ASHAs to study multiple topics thoroughly and has helped them to build strong confidence.
- **Computer training -** ASHAs are provided computer training which includes typing, data entry, sending mails, making google forms, word & excel training, etc.

- **Training on new diseases -** ASHAs are provided training on emerging diseases so as to build their capacity to deal with any potential outbreaks or epidemics.
- **Menstrual cups usage and counselling by ASHAs -** In some part of Thrissur district, ASHAs have been distributed free menstrual cups and trained to use those cups and spread counselling and awareness among community for using the same.
- **Cancer Screening -** Free cancer screening of all ASHAs in some facilities was started.
- **State insurance scheme -** ASHAs are insured under PMJJY, PMSYM, PMSBY, along with other State insurance scheme for accident, accidental death, and natural death.
- **Hamlet ASHA -** ASHAs are mapped for tribal areas in Kerala as Hamlet ASHAs.

Sikkim

- The State has its own software for stock keeping of medicine (True-PoS), and PHCs are using the software while SHCs are doing physical indenting of drugs. PHCs have been provided with Desktop computer to do stock entry.
- Counselling of adolescent girls by ASHAs on human trafficking and Incentivization of ASHA for reporting Gender based violence were observed in the state

Telangana

- State was providing palliative care treatment at the door step through ALANA vehicle. One MO, physiotherapist, staff nurses constitute palliative care team. Bed ridden, cancer patient, elderly people were benefitted with these services. Visit is made once in a two to three months' time.

Jharkhand

- Sahiya Information Management App (SIMA) is developed for streamlining the working and reporting of Sahiya and Sahiya Sathi. Currently the App is only used by Sahiya Sathi where she fills in details of work done by her Sahiyas.
- Mukhya Mantri Aarogya Kit for newborn care and early childhood development were provided to Sahiyas.

RECOMMENDATIONS

- With ASHAs role being expanded under CPHC, there is a felt need to strengthen her capacities to undertake her roles and new tasks which require higher level of skills and close coordination with the health systems. This indicates a need for states/UT to prioritize ASHA trainings and ensure timely, and quality trainings to be completed for all ASHAs and AF on relevant programme and services.
- Given ASHAs dependency on her supplies to undertake assigned tasks timely and efficiently, states need to ensure timely refurbishment of her kits, and ensuring elimination of stockouts of equipment and supplies.
- States need to ensure safe working conditions for ASHAs with rest rooms in all high case load health care facilities and an established grievance redressal mechanism at block, district and state level respectively.
- Use of IT platforms can be explored to minimize the load & ease the data collection process and link the same to incentive payments for ensuring comprehensive mechanism for data collection and reporting.
- ASHAs should be encouraged to enroll in training programs for enhancing their skills and subsequent career progression. ASHAs capacities should also be built on digital platforms and IT based solutions, thus enhancing her skills to provide her services efficiently, and aligned with reforms in her area of work.
- States to expedite the Constitution, orientation and training of different community platforms such as, VHSNCs/MAS and JAS. A strong monitoring and supporting mechanism needs be institutionalised across the states.
- Provision and optimal utilization of Untied Funds and constitution of Jan Arogya Samitis (JAS at

SC/PHC-HWC) with proper representation from PRI members needs to be ensured.

- JAS members to be oriented on AB HWC and their role as committee member. State / Districts to expedite the process for releasing advisories to dissolve RKS at facilities with functional JAS.
- States to prioritize empowerment of Community based platforms by enhancing their participation and engagement in health systems, which would need adequate orientation, training and mechanism for regular meetings and monitoring.
- State needs to prioritize training and orientation of ASHA Facilitators on national programmes, thus providing them required support to undertake their activities in the community.
- State needs to ensure enrolment of all ASHAs and ASHA facilitators in the three schemes - PMJJBY, PMSBY and PMSYMY, which are entitlements for ASHA/AFs as social security measures.

STATE-SPECIFIC OBSERVATIONS

Andhra Pradesh

- Total of 42,752 ASHAs are working in State and are getting a fixed incentive of Rs. 10,000 per month. All ASHAs are trained in module 6 and 7, along with HBYC, and HBNC.
- State does not have any provisions for career progression of ASHAs, although state government is supporting the ASHA's education through Open Basic Education.
- "ASHA day" is celebrated each month to review the ASHAs activities and to give orientation about new programme/intervention.
- An online application "e-ASHA App" has been developed for ASHAs to ensure efficient service delivery to all beneficiaries in the state and timely reporting of the data.
- All the VHSNCs were functional and an annual untied fund of Rs 15,000 was received on time in a joint account managed by ASHA and Sarpanch. The fund was mainly used for sanitization and emergency transport of pregnant women.
- Mahila Arogya Samiti (MAS) was formed in one of the visited Krishna district, with wide variations in the frequency of meetings andtraining/orientation of MAS members. In another Vizianagaram district, MAS was yet to be constituted.
- JAS/RKS reported to be non-functional in the visited districts (Krishna and Vizianagram).
- The RKS/JAS members were unaware of their roles and responsibilities because none of them have received trainings regarding their functions.
- UHNDs were found to be conducted only in one of the visited district (Vizianagram).

Bihar

- A total of 89,200 ASHAs were positioned in the state. It was observed that ASHAs performance varied across visited districts on knowledge, dedication and their role in undertaking program specific activities. ASHAs training status was also observed as sub optimal in the state.
- ASHAs were having ASHA kit with them but equipment and drugs were not being replenished regularly. Pregnancy test kit was not available with the ASHAs.
- The state has developed "Ashwin portal" to measure the performance, monitoring, and disbursement of incentives of ASHAs and ASHA Facilitators via DBT (Direct Beneficiary Transfer). The portal also facilitates the filing up of complaints along with the monthly reporting of community and facility-based activities.
- Grievance redressal mechanism was not formed in any of the health facilities.
- Lack of convergence between AWW, ASHA, ANM at VHSND in terms of activities and record sharing was observed.
- Although, outreach services (VHNDs/UHNDs/

special camps) were organized at Anganwadi centres, there was minimal engagement or dialogue with the community for organizing these services at village level.

Chhattisgarh

- A total number of 70,000 Mitanin (ASHAs) were positioned in the State.
- State has made arrangements for timely disbursement of the ASHA incentives using a "Mitanin Incentive Payment System" (MIPS) before the second week of every month.
- VHSNC/MAS were in place. However members were not trained on VHSNC module. Funds under MAS were not released for the financial year. It was observed that there was no follow up by UPHC for MAS to submit the expenditure reports.
- State has Rogi Kalyan Samiti (RKS) or Jeevan Deep Samiti (JDS) and JAS in place. It was reported that the frequency of RKS and JAS meetings was found irregular in both the districts.
- Partial utilization of RKS untied fund was observed for FY 2021-22 and FY 2022-23. It was observed that utilization of untied fund was done without the initiation of RKS meeting in the visited facilities.

Delhi

- State has poll booth wise recording of ASHA and ANM names in landscaping. Poll booth is the lowest administrative unit, hence it helps them understand their areas better.
- Most of the ASHAs were trained in Module 6&7, HBNC, HBYC and NCD. Community-based assessment checklist (CBAC) forms were not being administered in the UT.
- ASHAs focused on RCH activities. UT did not have career progression path for ASHAs.
- In Delhi, most of the ASHAs are enrolled in three social security schemes PMJJBY, PMSBY, PMSYMY
- Delhi has a three-tiered incentive structure for ASHA, jointly being funded by NHM and state government. A web-based portal is used for the calculation of the ASHA incentives. The incentives are transferred through Public financial management system (PFMS). Although a delay in receiving incentives was identified in one of the visited district because of issues in enrolment process with a new bank account.
- UT has a dedicated support structure in place wherein a unit/block level ASHA mentor group is present, followed by District & state level Mentoring groups, and state ASHA Resource Centre.
- In south west district, the MAS was well structured and functional. The minutes of the meeting were documented and availability and utilization of untied funds was also optimum. However in the northwest district, MAS was not constituted.
- RKS was practically defunct, and no regular meetings were being held. The funds for last four RKS were released between 2010 and 2016 and no other funds have been released after that because of poor utilization of existing funds. Given there are no RKS or JAS below district hospitals in the state, hence no mechanism of community involvement in facility-based decision making.

Goa

- The state has VHSNC, and MAS in place although their numbers were less as per target. Also, trainings of the MAS members were not undertaken by the state and submission of utilization certificates (UC) was pending at most of the facilities.
- RKS were formed at DH, CHC, PHC, and UPHC in adequate numbers as per the guidelines.
- RKS at the PHC is being replaced by the JAS. The meetings were conducted quarterly, and minutes were also documented.
- The District Health Society was monitoring the performance of the RKS at the District/Sub District

levels and provides need-based technical support and funds, based on state and national guidelines. Bank account was maintained, and proper audit was being maintained for each budget head.

- The committees also receive support from CSR. The committees had convergence with School health programs, Panchayats, ICDS, WCD.
- Grievance redressal mechanism was functioning at the DH, but nil complaints registered so far.
- Community Action for Health activities were not functional in the state.

Jharkhand

- ASHAs (Sahiya) are selected through 'public voting' in a transparent manner. In both the visited districts most of the ASHAs have undergone induction training, HBNC, HBYC, VISHWAS module and NCDs. Trainings on expanded range of services under CPHC were yet to be initiated by state.
- ASHAs in both the districts were enrolled under two social security schemes viz; Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY) and Pradhan Mantri Surakhsa Bima Yojana (PMSBY). However, it was observed that ASHAs in Deogarh district were unaware about the benefits availed through both the schemes. The premiums for these schemes are 436 and 20 INR respectively.
- VHSNCs were functional in the state. Each committee has around 12- 14 members and is headed by the PRI member and ASHA being the member secretary and convener conducts the monthly meeting. VHSNC members were yet to receive an orientation or trainings.
- Mahila Arogya Samitis (MAS), Rogi Kalyan Samiti and JAS were also constituted.
- SHC-HWC JAS were constituted only in one of visited Garhwa district but no meeting has been conducted so far and no training has been provided to JAS members.
- State has implemented "SIMA APP" (Sahiya Information Management App) an IT application to streamline ASHA payments. There were no incentive backlogs reported so far, and the funds were transferred to their account within 15 days of data reporting.
- Grievance Redressal was being done during 'Sahiyaa Diwas' on third Tuesday of every month.
- There is provision of career progression opportunities for ASHAs. The State mandates to fund 50% fees in case ASHAs register for ANM/ GNM courses and preference in selection for jobs as ANM/GNM.

Kerala

- State has mapped one ASHA for each ward, and for wards with bigger population, more than one ASHA are mapped.
- Refresher training of ASHAs are being done on annual basis. However, on every month end, review meetings are held at Sub centres where ASHAs present their monthly report.
- ASHAs were covered under three social security schemes PMJJY, PMSYM, and PMSBY, along with the state specific insurance scheme for accident, accidental death, and natural death.
- State has dedicated support structure for ASHAs. Overall, State Nodal Officer supports the ASHA programme at state level followed by district ASHA coordinator, Block Public Relationship Officer (PRO) and mentoring support by ANM at field level.
- ASHA grievance systems were observed in place. The first point of contact for grievance redressal for an ASHA is Medical Officer. However, a Junior health inspector also addresses the ASHAs' grievances and if the grievances are not resolved then a district level Grievance committee get involved to resolves ASHA's grievances.
- There was no JAS and MAS observed in Thrissur district. Thus, indicating a need to strengthen the community engagement in the district.

Madhya Pradesh

- ASHAs were seen motivated, getting incentives on timely basis and were registered under two social security schemes namely PMJBY and Pradhan Mantri Suraksha Bima Yojana.
- MAS and VSHNCs were constituted in the state.
- VHSNCs in Madhya Pradesh are known as 'Gram sabha Swasthya Tadarth Samiti'. It was reported that VHSNCs were mostly non-functional, meetings were not held regularly and meeting minutes were not documented. The members were not aware about the untied funds and no trainings of the members were held. The state had also not received the untied funds for the last FY.
- MAS meetings were held regularly, minutes of meeting and cash books were properly maintained under the supervision of UPHC Medical Officer. Major topics discussed were related to health and social challenges in the community, home-based care, first-aid in emergency etc.
- ASHAs were also seen to be involved in "Saas Bahu Sammelan" and routinely having Gram Sabha Swasathya Tadarth Samiti meetings which are equivalent to VHSNC meetings.
- Jan Arogya Samitis (JAS) constitution was reported to be in very nascent stages.
- VHND sessions were usually conducted monthly by ANMs as an outreach activity, with little involvement from VHSNCs members. Also, minimal engagement or dialogue with the community for organizing these services at village level was seen. Furthermore, the MCP cards were found to be incomplete and there was no record of HBNC visits or growth monitoring/charts in the Sidhi district.
- RKS funds authorization and utilisation were not in accordance with RKS guidelines and RKS funds had not been audited since last three years.

Maharashtra

- The training status of ASHAs varied in state. Total 60,909 ASHAs are in position in the state, while only 88%, 49% and 15% of ASHAs were reported trained on NCDs, HBYC and multiskilling respectively. A total of 60,909 ASHAs were positioned in the state and training for ASHAs was limited, only 15%-Multi Skill, 88%-NCD and 49%-HBYC were held in the state. Even for ASHAs trained on HBYC, the HBYC-ECD kit was not provided.
- A long-term gap in trainings (new & refresher trainings) was noted in the state which restricted the functionality of ASHA on tasks related to HBNC, family planning and expanded packages of services in Dhule district.
- Most of ASHAs had clarity on their roles and skills and were well rooted in community with good empathy and rapport. ASHA facilitators are yet to receive training on HBNC, HBYC, NCD and other expanded services (i.e. Oral, eye, ENT, Emergency, MNS & Elderly & Palliative Care).
- Non-functional items were observed in the ASHA's HBNC kit like thermometer, weighing scale has not been replaced since 2011-12. Most of the equipment of the kit were found non- functional.
- ASHAs were enrolled in 2 insurance schemes (PM Jeevan Jyoti Bima Yojana and PM Suraksha Bima Yojana).
- Career progression pathways were observed for ASHAs in the state.
- Mahila Arogya Samiti were not fully operationalized in the state and functionality of JAS was also noted as a challenge.
- Good coordination with Panchayat, SHGs and ICDS dept including ASHAs, ANMs - MAS & JAS was observed.
- Community Action for health (CAH) was found to be completely absent across levels.

Meghalaya

- Training of ASHAs was seen at different stages, where the district wise training status also varied within state. For e.g. In southwest Kashi hills, ASHAs were not found trained on VHSNC, NTEP and Malaria etc. Newly recruited ASHAs in the state were yet to be trained on the induction module. Some of the ASHAs were not trained on module 6 & 7.
- Under CPHC, ASHAs and ANMs are yet to be trained on expanded range of services.
- All the ASHAs were observed using revised CBAC forms for risk assessment of individuals of age group 30 years and above.
- The state has constituted Village Health Councils (VHC) (similar to VHSNCs) at every village level. VHCs are conducting regular meetings. However, they lack proper orientation/training on their roles and responsibilities.
- In the state, ASHA payments are made through 'ASHA First' mobile application to ensure the timely disbursement of incentives to the ASHAs. The payments are issued on a weekly basis thereby reducing the delays in ASHA payment. Two common challenges reported by ASHAs were lack of internet connectivity and issues with functionality of mobile phones.
- Almost all the AB -HWCs (PHCs and SHC) have JAS in place. Training cum orientation on JAS had been conducted for district level officials. Trainings for JAS members was yet to be initiated by the State.
- Two or three JAS meetings had been conducted so far in the visited facilities and for which the minutes were recorded and documented.

Nagaland

- Given the geographical distribution and tribal population subgroups in the state, ASHA in rural areas is at a population density of 600 approximately. ASHAs and ANMs knowledge and orientation on national programmes was found inadequate, and also their role in community activities was suboptimal.
- The state has constituted Village Health Councils (VHC) (similar to VHSNCs) at every village level. However, no formal trainings have been conducted for them.
- The state has circulated the new guidelines for establishment of JAS and all respective institutions were in process to constitute JAS.
- Trainings of JAS (where constituted) and RKS members were yet to be undertaken by the state.
- Inter departmental coordination between health education and ICDS needs to be established in the state. Currently, lack of interdepartmental coordination was observed.

Punjab

- Most of the ASHAs in state have completed their training on module 6&7, HBNC and HBYC and NCD services. They were aware of their routine activities and had knowledge regarding the incentives for each activity. It was observed that ASHAs were getting their incentives timely.
- The district level training of trainers (ToT) for ASHAs and ANMs on expanded range of services under CPHC is currently ongoing in the state.
- States has VHSNC/ MAS in place. However, lack of orientation of members on their roles and responsibilities, including availability and utilization of untied funds was observed across the platforms in both rural and urban areas.
- Regular monthly meetings by VHSNC, MAS and JAS were being conducted in the state, despite unavailability of funds. The state reported of not receiving the untied funds from last 3 years.
- JAS members also lack orientation and did not have the complete understanding of JAS role and functioning. In one of the visited Ferozepur districts, JAS was formulated, and the meetings

were conducted regularly. It has been observed during the JAS meeting, discussions were mainly related to infrastructure development of AB-HWC whereas health-related issues were not discussed.

Rajasthan

- ASHAs and ANMs have undergone training (5 and 3 days, respectively) on NCDs including their role in CBAC administration, record maintenance and creation of family folders at the HWCs.
- Knowledge of ASHA on newer initiatives like PMSMA, MAA, NCD services etc. was found sub optimal. In HBNC, ASHAs home visit were not being conducted regularly as per program guidelines.
- During interactions with ASHAs, they shared that they had concerns regarding their uniform and they are not happy with its colour and requested if that can be changed.
- It was observed that MAS committee was constituted in the state. Although, regular meetings were not being held. Jan Arogya Samiti (JAS) was yet to be constituted in the district Kota.
- The convergence was limited between community-based platforms and local bodies in rural and urban areas, i.e., VHSNC and PRI & MAS and ULB.

Sikkim

- ASHAs are getting additional incentive of Rs. 6,000 from state, which is under further revision. ASHAs across the districts are functional and motivated to work in their capacity of Community Health Worker. However, ASHA kit was identified as a concern, as it is not being refurbished timely, thus hampering their functionality.
- In urban areas, ASHA mapping was identified as an area of concern. It was observed that in urban facilities, approximately 29 ASHAs were covering a population of 4000-8500 population with 2 ASHA Facilitator at present. The ASHAs were of the opinion that covering 8500+ population is difficult for them.
- ASHAs were trained on NCDs and other recent programmes through virtual mode, for which they requested for an in-person training again for better understanding of the content and their role. In addition to training, in selected areas of Namchi district, ASHAs were provided with BP apparatus and glucometer from the panchayats to undertake screening activities along with CBAC administration. ASHAs in both districts were also involved in risk assessment through CBAC but follow up activities were missing from their roles.
- Rural ASHAs were not aware in both districts regarding social security benefits for ASHA and ASHA Facilitators.
- VHND Days are organized on different days in different villages. Health education sessions, wellness activities, NCD Screening are undertaken during VHND Days.
- It was observed that VHSNC untied funds was being used for VHND meetings as well, especially in the East district.
- In Sikkim, Jan Arogya Samitis (JAS) were formed across all AB-HWCs, and meetings were being conducted regularly. The records were well maintained across HWCs.
- In Sikkim at PHC level, it was observed that JAS and RKS are functional simultaneously, as facilities were yet to receive directions from district to dissolve RKS.
- Active involvement of PRIs and community ownership of public health facilities was observed during the field visits. Strong coordination across all primary healthcare providers (MLHPs, ANMs and ASHAs) was visible and evident. MLHP/CHO and MO interactions were in place, and were identified as a routine process.
- Reporting of Gender based violence were observed as good practices in the state.

Tamil Nadu

- A total no of 2606 ASHAs are positioned in the state, deployed only in the tribal/inaccessible parts of the State. Village Health Nurses (VHN) function in the other parts of the State similar to ASHAs and WHVs are also functioning in the state for community level activities.
- It was found that ASHAs/WHVs were given an orientation training on their initial recruitment, however, refresher trainings were not being conducted.
- Most of the PHCs, CHCs and District Health Facilities have patient feedback systems in place, and information is collected on about 20 parameters.
- VHSNCs meetings were not being held as per guidelines. The Panchayat Sarpanch and ward members seemed to be unaware of their roles and responsibilities.
- It was observed that mandated gram panchayat development plans do not comprehensively include the health-related components indicating the lack of awareness about their role in safeguarding the health of villages.
- Tamil Nadu has a different structure of Mahila Arogya Samitis (MAS) in place. State also engages women's Self-Help Groups (SHGs) and Women Health Volunteers (WHVs) in urban areas to perform functions similar to MAS especially for initiatives related to health promotion and disease prevention.
- Patient Welfare Societies (PWS)/ Rogi Kalyan Samiti (RKS) have been established as per guidelines in all the Block and Urban facilities.

Telangana

- ASHAs were found proactive in their roles within their catchment population area & across facilities/ communities. They are getting fixed incentive of maximum up to Rs 9,750/- and minimum up to Rs 7,000/- based on the predefined performance parameters entered into the KCR Kit app.
- ASHAs were aware about the social benefits under which they are covered - i.e. Arogyasri and PMSBY. However, it was observed that many ASHAs/ ANMs were not covered under this insurance scheme.
- ASHAs and ANMs were also using the digital tools for entering and updating the data in the field. They were using smart phones and tablets to enter the data on RCH, NCD and teleconsultation portal. Also, "ASHA Disease Profile app" was used for NCDs screening and annually maintain the disease profile of the community.
- VHSND/UHND sessions were conducted on a regular basis by ASHAs and were also visited by respective ANMs and CHOs, as in both districts.
- In the state, MAS functioning was supported by MEPMA, a Self-Help Group. However, it was observed that MAS meetings have not been conducted in either of the district in last year, thus the untied fund was unutilized for the given time period (Last year).
- Jan Arogya Samitis (JAS) is yet to be formed across HWCs, and currently RKS is functional at HWC-PHC level as facilities are yet to receive directions from state to constitute JAS and dissolve existing RKS at PHC level.

Uttar Pradesh

- ASHAs/ANMs' orientation on NCD care was found to be limited.
- Support structure at the block level was found to be adequate with all blocks having BCPMs and grievance redressal committee was found in place.
- JAS is constituted across the state in most of the SHC-HWCs and was found to be functional and regular meetings were being conducted. Record upkeep was in place with the JAS register being maintained regularly.
- The state was yet to initiate the trainings of JAS/RKS members.

HEALTH PROMOTION AND WELLNESS ACTIVITIES

Health promotion and information provision at the community level is an integral part of the expanded range of services under Comprehensive Primary Health Care. Health is affected by various social and environmental determinants and actions to address these issues often do not fall in the purview of health systems alone and therefore requires intersectoral convergence and people's participation.

The Health Promotion strategy recommended by the National Health Policy 2017 emphasizes institutionalizing intersectoral coordination at national and sub-national levels to optimize health outcomes, through constitution of bodies that have representation from relevant non-health ministries. This should be in line with the emergent international "Health in All" approach as complement to Health for All.

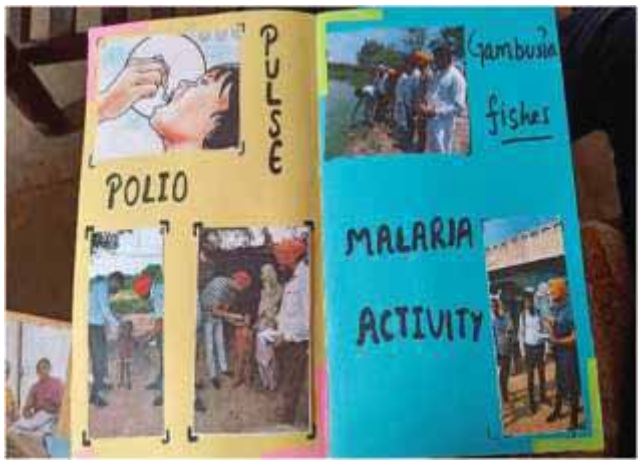
KEY OBSERVATIONS:

Health Education: Celebration of Health days: Annual health calendar of AB-HWCs facilitates organizing special events for several common disease conditions and health promotional activities, which also includes targeted age group and conditions specific days.

Annual Calendar Health Days were displayed at visited SHC-HWCs of Punjab, Sikkim and Madhya Pradesh, and the days were found to be celebrated with the community participation. Celebration of Health Days were reported to be regularly conducted in the visited facilities of Chhattisgarh.

INFORMATION, EDUCATION, COMMUNICATION (IEC): Availability of Health education material and Citizen Charters was varying across states, where in states like Meghalaya and Sikkim, Citizen charters were noted across all visited health care facilities. The IEC material was adequately displayed at visited health care facilities across all states. However, in Nagaland it was noted that most of the messages displayed were in English, and not being appropriate to local context. Meghalaya, on the other hand had more context specific approach where the IEC message were displayed in local language, thus

maximising its absorption and impact. The CRM team found that the members of the community and health functionaries not well-versed in English were not able to take any message from the materials being displayed in English. In Bihar Hand-made innovative IECs, Protocols and SOPs were prepared by the Staff nurses and displayed. In Sikkim, IEC corners were noted at all the visited health facilities. Similarly, in Delhi, Goa, Jharkhand, Punjab, Tamil Nadu the IEC material was reported to be displayed at visited health facilities. In Rajasthan IEC material was displayed at the public areas on National Health Programmes. Madhya Pradesh and Uttar Pradesh reported limited IEC activities being conducted across the districts.



Wellness activities: In most of the states visited, wellness activities at AB-HWCs were not regularly conducted and facilities did not have adequate space for conducting wellness sessions, especially in states of Punjab, Rajasthan, Madhya Pradesh, Telangana, Bihar, Uttar Pradesh, and Maharashtra. Regular yoga sessions as part of wellness activities were observed in Meghalaya, Sikkim, Tamil Nadu, Andhra Pradesh, and Chhattisgarh. Lack of dedicated space, lack of orientation and unavailability of trained yoga personnel was cited as the common reason for unavailability of regular wellness sessions and yoga activities. However, despite MLHPs not been trained on Yoga, they were conducting yoga sessions as a routine activity across AB-HWCs in Meghalaya.

RECOMMENDATIONS:

- State to ensure availability of trained yoga instructors across AB-HWCs to streamline yoga and wellness activities. This may also include exploring the training of MLHP/CHO on yoga.
- Annual Health Calendar / wellness activities to be planned and implemented across all AB-HWCs.
- Annual Health calendar activities when being planned, in addition to CPHC nodal, respective programme officers to be involved in planning and implementation activities.
- Promotive and preventive care activities at the HWCs are to be emphasized and active engagement and capacity building of community platforms can be planned across the catchment areas of HWCs, including existing local groups and individual volunteers.
- At the community level, committees are to be constituted with representation from health and relevant non-health departments for health promotion activities.
- In case of unavailability of dedicated space at AB-HWC, other options to be explored to ensure

regular wellness sessions are being held as a routine activity of AB-HWCs.

- IEC materials displayed at the health care facilities to be more context specific and in local language preferably.

STATE SPECIFIC FINDINGS:

Andhra Pradesh

- At AB-HWC, yoga activities were being undertaken by yoga trained MLHPs and outreach sessions were also being held regularly.
- Wellness sessions and Annual Health days as per the Annual Health Calendar were not organized regularly.
- Lack of dedicated space at health facilities to conduct wellness sessions. Also record maintenance was not observed for wellness activities.

Bihar

- Wellness activities were initiated but records were not available at the facilities visited in both the districts.
- Annual health calendar days were not being followed across any AB-HWCs.

Chhattisgarh

- Wellness activities/Yoga being carried out on a regular basis across heath care facilities, and records also maintained for the same.
- Celebration of annual health days as a routine activity was observed across facilities. However, attendance of the participants needs to be maintained.

Delhi

- No preventive, promotive and wellness activities were being undertaken. Only curative services were provided.
- No yoga services were available across health care facilities.

Goa

- Relevant IEC materials for all national Health programmes was available at the health facilities.
- No fixed calendar was being followed for Yoga sessions, but some facilities were conducting yoga activities as per the availability of a trained yoga instructor.

Jharkhand

- IEC material displayed across all facilities.
- Regular wellness activities such as Yoga were observed only in Deogarh district.
- Due to the unavailability of yoga instructors, wellness sessions were not being conducted in other facilities.

Kerala

- Wellness activities were yet to be initiated in most of the visited facilities.
- The Annual Health Calendar was not available at AB HWCs (FHC) visited.

Madhya Pradesh

- Annual health calendar were displayed at AB-HWCs, and health days were being observed and celebrated with adequate community participation.
- Wellness activities such as Yoga were not being regularly planned and conducted at AB HWCs.

Maharashtra

- Health Promotion and wellness activities were being carried out at the community level.
- Wellness sessions were not being held regularly, and records were not maintained.
- Lack of IEC was observed for public awareness on availability of services across health care facilities.
- No regular system of program review meetings for AYUSH service providers in the districts.

Meghalaya

- Wellness sessions were conducted at HWCs. MLHPs were conducting 4-5 yoga/exercise sessions on a monthly basis at AB-HWC level.
- MLHPs were conducting yoga sessions without any training in yoga.
- Knowledge regarding Annual health calendar days was found to be very limited.
- Patient charter and health promotion materials were adequately displayed in local language at the health facilities. This was well received and understood by the community.

Nagaland

- Yoga activities as part of health promotion and wellness was not being undertaken in most of the AB-HWCs. Yoga sessions were reported only in Zunheboto district facilities.
- IEC material was available and displayed at health care facilities.

Punjab

- IEC material well displayed at AB HWCs.
- Lack of focus on preventive aspects like information and counselling services, wellness aspects including yoga and physical activities. Yoga and wellness activities not being planned and conducted regularly at AB-HWCs.
- Regular outreach activities were observed only in Rupnagar district.
- Annual Health Calendar days were displayed across AB-HWCs and days were being observed with community participation.
- Records were being maintained for all wellness activities undertaken at AB -HWCs.

Rajasthan

- Health promotion and yoga sessions were not being conducted regularly.
- IEC material displayed across facilities for all National health programmes.

Sikkim

- Wellness activities are being organized at all AB-HWCs, where some facilities have a dedicated room/ space where Yoga and Zumba were being practiced.
- In one of the districts (south district), it was observed that some of the facilities, due to the lack of enough space inside, were organizing wellness activities in nearby schools, community centres, spaces near PHCs.
- MLHPs across HWCs have been trained for Yoga and were conducting yoga and wellness activities in schools and in community.
- The Annual Health Calendar was observed being followed across all primary level facilities and calendar days were displayed across all AB HWCs.
- IEC Corners were established at all the health facilities, along with Citizen Charter and Health Calendars at all the AB-HWCs.

Tamil Nadu

- Weekly yoga/wellness activities were being conducted at AB-HWCs.
- Adequate space for wellness and yoga activities in visited health facilities.
- Limited community awareness and engagement in health promotion and wellness activities.
- Patient support groups for NCDs - hypertension and diabetes were formed at AB-HWC- SHC level, for which separate wellness/IEC sessions were being conducted.
- UPHC in Thoothukudi (Therisapuram) - facility specific initiative where the UPHC has installed an exercycle and treadmill for walk-in patients to use free of cost.
- Model PHC - In Tiruvannamalai - with massive, lush park, walking path and a dedicated area for wellness activities.
- Adequate IEC material and counselling services were available as per the programme needs, However, maintenance of records was seen as a challenge.
- Mobile IEC van for Family Planning promotional activities were observed in the districts.
- "Mana Nala Vyazhan" (Mental health Thursdays) - Unique initiative at the Block PHC level focusing on IEC on mental health topics and mental well-being.

Telangana

- No designated space for wellness activities across the districts.
- Very few wellness sessions were being undertaken at AB-HWCs, and lack of documentation and records was seen.
- No annual health calendar observed across health facilities.
- Lack of IEC material was observed at health facilities.

Uttar Pradesh

- Inadequate space for wellness activities across health care facilities.
- Limited focus and awareness regarding wellness activities was observed amongst health care service providers and community members.
- Lack of trained Yoga personnel across AB-HWCs.
- Well displayed IEC/BCC for family planning activities was observed across facilities.
- NCD clinics did not have IEC material. However, some IEC material seen highlighting NCD associated risk factors.

REVIEW OF ALL IT APPLICATIONS, CP-CPHC – STATUS, UTILIZATION AND CHALLENGES

IT based solutions are a priority at the primary health care level, where NHM emphasizes on use of standardized digital solutions to support implementation through establishment of a seamless flow of information across levels of care. The IT based solutions at the level of AB-HWCs are being envisaged to ensure an integrated approach through an interoperable structure of existing applications/ software, thus providing not only data management support, but also enabling programme officers to analyse and know their population better.

Use of information technology would be essential to enable efficient service delivery at the AB-HWCs in rural and urban areas.

Currently several programme specific and process driven IT based portals or software are operational at the primary level across all states/UT. In addition to nationally designed IT based solutions, some of the states also have state specific IT based platforms to support NHM related activities and processes. The platforms capture the information at the facility level and community level, as per their design and are being used to provide an overall status at state level dashboards, thus ensuring availability of information as per the need of the programmes.

While the IT based solutions are a step towards ensuring expanded service delivery, in alignment with nation's path towards attainment of Universal Health Coverage, several factors like availability of IT support in terms of equipment and network play an important role in smooth functioning of these platforms.

The CRM team visited the states to understand the availability as well as functioning of the IT based solutions in similar contexts, across the primary health care level.

KEY OBSERVATIONS

- While the IT based solutions have been implemented across the states, the common issue observed during the CRM was unavailability of network or poor connectivity at the facilities, thus affecting the utilization of digital platforms at primary health level.
- Unavailability of fixed line internet was highlighted as a concern across AB-HWCs by service providers. While in states like Kerala and Tamil Nadu, internet connectivity issues were limited to tribal and far-flung areas, it was highlighted as a barrier across all other states.
- Several mechanisms were reported, which were used by primary health care team to address these challenges spanning utilization of personal internet or mobile data, digital entry being done after reaching home or an area with available internet connections and doing backdate entry in one go when internet connectivity is available.
- The other factors affecting the data management through defined IT based solutions was availability of IT equipment and the level of training of HWC team members on IT based platforms.
- Availability of IT equipment was not uniform across states where it was only reported positive from the states like Andhra Pradesh, Chhattisgarh, Jharkhand and Sikkim.
- However, in Sikkim, the tablets provided to the CHOs had functionality issues with lack of troubleshoot mechanisms at place, and in Jharkhand it was only observed in one district.
- In terms of training of HWC team members, Kerala reported training of ASHAs on IT functionality and Andhra Pradesh reported ease in use of application for HWC team members with high digital literacy, while it was not observed in any other state.
- Despite reported IT infrastructural constraints, the IT applications were still being utilized but in a

compromised manner, thus ineffective in yielding desired results.

- For RCH specific IT based solutions, ANMs across states were using ANMOL applications, but lack of training was reported as a common challenge for its effective utilization.
- IT system strengthening is a continuous process and needs focus on hardware and software provisioning and regular upgrading.
- For utilizing these services and smooth functioning technology literacy and knowledge are very important.
- In state specific examples, it was observed in Andhra Pradesh that among all cadres from MO to ASHA level, technology literacy and knowledge was quite high whereas in the Buxar district of Bihar due to lack of training on the portals, the portals like RCH, ANMOL, NCD, HWC, FPLMIS etc. were still not fully functional.
- Several states have their own state specific applications being developed and utilized, such as the developed SIMA App for streamlining the working and reporting of Sahiya (ASHA) and Sahiya Sathi (ASHA Facilitators), and an additional IT applications like ODCT (Open Data Collection Toolkit), Blood Management System and HRIS (Employee Management Portal).
- Delhi has not rolled out DVDMS and they have their own portal "NIRANTAR" for drug procurement.
- In Kerala Shaili app for ASHAs application has been implemented by the e-health in 140 panchayats under 1st phase. It covers Diabetes, Hypertension, Breast cancer, cervical cancer, Oral cancer, COPD, TB & Palliative care. Kerala has ASHA Incentive Software (ECMAN State application) "Ecman"- an online reporting system capturing activities of ASHAs and linked to the honorarium payments is operational.
- Madhya Pradesh has developed Performance and Incentive management portal - MP Aarogyam: Performance and Team-Based Incentive of the SHC-HWC team and Performance-Linked Payment of CHOs are managed through MP Aarogyam.
- Utilization of programme specific applications and software was sub-optimal and varied across states. With lack of integration, lot of duplication of efforts was observed as well as reported at the facilities.
- For NCD specific interventions, it was observed that some states were also using IHCI Simple application in addition to GoI's CPHC NCD application at the HWC level.
- Service providers across states shared that this was leading to duplication of efforts wherein they were entering similar data on both the softwares and thus resulting in additional work.
- Also, since IHCI was specific to hypertension, states were more comfortable in using CPHC NCD application, which is broader and comprehensive in nature. However, the AB-HWC team demanded training and established troubleshooting mechanisms for CPHC NCD applications for its smooth functioning.
- For e-sanjeevani services across the facilities, in most of the states, the medical officers were utilizing mobile phones for providing the tele consultations. Connectivity was again reported as a constraint in effective delivery of the tele consultation services.

RECOMMENDATIONS:

- States may expedite the availability of internet connectivity across AB-HWCs. Broadband (FTH) with stable connectivity is recommended for all primary health facilities to ensure high quality tele-consultation services. With MoHFW initiatives towards ensuring availability of last mile

connectivity, states may map facilities and prioritize the interventions.

- State may plan to undertake skill building activities for primary health care providers across the facilities. It is needed to build the capacities of the HWC team members on IT Based solutions, thus ensuring timeliness in reporting, recording and utilization of these applications and software. For already trained human resources, it is recommended to provide a refresher training on digital solutions and its use.
- States need to minimize the duplication of efforts, and plan towards integrated approach for state specific IT solutions, by ensuring a mechanism where data sharing between national and state specific portals is available.
- CPHC NCD application is yet to be utilized to its full capacity, due to technical constraints including training of the team and availability of connectivity. States may prioritize these concerns to resolve them on priority for effective CPHC service delivery at AB-HWCs. States are recommended to use National CPHC NCD application and avoid duplication with any other existing NCD applications. For state specific digital solutions, inter-operability must be ensured.
- Mechanism needs to be ensured for validation and verification of the data being entered in the portals at the primary level.
- Though teleconsultations via e-Sanjeevani were being conducted, it is imperative to ensure the e-prescription of drugs under EDL and the program implementers must ensure the availability of same at the health facility.
- States may provide refresher training on FPLMIS, HWC, NCD applications to all the Medical Officers.
- MoHFW is functioning in an integrated way to ensure that all IT applications are under same platforms, to be reflected under ABDM. States need to also prioritize the generation and usage of ABHA IDs across its facilities. ABHA ID is recommended for use at every health facility for line listing of the patients and avoiding duplication of data.
- Data analysis for trend, pattern and programmatic outcome reports needs to be shared with the health facilities at all levels.

GOOD PRACTICES

Pregnant women & Child Tracking System (PCTS) and its integration with HMIS as well as its integration with JSSK, JSY, ASHA payment App is good practice in the state of Rajasthan. In Andhra Pradesh a total of 30 mobile applications and 21 web portals were functional as state initiative apart from the mandated MoHFW, GoI initiative IT portals.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- Easy to use applications for ASHAs, ANMs and Medical Officers for monitoring, reporting data and tracking the stocks of essential consumables were available.

- Data from different applications were found integrated with the IT dashboard at State level for monitoring programme activities.
- Teleconsultation services were operationalized at all levels of the health facilities. 27 Telemedicine Hubs were established e-Sanjeevani OPD portal was widely used for tele-consultation, both by patients and doctors. Referrals were high at SC-HWC level (SC-HWC - 930 per month referrals/PHC-59/UPHC - 49 per month).
- Hub and Spoke Model for teleconsultation services has been adopted in the state.
- Connectivity issues were common especially in the tribal areas, affecting the quality of consultation services and increased waiting times.

Bihar

- Suboptimal reporting of CBAC forms on CPHC NCD portal was observed.
- e-Aushadhi portal and DVDMS were being used in Bihar up to the level of SHC-HWC.
- In the visited facilities ANMs were using ANMOL, IHIP and e-Aushadi portal.
- Due to lack of training on the portals, the portals like RCH, ANMOL, NCD, HWC, FPLMIS etc. were not fully functional in the Buxar district of Bihar.
- CHOs were very good in delivering services in the OPD, in their relationship with the patients and the doctor at the hub and handling IT systems such as indenting drugs through DVDMS and carrying out diagnostic tests etc.

Chhattisgarh

- Tele-consultation services have started in HWCs. Most of the teleconsultation cases accessed specialists services like Medicine, Surgery, Paediatrics, O & G, Psychiatry, ENT etc. However, network connectivity, hub-to-spoke ratio and printing of prescriptions were areas of concern.
- Software platforms like AB-HWC app, NCD portal, e-Sanjeevani, ANMOL were being used in the visited HWCs. The CHOs were being provided with IT tools (Tablet/Laptop).
- Kewara HWC conduct 5-6 telemedicine sessions per day. In UPHC, the separate drug management software was being used to manage inventory but the same is not linked with DVDMS.

Goa

- The State had streamlined important IT initiatives into place that are HMIS, RCH, HWC, NCD, NIKSHAY, FPLMIS, e-Raktkosh, IHIP and state specific portal for diagnostics i.e., inventory management system (DHS-IMS) and e-Vin, e-Sanjeevani etc.
- The State has well versed IT applications viz HMIS, RCH (RCH portal was functional and the registration in respect of EC was found to be 100%, more than 70% registration of PW and CH at State) HWC, NCD, NIKSHAY, FPLMIS, IDSP, E-Raktosh, DHS- State Inventory Management system which are functional and the reporting frequency of portals was daily and monthly and real time data entry was also available in portal such as HMIS, RCH etc.
- Nikhust and Nikshay Aushadhi Portal were not functional for 3 months at the time of visit. POSHAN Abhiyaan Jan Andolan dashboard was also not functional at any of the visited facilities. ANMOL was recently rolled out in Goa and few data entry issues were recorded at facilities visited.
- Jan Aushadhi Portal was also in use for procurement of the generic medicine at cheaper rates.

- State had implemented e-Sanjeevani but not in regular use. No teleconsultation services were being done at the primary and the community level.
- Internet connectivity was unavailable across the facilities.

Jharkhand

- Facility Based Newborn Care (FBNC) Database Portal for real time monitoring & tracking of small and sick new born at District hospital level, Family Planning-Logistics Management Information System (FPLMIS) portal for online monitoring and tracking of family planning inventory, Swalamban Portal for generating Unique Disability ID (UDID) and disability certificate, National Cold Chain Management Information System for online monitoring and tracking of vaccine inventory were all in place.
- CHOs did not have tablets in Deoghar while tablets had been provided in Garhwa. Uniform use of (CHO App) and CPHC-NCD app was not observed in Deoghar while regular use of IT portals such as HWC, NCD, e-Sanjeevani was seen in Garhwa.
- Use of e-Sanjeevani was inadequate, specialists/ MOs at Hub were not available on time which increased the waiting time during teleconsultations and loss of patients. In both the districts, ANMs were not comfortable using digital platforms.

Kerala

- e-sanjeevani is functional and tele-consultations were done with an average of 100-150 calls per day.
- HWC Portal was being used by the district, and PHCs and UPHCs were doing daily & monthly data entry.
- ASHAs were provided computer training which includes typing, data entry, mails sending, making google forms, word & excel training, etc.

Madhya Pradesh

- The staff were not trained in operating HMIS portal.
- The state has been using MP-Aushadi portal for indenting procurement till the level of PHCs.
- Cold chain was being maintained and monitored digitally by e-VIN portal. The cold chain supervision was standardized and streamlined in the form of Anand Diwas where cold chain of all stocking points are systematically assessed through checklist on 1st working day of each month.

Maharashtra

- NCD-HWC app, AB-HWC portal & ANMOL were found to be functional at AB-HWC.
- Daily & Monthly reporting in the HWC portal was being done. However, there was data mismatch observed in HWC Portal, NCD application and Manual registers maintained in the Health Facility.
- E-Aushadhi' is operational as part of the free drug policy. However, health facility level indenting and ASHA replenishment of drugs for ASHAs were not included in this system.
- HMIS Data for Immunization: Reporting errors, validation of data was found to be inaccurate.
- Tele-consultation services were below average.

Meghalaya

- There was internet connectivity issue across visited districts, which hindered data reporting & tele-consultation.
- MLHPs were conducting teleconsultation through e-Sanjeevani. There is a stipulated time and day for teleconsultations. Most of the time, specialists were not available to provide teleconsultations.

Nagaland

- Teleconsultations were earlier being done through Naga Telehealth (2,151 teleconsultations were done in a period from Oct 21 to June 22) but since adoption of e-Sanjeevani the systems were reporting problems and teleconsultation has come to a standstill.
- Fixed line internet connections were not found at the facilities. Staff was using their personal mobile internet to access the portals for data entry. ANMOL application has not been rolled out in the state yet. HMIS data entry is being done online at Block level. Data entry in HWC, NCD portal was not done regularly.
- DVDMS not rolled out universally and training of staff needs to be conducted for the use of DVDMS portal.

Punjab

- Although CBAC forms were being filled by ASHAs, data entry in NCD app was low. Adequate knowledge & practice of various health portals/ apps of the staff till SHC level.
- ANMOL was being used by all frontline workers.
- Relevant IT portals such as RCH portal, E-Aushadhi, HMIS, AB-HWC portal, e-Sanjeevani, CPHC-NCD portal, were found to be developed/ in place.
- Teleconsultation services at Health and Wellness Centres were being underutilized. Teleconsultation at SHC-HWCs was found to be adversely affected due to poor internet and mobile connectivity.
- Primary healthcare team was found to be not trained in using the IT portals/ or in data entry.

Rajasthan

- Telemedicine/ Teleconsultation services were not functional in all HWC-SC except in one health facility in Kota where it was being provided under CSR activity.
- Free drugs initiative under "Mukhyamantri Nishulka Dawa Yojana" has covered almost all drugs free for the patient. There is system of e-Aushadhi at each level facility except sub-centre. At the PHC and UPHC levels, there is a mechanism for indenting and consumption of drugs through e- Aushadhi portal software.
- Prasav Watch - This was a labour room digitization practices, supported by UNFPA. The application was not found effective with major concern reported and observed during visits that data entries were not done in real time. The State needs to record the events of labour progress in real time to have the quick information access about the status of pregnant women in active labour.

Sikkim

- Teleconsultation services were being offered in all the facilities - SHCs and PHCs. All SHCs have been provided with Tablets through which they connect to Hubs at various hospitals. Teleconsultation at UPHCs started in October 2021 but discontinued within a year due to transfer of MO. MO at present were using their own mobile phones for providing teleconsultation.
- The State has its own software for stock keeping of medicine (True-PoS), and PHCs were using the software while SHCs were doing physical indenting of drugs. PHCs have been provided with Desktop to do stock entry.
- The state reported duplication of efforts in data entry where service providers were entering data on both CPHC NCD portal and IHCI Simple app. Lag of data was observed on Simple application due to delay in software update. Also, due to being limited to hypertension, the data on Simple app was not being utilized for analysis at facility level or district.

Tamil Nadu

- About six crore individual health records (out of the 7.66 crore Tamil Nadu population) have been populated in the Tamil Nadu Population Registry Portal and the uptake of health services by the beneficiaries including reproductive maternal and child health care, NCD management and COVID vaccination, for which from different public health facilities can be tracked up to the PHC level.
- The internet connectivity and coverage were good in almost all the facilities, except for the tribal areas. Staff are familiar with all the applications and software. However, there were delays in capturing the data in a timely manner. Internet connectivity issues in the tribal block (Jamnamaruthur) of Tiruvannamalai district, hampered access to various portals and eVIN application. It was also an impediment when communication/contact with the referral centres in the local area and higher facilities was required.
- The state's Lab Information Management System is very well established, and all lab investigations are marked with clear biometric codes, thereby avoiding human error and saving substantial time for the laboratory staff and patients.

Telangana

- Teleconsultation services through HWCs were conducted by the MLHP/CHOs on daily basis. Target of minimum 5 teleconsultations was mandated at the HWC SC level in both the districts. Specialists' teleconsultation was also available in the districts and was according to the teleconsultation schedule.
- ASHA Disease Profile App: This app syncs with CPHC NCD app- All the activities done by ASHAs have been covered under this App.

Uttar Pradesh

- Digital technology was being used by CHOs despite IT infrastructure constraints and the use of CPHC-NCD application for NCD monitoring was limited to CHOs only.
- Teleconsultations via e-Sanjeevani were being conducted. However, some of the e-Sanjeevani prescriptions were found to be irrational and substitute medicines were issued.
- CommCare-based supportive supervision application for ASHA facilitators was found to be functional.
- The MaNTrA application was being used for data entry related to mother and child services.
- Multiple IT software in place raises the issue of data security.
- State specific innovation "e-Kawach" is yet to be fully implemented. ABHA ID creations were found suboptimal through e-Kawach.

CONTINUUM OF CARE – TELECONSULTATION SERVICES AND REFERRAL LINKAGES

KEY OBSERVATIONS

- The linkage of the SHCs with their linked PHCs was crucial for facilitating the continuum of care. A systematic approach to service delivery throughout the continuum of care i.e. starting from health promotion to screening to diagnosis & treatment and follow-up was lacking across all programs and needs strengthening.
- The referral linkages between SC-HWC and PHC-HWC for RMNCH+A services was found to be differential. In Madhya Pradesh, follow-up and community-based care through ASHAs such as HBNC services were found to be sub-optimal.
- For NCDs, most of the SHC-HWCs refer the patients to the nearby PHC/CHC. While the upward referral was facilitated and documented well, a mechanism for downward referral and follow-up of patients post treatment is yet to be established. Poor linkages between the primary level and secondary level facilities, coupled with shortfall in medicines affect the care continuity of a large section of NCD users.
- There is a need to increase the adoption of CPHC-NCD IT platforms to ensure the continuum of care through proper training or reorientation of the users (CHOs and MOs).
- A lack of coordination between the PHC and SHC teams, lack of orientation on the providers' role in NCD services, lack of functionality of the first referral units and lack of user awareness were observed to affect the care continuum.
- The mechanism for tracking upwards and downward referral from the AB-HWCs for various national health programmes (RBSK, NTEP, NLEP, NPPCD) needs to be strengthened.
- In order to facilitate access to specialist services, teleconsultations were being provided by the specialists at the CHC or DH through the CHOs at the level of SHCs and MOs at the level of PHCs / UPHCs. For example, Physician and Paediatrician were offering teleconsultation services in Vizianagaram district of Andhra Pradesh. Most of these consultations were being facilitated through e-Sanjeevani platform. In Tamil Nadu, both e-Sanjeevani AB-HWC and e-Sanjeevani OPD have been integrated with the ABDM platform. The MLHPs were facilitating teleconsultations through their personal phones as equipment was not provided.
- However, the uptake of teleconsultation services was poor. Poor record maintenance and follow up of patients availing teleconsultation services were observed.
- In Asifabad district of Telangana, the users could not avail the services of 102/108 ambulances from the village as there were no mobile signals. To call the ambulance services the caller has to travel 6-7 km to get connectivity and response. To facilitate the transportation of pregnant women and for ANC services, 'AVVAL ambulances' have been provided by the tribal department. The district has made arrangements for the users to allow inter-district travel from Asifabad to Mancherial without having to change the vehicle.

GOOD PRACTICES

- Andhra Pradesh - Teleconsultation services were operationalised at all levels of the health facilities. A total of 27 Telemedicine hubs were established in the State. Uptake and acceptance of Tele-consultation services was high among the community and service providers. Specialist - physician and paediatrician were offering teleconsultation services in Vizianagaram.
- Goa - STEMI project was launched in 2018 as a hub and spoke model for rescue of cardiac patients in their golden hours using Tele-ECG, thrombolysis, and transfer to the apex institution, while the follow-up would be done through ANMs. Hub is GMCH Babolim and 2 private hospitals. Victor Hospital, Healthway and Manipal Hospitals. While spokes are across the Sub-district hospital Ponda, and others centres.
- Rural Medical Dispensary - Rural Medical Dispensary is a primary healthcare OPD facility in Goa. It is headed by medical officer who are deputed from the primary health centres on rotation basis. The RMDs are now transformed into AB-HWC.

TOR 2- SECONDARY CARE

CATEGORY 1-

Availability of critical care services and operational status of critical care: Emergency, SNCU, ICU, OT, MOT, LDR, Obstetric HDU & ICU etc. at FRUs- CHC/ SDH/ DH; NMTI/ SMTI

SUBCATEGORY 1- Assessment of adequacy and accessibility to critical care services with reference to population and time to care approach

Critical Care Services comprise of emergency, surgical and intensive care services. As per NSSO/NHA, most of the critical care services are confined to tertiary level with limited access to secondary care and referral transport systems. The top five causes of mortality are Ischemic Heart disease, COPD, Stroke, Diarrheal Diseases, and Neonatal disorders (Global Burden of Disease Study, 2019). If these are managed timely at the level of district hospital itself, it will not only reduce the burden on tertiary care facilities but will also reduce the OOPE significantly.

The secondary care health services are expected to have functional units for critical care including emergency area and ICU, isolation wards, OT, Labor Delivery Recovery rooms, New-Born Care Corners etc. These service areas should be supported with Medical Gas Pipeline Systems, Oxygen generation plants/ Oxygen supply, Air Handling Units (AHUs) etc., and appropriate mechanisms for Infection Prevention & Control.

KEY OBSERVATIONS

1. Emergency Services

Emergency care services were available round-the-clock at the district hospitals and were limited and uneven at the CHC/SDH levels. The overall infrastructure was satisfactory and well equipped; with defined parking, public waiting areas, adequate signages, citizen charter, and IEC material. The

emergency facilities were easily accessible by road, and the emergency departments visited had separate entry with provision of ramps, stretchers, and wheelchairs at the entrance (Andhra Pradesh, Kerala, Punjab, Tamil Nadu, Telangana and Sikkim). Accessibility was a concern in Maharashtra due to the lack of ramps. The emergency departments had a demarcated area in the visited states, however, the space available for running the services was limited in a few states (Andhra Pradesh, Maharashtra, Tamil Nadu, Uttar Pradesh).

Triage areas and zoning were clearly demarcated in Goa, Kerala and Tamil Nadu. However, triaging, zoning and unidirectional flow of services were missing in the State/ UTs of Andhra Pradesh, Bihar, Delhi, Madhya Pradesh, Meghalaya, Nagaland, Punjab, Sikkim, Uttar Pradesh. The facilities in Nagaland were geographically inaccessible with limited amenities and staff, without any protocols or SOPs in place. Emergency beds with multi para monitors, ventilators and other life-saving equipment were either not supported or non-functional in Punjab, Maharashtra, Madhya Pradesh, Uttar Pradesh and Bihar.

Medicines and supplies were generally available in critical care areas. Near expiry medicines (e.g., adrenaline) and expired supplies (e.g., cannula) were found in Sikkim.

Connectivity with the High Dependency Unit (HDU), ICU, and Trauma Unit was present in Tamil Nadu. Referral for complicated cases was made to tertiary centres from the district hospitals in Tamil Nadu and Sikkim, upon stabilisation. Pre-arrival intimation was being practised at the facilities and continuum of care was being ensured in Tamil Nadu. Tamil Nadu Accident and Emergency Care Initiative (TAEI) pre-arrival information was flashed on the LCD screen in the reception at the DH and Medical Colleges.

Human Resource shortfall was observed across secondary level of care. Round-the-clock staff including Medical Officer and staff nurses were available at the DH in emergency department in Punjab and Kerala. The knowledge of staff on the emergency protocols and biomedical waste management was found to be inadequate (Punjab, UP, Bihar, MH). The Specialists at TKMC in Tamil Nadu were handholding MOs at lower-level facilities through a WhatsApp group where case discussion of coronary patients was being done and appropriate pre-referral management was being advised.

Oxygen supply was being maintained mostly through oxygen cylinders and concentrators. In Andhra Pradesh and Kerala, the oxygen generation plant in DH was not operationalized but manifold area was available at DH for central supply through oxygen cylinders. In Maharashtra, alternative oxygen cylinders/manifold was not available for use. An oxygen plant was established at the DH in Meghalaya.

In Maharashtra, the utilisation of emergency services was low. Also, cases of Left Against Medical Advice (LAMA) were found high in Maharashtra and Punjab.

2. Operation Theatre

The Operation Theatre (OT) and maternity operation theatre (MOT) were well maintained and fully functional with zoning (Protective, Clean, Sterile & Disposal) and clear demarcations (Andhra Pradesh, Goa, Sikkim, Tamil Nadu, Kerala, Maharashtra) at the level of DH and above in most of the visited State/UT. The principles of zoning were not observed in Bihar, Madhya Pradesh, Nagaland, Telangana and Uttar Pradesh. Unidirectional flow of materials has been ensured in Sikkim and Maharashtra but not in all facilities in Meghalaya and Tamil Nadu. In Uttar Pradesh, the number of OTs were inadequate.

Modular OTs were functional in Andhra Pradesh, and although available, were not being utilised in Sikkim due to challenges in power supply and in Uttar Pradesh due to an impending investigation. The Heating, Ventilation, and Air Conditioning (HVAC) system was installed in most of the visited OTs except in Delhi, Telangana, Jharkhand and Uttar Pradesh. There was no power backup in one of the visited OTs in Uttar Pradesh.

Infection Prevention & Control (IPC) was observed to be compromised in Nagaland, Delhi, Tamil Nadu and Uttar Pradesh. In Sikkim, although appropriate IPC measures were reported, only a single autoclave unit was available for the DH and scrub area was used for cleaning and disinfection of articles. Cleaning protocols, including decontamination of critical care areas were found compromised in Uttar Pradesh. Infrastructural challenges have been reported in a few states, for e.g., an OT at DH in Maharashtra was non-functional during monsoon season and leaks were noted in a facility in Sikkim.

Challenges pertaining to human resource was a common finding across State/UTs. This includes both HR shortages (Punjab) and underutilisation of specialists (Andhra Pradesh). Unavailability of specialists led to limited functionality of OTs (Madhya Pradesh, Maharashtra) and high referral rates to higher facilities (Uttar Pradesh). The need for trainings on biomedical waste management, infection prevention and control and emergency protocols was apparent.

The OTs at the level of CHC/SDH had limited functionality (Bihar, Goa, Jharkhand, Punjab, Tamil

Nadu) owing to unavailability of specialists and blood storage units; and infrastructural challenges. The facilities were utilised primarily for minor surgeries and sterilisation services.

3. High Dependency Unit/ Intensive Care Unit

The ICU facilities were well maintained with ventilator support in Andhra Pradesh, Sikkim, Kerala and Tamil Nadu. Piped oxygen, concentrators, ventilators, multipara monitors, necessary drugs and equipment were available. Inadequate spacing between two beds as well as inadequately maintained beds and walls were observed in Tamil Nadu.

There were no functional ICU beds in the visited DHs in Goa and Uttar Pradesh and the availability varied within the States of Bihar, Maharashtra, Meghalaya and Punjab. The ICUs installed for the management of COVID-19 were now either underutilised (Andhra Pradesh) or non-functional (Uttar Pradesh). Most of the visited State/UT did not have any linkages between OT complex, ICU/HDU, blood bank and surgical wards. In Delhi, at the time of visit, the ICU reported shortage of critical medicines and ABG machines; and the ventilators were non-functional.

Shortage of human resources led to the underutilisation of ICU facilities in Sikkim (Intensivists), Meghalaya, Rajasthan, Tamil Nadu (Nurses) and Punjab. Patients were referred to private facilities/laboratories in cases of emergency. The observations also reflect the need for refresher trainings for the assigned staff in OT on emergency and trauma protocols and infection control measures.

4. Labour Delivery Recovery (LDR) Complex

There have been concerted efforts for standardising labour rooms in every delivery point for delivering high quality services during childbirth. LDR concept

was client-centric and ensured better care, privacy, and comfort for the pregnant women. It also obviated the need for having additional waiting area or labour area and associated services. It has been recommended that, if there was adequate space available without any significant resource constraints, all the DHs, AHs, SDHs, and FRU CHCs, and any facility with more than 500 deliveries in a month should upgrade the labour rooms as per the LDR concept. The progress in its implementation had not been uniform across State/UTs.

In Tamil Nadu, the Labour rooms were of conventional type, and LDR complex was not found in any of the CEmONC centres visited. The concept of LDR has not been implemented yet in the visited facilities of Kerala, Punjab, and Uttar Pradesh. Rate of early discharge was high in Telangana due to insufficient beds.

Most labour rooms were well equipped and essential and emergency medicines were in stock. The labour rooms at the DHs in Kerala and Maharashtra were LaQshya certified. Trays with expired medicines were noted in Punjab and occasional stock-outs of Misoprostol was reported in Sikkim. The need for upgradation of infrastructure in Sikkim was an observation. The availability of dedicated Obstetric HDUs varied within Tamil Nadu, however, there were eclampsia rooms dedicatedly used for the management of eclampsia patients only and they were not being used for the management of other high-risk pregnancies.

The LDR complexes at DHs in Bihar, Goa and Maharashtra were well equipped and maintained; with triaging. Functional triage area was missing in Punjab, Sikkim. Staff were aware of respectful maternal care (RMC), and birth companions were allowed in Goa, Tamil Nadu, Telangana and Sikkim. Birth companions were not allowed in Kerala, Punjab, and CHCs in Sikkim and Goa.

Lack of specialists has been a major concern in service delivery, particularly at the level of CHC. The need for refresher training on respectful maternity care and infection control protocols and biomedical waste management was highlighted. Free drugs and diagnostics were available to beneficiaries at the visited facilities. Concerns were apparent in the maintenance of labour room records and reports. In Rajasthan, Prasav Watch, a software for the digitization of the records in the labour room had been installed. However, lack of timely data entry delayed the intended real-time monitoring of labour room practices and outcomes.

5. Newborn Care Corner (NBCC), Newborn Stabilization Unit (NBSU), and Special Newborn Care Unit (SNCU)

NBCC is a space within the delivery room in any healthcare facility where immediate care is provided to all newborns at birth. This area is mandatory for all facilities where deliveries are conducted.

NBSU is a facility within or in close proximity of the maternity ward where sick and low birth weight newborns can be cared for during short periods. All FRUs and CHCs are required to have an NBSU, in addition to the NBCC.

SNCU is a neonatal unit in the vicinity of the labour room to provide special care (except assisted ventilation and major surgery) for sick newborns. Any facility with more than 3,000 deliveries per year (most DHs and SDHs) should have an SNCU.

Functioning NBCCs and NBSUs at district and subdistrict levels were observed in most State/UTs. Dedicated KMC chairs and breastfeeding corners were available at the DHs in Andhra Pradesh, Bihar, Delhi, Goa, Jharkhand, Kerala, Maharashtra and Punjab. However, the concern across the facilities visited included limited functionality of NBSUs leading to poor utilisation of NBSU beds, and unnecessary referrals to SNCUs. Admission criteria was not defined for NBSUs and SNCUs at the facility in Kerala. Poor utilisation of SNCU & NBSU beds were noted in Kerala. SNCU/MCH building had not been integrated with DEIC. Follow-up mechanisms required strengthening in all the State/UTs.

The DHs in most of the State/UTs were observed to have well equipped and functioning SNCUs with

appropriate triaging and single entry/exit points, except in Meghalaya where there were no functional SNCUs. Trained staff, critical equipment and essential and emergency medicines were found adequate. Centralised oxygen supply was not installed at the DH in Punjab. Two out of ten SNCU beds were non-functional at the DH in Kerala. One of the SNCUs visited in Jharkhand was found non-functional due to shortage of human resources, particularly specialists.

Non-functionality of critical equipment like radiant warmers was observed at the SNCU in Delhi and Nagaland. In Sikkim, the SNCU was visibly crowded with placement of extra beds in between the regular beds. In Sikkim, it was reported that the funds were inadequate for the maintenance of the SNCU. Infection prevention and control measures were questionable in a few facilities in Jharkhand, Madhya Pradesh, Nagaland and Punjab. For example, at a facility in Punjab, routine swab culture was not performed regularly and in Jharkhand autoclaved delivery sets were not found during the visit.

Provision of KMC services and family participatory care had been initiated in the SNCUs visited in Andhra Pradesh but FMC was found missing in Kerala. Care Companion Program (CCP) and family participatory care has been rolled out in a few facilities in Andhra Pradesh for better coordination and follow up to improve infant health outcomes. The SNCU software was being used in Andhra Pradesh, Kerala and Punjab.

The staff nurses posted in NBCC, NBSU and SNCU require refresher training on the FBNC module, protocols and guidelines. Data entry operators were not available in the units of all State/UTs. Lack of dedicated nursing staff for the SNCU in Jharkhand was found to compromise the quality of care delivered. However, paediatricians were available on a shift basis round-the-clock. Underutilisation of specialists (Paediatricians) were reported in an SNCU from Uttar Pradesh.

6. Midwifery Initiative

It was observed that the Midwifery Training Institutes (MTIs) have not been identified or operationalised in most of the State/UTs visited, except in Andhra Pradesh and Telangana. In Andhra Pradesh, two MTIs have been operationalised and two batches were undergoing Nurse Practitioners in midwifery training.

7. Paediatric Intensive Care Unit/ New-born Intensive Care Unit (PICU/NICU)

The PICU in Tamil Nadu, established under ECRP II, has state-of-the-art equipment and has a high utilization with a bed occupancy rate of over 90 percent. The DH in Andhra Pradesh has a modular PICU with oxygen and ventilator supported beds with a step-down unit. Adequate staff and specialists available to provide round-the-clock critical services in Andhra Pradesh and Uttar Pradesh. Goa has a well established NICU with a command centre at the level of medical college. The PICU at the DH in Uttar Pradesh did not have a functional ABG machine and also did not have provisions for small-volume blood packs. The upkeep of the PICU was found unsatisfactory.

PICU/NICUs were not functional, and patients requiring critical care services were referred to tertiary centres, in Kerala, Sikkim, Goa, Maharashtra and Uttar Pradesh.

8. Blood Bank

District hospitals with licensed blood banks were observed in Andhra Pradesh, Bihar, Maharashtra, Nagaland, Punjab, Tamil Nadu. The status of infrastructure, collection sites, and human resources; utilisation of e-raktkosh portal; routine screening tests and registration and counselling mechanisms were found satisfactory. Blood Component Separation Units (BCSU) were functional in Andhra Pradesh and Punjab.

9. Mechanised laundry/Central Sterile Supply Department (CSSD)

CSSD units were available at the DH level in Bihar, Kerala, Maharashtra and Nagaland and not in Andhra Pradesh, Meghalaya, Punjab, Sikkim, Tamil Nadu and Uttar Pradesh. The Theatre Sterile Supply Unit (TSSU) was functional and adherent to protocols in Punjab.

Occasional sterilisation failures were noted from the records in Punjab and Tamil Nadu. In Tamil Nadu, autoclaving was being done in the respective OTs. In Bihar, the critical areas were provided with vertical small and medium sized autoclave machines for sterilization.

In most states, there were no linkages between sterilisation unit and laundry system. Laundry services were in-house in most of the states but outsourced in Andhra Pradesh, Bihar, Delhi, Maharashtra and North Goa.

10. Dietary and Kitchen Services

In-house functioning kitchen were observed at the level of SDH/DH/MCH in the States/UT of Bihar, Delhi, Goa, Kerala, Maharashtra, Meghalaya, Tamil Nadu and Telangana. The kitchen services were outsourced in Andhra Pradesh, Punjab, Sikkim, and Uttar Pradesh. Medical examinations of food handlers were regularly done and recorded in registers only in a few states. The quality of dietary and kitchen services was found unsatisfactory in Nagaland. In Punjab, dietary services were available only for selected beneficiaries like pregnant and post-natal women and patients undergoing de-addiction treatment.

RECOMMENDATIONS

- The location and layout of emergency departments needs to be in accordance with the prescribed guidelines and protocols, in terms of triaging facilities and earmarking of beds, adequate equipment to support the triage bed, zoning and unidirectional flow of services, to ensure comprehensive emergency care across secondary care level.
- To maintain the continuum of care, the secondary care facilities need to be equipped with HDUs/ ICUs in accordance with IPHS, with direct linkages to emergency services and other departments.
- There needs to be dedicated human resources in each critical care unit and effective utilisation of the staff needs to be ensured for round the clock services. The staff need to be supported with the timely provision of logistics required to run the services and also adequate training for the management of emergency services.
- Appropriate protocols in the OT regarding zoning, unidirectional flow of services, infection control protocol, air exchange, etc., need to be ensured.
- To make LDRs functional as per the standards, further strengthening in both infrastructure and services is required in order to provide respectful maternity care, while maintaining the privacy of the birthing mother.
- To maintain the continuum of care for neonatal services, the referral linkages from peripheral

services to SNCUs need strengthening. This can be achieved by defining the referral protocols and orienting the staff involved in providing referral services. It is imperative that NICUs/PICUs must be established in all districts.

STATE SPECIFIC FINDINGS

Andhra Pradesh

Emergency: In most of the facilities visited, the specialists were available in adequate numbers for emergency units, but grossly underutilized.

HDU/ ICU: A 8 bed ICU with ventilators and adherent to technical protocols was available at the DH Machlipatnam. However, the space earmarked for treating COVID cases in the general HDU (20 bed) was found underutilised.

OT: Zoning was observed in OTs and the facilities visited had well-equipped OTs. The hospital had 3 OTs for general use and one OT for septic cases. One OT was exclusively for orthopaedic.

LDR: Labour Rooms and Labour OTs were maintained with the concept of Respectful Maternity Care. In the state, a total number of 41 Labour rooms and 33 Maternity OTs are LaQshya certified. C-section audits are being conducted however, the utilisation of data for gaps identification, analysis and improvement is lagging. The number of Staff Nurses for the provision of 24x7 emergency services was inadequate, resulting in unnecessary referrals to higher facilities.

NICU/ PICU: Modular PICUs were found to be functional in District hospital Vizianagaram with 4 oxygen-supported ventilator beds and a step-down unit was also established adjacent to the paediatric ward.

SNCU: The state has functional SNCU with more than 80% successful discharge rate and a nearly 120% bed occupancy rate. NBSUs were found to be functional at the sub-district level in the state for the provision of care and stabilization before referral. Staff nurses posted at NBSU require training as per the NBSU training module and rotational observer-ship for 15 days at SNCU at DH Level.

Bihar

Emergency: Emergency services are being provided in both districts. A suction machine and oxygen concentrator were available but ventilators and triage beds were not available in the districts. It was observed that the minor OT of one of the visited facilities in the Buxar district was unsanitary and the staff of emergency department were not trained in handling emergency cases.

ICU: DH Aurangabad had functional ICU (3-4 bedded) but there was no ICU at DH Buxar. Refresher training on management of critical patients was not provided to the staff.

LDR: The labour rooms were found well equipped with all essential equipment including 7 trays, radiant warmer, suction machine, and an autoclave. Hand-made innovative IECs, Protocols and SOPs were prepared by the Staff nurses and displayed. Safe Birth Checklist was used and partograph was also plotted for every case. Staff Nurses were trained in SBA and DAKSHATA long back and no refresher training has been provided by the district/state.

Operation Theatre (OT): The OTs were found functional in the facilities visited but only catering to minor surgeries (hydrocele, hernia, suturing procedures etc.) and some family planning operations like (vasectomy, and tubectomy) at selected facilities.

NBSU & NBCC: A total of 41 NBSUs and 735 NBCCs are functional across the state. They were logistically well set-up with critical equipment, HR and consumables. Lack of proper documentation was a concern.

SNCU: A total of 43 SNCUs are operational in Bihar. In DH Buxar on average 70 to 80 cases and in DH

Aurangabad 100-120 cases on a monthly basis were being referred to SNCU for critical care treatment.

Chhattisgarh

Emergency: Emergency services were being provided at all levels of health care facilities like CHC & DH, however, proper triaging was missing. Also, the staff needed training in the emergency management of patients as per the SOPs.

HDU/ICU: Intensive care services were not found to be available.

LDR: Labor Room (LR) & Maternity-OT (M-OT) of Surajpur DH was Certified under LaQshya in FY 2022-23. Kondagaon DH stands as an exemplary facility in terms of infrastructure and its services mainly - Labor Room, M-OT, OPD, ICU/HDU etc. LR registers were reflecting entries of LBW (below 2.5 kg) but babies were discharged from HCFs without any intervention. USG facility was only available for 3 days/week in DH Kondagaon.

OT: Quality of construction work is an issue in most parts of CHC and DH. Seepage problem found across OT in District Kondagaon. No proper zoning was found in the OTs.

Delhi

Emergency: The emergency area had four triage beds and demarcations as per triage norms, however colour coding system was not being followed. The protocols on antibiotic use, STGs, and LASA were displayed in the emergency area. MGPS connection installation was still under process. Emergency ward did not have clear segregation of filled and unfilled cylinders.

HDU/ICU: The DH has a 10 bedded ICU with continuous oxygen supply, functional ventilators, and a single entry and exit point. There were 5 senior residents and other staff were available on a shift basis, however, intensivists were not available. Shortage of critical care drugs in the ICU has been reported four times in the last six months and the procurement process reportedly takes 4-5 days.

OT: The DH had four functional OTs in place. The HVAC system was not in place.The operation cancellation rate is zero and on an average 4-5 surgeries are conducted per surgeon per week.

LDR: In the northwest district, the maternity ward was well structured and had a 2 bedded labour room with one SNCU. All the critical care equipment and medicines were available, with round the clock care from staff. The staff posted were not aware of respectful maternity care concept.

SNCU/NICU: The SNCU in DH was functional with critical equipment and medicine, and has optimal bed utilization. A dedicated MO for SNCU was available and paediatricians were on call duty for emergency hours.

Goa

Emergency: At the DH level, emergency services were found appropriate with triaging and zoning. At CHC level, triaging was not followed. It was also found that multipara monitors and oxygen cylinders were not available with every bed.

OT: North Goa DH had 4 functional OTs and South Goa DH had 11 OTs out of which 6 were functional. The OTs at the district level were well utilised. However, the OTs and MOTs at the CHCs had limited utilisaiton.

HDU/ICU: There were no functional ICU beds in both District Hospitals.

LDR: LDR at DH was well maintained with adequate triage facilities, critical equipment and medicines. CHCs have LDR beds and reported to conduct only normal deliveries. The complicated cases were referred to the DH or GMC. It was reported that birth companions were allowed at DH, but in CHCs they were allowed only till the waiting area.

NICU/PICU: DH Margao did not have NICU/PICU facilities.

SNCU: SNCU facility at the SH followed triaging and single entry/exit point. One of the DHs reported shortage of ABG cartridges.

Jharkhand

Emergency: Emergency units at the facilities visited were not found prepared to cater to incoming emergencies. Zoning and critical equipment were not in place.

HDU/ ICU: ICU services were not functional.

OT: Zoning was not observed in the OTs.

LDR: The Labour room at District Hospital, Deoghar provided comprehensive basic and emergency obstetric care services and caesarean sections constituted around 20% of deliveries. All the seven trays for delivery were found as per standard guidelines but the total number of delivery kits were low.

NBCC: NBCC units were fully functional with a radiant warmer and new-born tray.

SNCU: District Hospital at Garhwa & Deoghar had a 12 bedded SNCU with radiant warmers and a pediatrician was posted at the unit

NICU/PICU: A 20 bedded PICU was observed at the District Hospital.

Kerala

Emergency: All emergency departments visited had separate entry with provision of ramps, stretchers, and wheelchairs at the entrance. Emergency unit was equipped with essential drugs and ventilators (03) in DH Wayanad, with appropriate triage and zoning.

OT: Well-maintained OT with clearly demarcated clean, buffer, and sterile zones in all visited facilities of Wayanad district.

HDU/ICU: Dedicated staff for intensive care units was not found to be adequate and trained for resuscitation, stabilization and management of critical patients before referral to higher centres.

LDR: Labour rooms did not have LDR units and linkages with support service areas.

SNCU: Comprehensive Newborn screening was being done at all visited facilities by public health nurse. Well-equipped infrastructure with defined KMC area at SNCU was observed in DH Manathawady, Wayanad.

Madhya Pradesh

Emergency: There was no provisioning for triaging and separate entry for emergency services. There was no dedicated staff nurse for the emergency unit. Display of protocol for emergency unit was not observed in the units visited.

HDU/ICU: A full-time medical officer was not available at the HDU/ICU.

OT: Zoning and unidirectional flow of services have not been implemented. Acute shortage of specialists like Anaesthetics, Paediatrician and Obstetrician was reported.

LDR: All staff nurses at the labour room were well versed with the quality protocols and treatment procedures, however had not received formal trainings. The LaQshya certification had expired and no process to re-certify the same had been initiated.

NICU/PICU: The NICU units had regularly been undertaking swab culture at various points and the data was well maintained.

SNCU: The SNCUs and NICUs were not adhering to the BMW guidelines. SBA/midwifery trainings of all the SNCU and NICU staff were not completed.

Maharashtra

Emergency: A 100 bedded District Hospital was functional in Dhule block to provide secondary care services. The district hospital had separate entry for emergency patients and triaging facility. The staff were not trained on the processes and protocols of triaging. The beds were not equipped with multipara monitors.

HDU/ICU: The staff required training on necessary protocols and STGs.

OT: DH Dhule had three modular OTs wherein but some constructions were still ongoing. The main OT complex had proper zoning with a direct linkage between OT and CSSD department to ensure systematic flow of services. Temperature was maintained and being monitored in the OT complex continuously.

LDR: Labour room was as per LDR concept, in most of the visited facilities. District hospital and RH Pimpalner Dhule had an MCH facility with Triaging attached to LDR complex, four bedded NBSU and female ward for postpartum mothers and newborns. Zoning and changing protocols were being followed by the staff and patients. NBCC corners had the essential equipment like radiant warmer, resuscitation tray and size appropriate ambu bags with masks.

SNCU, HDU, ICU, PICU, NICU services were not available at visited facilities.

Meghalaya

Emergency: No FRUs or District Hospitals were available in South West Khasi Hills, as a result of which limited secondary care services were available in the district. Critical care services were not available in both districts visited. However, a dedicated emergency room with 2 beds, necessary equipment, drugs and emergency nurses were available. Triaging was followed but zoning was not observed despite the availability of space.

HDU/ICU: Intensive Care facilities were not available at the DH and critical patients were referred to higher facilities. HDU had been newly established but not functional as dedicated staff were not posted.

OT: The DH had two major and one minor OT. Zoning was followed, but there was no separate entry and exit. Unidirectional movement could not be followed due to space constraints.

LDR: Triaging, critical equipment and medicines, dedicated hand washing area were available. Birth companion was allowed. NBCC had radiant warmer, new-born resuscitation equipment and Ambu bags. Dedicated staff were posted in the labour room on a shift basis.

NICU/PICU and SNCU units were not in place at the visited facilities.

Nagaland

Emergency: In both the districts, emergency services were operating from a single room at the DHs with limited amenities and no zoning. The location of emergency room was not accessible from main road and linkages with other service areas was also limited. No dedicated medical officers were available and protocols and SOPs were not in place for the management of emergency cases.

OT: The infrastructure of operation theatres was not amenable to protocols. The zones were not demarcated and infection prevention protocols were found compromised.

HDU/ICU facilities were not available at the visited facilities.

LDR: Records in labour rooms, SNCU, and NBSU registers suggest inadequate identification and management of HRP cases. Triangulation of data from labour room register, admission record and patient case sheet suggest that early neonatal death were being recorded as fresh still birth. Also, normal weight babies admitted with birth asphyxia and

sepsis in SNCU suggest compromised aseptic precaution at labour room.

NICU/PICU facilities were not available at the visited facilities.

SNCU: Critical equipment like radiant warmers were non-functional at the SNCU. Rate of antibiotic use was found high (92%).

Punjab

Emergency: In the visited facilities there were separate entry for the emergency department and beds for triaging were demarcated. Round the clock staff including Medical Officer and staff nurses, critical equipment and medicines were available.

HDU/ICU: HDU and ICU beds were 12 in number and are available with Central Oxygen supply & Multipara Monitors.

LDR: Birth companion were allowed in the LDR unit but privacy measures were not maintained.

OT: Four theatres were functional at the DH with functional HVAC system, medical gas line and Theatre Sterilization unit (TSSU).

NICU/PICU facilities were not available at the visited facilities.

SNCU: Triaging facilities, critical equipment and medicines were available at the SNCU with a single entry and exit point.

Rajasthan

Emergency: The emergency department in the facilities have inadequate space and a dedicated triage area and zoning was not in place.

HDU/ICU: There was no district hospital in Kota district and ICU facilities were available at the medical college. The beds were well equipped with continuous oxygen supply, but unidirectional flow of services were not maintained. All critical equipment and drugs were available. Both HDU and ICU had only one entry exit point.

OT: There were two well equipped OTs at the medical college in Kota. Protocols and zoning were followed. However, several non-functional equipments were found to be stored in OT.

LDR: The labor rooms at the DH and SDHs were well equipped and functional with 7 trays. Birth companions were allowed. Prasav Watch, a software for digitization of the records in the labour room was in place. SUMAN programme is yet to be rolled out in the hospitals.

NICU/PICU facilities were not available at the visited facilities.

SNCU: The SNCU at the district hospital of Jaisalmer was functional. Kangaroo Mother Care has not been implemented.

Sikkim

Emergency: Human resource shortfall was observed across the secondary level of care. Adequate emergency equipment such as Multipara monitors and other instruments were available. Oxygen supply was being maintained through oxygen cylinders and concentrators.

HDU/ICU: At DH Namchi, ICU had only one Intensivist who was working round the clock. Patients were referred to private laboratories in case of emergency. Near expiry adrenaline and expired cannula sets were found. Hub cutter was not available thus the syringe was discarded with the needle intact.

OT: Zoning was followed in OT and MOT, and unidirectional flow of materials has been ensured. Appropriate infection control measures were maintained but due to space constraints, scrub area was also used for cleaning and disinfection of articles. Infrastructure was not maintained leading to seepage issue in Operation theatre. Old OT table was being used instead of Modular OT table for conducting caesarean section due to lack of electric connection.

LDR: Staff followed respectful maternity care, and birth companions were allowed at the DH. However, it was not practiced at CHC Rhenock. In Namchi district, lack of screens was a deterrent for allowing birth companions. Staff nurses were trained and were aware about LR protocols and INAP intervention. The critical equipment and medicines were available but occasional stock-outs of Mioprostol were reported. Radiant warmer was available but temperature setting was not functional. Emergency USG services were available as it was performed by in-house gynaecologists.

PICU and NICU facilities were not found functional in the visited facilities.

SNCU: There were no dedicated beds at DH Singtam. At DH Namchi, 5 SNCU beds were available with critical equipment and medicines at the facility. Follow up of patients were not being done due to the lack of landline connection.

Tamil Nadu

Emergency: Emergency care services were available round-the-clock in both the DHs and both were designated as TAEI facilities. They were easily accessible by road, and stretchers, wheelchairs and ramps were available. Triage areas and zoning were clearly demarcated. Oxygen, multipara monitors, ventilators, and functional resuscitation equipment were available, however, the staff required refresher training on its use. Connectivity with the High Dependency Unit (HDU), ICU, and Trauma Unit was present.

HDU/ICU: Independent Intensive Care and HDU facilities were available at both the DH. Single entry/ exit points were observed. The 8-bedded HDU at DH Kovilpatti had been operationalized in October 2022 and had low utilization due to the same. The 7-bedded ICU had high bed occupancy, with approximately 80-90 admissions in a month, and 1-2 fatalities. Only one staff nurse was posted in the ICU and HDU at all times, and doctors and specialists were available on call, hence the advisable nurse-bed ratio was not maintained. In both the ICU and HDU at DH Kovilpatti, piped oxygen, concentrators, ventilators, multipara monitors, necessary drugs and equipment were available. However, adequate spacing between two beds, and between the beds and walls was not maintained.

OT: In DH Cheyyar, the zoning of the OT and Maternal OT has been implemented. The lack of a dump lift in the Medical College hospital showed improper disposal. There were 7 OTs in the OT complex and the CEmONC centres had three OTs in the facility. The DH Kovilpatti had a minor OT and access to trauma OT for accident and emergency cases. Unidirectional flow of goods was not observed but single entry/ exit points were observed.

LDR: The labour rooms at secondary care level facilities were well maintained and with functional equipment. Pre-natal and post-natal ward, breastfeeding area/room, counselling area were present in both the districts and these areas were well connected.

PICU/NICU: The PICU at TKMC was established under ECRP II, and had State-of-the-art equipment like ventilators, multi-para monitors and other facilities, with an average length of stay of 3-5 days and a Bed Occupancy Rate (BOR) of 83%. The PICU at Tiruvannamalai Medical College had 13 beds and a bed occupancy of more than 95% in the last three months. The 45-bedded NICU at Tiruvannamalai Medical College was overutilized with a BOR of 147% in the last three months. The NICU at Thoothukudi also had a high utilization with a BOR >94%.

SNCU: The SNCUs at DH Cheyyar and Kovilpatti had 18 and 19 beds respectively and the average duration of stay ranged from 4.8 days at Tiruvannamalai to 6.3 days at Thoothukudi.

Tamil Nadu has state-of-the-art CEmONC, SNCU and NICU facilities.

Telangana

Emergency: In both the visited districts, facilities provide emergency services round the clock. The location of emergency room was separate, with accessible entry from main road and there were linkages with other service areas in the visited facilities. Triage bed was available but not as per the IPHS guidelines (red, yellow, green, black). Multi para-monitors, oxygen supply and critical equipment were available.

ICU/HDU: In Asifabad district there was a need to establish facilities for Obstetric HDU and ICUs. Shortage of specialists have been reported.

OT: OTs in both the districts were well maintained but lack of clear demarcation of zones in all facilities of Suryapet and Asifabad District were reported. HVAC system had not been installed.

LDR: The labour rooms in Suryapet district at secondary care level were well maintained and with functional equipment even without quality certifications. Pre-natal and post-natal ward, breastfeeding area/room, counselling area were present in both the districts and these areas were well connected. The 50 bedded hospital (GGH-MCH Centre) requires expansion to cater to the patient load, reduce the rate of referrals and to ensure respectful maternity care.

SNCU: 10 bedded SNCU was established at DH Asifabad and GGH Medical college in Suryapet district, with functional equipment.

Uttar Pradesh

Emergency: The emergency department in both districts had a separate area, however, the space allocated for running the emergency was inadequate. A unidirectional flow of services with a dedicated triage area, red zone, yellow zone and green zone was not maintained. Emergency beds were not supported with Multi para monitors, ventilators and other life-saving equipment. The knowledge of the staff on the emergency protocols and BMW management was found inadequate.

ICU/HDU: There was no functional ICU/ HDU in the visited facilities. In Maharajganj, ICU created during COVID, was not functional and there were 20 unused ventilators in the ICU at the time of the visit.

OT: A separate OT complex was available in both districts; however, principles of zoning have not been implemented in the OT complexes. In both districts, inadequate number of OTs were reported and power backup was found lacking. A modular OT was available in Chitrakoot. However, it is currently non-functional due to an ongoing investigation and all the equipment was stored together in one room. Knowledge and skills on the various treatment protocols needed strengthening for all levels of staff. Infection control measures were found compromised.

LDR: The concept of LDR has not yet been implemented in either of the districts. There are 97 delivery points in Maharajganj and 58 delivery points in Chitrakoot. Structural and organisational deficits were found in the design of the MCH wings in both districts. Bio-Medical Waste Management / IPC protocols were being followed across facilities. Essential consumables were found in short supply.

NICU/ PICU: The PICU in Maharajganj was primarily made for AES cases, but now beds are also being used for other paediatric emergencies. All beds were fully equipped with oxygen and ventilator support. Specialists and staff were posted on a shift basis. It was also found that outsourcing for cleaning and housekeeping was not linked with standard cleaning protocols as defined in IPHS/ Kayakalp.

SNCU: In Maharajganj, a 26-bedded SNCU while at Chitrakoot a 12-bedded SNCU was available. Bed Occupancy Rate was more than 100% in both districts. Paediatricians were available in both districts. However, only 3 out of 6 paediatricians were being utilised in the SNCU at Chitrakoot. Follow up mechanisms required strengthening.

SUBCATEGORY 2-

To understand the gaps in implementation of RMNCH+A, RBSK, RKSK, SUMAN, PMSMA (e-PMSMA), JSSK, NVBDCP, NLEP, NRCP, NTEP, IDSP, NVHCP, NACP, NPCDCS, NPPCD, NPHCE, NPPC, Trauma and Burn Injuries, NPCBVI, NPPCF, NTCP, NIDDCP, NOHP, NMHP, Free Diagnostic Service Initiatives, BMMP, PMNDP

KEY OBSERVATIONS

1. Family Planning

- Family planning commodities were available in most secondary care facilities visited in the State/UTs. The expanded contraceptive basket comprises condoms, combined oral contraceptive pills, emergency contraceptive pills, Intrauterine Contraceptive Device (IUCD) and sterilization along with the new contraceptives namely injectable contraceptive- Antara and centchroman-Chhaya. Uptake of newer contraceptives like Antara injection and Chhaya (non-hormonal pill) were found suboptimal in a few State/UTs.

- Basket of choice was available in all facilities visited in Andhra Pradesh, Bihar, Delhi, Punjab, Chhattisgarh, Rajasthan, Sikkim, Tamil Nadu, Telangana, and Uttar Pradesh. In Maharashtra, contraceptive boxes and basket of choice were not displayed even though they were available in all visited facilities. There was a reported acute shortage of Injection Antara and Chhaya at the secondary facilities visited in Maharashtra. In Tamil Nadu, the MEC wheel and penile & uterine models for contraception counseling were not found. In Sikkim, ECPs were out of stock in facilities but were available at the State warehouse. Supply chain issues were noted in a few states. In Sikkim, Pregnancy Test Kits (PTK) were surplus in stock but of near expiry and in Uttar Pradesh timely indent, issue to the sub-store and maintenance of buffer stock were not practised.

- Adequate resources were found to be available at DH and CHC levels for interval IUCD and PPIUCD. Uptake of PPIUCD among users undergoing institutional deliveries was low in Andhra Pradesh, Bihar, Punjab, and Uttar Pradesh; whereas the acceptance rate was found better in Chhattisgarh and Kerala. Acceptance of IUCDs were a concern in Bihar, Punjab, and Uttar Pradesh.

- Sterilization services on fixed days were being offered at the secondary health facilities visited in Andhra Pradesh, Maharashtra, Tamil Nadu; however, utilisation of these services was not optimal. Kerala reported a decline in the use of sterilisation services and fixed day sterilisation services were not observed at the facilities. The uptake of male sterilisation services was considerably low in most State/UTs.

- Postpartum sterilisation rate was low in Uttar Pradesh, but a high load of interval laparoscopic sterilisation had been reported. In Uttar Pradesh, beneficiaries have not reported any OOPE as they also receive transport services through 102. The patients incurred expenses on diagnostics for the tests that were not available at the facility and prescribed prior to sterilisation procedures in Bihar. The follow up and maintenance of records

for the sterilisation services were reported challenges across the facilities visited.

- Comprehensive Abortion Care services were being provided at DH level in Andhra Pradesh, Goa, Kerala, Punjab, Uttar Pradesh. However, appropriate documentation of MTP forms and services was a concern.
- A dedicated counsellor for family planning services was available at the DH in Chhattisgarh and Tamil Nadu. Inadequate awareness and knowledge on services were reported among the healthcare providers in Bihar, Goa, Sikkim, and Tamil Nadu.
- Sensitisation and mobilisation of eligible users were found sub-optimal across facilities, except in Kerala where community acceptance of contraceptive methods was high and the providers were motivated to deliver such services at facility level. In Tamil Nadu LED screens have been installed for IEC/BCC activities including a video on the basket of choice was playing at the patient waiting area.
- FPLMIS had limited functionality in Bihar, Goa, Maharashtra, Punjab and Tamil Nadu, and was efficiently utilised in Uttar Pradesh.

2. Maternal Health

- Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) aims to provide assured, comprehensive and quality antenatal care, free of cost, universally to all pregnant women on the 9th of every month. PMSMA and Extended-PMSMA have been reported from Andhra Pradesh, Bihar, Goa, Kerala, Maharashtra, Sikkim, Tamil Nadu, Telangana and Punjab. Data documentation was not maintained in Punjab.
- Under the Surakshit Matritva Aashwasan (SUMAN) initiative, all pregnant women/ newborns visiting public health facilities are entitled to free and quality services- antenatal, delivery and postnatal care; management of sick infants and neonates; and assured delivery plan for the High Risk Pregnant (HRP) women. All the CEmONC facilities in Tamil Nadu were SUMAN notified and SUMAN volunteers had been identified. There was adequate display of IEC material related to provisions under SUMAN initiative. In Chhattisgarh, although the CHC and DH have been identified as SUMAN notified facility and IEC materials have been displayed at the facility, the staff was not aware of the initiative. None of the facilities visited in Kerala were identified/notified under the initiative.
- Comprehensive Emergency Obstetric and New born Care (CEmONC) facilities have been established at all secondary care institutions and Medical College Hospitals in Tamil Nadu and services in line with MNH toolkit had been reported from Kerala. Similar services were also reported from Jharkhand. The facilities were well equipped and functional on round-the-clock with laboratory and USG services, C-section, and blood storage units. Lack of training on CeMONC was reported a concern from Chhattisgarh and Kerala.
- DAKHSATA initiative was introduced to strengthen the competency and adherence of providers to perform evidence-based practices as per the labour room protocols and standards, improve availability of essential supplies and commodities and to improve accountability of service providers through improved recording, reporting and utilisation of data. The training has been reported by the staff in Kerala and has not been initiated in Chhattisgarh and Tamil Nadu.
- Adequate ANC care with line listing and appropriate referrals and follow-ups of High-Risk Pregnancies (HRPs) were observed in Andhra Pradesh, Chhattisgarh, Sikkim and Telangana; but was limited in Bihar, Goa and Kerala. Partographs were maintained to monitor the progress of labour

in Bihar, Chhattisgarh, Goa, Kerala, Maharashtra, Tamil Nadu and Telangana. The status of Skilled Birth Attendant (SBA) training was uneven across the facilities and State/UTs. Caesarean section rate was high (close to or more than 50%- Kerala, Sikkim, Tamil Nadu) in the visited facilities. High referral of labour cases was seen in Kerala.

- Adequate infrastructure, essential equipment and commodities were available at the ANC clinics except in Chhattisgarh (limited space) and Punjab (stock-out of Dual HIV/syphilis rapid diagnostic tests). MCP cards were not being used in Bihar, Goa, Maharashtra.

- Challenges in human resources were reported across facilities. This includes overburden on specialists due to shortage of GDMOs in Tamil Nadu; unavailability of c-section services at the CHC in Bihar and Telangana due to shortage of specialists, and unnecessary referrals to higher facilities due to shortage of nurses in Andhra Pradesh.

- Entitlements under JSY and JSSK including free services, medicines and consumables, diagnostics, diet, and referral transport were well utilised by the beneficiaries in Andhra Pradesh, Bihar, Punjab and Tamil Nadu. Utilisation of JSSK benefits were limited in Maharashtra and delayed JSY and JSSK payments were reported across facilities in Maharashtra and Sikkim.

- Out of pocket expenditure on MCH services, particularly diagnostics, was a common finding across states (Bihar, Goa, Maharashtra, Punjab, Sikkim). In Bihar this was owing to the preference of private laboratories over the diagnostic facilities at the DH and limited enrollment of private providers for PMSMA. To reduce the OOPE for tribal communities, district administration in Wayanad provides free transportation support to pregnant women for delivery to the Taluka hospital/DH and after delivery to return home in a special cab.

3. Child Health

- Comprehensive newborn screening was done at all visited facilities by the public health nurse in Kerala. Dedicated neonatal ambulances were functioning in Goa.

- In Chhattisgarh, LBW newborns were discharged without any interventions despite the recording of their status at the facilities. Nagaland reported inadequate identification and management of HRP cases and compromised infection prevention and control, leading to adverse outcomes on neonatal health.

- Assessment of newborns for inborn errors and congenital birth defects was being done by paediatricians before the sterilization procedures for postpartum mothers in Tamil Nadu. Mothers were also counseled on breastfeeding, identification of danger signs and on the prevention of hypothermia & hypoglycaemia. Breastfeeding within one hour was practiced in most of the facilities visited in Kerala, however, Comprehensive Lactation Management Centres (CLMCs)/ Lactation Management Unit (LMUs)/ Lactation Support Units (LSUs) had not been established in the State. A Comprehensive Lactation Management Centre (CLMC) was available in Tamil Nadu and Goa.

- Navjaat Shishu Suraksha Karyakram (NSSK) training had not been provided to the nurses and doctors posted at the labour rooms in Tamil Nadu. Staff nurses and ANMs in Uttar Pradesh expressed the need for refresher training on new born resuscitation techniques.

4. Maternal and Child Death Surveillance and Response

- MDSR was functional in Goa, Jharkhand, and Tamil Nadu. MDSR committees although in place, had limited functionality in Andhra Pradesh. Bihar, Chhattisgarh, Sikkim, and Uttar Pradesh.

- Maternal, Perinatal, Child Death Surveillance and Response (MPCDSR) software was not used in Punjab, UP and Bihar. In addition to MPCDSR, PICME portal was used in Tamil Nadu and a WhatsApp group was active for the immediate reporting by facility/ community on maternal and child deaths.
- Most of the state/UTs have initiated facility and community-based child death review, however, data entry in portal was not observed. Child Death Surveillance and Response (CDSR) mechanism was non-functional and needed focus in Bihar, Chhattisgarh, and Uttar Pradesh.

5. Universal Immunisation Program

- All the vaccines were found to be adequate in number and stock registers are well maintained and updated in e-Vin portal on regular basis in Andhra Pradesh, Bihar, Goa, Jharkhand, and Tamil Nadu. PCV and RVV and Hepatitis-B vaccine shortage was reported from Maharashtra. In Andhra Pradesh, cold chain points were observed to be well maintained, however, there were discrepancies in the temperature loggers.
- Open vial policy was followed and date and time of opening of vials were recorded in Andhra Pradesh and Tamil Nadu. Zero dose vaccination was followed at the delivery points in these states but not in Punjab. Bihar rolled out Model Immunization Corner within the health facilities that has helped the immunization coverage.
- Due list and RI micro plan had been updated in the facilities visited in Punjab, Sikkim and Tamil Nadu. Supportive supervision plan for routine immunization was not implemented in Andhra Pradesh. Immunisation cards were not updated in Bihar. AEFI registers were maintained in Punjab and Tamil Nadu but was missing in Maharashtra. Disparity between physical registers and e-VIN portal was found in Andhra Pradesh.

6. Child Nutrition

- The Anemia Mukt Bharat programme was functional in Andhra Pradesh, Tamil Nadu and adequate stock of IFA syrup and tablets were found at DH/SDH levels with mechanisms in place to notify stock-outs.

- Most of the State/UTs have well-equipped Nutrition Rehabilitation Centres (NRCs) with adequate staff and established referral linkages. In the districts where NRCs have not been established, the cases were managed in the paediatric wards. Feeding demonstrators were not available at all the centres. There was no established follow up mechanism for discharged children. A need for refresher training on the management of SAM was reflected through the observations.

7. Rashtriya Bal Swasthya Karyakram (RBSK) and Rashtriya Kishor Swasthya Karyakram (RKSK)

- In 2013, the Government of India launched the Rashtriya Bal Swasthya Karyakram (RBSK) under the National Health Mission for early detection and timely management of illnesses among children (0-18 years) by periodic screening through the platform of Schools and Anganwadi centres. Government also launched a comprehensive programme called, 'Rashtriya Kishor Swasthya Karyakram' (RKSK) in 2014 to respond to the health and development requirements of adolescents in a holistic manner.

- District Early Intervention Centre (DEIC) are to be established at the District Hospital level to provide referral support to children detected with health conditions during health screening, primarily for children up to six years of age group. The states of Kerala and Tamil Nadu have state of the art DEICs providing services including medical, dental, physiotherapy, psychology, speech and audiology, club foot clinic, and referral transport services. The DEIC in Maharashtra reported shortages of audiologists and dentist. The DEIC established in Sikkim was found to have only limited functioning. The utilisation of services at the DEIC in Andhra Pradesh was sub-optimal.

8. Adolescent Friendly Health Clinic (AFHC)

- Under RKSK, AFHCs at all levels of care entail clinical and counseling services on nutrition, sexual and reproductive health, injuries, violence including gender-based violence, non-communicable diseases, and mental health.

- Adolescent Friendly Health Clinics (AFHC) were established at all secondary care institutions having most of the necessary commodities as per the guidelines, in Kerala and Tamil Nadu. However, the demand for adolescent health services and commodities remained low as evidenced by a daily attendance. Most of AFHCs had ample IEC material needed for counselling. The training status among the counsellors and staff remained non-uniform through the States.

- The AFHC clinics in Punjab, named 'UMANG', have been established at the levels of DH and SDH. AFHCs in Andhra Pradesh were functional on dedicated days. There were no designated rooms for the AFHC 'Yuva' clinics at the DH in Goa, compromising confidentiality. Essential commodities were unavailable at the clinics visited in Goa, Sikkim (e.g., IFA syrup and tablets) and Tamil Nadu (condoms and ECPs). Documentation practices were suboptimal in Andhra Pradesh, Goa and Tamil Nadu. Functional AFHCs (Yuva clinic) were not observed in Bihar.

9. Free Diagnostic Service Initiative

- The diagnostic services were provided in-house in Andhra Pradesh, Kerala, and Tamil Nadu; PPP mode in Madhya Pradesh and Maharashtra; and hybrid mode (in-house and PPP services) was observed in Goa, Punjab, and Uttar Pradesh.

- The Free Diagnostics Service Initiative was being implemented at the secondary care facilities, however, the number of tests available free of cost was not as per the FDSI guidelines in Andhra

Pradesh, Punjab, Rajasthan, Tamil Nadu, and Uttar Pradesh. A nominal user fee was collected for the diagnostics and radiological services in Kerala, Maharashtra, and Punjab.

- The facilities visited in Tamil Nadu and Uttar Pradesh had satisfactory turnaround time (TAT) and were found to have essential diagnostic supplies and equipment. Non-functional equipment and shortage of rapid kits were reported from Punjab. Andhra Pradesh had a robust supply chain for lab equipment, reagents & consumables.

- Optimal quality assurance mechanisms and protocols were in place at the in-house laboratories in Kerala and Tamil Nadu. Institutional mechanisms for quality control were not observed in Andhra Pradesh, Punjab, and Uttar Pradesh. Laboratory Information Management System (LIMS) was found to have limited functionality in Andhra Pradesh, Punjab, Tamil Nadu, and Uttar Pradesh. Lab reports and critical alerts were not shared through mobile with patient or treating doctor.
- Multiple laboratories for various programs were set up at the DH/SDH in Punjab and the staff were underutilized at these facilities. Awareness of the Lab Technicians on sample handling, packing and transportation; quality assurance mechanisms; and biomedical waste management including sharps, were limited in the State/UTs.
- The in-house model of Andhra Pradesh was observed to have the potential for implementing a robust Hub & Spoke model with upward and downward linkages, eventually helping in the establishment of an Integrated Public health Laboratory (IPHL).

10. Biomedical Equipment Maintenance and Management Programme (BEMMP)

- The program is operational in PPP mode in most of the States visited (Andhra Pradesh, Jharkhand, Nagaland, Punjab, Maharashtra, Kerala, Bihar, Rajasthan, and Uttar Pradesh). The equipment has been mapped and tagged across levels of care in Kerala and Punjab; and was under process in Andhra Pradesh, Nagaland, and Uttar Pradesh. The service provider had set up a functional centralized toll-free number for fault registration in Bihar, Maharashtra, Kerala, Punjab, and Rajasthan.
- Not all equipment were covered under AMC/CMC in Punjab and mapping and compliance with AERB were partial in Maharashtra and Uttar Pradesh.
- Service provision was not found timely in Bihar, Nagaland and Uttar Pradesh and the states were yet to initiate calibration of equipment. The shortage of biomedical engineers led to delays in equipment maintenance in Nagaland. Non-functional and old equipment were found stored/ stacked in Andhra Pradesh, Bihar, Maharashtra, and Nagaland.
- Preventive maintenance and calibration were done for all equipment in Tamil Nadu. Periodic preventive maintenance and calibration records were not found in Andhra Pradesh. IT dashboards/ portals were not being utilised for monitoring the functionality of equipment in Andhra Pradesh and Bihar.

11. Pradhan Mantri National Dialysis Programme (PMNDP)

- PMNDP was reported operational in Delhi, Jharkhand, Kerala, Maharashtra, Punjab, Tamil Nadu, and Uttar Pradesh, providing free of cost dialysis services, including medicines and diagnostics, to all beneficiaries through NHM and state insurance schemes. Dialysis services at the secondary care facilities were available in Kerala, Punjab and Tamil Nadu, with adequate number of dialysis machines including separate machines for seropositive patients.
- The dialysis units run in PPP mode in Andhra Pradesh, Bihar, Delhi, Rajasthan and Uttar Pradesh. Peritoneal dialysis facilities were not available in Andhra Pradesh and Uttar Pradesh.
- The facilities in Tamil Nadu had an optimal machine utilization rate, however, a Nephrologist was available only at the tertiary centres; and several practices not in line with the guidelines were observed (e.g., reprocessing dialyzer manually, reuse of bloodline over 10-20 times, infrequent chemical analysis of water). Critical equipment was not available in Rajasthan.
- Pradhan Mantri National Dialysis Portal is regularly updated in Tamil Nadu but not utilised in Andhra Pradesh and Punjab.
- The patient waiting lists were not updated at all the visited facilities. Underutilisation of services and staff were reported from Maharashtra and Punjab. The challenges reported from the units include infrastructural disintegration and shortage of staff. User fee for services were reported from Bihar, Uttar Pradesh and Jharkhand and occasional OOPE on medicines were a common finding across states. Testing for quality of water was not a routine practice at the units.

12. Integrated Disease Surveillance Project (IDSP)

- The IDSP lab is established at DH level and all tests are available free of cost in Andhra Pradesh and Punjab. Epidemiologists, Microbiologists, and pathologists were in position; and had essential equipment and consumables. Testing of Malaria and Dengue at the SDH level was limited. Integration of existing labs and involvement of program officers is essential in the planning & up-gradation of DPHL into IPHL to address program priorities.
- Staff were seen to be updating the IHIP portal on a daily basis only in a few states. Follow-up actions based on IDSP data in terms of presumptive cases were not followed up for diagnosis/subsequent care. Integrated Health Information Platform (IHIP) training is ongoing in various states and is under implementation. Real-time update of data for timely action on disease containment activities needs improvement.

13. National Tuberculosis Elimination Programme

- Timely diagnosis, treatment, referral and follow up services for management of tuberculosis have been reported across the secondary care facilities; however quality assurance mechanisms; infection prevention and control practices; and recording and reporting mechanisms required improvement. In Sikkim the patients sought care directly from the tertiary centres.

- Designated Microscopy Centres (DMC), CBNAAT and TrueNAT facilities were available at secondary level in most of the State/UTs (Andhra Pradesh, Sikkim, Kerala, Maharashtra, Nagaland, Bihar, Jharkhand, Rajasthan, Telangana, Meghalaya). The availability of X-ray services was not uniform across the visited facilities and some were functional in PPP mode.
- The medicines were available and stored in optimal conditions with a well-maintained registry on stock-outs and expiry details. Nikshay Aushadi and Nikshay Mitra were functional but its utilisation was minimal across the facilities. Nikshay Portal was well utilised in Chhattisgarh, Kerala, Maharashtra, Nagaland and Uttar Pradesh. The staff required training on the use of these portals.
- Bidirectional screening of TB-COVID and TB-HIV; and the involvement of the private providers need to be strengthened to facilitate timely notification of cases.
- Verbal autopsies were being conducted at the district level for deaths among the notified TB patients but follow-up action based on the review was missing.
- Shortage of staff to ensure active functioning of NTEP was a common finding across the facilities. Training of NTEP staff at the District Tuberculosis Centre (DTC) & Tuberculosis Unit (TU) were found inadequate in Tamil Nadu.

14. National Leprosy Eradication Programme

- Early detection and Disability Prevention & Medical Rehabilitation (DPMR) activities for leprosy cases were being carried out at the secondary care level facilities in most of the State/UTs. However, contact tracing and monitoring of adherence to the regimen were sub-optimal in Uttar Pradesh. Stock-out of medicines were reported from Meghalaya (MDT drugs) and Uttar Pradesh (Rifampicin).
- Slit Skin Smear (SSS) test was not performed at the secondary levels and patients were referred to tertiary centres where dermatologists were available to conduct the test. Self-care kits including MCR footwears, splints and goggles were provided from the DH in Jharkhand, Punjab, Telangana, Uttar Pradesh and also in Chhattisgarh.
- Nikusth portal was not implemented in Chhattisgarh.
- Grade 2 disability investigation & focused leprosy campaign not undertaken in visited districts of Chhattisgarh as per guidelines.
- Positions of Leprosy Consultant and Physiotherapist were found vacant in Jharkhand. Space constraints limited the services provided by the physiotherapist in Bihar.

15. National Viral Hepatitis Control Programme

- Screening for Hepatitis-B was done as part of antenatal care across State/UTs. Hepatitis B immunoglobulin was available at the level of DH (except Sikkim and Telangana) in the states and disposable syringes were being used for the same. The healthcare workers have been vaccinated and records were maintained for the same; however, it was a concern in Punjab.
- Treatment for Hep-B and Hep-C were available at the DH in Chhattisgarh and Punjab; and HBsAg, Anti HCV and RDT kits were sufficiently available. Hep-C cases were transferred to tertiary centres as reported from Delhi, Sikkim, Tamil Nadu, and Telangana.
- Patients reported OOPE on diagnostics while travelling to higher centres and for tests done at private facilities.

16. National Rabies Control Programme

- Anti-Rabies vaccine was available at most of the DHs but the shortage of immunoglobulins across the State/UTs was concerning.
- There was a knowledge gap among healthcare providers on the categorization, management, and reporting of animal bites across regions.

17. National Vector Borne Disease Control Programme

- The programme needs strengthening across levels of care in the visited State/UTs. The preventive activities of the programme were being conducted by the facilities through surveillance, vector control measures and awareness generation activities, however these require further strengthening. For e.g., surveillance activities were being conducted by the district health team in Uttar Pradesh. However, there was a gap in communication between the CHC and peripheral centres compromising the quality of these activities. Shortage of ELISA kits for dengue testing were reported from Bihar and Delhi.
- Tamil Nadu has completed its third Transmission Assessment Survey and are heading towards Filaria elimination.

18. National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke

- NCD Clinics have been set up in secondary care facilities and functions as referral centres for peripheral facilities and also facilitated upward linkages; however, their functionality was sub optimal in Bihar, Delhi, Maharashtra, Meghalaya, Punjab and Uttar Pradesh.
- Opportunistic screening of DM, HTN and common cancers was being undertaken at the DH level in Goa, Tamil Nadu, and Uttar Pradesh and at CHC level in Chhattisgarh. However, in Uttar Pradesh the screening was not well-defined and the NCD registers were not in use.
- The NCD medicines and consumables were available at the facilities except for the stockout of antihypertensives and antidiabetics in Uttar Pradesh. Chemotherapy services were not available at the DH level in certain districts whereas it was underutilised in a few others.
- Effective implementation of the programme has been hampered by the vacant posts of district program coordinator in Maharashtra; and district-level programme officers, coordinators, consultants, and data entry operators in Uttar Pradesh. Orientation on the programme guidelines needed for the programme implementers & the nodal officers in Sikkim and Uttar Pradesh.
- The underutilisation of services and limited awareness among community point towards the need for strengthening IEC/BCC activities across levels of care and regions. Documentation and maintenance of records were not followed in most of the facilities. Goa has launched STEMI project in a hub and spoke model.

19. National Programme for Control of Blindness and Visual Impairment

- Diagnosis and management of cataracts, glaucoma, diabetic retinopathy, and other retinal conditions were routinely done at the DH in the State/UTs; with referral linkages being set up with tertiary centres.
- Facilities were underutilized due to shortage of specialists in Bihar, Punjab and Tamil Nadu, leading to a backlog of cases. Referral linkages, flow of information and continuum of care were not optimal at the CHC/DH level. Surgical consumables were not in stock at the DH in Sikkim.

20. National Oral Health Programme

- Dental services were provided at the facilities in Bihar, Chhattisgarh, Delhi, Punjab, Rajasthan, Sikkim, and Tamil Nadu, although limited in accordance with IPHS. The programme needs strengthening in Telangana and Uttar Pradesh. Sterilisation practices were unsatisfactory across regions.

- Lack of dental X-ray services and non-availability of consumables were observed in several states (Sikkim, TN, Bihar) limiting service provision, leading to patients seeking care from private dentist.

- Optimisation of human resources was required as there was a shortage of dentists in Maharashtra and dentists were surplus in Sikkim; and more dentists were being posted in Tamil Nadu. However, there was a shortage of dental assistants and technicians. Oral cancer screening and suspect referrals require strengthening at the DH level.

21. National Tobacco Control Programme

- The programme and Tobacco Cessation Centres were functional in Chhattisgarh, Goa, and Tamil Nadu; had limited functioning in Bihar and Meghalaya; and dedicated centres were missing in Delhi, Madhya Pradesh, Rajasthan, Sikkim, and Uttar Pradesh.

- IEC materials although displayed at the facilities, IEC/ BCC activities require strengthening across State/UTs.

- COTPA trainings and raids have been reported. Eight villages in Punjab have been declared as tobacco-free villages as a result of the concerted efforts.

22. National Mental Health Programme

- Mental health treatment and de-addiction services were being provided to the inpatients at psychiatric wards at the secondary level facilities in a few State/UTs. Psychiatrists were providing OPD and outreach services, along with the Counsellors posted in the District Counselling Centre. Outreach services and linkages were in place with schools, jails and government aided rehabilitation centres.

- Tele-MANAS is being established at the State/UTs. Shortage of human resources was observed across levels of care. A toll-free number/landline number available and displayed across facilities for awareness generation and suicide prevention in Sikkim. Calls were addressed by counsellors and appropriately referred to higher centres. Community awareness on the government initiatives were limited in most of the State/UTs.

23. National Programme for Health Care for Elderly

- Regular geriatric OPD clinics and functional geriatric wards were available in Goa, Meghalaya, Punjab, Sikkim, Tamil Nadu, Telangana, and Uttar Pradesh; however, functionality varied across regions. The facilities in Bihar and Uttar Pradesh were not compliant to accessibility guidelines. Home-based visits have not been reported.

- There was a shortage of physiotherapists in Delhi, Tamil Nadu, and Uttar Pradesh. The providers require further training on the programme, service provisions and continuum of care.

- The users from Tamil Nadu expressed their satisfaction with the services and providers and reported nil OOPE.

24. National Programme for Palliative Care

- The roll out of NPPC has not been uniform in and across State/UTs. The programme had limited functioning at the secondary care facilities in Bihar, Chhattisgarh, Maharashtra, Punjab, Sikkim, and Uttar Pradesh.
- Palliative care units in Kerala and Tamil Nadu at the district level were well-equipped with necessary equipment and medicines; and provides quality palliative care with timely follow-up of the users. The services include OPD, IPD and home care provided by dedicated staff for palliative care.
- National programme for palliative care is being implemented in Health & Wellness Centres and PHCs

25. Other National Health Programmes

a. Prevention and Control of Leptospirosis- An apparent increase in the detected cases in one of the districts in Tamil Nadu (Thoothukudi) could be attributed to the increased testing capacity of the district through the District Public Health Laboratory (DPHL) and Medical College. Capsule Doxycline was available in all facilities for the management of detected cases.

b. National Iodine Deficiency Disorders Control Programme (NIDDCP)- The iodine testing services, and salt kits were inadequate at the facilities visited in Punjab. The procurement process of salt testing kits was underway in Chhattisgarh.

c. National Programme for Prevention and Control of Deafness- The Ferozepur district in Punjab had initiated a new project known as 'SOHUM' under Universal Neonatal Hearing Screening programme for early detection and management of hearing loss in neonates. The programme was found to be non-functional at the visited facilities in Uttar Pradesh.

d. National Programme for Prevention and Control Fluorosis- The programme has been implemented in the endemic districts of Chhattisgarh and water samples have been tested. Maharashtra has identified fluorosis affected areas and the water supplies have been demarcated.

e. National AIDS Control Programme (NACP)- HIV testing was available at the secondary care facilities, and antenatal women were being routinely screened.

RECOMMENDATIONS

- Capacity building on newer initiates in Family Planning as well as FPLMIS needs to be ensured.
- Healthcare providers need to be trained in SBA, NSSK, FBNC & Dakshata.
- States to ensure that line listing of pregnant women, and identification, management and follow-up of High-Risk Pregnancies (HRPs) need to be strengthened at sub-district and district level secondary care facilities.
- States to ensure that HR is deployed rationally at delivery points and for various national health programmes for effective service delivery.
- States may strengthen the periodic reporting, auditing and review meetings under MDSR/ CDR and regularly updating the same on MPCDSR platform.
- Availability of essential diagnostics as per FDSI guidelines must be assured at all secondary level healthcare facilities. Measures should be taken to improve the functionality of Laboratory Information Management System (LIMS).
- Laboratory diagnosis of common outbreak prone diseases like dengue, and malaria etc. needs to be strengthened under IDSP at SDH level. States need

to expedite the process of establishing integrated public health laboratory (IPHL) at each district hospital.

- Under PMNDP, availability of specialists at the dialysis units must be assured at every dialysis centres and state should ensure provision of free dialysis services to all BPL patients to reduce OOPE.
- States to strengthen their supply chain management to ensure uninterrupted supply of logistics, enhancing the functionality of facilities and reducing out of pocket expenditure on users.
- States should ensure the functionality of the NCD clinics, availability of medicines, strengthening the existing reporting and recording mechanisms and timely follow up of diagnosed individuals.
- States need to strengthen the infrastructural requirements for effective implementation of various programmes. e.g., establishment of Tobacco Cessation Centres under NTCP, geriatric wards under NPHCE and Tele-MANAS cells under the digital arm of NMHP.
- To strengthen NPPC, states may 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.
- States needs to develop and disseminate IEC material specific to the programme guidelines to increase user awareness.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) on 9th of every month and Extended PMSMA on 10th of every month have been implemented in both the districts. The visibility of program was also observed in the community.
- Labour rooms were LaQshya certified with conditionality at the DH level in both the districts.
- Utilisation of services under Janani Shishu Suraksha Karyakaram (JSSK) was satisfactory, however dietary compliance for anaemic women was not followed.
- The services at the DEIC were underutilized and only 50 percent of equipment were available. DEIC needs to be linked with SNCU & NRC to provide follow-up services and monitor overall development of the children discharged from these units.
- Cold chain points were well maintained, however few discrepancies in temperature loggers were observed.
- Government of Andhra Pradesh has operationalized 2 State Midwifery Training Institutes (SMTIs) at Guntur and Tirupati. Two batches with batch size of 30 were undergoing training as Nurse Practitioners in Midwifery in collaboration with UNICEF and Fernandez Foundation.
- State has shifted to IHIP reporting since 2021, from IDSP weekly reporting. IDSP Lab was functioning separately from the Central Lab at DH Vizianagaram.
- State provides diagnostic services through an in-house model and has a robust supply chain for equipment, reagents & consumables. State has the potential for implementing a robust hub & spoke model with upward and downward linkages which will help in establishing an Integrated Public Health Laboratory (IPHL). However, the number of tests offered at the facilities were not in line with FDSI guidelines and quality control measures were not in place.

- The state provides Tele-radiology, CT scan and MRI services through PPP mode.
- AERB license was available at the facilities, however, awareness about the norms were inadequate among the healthcare staff.
- The state had finalised the service provider for BEMMP, and equipment mapping was under progress. The state has in-house biomedical engineers at DHs, AHs and CHCs, however, equipment uptime was around 70 percent.
- Dialysis services were running in PPP mode in the State. Peritoneal dialysis service has not been rolled out yet. PMNDP portal was not in use and real time patient registration was not in place.
- District Vizianagaram and East Godavari received bronze medal in TB- Sub National Certification 2021. It is one of the leading states in the adoption of molecular diagnostics. TB Free Roadmap/Plan at the state and district levels have not been prepared.

Bihar

- Significant improvement has been noticed in infrastructure, availability of medicines, diagnostic facilities, and technical resources along with an assured network of ambulances in Bihar. This has resulted in an increased utilisation of RMNCH+A services. However, there is a scope for further improvement in the quality of services being delivered.
- There were delays in ANC registration and MCP cards were incompletely filled. Identification and management of HRPs was weak. PMSMA and e-PMSMA were being organized at DH/SDH/CHC level. USG machines were underutilised at the DH.
- Out of Pocket Expenditure (OOPE) was reported for MCH services in both the districts as c-sections were not performed at the CHC due to shortage of gynaecologists and anaesthetists.
- Underreporting of maternal and child deaths was observed and Death Surveillance and Response was limited in the districts.
- Integrated Health Information Platform (IHIP) training under IDSP has been initiated.
- Under PMNDP, user charge was exempted only for gold card holder and users including BPL beneficiaries were charged for dialysis.
- MoU was signed in 2022 between the State Health Society- Bihar and Homi Bhabha Cancer Hospital & Research Centre- Muzaffarpur for strengthening cancer and palliative care services.
- Diagnostic facilities for Hep-B and Hep-C were observed at all levels, however, programmatic activity has been minimal.

Chhattisgarh

- The CHC and DH have been identified as SUMAN notified facilities with IEC materials in place, however, the staff were not aware of the SUMAN program and SUMAN volunteers have not been identified in Kondagaon District.
- Maternal and infant deaths were reported in both districts, however, MDSR and CDSR activities were irregular in Kondagaon district.
- Despite the implementation of FPLMIS, the system was not functional due to challenges in training and network connection.
- The weekly skin clinic at DH has been initiated for the management of leprosy.
- The District Hospital NCD clinic functions as a

referral centre for the referred cases from peripheral facilities as well as a centre for opportunistic screening at the District Hospital.

- "Sparsh Clinic" in DH provides mental healthcare services and individual health card was maintained for each patient visiting the clinic. As the DH does not have any Psychiatrist, the medications were prescribed by medical officers, and the counselling services were provided by a counsellor. The clinic also provides monthly outreach services to the CHCs. A state specific software has been developed with the support from NIC for maintaining the line-listing of the patients.
- The DH did not have any structured mechanism for the provision of elderly and palliative care services.

Delhi

- Dialysis centre at Pandit Madan Mohan Malavya Hospital was being managed by Apex Care Centre under PPP mode under Pradhan Mantri National Dialysis Programme. Dialysis was available free of cost for only BPL and other card holders, user fee is levied for other users.
- The district hospital did not have a chest physician in place and there was no separate TB ward.
- There was no stockout of the MDT drugs for the last 6 months but the loose tablets of Clofazimine supplied for treatment of the leprosy was not in stock as the tabs were not available through either central warehouse affecting the reaction management.
- No system of community surveillance as part of IDSP has been formulated in the districts or state.
- All the pregnant women tested HBsAg positive were not followed up at the facilities.
- The district hospital had NCD clinics in which opportunistic screening of diabetes and hypertension were done on Tuesdays and Fridays. The screening for Breast and Cervix Cancer were done by the OBG department and referred to higher centres in case of suspicion for diagnosis and management.
- The district hospital conducted weekly elderly clinics jointly by the medicine and orthopaedic department.
- There were no Tobacco Cessation Centres at the district hospital in northwest and no counselling and pharmacotherapy sessions conducted at DH. The de addiction services were also not available due to the absence of a psychiatry department and a psychologist.
- Outreach camps for cataract and other eye conditions were organized in coordination with All India Institute of Medical Sciences.
- The palliative clinics did not run at the DH but there was round-the-clock availability of pain medications and basic procedures helping in palliation were available at the DH.
- Psychiatric OPD was functional at South Delhi and psychotherapy/counselling services are available. Suicide prevention helpline was not operational in the district psychiatrist and psychology/ counselling services were not available at the DH in Northwest.

Goa

- The utilisation of family planning services was minimal, particularly male sterilisation services.
- Sub-optimal efforts on the mobilization of eligible clients in the community by the health care providers was observed at one of the immunization centres with eligible clients. At a

few secondary care levels in North Goa, FP services were not available for the eligible clients. Inadequate knowledge on FP methods and use of contraceptives among the health care providers. Another major finding at the facilities was 'Missed opportunities', i.e., 0% PPIUCD insertion to the potential clients.

- During beneficiary interaction, it was found that 20% of them did not receive any MCP card and ANC registration at DH level was found to be lacking.
- Goa had an RBSK mobile health micro plan in place. The state has a well-equipped and functional DEIC.
- There was no designated room for AFHC Yuva clinic in DH, but counselling services were functional.
- Psychiatrist was appointed at South Goa District Hospital to conducts psychiatric OPD for elderly patients and visit to peripheral facilities and Old Age Homes in the South District.
- Under Swayampurna Goa scheme, various geriatric health camps, day-care centres, and counselling centres were established.
- At a few CHCs there were retina clinics to screen for diabetic retinopathy and other injuries or infections once a month.
- Free Diagnostic Service Initiative was provisioned under NHM along with support of state government. Essential pathology services were made available at all public health facilities and the expanded range of laboratory tests were available at both DHs. The EDL was available and finalized during tendering every 3 years, however none of the visited healthcare facility had the copy of updated EDL/EML.
- Anti-rabies clinics functioned at the DH and immunoglobulin was provided at the Medical College.
- At the district level, a rapid response team with necessary logistic support was functional for epidemic response activities.
- Regular psychiatric OPD at DH with de-addiction services were functional.
- STEMI project was launched in 2018 in a hub and spoke model for the management of cardiac patients in their golden hours using Tele-ECG and thrombolysis, and then to transfer to the apex institutions.
- Under the India Hypertension Control Initiative (IHCI), opportunistic screening for hypertension at all facilities for users more than 18 years of age.
- Goa will be launching 12 iBreast devices to screen for breast cancer.
- Nikusht Portal had been non-functional at the facilities for the last 3 months, at the time of CRM Visit.

Jharkhand

- MR elimination was a priority for the Deoghar district. WHO surveillance had been intensified with most confirmed cases being migratory in nature from neighbouring States, particularly West Bengal.
- Hep-B coverage was poor at 59% as vaccines were not available at delivery points.
- Deoghar also had a Regional Vaccine Store for supplying 7 districts. However, due to insulated vaccine vans not functioning, RVS supply has been restricted and districts collected vaccines directly from the State Vaccine. Vaccine hesitancy was observed in minority communities for COVID-19 vaccine as well as routine immunization.

- At DH, Garhwa, there was a separate cold chain unit and immunization corner in the facility with dedicated staff. In cold chain unit, open vials were not stored for more than 28 days, and recording done on the portal and hard copies. All records were well maintained and in line with the eVIN portal.
- FDSI was provided through PPP mode at the CHC in Garhwa.
- At DH Deoghar, the USG machine was outdated, and X-ray machine was non-functional.
- Dialysis services were delivered under PMNDP implemented in the PPP Mode. Dialysis service was free for BPL and PMJAY beneficiaries, user fee was levied by other users.
- The State IEC officer was aware of the ACSM indicators for TB. However, neither the state nor the district was aware of the COVID and TB campaigns, for which a letter for dissemination has been issued by the CTD.
- The District TB Centre (DTC) in Deoghar was well-equipped with 1 CBNAAT and 1 TrueNAT machine with a turnaround time of less than 2 hours. However, infection prevention and control practices were unsatisfactory.
- Slit Skin Smear (SSS) test was not available at District Hospital, Deoghar and patients were referred to a private clinic where patients incur OOPE.

Kerala

- The District Hospital Wayanad had LaQshya certified labour room (score LR-86% and maternity OT-70%). The Maternity OT was yet to be certified. The district must ensure quality certification of DH and Taluka hospitals under NQAS. The facilities visited were not identified/notified under the SUMAN initiative.
- In an attempt to reduce the OOPE for tribal communities, the district administration in Wayanad provides free transportation support to pregnant women for delivery to the Taluka hospital/DH and after delivery to return home in a special cab.
- Comprehensive Lactation Management Centers (CLMCs)/Lactation Management Unit (LMUs) (DH/SDH)/ Lactation Support Units (LSUs) were not observed at the facilities in both districts.
- DEICs were functional in both districts. DEIC Kalpetta in Wayanad district has state of art infrastructure, and provides medical, dental, physiotherapy, psychology, speech, audiology, club foot and referral services. It also had linkages with private providers for early detection, referral and follow up of cases.
- AFHC was functional at GH Thrissur.
- A total of 5 counsellors were posted under different programmes- AFHC, STI, ICTC, blood bank services and Bhoomika (gender based violence management centre).
- CBNAAT testing facility was available at the SDH/DH levels. Sputum for CBNAAT was collected from health facilities and private hospitals (13 Private hospitals to SDH Sultan Bathery, District Wayanad) of the block using separate vehicles under National Tuberculosis Elimination Programme.
- Secondary palliative care units were available in District Hospitals and separate OPD for palliative patients were available on specific days (Tuesdays).

- The state has a suicide prevention helpline named Jeevan Raksha and was providing psychotherapy and counselling services.
- State provides in-house diagnostic services across all levels of care. Nominal user charges were levied for all the tests. Radiology services were available at the level of SDH and above.
- The Pradhan Mantri National Dialysis was operational in an in-house mode, in all the districts.
- BEMMP was operational in PPP mode across the State. The service provider had tagged and mapped all equipment and set up a toll-free number for resolving complaints.

Madhya Pradesh

- High-Risk Pregnancy was not highlighted and regular follow-ups/ monitoring mechanism for HRP was not found in CHC (Singruali) under RMNCHA+N services.
- Cold chain was being maintained and monitored digitally by e-VIN portal. In the form of Anand Diwas, the cold chain supervision was standardized and streamlined where cold chain of all stocking points was systematically assessed through checklist on the 1st working day of each month.
- For the National Oral Health Programme, optimal utilization of human resources was not observed.
- Implementation of Pradhanmantri TB Mukta Abhiyan was done in both districts and all block-level facilities were saturated with NAAT machines with the availability of upfront NAAT.
- X-ray screening of presumptive TB patients was found to be low in both districts due to the unavailability of X-ray machines in facilities.
- Viral load testing for Hepatitis B & C was found to be undertaken through outsourcing in both districts.
- Tobacco Cessation Centres were seen to be non-functional in both the districts visited.
- There was no mechanism for the maintenance of diagnostic equipment and AERB licensing had not been initiated under free diagnostic service initiative.

Maharashtra

- Services under RMNCH+A was variable across the districts. Maternal health services such as line-listing of high-risk pregnancies, provision of round-the-clock lab and ultrasound services, and use of partograph to monitor the progress of labour were provided at the level of DH. Due to this, patients referred from primary level facilities preferred accessing the DH or the medical college instead of the rural hospital or SDH.
- At the level of SDH, it was observed that the RCH portal was not updated for the past three financial years, MCP cards were not adequately supplied to the health care providers, while photocopied and incompletely filled MCP cards were given to Pregnant Women. Identified high-risk pregnancy cases were not recorded in the MCP cards.
- Irregularities in JSY payments to the eligible beneficiaries were reported. Provision of transportation facility under JSSK was underutilized. The implementation of PMSMA at the SDH level was satisfactory.
- Immunization activities at the DH were robust. Vaccine shortage, improper storage conditions and inadequate recording were observed at the SDHs.

- Availability and uptake of contraceptives basket of choice, injectable contraceptives and sterilization services were variable across the districts. While family planning activities needed strengthening at Dhule district, the programme implementation was satisfactory at Washim district.
- Newborn Care Corner was available in the labour rooms of visited facilities. However, provisions for patient privacy need attention.
- TB notification has increased substantially, with the public and private sector notification ratio being 60:40. Private Provider Support Agency (PPSA) have been established in most of the districts to enhance private sector notifications and completion of Public Health Actions.
- NIKSHAY platform was being utilized regularly by all the health facilities for reporting notification, Public Health Actions, and outcomes. Health facility IDs have been generated for all the private sector facilities.
- Bidirectional screening of COVID-19 and TB, and efficient utilization of TrueNAT required strengthening.
- NCD clinics at the SDHs were either non-functional or poorly utilized. There was no referral linkage between the primary healthcare facilities and the district hospital for NCD cases. Absence of district programme coordinator hampered the effective programme implementation.
- Tobacco Cessation Centre was functional in all the visited facilities. However, infrastructure and equipment for TCC needed improvement at sub-district level facilities.
- Cataract screening camps were arranged regularly by all facilities. Diagnostic and correction of refractive error camps were also organized. Free eyeglasses were provided for school children, 40 and above patients and post-surgical patients.
- At the level of Rural hospital, 40 routine tests and 12 special tests were outsourced under FDSI. Whereas, at the SDH, 38 routine tests and 12 special tests were outsourced. An MoU has been signed between the State Health Society (SHS -NHM), Directorate of Health Services and a private provider for the implementation of free radiology services and CT scan services under the FDSI. The implementation of diagnostic imaging services was observed to be satisfactory.
- The state has implemented the PMNDP programme in 54 centers through in-house mode in 29 districts. It has been operationalized with 324 functional machines and has covered all the four Aspirational Districts (Nandurbar, Washim, Osmanabad and Gadchiroli). The 54 Centres include DH-22, SDH-16, GH-6, WH-2, RRH-2, RH-6. The state was planning to provide dialysis services in 4 new dialysis centres at Dhule (Sub-District Shirpur and District Dhule) and Osmanabad (Sub-District Umarga and Sub-District Tuljapur).
- Biomedical waste management at the facilities needed to be streamlined as protocols were not followed prior to their disposal.
- The implementation of BEMMP had been robust. The secondary level facilities adhered to the state guidelines, and the complaints were resolved on time.
- The state has been processing the AERB certification for all radiology equipment in PPP mode for all the facilities.

Meghalaya

- Implementation of FP services needed attention. Basket of choice for FP services was available at the facility but under-utilized. Sterilization services

were unavailable. As per records, usage of newer contraceptives was low.

- High risk pregnancy line listing was available, but routine follow up was not conducted. SUMAN was yet to be notified. There were no 24X7 lab facility nor USG services and C-section facility was available.
- Under the Universal Immunization Programme, the district hospital and CHCs were cold chain points. All the vaccines were available, and e-VIN was utilized for stock management of vaccines. Biomedical Waste was not being managed as per the guidelines.
- The implementation of national health programmes such as NRC, NRCP, NACP, NPPCD, NPPC, Trauma & Burn Injuries, NPCBVI, NPPCF, NTCP, NOHP, PMNDP, BMMP and Free Diagnostic Services initiative were not robust.
- Under the NTEP, TrueNAT machine was available, but X-ray services were not available. There were no proper storage conditions maintained for Anti TB drugs/ Diagnostics/ Consumables.
- NCD clinics with dedicated staff for services were unable. Medicines were issued for only 2 weeks. The CPHC NCD application was not being used.
- Free Drug Service Initiative had not been notified. Annual indent was done as per the request raised in State DVDMS. EML was not available, inventory management was poor and local purchase of drugs was not done.

Nagaland

- While the state had been undertaking efforts to improve maternal health services, the proportion of institutional deliveries was only 38%. Irregularity in the implementation of PMSMA was observed, leading to missed opportunity for identification of High-Risk Pregnancy (HRP) cases. Line-listing and tracking of HRP were not done at the facilities.
- Most of the staff nurses who worked in labour rooms were not trained in SBA, Dakshta, LaQshya and NSSK. Trained staffs, on the other hand, were frequently posted to other wards as per the duty roster set by the State.
- The State has only one functional 6 bedded NRC at the district hospital of Kohima district. Its Bed Occupancy Rate (BoR) was sub-optimal.
- The facilities had family planning corners and the uptake of family planning services were satisfactory. However, it was observed that the preference for injectable contraceptives was low. 'Saas Bahu Sammelan' was launched recently at the district level in ZBT.
- Though laparoscopes were available at the secondary level facilities, they were not used. Sterilization services were provided daily at the level of DH. However, even fixed day services were not available at sub-district level. While FPLMIS was functional at the CHCs, it was yet to be established at the DH.
- The implementation of universal immunization programme was satisfactory. One of the challenges reported by the State was that the immunization targets as per Census were more compared to the actual headcount survey for the state of Nagaland. As a result, the coverage rates were low for the state.
- The state had adequate Cold chain equipment including dry stock but there was no standby/ buffer ILRs/DFs available at the SVS/DVS for replacement in case of equipment failure. Further, transportation of equipment was a challenge owing to difficult terrains and roads.

- The districts vaccine vans were reportedly unavailable in most of the districts and have not been repaired yet. Due to their unavailability, neither the route charts nor the vaccine distribution plans were in place.
- Though MDSR and CDR were in place, case presentation at District Collector/Magistrate level was yet to be taken up.
- Treatment for diabetes and hypertensive patients was given at the district hospital, however, follow up mechanisms were not well-established.
- Activities under other NCD control programmes were either unavailable or yet to be implemented.
- District TB Hospital was converted into the COVID Ward and TB services were shifted outside the hospital, while the isolation ward was converted as TB ward.
- The DTC functioned well, with adequate infrastructure and medicines in stock. Relevant HR, namely, the DTO in-charge and MO-TC need to be positioned. Irregularities in the remuneration of other NTEP staff were reported.

Punjab

- Most labour rooms were well-equipped with emergency medicines. Dedicated ANC and PNC wards were attached with the labour rooms.
- Due to the shortage of HR and under-utilized sub-district delivery points in Ferozepur district, 30-40% of cases were referred to medical college in nearby district. Specialists were available only at the district hospital.
- At DH Ferozepur, there was a shortage of specialists and a dedicated RMNCHA counsellor. Training gaps of staff nurses in SBA and infrastructural deficiencies in labour rooms were noted.
- Entitlements like free deliveries, free drugs and consumables, free diet, free diagnostics, free unit blood, free referral transport services were available. Diet was being provided to pregnant women admitted in DH/SDH/CHC. However, Pregnant women undergoing USG in the DH, Ferozepur incurred user charges during ANC period.
- Maternal death reviews were not regular. Facility based forms (FBMDSR) were not available in most facilities.
- Immunization services were being provided effectively. RI Micro plan was updated in most of the facilities. Service providers at various levels had knowledge about full and complete immunization. Line listing of due beneficiaries was also available.
- FP Commodities were available in most of the facilities. The uptake of newer contraceptives i.e., Antara injection and Chhaya as well as PPIUCD among institutional deliveries were poor in both the districts. Pregnancy testing Kits and Basket of Choice were available across all the facilities in the districts. FP-LMIS was observed to be non-functional.
- AFHC clinics namely "UMANG" clinics were established at DH and SDH. Their functionality was satisfactory in Rupnagar district but lacked dedicated trained staff in Ferozepur district.
- Provision of full PMSMA service package including ultrasound was available at DH, and in few CHCs. However, data was not being captured in proper formats given in PMSMA guidelines issued by GoI.
- One District Early Intervention Centre (DEIC) was functional only at DH Rupnagar but not in Ferozepur district.

- Comprehensive Abortion Care services were being provided mostly at DH level in both districts. However, 34% of abortions took place at home.
- Districts have achieved more than 90% of TB notification target and Treatment success rate was more than 80%. District drug store was properly maintained.
- The IDSP lab was established at DH level and all tests were available free of cost. The lab consumables were sufficiently available. All equipment were functional, and diagnostic algorithms were displayed. Epidemiologist, Microbiologist, and Pathologist were in-position. The testing of Malaria and Dengue at SDH level needed to be strengthened.
- Integration of existing labs and involvement of program officers in planning and up-gradation of DPHL into IPHL need to be ensured so that program priorities were addressed.
- Under the Viral Hepatitis Control Program, delivery of Hepatitis C and Hepatitis B positive pregnant women were ensured at Government institutions. HBsAg kits and Anti HCV kits were available at DH, SDHs and CHC. Treatment and diagnostic facility were available only at the level of DH. Availability of the same at the SDHs needed attention.
- Diagnosis of leprosy treatment of MDT, management of early disabilities and reaction management were available at the level of DH.
- The state had designated NCD corners in DH, SDH and CHC. The treatment regimens/protocols for hypertension were displayed in DH, SDH and CHC. Medicines for DM and HTN were available in all health care facilities. The IEC materials on dietary habits were not found in health care facilities. Patients expressed their satisfaction in getting drugs for DM and HTN.
- The state has implemented National Mental Health Programme (NMHP) program at the secondary level. The de-addiction and rehabilitation center were well functional in DH with good infrastructure and adequate HR. The daily OPs were managed by the Psychiatrist and counselling services were provided to the patients by the Psychiatrist and social worker.
- The mental health team in the DH undertook several community-based interventions, particularly education campaigns in schools and colleges to deter drug usage. However, there were no screening programmes at field level to identify the cases of depression and other mental illnesses.
- The implementation of NMHP in CHC was found to be minimal. Due to the high rates of alcohol and drug abuse, a need for psychiatric specialist was reported.
- IEC materials for the tobacco control programme were well displayed in the Tobacco Cessation Centre in DHs, but poor in CHCs. Counselling services and treatment facilities were available and provided through the psychiatric OPD of the DH.
- The NOHP has been functioning well at the DH, with operational dental units at the DH, SDH and CHC with adequate HR.
- Elderly care wards were functional at the DH. The Red Cross Society donated a physiotherapist to DH for elderly physiotherapy treatments. Separate queues were available in DH for elderly patients, however, the posts of Physiotherapists remained vacant in DH Ferozepur.
- Convergence between the NCD cell and Elderly Care clinics was not found anywhere. The healthcare professionals in the CHC lacked familiarity of the program.

- Well-equipped units with good infrastructure under the NPCB&VI were found at the DHs.
- The Ferozepur district has initiated a new project 'SOHUM' for the screening, early detection, and management of hearing loss in neonates. ENT specialist for the programme was available at the DH.
- The Free Diagnostic Service Initiative (FDSI) was implemented in hybrid mode in the state. The diagnostics were being provided free of cost to BPL, ANC/pregnant women, children, whereas OPD/IPD patients have to pay nominal charges.
- At the secondary level (DH & SDH), the labs were well equipped. However, only 60% of tests as per the EDL was conducted at DH, 68%-85% at the SDH and 73%-79% at the CHC. LMIS was not implemented at the facilities.
- Though multiple laboratories were observed in the DHs/SDH under various programs, the staff was underutilized.
- The equipment maintenance program was implemented in PPP mode and services were outsourced by the central agency to a private provider. Though the activities under the BEMMP were robust, critical equipment for secondary facilities like X-ray, fully automatic analyzer, refrigerators for blood storage were nonfunctional.
- Under the Free Drugs Service Initiative, the availability of medicines against the State EDL in all the secondary care facilities varied grossly. For instance, 148-190 medicines were available at the DH (280), 76-83 at the SDH (280) and 52-54 at the CHC (181).
- Free drug entitlements were displayed in English in most of the visited facilities and not in local language.
- State has implemented DVDMS for online drug procurement and logistics management system. E-Aushadhi, an inventory management was functional up to PHC level in Ferozepur & CHC in Rupnagar.
- Power back up available in the DHs to maintain the temperature for sensitive medicine but the provision was limited in the facilities below district level.
- The State has rolled out PMNDP in 2016 and haemodialysis is being provided at 33 locations in the State using 103 dialysis machines installed at 21 DHs, 11 SDHS and 1 CHCs. Dialysis services are being provided in-house and are free for all beneficiaries including drugs and diagnostic services.

Rajasthan

- Well-equipped labor Room was observed in most public health facilities. However sub-district delivery points were underutilized.
- Prasav Watch (digitalization of labor room) was implemented in high case load facilities to monitor and track delivery. However, lack of timely data entry delayed real-time monitoring of labour room practices and outcomes.
- Tracking of each pregnancy was observed in PCTS portal (state specific portal). Implementation of Respectful Maternity Care- Privacy, Prasav Sakhi (Birth Companion) were in place. Separate triage area for labor case at DH (Jaisalmer) and use of Color-coded bed (Red, yellow & green) for high, moderate, and low risk cases were observed under RMNCAH^{+} N services.
- Under NLEP, no dedicated program officer was in place. There was a need to establish a leprosy cell in the state.

- Under National Tuberculosis Elimination Program, transport of samples for TrueNAT or CBNAAT was infrequent, hence patients incurred OOPE.
- The State has rolled out the Biomedical Equipment Management and Maintenance Program (BMMP) in Public Private Partnership mode (PPP) since 2015.
- At the time of visit, CT-Scan machine at DH Jaisalmer reported to be dysfunctional for the past one month. IT enabled dashboard/Laboratory Information Management system was not available.
- It was reported that Erythropoietin was being provided free of cost to all patients under Mukhya Mantri Nishulk Dawa Yojana but emergency equipment like defibrillator, basic diagnostic equipment, and monitors were not found in place at the dialysis centre for handling emergency cases.
- The state noted that the dedicated Tobacco Cessation Centre was not functional.
- Under the National Program for control of Blindness & Visual Impairment, Screening and Cataract surgeries were performed by a private NGO.

Sikkim

- Female Sterilization were available only at DH level and supply chain issues were observed at the facilities.
- High OOPE was reported for MCH services and delays in JSY and JSSK payment were reported across facilities. There were no functional NRCs at the DHs.
- Due list, micro plans and logistics were available, and eVIN entries were updated across all facilities. Cold chain equipment was available at facilities but e-VIN sensors were not present and temperature monitoring was done using a thermometer.
- District Hospital at Singtam had dry storage. Space constraint was a major concern for the supplies that were piled up in the corridor.
- Under National Tuberculosis Elimination Program CBNAAT and TrueNAT facilities were available at secondary facilities. Patients directly visited STNM for TB diagnosis and collection of medicines. Nikshay Portal was not functional across all facilities and Nikshay Mitra scheme was not implemented in the state .
- Pregnant mothers were screened for Hepatitis B. Hep-B immunoglobin was not available below the DH level. Hepatitis B & C cases referred to STNM for treatment. Sikkim has included HPV vaccination for eligible girls (9- 14 years) in the immunization schedule.
- The state has only one DEIC at STNM and was observed to be partially funcitonal.
- The state has a dedicated counsellor at AFHC, however the user load was minimal. There was a shortage of IFA syrup and tablets.
- The elderly care clinic was run along with the NCD clinic and was functional in both the districts. A dedicated elderly care OPD was functional at DH Singtam and home-based visits have not been reported
- A toll-free number/landline number was functional and displayed across facilities for awareness generation and suicide prevention.
- The State has identified a Tele MANAS cell under the NMHP.
- A speciality hospital, Centre for Addiction

Medicine (CAM)- West Pendam, had been established and dedicated for the treatment of alcohol and substance use disorders, and comorbid psychiatric and medical conditions.

- Common dental services under the NOHP were available at facilities. The users reported OOPE on consumables as they were not available at the facility. The patients were referred to higher centres or private clinics for x-ray services as the machine was non-functional.
- Online training was provided for the staff on palliative care at the DH level. No dedicated OPDs were functional at the facilities but the necessary equipment and consumables were available.
- The service providers had limited orientation on various national programmes.

Tamil Nadu

- Respectful Maternal Care (RMC) was provided, and the presence of birth companion was encouraged in the facilities conducting deliveries. The Partograph was maintained by the staff nurses at secondary care facilities. Regular PMSMA (9th & 24th of every month) was being conducted to identify and manage HRP. 24x7 Lab services/USG and C-section facility was available at all the CEmONC facilities visited. Blood bank/ storage facility was available in all CEmONC facilities.
- Caesarian section rate was high (more than 50%) in all the CEmONC facilities.
- All the CEmONC facilities were SUMAN notified and SUMAN volunteers have been identified. There was adequate display of IEC material related to provisions under the SUMAN initiative.
- All the free entitlements under JSSK were being provided to the beneficiaries. The entitlements under JSY and the Muthulakshmi Reddy Maternal benefit scheme were provided through Direct Beneficiary Transfer (DBT).
- Birth doses were being provided within the labour room at all delivery points visited. eVIN was functional at all cold chain points in secondary care institutions & no stock-outs of vaccines and logistics were reported. Mother Child Protection Cards and counterfoils were available and updated. Micro-plans were being complied with, and open vial policy has been followed. AEFI kits were available and AEFI registers were being maintained. Overall awareness of the vaccination staff on vaccination schedule and cold chain management was very good in both the districts.
- Anaemia Mukt Bharat program was being implemented and the CEmONC facilities had adequate provision of blood transfusion and iron sucrose facility for severe anaemia cases. Adequate IEC material on anaemia prevention and management was available in all health facilities visited and counselling on good dietary practices, sanitation and hygiene and compliance to IFA, Vit. A supplementation, deworming and non-nutritional causes of anaemia were being done.
- The RBSK program was functional and State-of-the-art DEICs were established in medical college hospitals in both districts, providing all mandated services for the beneficiaries.
- Basket of choice of contraceptives was available in all the facilities. Sterilization services on fixed days were being offered at the secondary health facilities visited. Staff was trained on sterilization (laparoscopic, Minilap, Tubectomy & NSV). Use of FPLMIS was variable.
- Adolescent Friendly Health Clinics (AFHC) were established at all secondary care institutions having most of the necessary commodities as per

the guidelines. Most of AFHCs had ample IEC material needed for counselling.

- The demand for adolescent health services and commodities remained low as evidenced by a daily attendance of 1-2 only per day per facility. Recording of the counselling sessions and the outcomes were not being captured, and triplication of documentation was observed, as with the primary care facilities. Adolescent Health Resource Centre at the level of DH was not found.

- Opportunistic screening of DM, HTN and common cancers was being undertaken in both DHs. Staff members have been designated for NCD screening at the CHC and DH levels. All NCD drugs and consumables were available at the facilities.

- Chemotherapy services were not available at the DH level in Tiruvannamalai and were underutilised In Thoothukudi.

- To cater to the complications of NCDs, i.e, coronary events and stroke, the Medical College (Thoothukudi) had State-of-the-art facilities including Cath-labs for managing both events, integrated with TAEI. All efforts were in place to keep door-to-door time within the golden period. Alteplase was available to treat patients with ischaemic stroke.

- The faculty of the Medical College (Thoothukudi) actively maintained a WhatsApp group where cases of coronary events from lower-level facilities were discussed with Medical Officers to guide them regarding prompt diagnosis and appropriate pre-referral care of Myocardial Infarction patients.

- Mental health treatment and de-addiction services were being provided to the inpatients in the 10-bedded psychiatric ward available at the DH Tiruvannamalai. In Thoothukudi, a 30-bedded psychiatric ward was functioning in the TKMC. Patients from DH, Kovilpatti requiring admission were referred to TKMC as the psychiatric ward had been operationalized only last month, and the Psychiatrists were not available full time.

- In DH, Kovilpatti, both the psychiatrists were providing OPD and outreach services, along with the Counsellors posted in the District Counselling Centre. Outreach services and linkages were in place with schools, the Jail and Govt. aided rehabilitation centers. The District Psychiatrists from the District Hospital, Tiruvannamalai were taking turns to provide OPD services at the Block PHC level, along with the Clinical Psychologist.

- The State has started its 24 X 7 TeleMANAS cell with the helpline number 14416 on 27th October 2022 along with an existing general helpline number 104. The TeleMANAS cell was functioning with 14 counsellors, 3 Clinical Psychologists and 1 Psychiatrist. The counsellors have received training from NIMHANS and were continuing to receive support and mentorship periodically. Knowledge about the role and linkages with TeleMANAS, the digital arm of NHMP was suboptimal among the Psychiatrists and health workers in the facilities, even though they had been sensitized to the same.

- Emergency Care and Recovery Centre (ECRC) has been established at the Tiruvannamalai Medical College which provides screening, diagnosis, treatment, and rehabilitation services for wandering mentally ill patients.

- A delay in the supply of dental consumables (permanent fillings etc.) at the Block level was observed.

- Dental X-rays was not available at the DHs in Tiruvannamalai and Thoothukudi, thus limiting the service provision. Posting of Dentists through NHM was started in the Secondary care hospitals where regular Dentists were also available,

however, Dental Assistants and Dental technicians were not available at the DH Tiruvannamalai.

- Services in the DH were limited as per IPHS standards, and dentures were not being provided at the DH level because of the unavailability of a Dental Technician. Oral cancer screening at DH Thoothukudi and suspect referral were inadequate.

- Well-equipped newly constructed ophthalmic block was not fully operational due to the unavailability of an Ophthalmic Surgeon in Arani GH, Tiruvannamalai for the last two and half (2.5) years, which has led to pending cataract cases. The number of cataract surgeries at Thoothukudi DH was very low compared to the cataract backlog-free target.

- Referrals from PMOA were negligible in District Thoothukudi. There has been a backlog in the delivery of spectacles for presbyopia patients at DH Thoothukudi, and screening for Diabetic Retinopathy was also minimal.

- Geriatric OPD clinic was also functional thrice a week in the DH Tiruvannamalai. The logo used for the Geriatric Wards was heartening as it showed a smiling elderly couple, depicting Tamil Nadu's vision of a happy and fulfilling geriatric age, rather than conventional images of the elderly with walking sticks.

- Palliative care unit in DH Kovilpatti provided quality palliative care with adequate necessary equipment (Ryle's tube, catheters, etc.) and medication. Morphine tablet stock was updated and kept under double lock and key system. Regular telephonic follow-up of patients is done by the staff. The DH at Tiruvannamalai had only 1 physiotherapist to cater to all OPD and IPD patients. Patients were extremely satisfied with the services they were receiving and acknowledged the commendable and compassionate behaviour of the staff. They also reported no Out-of-Pocket-Expenditure (OOPE) associated with the treatment.

- NTCP was initiated in Thoothukudi district recently with the establishment of the District Tobacco Cessation Centre in TKMC. Apart from Psychologist, other posts were filled. Pharmacotherapy drugs were not available at the time of the visit. COTPA trainings, COTPA raids and outreach awareness camps were being conducted.

- Dialysis services at the secondary care facilities were available in all the districts with adequate number of dialysis machines. At the community level, MTM workers were delivering Peritoneal Dialysis bags to beneficiaries.

- Districts had Hemodialysis facilities with adequate number of dialysis machines and RO water plants, including separate machines for seropositive patients. The facilities had an optimal machine utilization rate; however, a Nephrologist was available only at the Medical College level.

- Several practices were found that were not in line with guidelines, such as reprocessing of dialyzer using the manual method, reuse of Bloodline beyond 10-20 times, infrequent chemical analysis of water, etc. The patient waiting list for Haemodialysis was not found in visited centres except DH Cheyyar. Approximately 100 CKD deaths were reported in 2022, of which 20 CKD deaths were of patients less than 40 years of age in Medical College, Tiruvannamalai. Most of these premature deaths were occurring among agricultural workers who were exposed to heavy quantities of pesticides, stay dehydrated while working in the fields, and regularly consume over-the-counter painkillers for musculoskeletal pain occurring on account of their heavy labour.

- The State has been updating the Pradhan Mantri National Dialysis Portal regularly. Login IDs have

been created for all the facilities. The State undertakes dialysis monitoring of each facility at least once a year.

- The COVID pandemic had disrupted TB case finding and other related services, and also increased the stigma of revealing symptoms to be screened for testing. Though the notification of TB cases dropped significantly during COVID, continuous effort from the State and District has resulted in improvement of case-holding indicators like Known HIV Status, UDST and Treatment Success Rate. District Strategic Plan for TB elimination in Tiruvannamalai has been drafted and submitted for approval.
- NTEP staff at District Tuberculosis Centre (DTC) & Tuberculosis Unit (TU) were trained in Technical and Operational Guidelines, Revised PMDT, Nikshay and Active Case Finding. However, the training was not conducted as per norms in terms of the number of sites, days, etc.
- District and block-level TB forums have been formed and actively function in the districts. Committed and dedicated leadership by District Tuberculosis Officer (DTO), Tiruvannamalai and NTEP programme staff were observed. Regular district-level review of the NTEP performance was being conducted by the DTO. Virtual review of the NTEP activities was conducted during the pandemic lockdown.
- All the NTEP staff and some of the general health staff were observed to be well-versed with Nikshay Aushadhi. All the stock records were well-maintained and updated.
- Lack of review of the health staff under DDHS was noted pertaining to case-finding activities. RBSK, RKSK and ICDS activities and high-risk children for TB like severe acute malnutrition (SAM), children in juvenile homes, children in brick kilns etc., were not being reviewed at the district level by respective programme nodal officers and by DTO.
- Verbal autopsies were being conducted at the district level for deaths among the notified TB patients, but follow-up action based on the review was not taken.
- Despite having a number of industries and companies in the district, a multi-sectoral action framework for TB is yet to be developed and implemented.
- Both the districts have completed the 3rd Transmission Assessment Survey and are heading towards Filaria elimination.
- DH had fever wards with mosquito-netted beds. Adequate IEC posters were displayed in and around the facilities. Tests for Dengue were not being done in Sub-district hospital Arani and DH Cheyyar due to the non-availability of ELISA kits.
- Reconstructive surgeries were being done and cash transfers were also being given as per the NLEP. The dermatologists at medical colleges were involved in NLEP and performed slit skin smear examinations for the diagnosis. Awareness of the NIKUSTH portal at the Block and District level was suboptimal among some of the staff.
- Both Anti- Rabies vaccines and immunoglobins were available at the DH level and had proper storage facilities. Gap was observed in the categorization, adequate management, and reporting of animal bite cases. ARS was not being provided to all Category III bite patients, including Monkey bite cases.
- Under the NVHCP, high-risk behaviour cases were screened for Hepatitis C at Block PHC and above levels. Most of the healthcare workers were vaccinated and records were maintained.

- IEC on needle stick injury was available in all the health care institutions and displayed. Separate registers were found in centres that mentioned the status of needle stick injury every day. Needle stick injury follow-up and PEP were mentioned. Treatment was available for Hepatitis B patients but for Hepatitis C they were referred to a higher centre. Patients reported incurring OOPE for viral load testing by travelling to higher centres or testing in private laboratories.
- Hemoglobinopathies were being identified in the antenatal period with the help of CHAD, CMC Vellore and traits were also being diagnosed.
- Counselling was being given for all ANC mothers followed by testing and pre-marital counselling was being given for adolescents for haemoglobinopathy. Antenatal mothers and spouses with diagnosed hemoglobinopathy traits were given Genetic counselling.
- Testing facility for leptospirosis was available, both at the DPHL and Medical College (Thoothukudi). Capsule Doxycycline was available in all health facilities for the management of leptospirosis.
- The Free Diagnostics Service Initiative was being implemented at the Secondary care facilities as well, with 58 tests being offered at the DH level. However, the number of tests available free of cost was not as per NHM recommendations (Block PHC Eral - 32, DH hospital Kovilpatti - 60). The visited facilities had sufficient equipment like Biochemistry Analyzer, Hematology Analyzer and Centrifuge and were performing satisfactory number of tests. Turnaround time (TAT) was found to be satisfactory in all the facilities.
- Tender for the transportation of samples was yet to be finalized. Sample transportation was being done by facility employees and incentives (Rs. 150/- - 200/-) were paid for transportation. CT Scan services (in PPP mode) were made available to the beneficiaries at District Headquarters hospital, Kovilpatti. Preventive maintenance and calibration were being done for all equipment.
- Laboratory Information Management System was available, however, none of the facilities had an inventory management system in place.
- Optimal quality assurance mechanisms and protocols were found to be in place for in-house laboratories. All the facilities in Tiruvannamalai district were linked with CMC Vellore for EQAS of Biochemistry tests.
- In the Medical College, Lab technicians were available in the laboratories round-the-clock on shift duties. In some of the visited facilities, the staff nurses conducted tests for emergency cases. Orientation training was given to the Lab Staff at the time of joining; however, refresher training and capacity building on Quality Control and newer technologies had not been done.
- The State is implementing the 'Free Drugs Service Initiative' and is using the online mechanism i.e., DDMS for supply chain management of drugs & logistics and facilitating the inter-district transfer of drugs to avoid any sudden stock-outs in districts.
- The BEMMP is implemented in the state through in-house mode. TNMSC has been a model state procurement agency for health-related drugs, vaccines, equipment, and other medical supplies. TNMSC has a policy of procurement of equipment with 3 years warranty plus 7 years of CAMC through OEM.
- Each District had a Biomedical Engineer as a nodal person for monitoring the program. QR code-based tags were placed on most of the equipment. Staff at most facilities were well-aware of the toll-free number where complaints can be logged.

- Central call centre (Toll-Free Telephone number) for complaint management was available for attending breakdown calls. All the equipment was well maintained, and timely preventive maintenance was done, and records were maintained. Only the X-ray machine at the dental OPD at the District headquarters hospital Kovilpatti was found to be non-functional since 2019. All facilities visited in district Thoothukudi were AERB compliant.

Telangana

- Services delivery largely focused on the Maternal, Child Health, Family Planning, and Immunization Programme.
- Services under Oral health, Viral Hepatitis, Blind and Visual Impairment, Health Care Elderly, and Palliative Care need adequate human resources and the strengthening of facilities.
- The state reported low awareness on the National Tuberculosis Elimination Program activities/ guidelines among the healthcare staff, and others across all facilities in both districts.
- The state had notified that Lepra Society is facilitating the management of early disability, self-care kits, and Micro Cellular Rubber (MCR) footwear in Asifabad and the medical college was providing the MCR footwear in Suryapet.
- Under the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke, in both districts it was observed that multiple registers were being maintained for NCD, rendering duplication of work and data verification challenging.
- The state noticed that there were no Tobacco Cessation Centres (TCC) in either district and it was also found that any plans to develop TCC were not in the pipeline.
- PMNDP was initiated in PPP mode in the Suryapet district but there were no dialysis services being provided in the Asifabad district.
- The state noticed that the population in and around the facility was seen suffering from fluorosis, but no records were found in terms of rehabilitative services provided to these patients. However, water testing was done by the facilities but not regularly.
- The agencies cover calibration of equipment for 7 years and almost all critical equipment were covered under AMC. Toll free number was used for e-Upkaran.

Uttar Pradesh

- Services under maternal health need strengthening. Triaging area in labour rooms were under-utilized in both CHCs and DHs. Knowledge gaps on triaging were observed in labour room staffs. Availability of trained HR, especially the specialists were inadequate in DH Chitrakoot.
- Newborn and child health services were satisfactory. The secondary facilities had KMC areas and well-maintained NRC. NBCCs were available at all delivery points with functional equipment. However, implementation and compliance with quality parameters under MusQan for SNCUs needed to be expedited.
- Child Death Surveillance and Response (CDSR) mechanisms were non-existent and needed focus in both districts.
- Family Planning services were delivered variably across the districts. Knowledge and skill gaps were observed.
- The implementation of NTEP was robust. District DR-TB centres were functional. Areas needing improvement were sample collection and

transportation to linked microscopy centre and NAAT sites, quality assurance of the DMC, referred for presumptive TB examination and equipment maintenance.

- The state had earmarked beds for vector-borne disease in both DH and CHC. Coordination committee meetings with other line departments were held in both the visited districts.
- The reporting under IDSP was suboptimal and systematic monitoring of an outbreak or early warning signals from higher centres was lacking.
- NCD clinics were available in all secondary care hospitals but functionality regarding curative service was sub-optimal. Opportunistic screening was conducted in both districts, yet they were not well-defined.
- Availability of anti-hypertensive and anti-diabetic drugs were suboptimal and the Standard Treatment Guidelines of NPCDCS were not thoroughly met.
- IEC activities under NPCDCS needed strengthening and HR vacancies of district programme coordinator, finance and logistic consultants and DEO needed to be filled.
- Activities and provisions under the NPHCE were not substantial at the secondary level facilities. Infrastructural and training gaps for geriatric services were reported.
- National health programmes on blindness control and visual impairment, palliative care, fluorosis control, oral health, mental health, and deafness control did not have substantial activities at the secondary level.
- The PMNDP unit at the Chitrakoot district was implemented on PPP mode with Eskag Sanjeevani Multispecialty Hospital. No facility for peritoneal dialysis was available in both districts.

CATEGORY-2 MEDICINES:
FREE DRUGS SERVICE INITIATIVE (FDSI)

Accessibility to affordable and quality medicines is crucial for the attainment of Universal Health Coverage (UHC). To achieve this end, the Government of India had launched Free Drugs Service Initiative (FDSI) to expand the availability of free medicines provided in all public health facilities. This initiative not only supports states in purchasing medicines, but also enables them to establish transparent procurement systems and implement quality assurance measures. This is envisioned through the implementation of IT-backed supply chain management systems such as the Drugs and Vaccines Distribution Management System (DVDMS), as well as robust systems for procurement, quality assurance, warehousing, prescription audit, grievance redressal, information dissemination, and training. The initiative also facilitates the dissemination of Standard Treatment Guidelines (STGs) and improves Information, Education, and Communication (IEC) efforts to ensure the highest levels of safety and quality in drug administration.

The implementation of FDSI in public health facilities aims to reduce the Out-of-Pocket expenditure on medicines by providing free essential medicines to all patients attending public health facilities. The National Health Mission (NHM) conducts Common Review Mission (CRM) every year to assess the implementation status of national health program including but not limited to "FDSI," key strategies, priority areas for improvement, and analyse strengths and challenges. CRM identifies trends in progress of key indicators, particularly relating to coverage, equity, and affordability of medicines. Key observations and recommendations in reference to the seventeen visited states are given below.

KEY OBSERVATIONS

- The Free Drugs Service Initiative (FDSI) has been implemented and notified to the public health facilities in all 17 CRM states.
- Most of the states have established procurement agencies for the centralized procurement and district warehouses for distribution.
- Drugs and Vaccine Distribution Management System (DVDMS) has been implemented in Bihar, Jharkhand, Meghalaya, Nagaland, Punjab, Telangana and Uttar Pradesh.
- Andhra Pradesh, Bihar, Maharashtra, Rajasthan and Punjab used the e-Aushadhi application for inventory management.
- Some states like Meghalaya, Kerala and Tamil Nadu have developed customised software for indenting and inventory management.
- The Essential Medicine List (EML) list was disseminated and displayed in public facilities in most of the states, except for Sikkim and Meghalaya. Periodic revision of EML was practiced only in a few states. The availability of medicines as per the EML was a concern in most of the states.
- Look-alike Sound-alike (LASA) medicines were kept separately from each other in states like Goa, Kerala, Madhya Pradesh, Tamil Nadu, and Punjab.
- States like Delhi, Goa, Maharashtra, Sikkim, and Tamil Nadu faced the issue of stock outs of medicines as buffer stock was not available. However, Rajasthan reported that all the health facilities in certain districts had a sufficient stock of medicines.
- In Jharkhand, Kerala, Maharashtra, and Madhya Pradesh, there was a shortage of pharmacists, and the available pharmacists were found to have insufficient training to handle inventory management.
- Although Standard Treatment Guidelines (STGs) were widely available across most of the states, adherence to these guidelines remains a significant concern, except for Madhya Pradesh and Maharashtra where adherence appears to be better.

RECOMMENDATIONS

Procurement of Drugs

- States may consider strengthening a cost-effective procurement system which can be achieved through evidence-based demand generation, along with the use of technology.
- States are encouraged to establish a centralized and separate Drug Warehouse/Medical Store Depot.
- Local purchase of medicines should be limited to emergency requirements, with the aim of minimizing costs and ensuring effective inventory management.

Inventory Management of Drugs

- To enhance the storage and accounting of medicines, states could consider adopting modern inventory management control techniques while monitoring medicine usage through ABC (Always Better Control) analysis.
- Better storage facilities may be provided for medicines at all health facilities. Categorization of medicines as per inventory control can be done, and the First in First Out (FIFO) principle may be followed.
- States should review the Essential Medicine List (EML) periodically through an institutional mechanism and provide updated copies to all health facilities to ensure availability of essential services. A committee comprising health officials from district and sub-district levels can be constituted for EML revision.
- It may be worthwhile for states to consider maintaining buffer stocks of essential medicines at the warehouse and at least 1-month reserve at all health facilities to avoid stockouts.
- A list of available commonly used critical medicines should be displayed at the facilities.

Drugs and Vaccine Distribution Management System (DVDMS)

- To obtain accurate information about drug stock at the facility level, a real-time supply management system should be developed.
- The DVDMS can be integrated with parallel software to enhance its functionality.

Adverse Drug Events

- Facilities should be encouraged to report Adverse Drug Events on the web-portal of Pharmacovigilance Programme of India.
- Staff should be sensitized on the importance of Adverse Drug Reactions (ADR) and protocols should be established.

Training of Human Resource

- Facility pharmacists must be oriented for proper forecasting using scientific methods.
- States may want to assess the benefits of training and capacity building of HR on inventory management, software, and procedures for storing medicines on a priority basis.

STATE WISE FINDINGS

Andhra Pradesh

- Infrastructural investments for drug storage were done by the state, and a spacious building was constructed and maintained by Andhra Pradesh Medical Services and Infrastructure Development Corporation (APMSIDC) and Vizianagaram district. However, there was no separate area for receipt, storage, and dispatching of medicines.
- The storage of medicines was not classified either in alphabetical order or with their shelf life, and modern inventory management control techniques (e.g., ABC analysis, FSN or VED categorization) were not used.

- Inventory at the drug warehouse consisted of 603 medicines (EML) plus 378 additional medicines.
- Availability of medicines at district hospitals and CHCs were not as per the EML.

Bihar

- Medicines as per the state EML were not available in the visited facilities in both the districts. At the SHC, an average of 20-30 Medicines out of 91 were available, and at the APHC, 30-40 Medicines out of 171 were available.
- NCD Medicines were prescribed for a month and were available in good amounts in the store.
- The medicines were not arranged according to the First Expiry, First Out (FEFO) rule. No expired medicines were found in the facilities.
- Most CHOs indented medicines through the e-Aushadhi portal, and the DVDMS has been implemented in both districts. However, maintenance of the stock register needs to be improved.

Chhattisgarh

- Currently, only 107 out of 154 recommended medicines were available at the HWC. The state was yet to start the procurement of newer recommended medicines for a particular medical condition called TPT (which requires a medication called 3HP).
- Anti-malaria medicines were available, but there were still some medicines missing that were recommended by the Essential Medicine List (EML).

Delhi

- There are two agencies, GeM and CPA, under DHS who procure the medicines & consumables for the State and supplied to the District Drug Stores.
- Local transport was being hired for the delivery of medicines as there was no vehicle for transportation of medicines and consumables to different hospitals and clinics.
- There were no funds provided to the store for transportation, labour cost or contingencies and all expenditures were reimbursed after submission of bills.
- There was only one district-level ad-hoc store available for two districts, and the construction/ layout/zoning were not as per the protocol.
- The inventory management system in Delhi includes an IT-based application called "NIRANTAR" which is used for submitting annual demands and indents related to inventory management. Yet, inventory management was manually done by the district store as well as at the facilities. The UT is yet to implement an IT enabled inventory management system. Few incidences of 'Stock Out' situations identified, substantiating the need for more vigilant and IT enabled inventory management system. Out of 257 medicines were out of stock since last one month at NW district store.
- Physical verification of stock (medicines & consumable) was not done on a regular basis, and drug storage of anti-TB medicines in both the districts was not as per guidelines.
- The 2nd quarter indent was missed because the store in-charge was absent, and the 3rd quarter indent could not be initiated because the application was not functioning.

Goa

- The Essential Medicines List (EML) was available and updated every 3 years during tendering, but none of the visited facilities had a copy of the updated EML.
- An IT-enabled inventory management system was functional up to the Primary Health Centres (PHCs), and medicines were forecasted and procured using scientific inventory tools such as ABC/VED/ABC-VED and dispensed using the First Expiry First Out (FEFO) method.
- The issuing store at the state level (MSD Ponda)

was unable to view the available medicines and stock levels of the receiving stores in the state.

- The Deputy Director (Medical) position in the state had been vacant for more than three months.
- No damaged or expired stock was observed in any of the pharmacies.
- Look-alike Sound-alike (LASA) medicines were kept separately from each other, and Psychotropic and Narcotic medicines were kept at a secure place under double lock & key systems.
- There was no mechanism/system for pharmacists to calculate the requirements of medicines at lower levels.
- There was a high stock-out rate/non-availability of many medicines at all levels of healthcare facilities, including the Medical Store Depot, which led to high amounts of local purchase. For instance, approximately 30-40% of the stock was found unavailable at SDH Ponda.
- Goa Broadband Networks (GBBN) availability was not consistent across the drug stores, which led to missing out on real-time, 24X7 stock visibility of all stores.
- Free medicines were provided to all the beneficiaries, and medicines prescriptions were mostly in non-generic names. At least 30-day medicines were being dispensed for Hypertensive and Diabetic patients.
- Good storage practices were followed at health facilities, but the documentation required improvement. Quality control testing was in place only at the Medical Store Depot (drug warehouse) and not at the healthcare facilities.

Jharkhand

- During the visits to some of the facilities, it was noted that medicines listed in the Essential Medicine List (EML) were not available. Additionally, the EML was not displayed at most of the facilities visited.
- Implementation of the District Drugs Management System (DDMS) was not observed below the district hospital level. Even at the district level, appropriate utilization was not seen.
- Most of the Schedule H drugs were not available during the visits.
- At some facilities, the absence of the pharmacist challenged the maintenance of the drug store. The records indicated that 55 medicines were directly purchased by the Garhwa district, and 99 medicines were provided by the state via the district. All indenting was done using hard copies.
- It was observed that the stock registers of some secondary facilities had not been updated since 2018-2019.

Kerala

- The state had notified the Essential Medicine List (EML) for all levels of health facilities. The number of medicines under the EML for each facility was as follows: Mini PHC/ Dispensaries - 107, Block PHC/CHCs - 157, Taluk Hospitals - 234, District Hospital, General Hospital, and Medical College - 337. However, there was a lack of clarity on EML at the facility level.
- The State Drug Distribution and Management Information System (DDMIS) was implemented in all facilities instead of DVDMS. It was functional up to the PHC level.
- The Kerala Medical Services Corporation limited (KMSCL) performed centralized procurement, and some medicines were procured through local purchasing. Large funds were provided by LGBI/HMC for local purchase. Rates of KMSCL were 60% cheaper than local purchase. Many items were not provided from KMSCL, so local purchasing was done. With central purchasing, 60% more medicines could be purchased, and funds could be utilized efficiently.
- Demand generation was not as per EML and was not properly forecasted. Facilities did not consider

the balance available with them while finalizing the drug demand.

- Indenting was done annually by all facilities.
- KMSCL provided indented medicines in quarterly instalments as per the availability at district drug warehouses. If medicines were not supplied on time or if any essential drug was stocked-out at the warehouse, the facilities were allowed to locally purchase the drug after receiving the NOC from KMSCL.
- High-risk and LASA medicines had been identified and stored separately, and psychotropic and narcotics medicines were kept with a double lock system securely.
- Drug storage areas were well maintained in all facilities. Medicines were properly stacked on the shelf with proper labelling and expiry date.
- Annual physical verification of stock was not done as per guidelines.
- Quality control of centrally purchased medicines was done by KMSCL, but there was no system of quality control for locally purchased medicines.
- Pharmacists lacked clarity on the disposal of expired medicine. Expired and frozen medicines were kept in the facility until communicated by KMSCL. The last condemnation of expired medicines was done in 2019 as per directives of KMSCL.
- The availability of medicines was displayed at the drug distribution counter in all facilities, and pharmacists updated the information daily. Medicines were prescribed only under generic names.

Madhya Pradesh

- The FDSI scheme was notified at public health facilities, and the Essential Medicines List (EML) was revised every 2 years for each facility level (last updated in 2022). However, during the district visits, the EML was not available as per norms of DH and CHC.
- The procurement of medicines and equipment was done by MP corporation procurement department. After procurement, bills were reimbursed by the State Health Society. The MP-Aushadi portal was used for indenting procurement till the level of PHCs. A 20% grant was released for local purchase, while the rest were procured centrally.
- The FDSI program was covered in PPP mode. The Essential Medicines List was available and displayed in the OPD area, but free drug entitlements were not displayed at the facility in local languages. There had been a lack of awareness regarding the EML in the pharmacy for expenditure and stock-outs of medicines.
- Feedback and cross-validation were not practiced, and high-risk and LASA medicines were labelled and stocked separately. However, narcotic medicines were being kept along with other medicines.
- Medicines were prescribed by generic names as per STGs, Program Guidelines, and EML. Moreover, the HR in the drug store was not completely aware of the EML. Duplication of resources was seen in Sidhi district where two drug warehouses had been functional, both of which had the same medicine stock.
- Fewer medicines were available compared to the recommendation of the national Essential Medicine List for SHC-HWC (105) and PHC-HWC (172). MP-Aushadhi was not used at several PHCs due to the lack of pharmacist/ trained pharmacist. Only 36-40 essential medicines were available at SHC-HWC, and 80-100 at PHC-HWC. All essential medicines for diabetes and hypertension had not been available at both SHC-HWC and PHC-HWC. Instances of patients visiting DH to avail prescribed medicines for NCDs was found. A standard process of indenting at SHC-HWC and PHC-HWC from higher facilities/ drug stores was

not being used, and poor record-keeping of indenting was noted.

- None of the facilities were IPHS compliant, and since the district did not have the authority to recruit, purchase (medicines & equipment), and create infrastructure at the local level, no initiatives was found at the district level.

Maharashtra

- The medicines were not available as per the EML, and high and prolonged duration of stock-outs were observed.
- Although the EML was displayed at the facility, it was not updated. However, an IT-enabled inventory management system was functional, and bin cards were maintained in the warehouse. The e-Aushadhi software was used to purchase medicines at the civil hospital.
- The VED inventory tool was being used, and the First-In-First-Out (FIFO) method was followed. Medicines were prescribed using their generic names and as per the Standard Treatment Guidelines (STGs).
- Medicines under HIV/AIDS, National Tuberculosis Elimination Program (NTEP), National Leprosy Eradication Program (NLEP), and Malaria medicines were not supplied.
- The drug quarantine mechanism of quality control was followed, with well-maintained analysis reports at the drug warehouse. Medicines were released only after receipt of quality testing reports.
- Expired medicines were kept separately in the drug warehouse and were disposed of as per the Biomedical Waste Management rules of 2016 to the Common Treatment Facility.

Meghalaya

- The Meghalaya Medical Drugs and Services Limited Procures, tests, stores, and distributes medicines, medical items, and support services to government health facilities.
- There was no Centralised Drug warehouse in the state. The state required districts to generate indents for a one-year supply but procured the medicines on a quarterly basis. This may have caused a mismatch between demand and consumption, which in some instances led to expiry of medicines.
- Drug warehouse infrastructure was inadequate, lacked SoPs for stock verification, display of drug names, and temperature/humidity recording equipment, cross ventilation, and fire safety equipment.
- While one state and seven district warehouses were available, most district warehouses had a limited storage capacity and staff shortages. Insufficient handling staff and qualified pharmacists posed a challenge.

Nagaland

- The Free Drugs and Diagnostic Service Initiative was implemented in-house. Through this initiative out of the 388 essential medicines, 221 were available.
- The mechanism for medicines and vaccine delivery in these facilities was a mix of manual and software-based indenting and supply.
- DVDMS implementation status varied across facilities in the state. During visits to several facilities (CHC, DH), it was observed that appropriate implementation of DVDMS was lacking.
- Frequently used medicines such as Amlodipine were not available in sufficient quantities. There was no plan to distribute prophylactic medicines such as IFA tablets though they were nearing expiry.

Punjab

- Punjab Health Systems Corporation (PHSC) is responsible for central procurement, rate contracting, e-tendering and quality control of all medicines in the state, while local facilities have the flexibility to purchase 20% of the medicines locally.
- The state has its own Essential Medicine List (EML) for different levels of health facilities, with the number of medicines being almost half of the suggested national Essential Medicine List.
- The availability of medicines against the State EML varied from 27% to 68% in all secondary care facilities. In some visited facilities, the list of medicines displayed had more medicines than the state EML, indicating irregular updates.
- The medicines under various national programs were supplied to the DHs by the District Warehouse, but also directly indented by the DHs from the regional warehouses. Local purchasing was done to maintain the inventory for medicines unavailable at the warehouse.
- Free drug entitlements were displayed in English in most visited facilities, and handwritten EML was displayed at DH Rupnagar, but not in the local language.
- There was limited staff capacity to calculate stock-out days.
- The lead time for drug receipt at facilities varied from 25 to 30 days for medicines available at the warehouse, while local purchasing was done for medicines that were unavailable.
- Multiple drug stores were observed in the facilities, with a drug store available in the OPD area besides the pharmacy. The separate main store located on the ground floor was observed in DHs, with AC facilities for maintaining temperature.
- The state implemented DVDMS for online drug procurement and logistics management, while E-Aushadhi, an inventory management software, was functional up to PHC level in Ferozepur and CHC in Rupnagar. The software indicated drug availability at the warehouse, and facilities indented medicines accordingly. Information related to daily consumption was not available with the main store.
- Prescription of branded medicines was common, given that the pharmacists were not aware of the generic form of the prescribed branded medicines except at the DH.
- During the field visit, no records of prescription audit were observed.
- The staff was unaware of the bin cards, but information related to each drug was available with the staff using e-Aushadhi software.
- The staff was well-informed on the mechanism to report adverse drug reactions, although no such reporting was done by the facilities visited.
- Psychotropic and narcotic medicines were kept separately in a secure system in the almirah under lock, with SMO supervising their utilization in District Rupnagar, but not in Ferozepur.

Rajasthan

- Medicines procurement was done by Rajasthan Medical Service Corporation, but facilities could locally purchase medicines with NOC from district drug warehouse if they were not available at DDW.
- Mukhyamantri Nishulka Dawa Yojana provided essential medicines free of cost to patients with cancer, heart and kidney-related diseases, and other severe ailments, who visited government healthcare institutions.
- The e-Aushadhi system was in place at all health facility levels except sub-centre. At PHC and UPHC levels, medicines were intended through the e-Aushadhi portal software. The portal manages stocks of medicines and surgical items required by

different district drug warehouses of Rajasthan state.

- Medicines for HTN and DM were available at CHC and DH levels. The EML was not displayed at DH Jaisalmer. All health facilities in District Kota had sufficient stock of medicines.
- Narcotics and psychotropic medicines were kept separately. TB medicines were not stored as per the desired protocol. TB treatment protocols, medicines boxes, treatment cards, etc. were well kept and displayed at Jaisalmer, while at Kota, a mismanaged account of medicines was found at District TB Centre, JK Lon Campus, with a huge discrepancy between the record of medicine in the computer and the physical quantity available. Medicines were not arranged in order either.

Sikkim

- The State has its own software for stock keeping of medicine called True-PoS.
- Primary Health Centres (PHCs) were provided with desktop computers to use the True-PoS software for stock entry, while Sub-Health Centers (SHCs) did physical indenting of medicines.
- One-month supply of hypertension and diabetes medicines were being given to patients whenever the supply of medicines was available.
- Availability of medicines for Non-Communicable Diseases (NCDs) had been a concern at the PHC level. Medicines were available as per the supply, and sometimes, if a particular medicine was not available for the following month, then patients had to purchase the same from private pharmacies.
- Procurement of medicines was done by a central agency called the "Central Health Store Organization" for both the state and National Health Mission (NHM).
- Availability of medicines was there with few stock-outs at times (e.g. Mioprostol). Surgical items and medicines were not available at DH Namchi for the Eye Care program.
- Essential Medicines List (EML) were not displayed in any of the facilities visited.
- DVDMS (Drugs and Vaccine Distribution Management System) was not functional in the state.

Tamil Nadu

- The facilities visited were implementing the 'Free Drugs Service Initiative' and had the Essential Medicine List (EML) displayed.
- Medicines were stored separately in designated areas, with hypertensive, diabetic, and leprosy medicines readily available, and psychotropic and narcotic medicines kept under double lock in a secure location.
- Manual indenting was used at all facility levels, and IT-enabled logistics and supply-chain systems were not in place at the primary level facilities.
- Stock-outs of a few medicines were reported in some facilities in the last month.
- IT-enabled logistics and supply-chain systems were only used in the drug warehouse.
- The warehouses used DVDMS for drug supply-chain management and inter-district transfers to avoid stock-outs. The DVDMS platform at the primary level facilities did not support facility-level indenting, short-expiry tracking, or minimal quantity order alert features.
- The state has a Centralised Procurement Agency (TNMSC) and 32 modern drug warehouses, and medicines were kept organized and maintained with clear protocols.
- Bin cards were maintained at drug stores, and the "first in, first out" principle was followed for the movement of medicines out of the district drug warehouse.

- Double blinding method was used for quality control, and there was a robust mechanism of quality control through random sampling of medicines for quality checking.
- Some medicines that expired in 2016-17 were found in condemned fridges, indicating a need for better practices in dispensing old and expired medicines.

Telangana

- The Telangana government initiated the Free Drug Service Initiative (FDSI) along with Centralised Procurement Agency and Telangana Vaidya Vidhana Parishad (TVVP).
- The Essential Medicine List (EML) was not visible in most of the facilities of both districts. Some facilities displayed only specific available medicines.
- Common medicines were consistently supplied, but not all medicines were available as per EML. Extra stocks were kept in each department despite sub-stores.
- The districts implemented Drugs and Vaccine Delivery Management System (DVDMS) through e-Aushadhi portal for medicines and e-Vin portal for vaccines. Integration of these portals was required for better implementation.
- Proper drug stacking, labelling, and bin card system were used in drug stores. Medicines with similar appearances and sounds were kept and displayed separately.
- In Suryapet district, no out-of-pocket expenses were noted, but in Asifabad, significant expenses were incurred by the patients while purchasing medications from independent pharmacies.
- HWCs had access to medications but were not listed on the state EML. HWC SC had 15-20 medicines, while PHC/UPHC had 40-45 medicines available. The pharmacy at HWCs was well-maintained, and insulin was stored at HWC PHC and UPHCs. The e-Aushadhi app was used to track medications.
- Secondary care facilities had access to medications for managing diabetes and hypertension.

Uttar Pradesh

- The state used a Centralized Procurement Agency (CPA) UPMSCL for drug supply in districts.
- Medicines and diagnostics were available but not in accordance with the state EML at all facilities.
- Implementation of the DVDMS portal for indent/ procurement management and stock monitoring varied across facilities.
- Pharmacists needed training and hand-holding support on inventory management protocols and DVDMS.
- Drug supply from UPMSCL was based on procurement and availability, not on facility indents, which indicated a 'push mechanism' from the state level.
- The state had a robust supply chain management system and efficiently used the DVDMS portal. Some facilities received requirement-based indenting and medicines directly supplied from the warehouse.
- Areas of concern included gaps in availability of medicines as per EML, lack of monitoring and recording of temperature during transportation and storage of temperature-sensitive medicines, lack of standard protocols for management of expired medicines, and no mechanisms for forecasting and maintenance of buffer stock.

CATEGORY 3
REFERRAL TRANSPORT SYSTEM (AMBULANCES)

Emergency Medical Service (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. An ambulance, in general parlance, is a vehicle to provide emergency care to people with acute illness or injury. Such services should be provided free of cost in all public health facilities. In a typical medical situation, Emergency care includes a well-equipped ambulance and managing emergencies at the referred-health facility.

The Ministry of Health & Family Welfare introduced National Ambulance Service in the country with a toll-free number and centralized call centre. Under National Health Mission, the Government of India provides technical and financial support to States/UTs for strengthening health systems. This support includes support for Emergency Medical Services in States/UTs through a functional National Ambulance Service (NAS) network to cater to medical, surgical and trauma emergency cases.

KEY OBSERVATIONS

- Most of the states had implemented referral transport services integrated with a centralized call centre in PPP mode. In addition to this, state-specific initiatives like Cardiac Care ambulances in Goa, Hearse van in Nagaland, Neonatal support ambulances, and First responder bikes and VVIP ambulances in Tamil Nadu were noted.
- In Nagaland, Advanced Life Support ambulances were not available under the NHM, whereas only patient transport vehicles were operational in Meghalaya. In some states, Advanced and Basic Life Support ambulances were also being used as patient transport vehicles and thus the purpose of pre-hospital stabilization during transport was not met.

- Most of the ambulances were equipped with essential life-saving medicines and equipment; however, regular monitoring of the quality and functionality of equipment needed attention.
- Availability of trained HR for ambulances was an area of concern in most of the states.
- Average response time of less than 30 minutes was reported in Andhra Pradesh, Bihar, Goa, Jharkhand, Kerala, Tamil Nadu and Uttar Pradesh, whereas a wide range of response time was reported in the North Eastern states which warranted due attention and redressal.
- The need for capacity building and refresher training of the EMTs was felt. Knowledge and awareness gaps were identified.
- The general population was aware of the centralized toll-free number for ambulances (wherever available), however, community interactions in most of the states revealed a general sense of dissatisfaction among the communities regarding the service availability.

RECOMMENDATIONS

- States are recommended to appraise the requirement for ALS ambulances based on both geographical and population norms.
- States must ensure that ambulances are adequately supported with trained human resources, functional equipment and medicines to ensure round-the-clock services (24*7). It is also recommended to enable GPS tracking of the existing ambulances that may be centrally monitored at the call centres.
- Regular capacity building and refresher training for the EMTs and the pilots need to be ensured. In PPP mode, the execution of this by the private provider must be monitored as per the agreement in the MoUs.
- States implementing the ambulance services in PPP mode must periodically assess the operations for mid-course correction and for deciding the duration of engagement with the private provider.
- District level analysis of the number of trips, average response time and percentage of calls denied to improve service efficiency.
- States need to conduct referral audits to review delays in transportation and adherence to protocols by the EMTs as well as the quality and functioning of equipment installed in the ambulances.
- Awareness activities on ambulance services may be improved through the display of IEC, helpline numbers and information disseminated through community-based platforms.

STATE FINDINGS

Andhra Pradesh

- The State has operationalized a fleet of 748 emergency ambulances. They have been GPS enabled and undertake an average of 3 -4 trips a day.
- Dial '104' vehicle was used for the referral transport of mothers and infants, whereas 108 ambulances were available for emergencies and inter-facility transfers. The 108 ambulances were well equipped with oxygen and other life-saving medical equipment with trained staff for round-the-clock operations. Few of them were also equipped for neonatal resuscitation.
- Client satisfaction was found to be good with both 108 and 104 ambulances having an average response time of 30 and 45 minutes, respectively.

Bihar

- The state has operationalized both Basic and Advance Life support (ALS & BLS) ambulance services in PPP mode with PDPL Swasthya Foundation. Each ambulance has been equipped with one pilot and one trained EMT.
- The ambulances were well equipped with cardiac monitor, ventilator, suction, oxygen, defibrillator and 2 types of stretchers.
- BLS ambulances were available for referral transport from primary and secondary care facilities. On average BLS takes 4-5 trips a day and covers around 200 km. The response time has been recorded to be about 30-45 minutes.
- It was noted that monitoring of medicines and equipment was done every three months and maintenance was provided by a third party.

- Community awareness of ambulance services needs to be improved.

Delhi

- Ambulance services in Delhi are being provided by the Centralized Accident and Trauma Services (CATS). It is an independent body of the government of Delhi providing free ambulance services. The ambulances were GPS-enabled and are operational round the clock.
- Free ambulance services are being provided to everyone, including transportation of pregnant women. However, community awareness regarding CATS services was significantly low, resulting in reduced utilization of CATS among pregnant women. The service is linked to a toll-free number 102.
- The regular monitoring and maintenance of the ambulance services need to be streamlined.

Goa

- Ambulance services in Goa run on a PPP not-for-profit model with EMRI Green Health services. The provider shares the patients' information with the hospitals through an app and also does 48 hours of follow-up of the patients admitted to hospitals.
- The state has operationalized different types of ambulances like ALS, BLS, Neonatal ambulances, Advanced Cardiac Care Ambulances (CCA), Hearse Vans, First Responder Bikes, and facilities to transfer dead bodies (freezer boxes, coffin boxes, corpse ambulances, etc).
- All the ambulances had Emergency medical technicians to handle pre-hospital care and emergency life-saving services. Ambulances also have human resources like one MBBS doctor (trained for critical cardiac care AHA BLS and AHA ACLS), Advanced Emergency Medical Technicians, and Pilots. However, the availability of trained paramedics for BLS ambulances needed attention.
- Goa is the first state to launch Advanced Cardiac Care Ambulances in India equipped with ventilators, defibrillators, syringe infusion pumps, volumetric infusion pumps, suction apparatus, etc.
- The community was aware of the access to the universal toll-free number, and the availability of Lifesaving ambulances to reach quickly the nearest and appropriate health facility. The response time for each call was around 15-20 minutes.

Jharkhand

- The state provides both ALS and BLS services.
- Mamata Wahan was the preferred mode of patient transport in Jharkhand.
- In the ambulances surveyed, oxygen cylinders were filled and functional.
- Majority of calls are received within the 'golden hour' in both the districts. The percentage of calls declined due to unavailability in Deoghar and Garhwa was 32% and 41% respectively. The average response time of the ambulances ranged from 14-27 minutes in the state.
- Referral and follow-up mechanisms need to be implemented.

Kerala

- Dedicated ambulance services are provided in hard-to-reach areas, particularly in tribal communities in the state.
- Not all 108 ambulances were operational 24*7. As such, the state needs to provide 24*7 ambulance

services in the state and particularly in the hamlet areas of Trissur.

- Free of cost services need to be provided for home to hospital pick-ups.
- All available ambulances need to be linked with the 108 call centres as several modes of referral transport were operational through multiple sources.
- A monitoring mechanism for the ambulances needs to be implemented for efficient service delivery.

Nagaland

- ALS ambulances were unavailable in the visited districts and need to be proposed.
- BLS ambulances were not rationally deployed and did not have EMT and GPS Tracking. The availability of essential medicines and maintenance of equipment was not monitored regularly. Utilization rate of these ambulances was low and average response time ranged from 40-100 minutes.
- Patients incurred OOPE in transportation due to an unsatisfactory performance by these ambulances. Community interactions revealed that community members often pool funds in advance to avail referral transport facilities during an emergency. The average expenditure for a one-way trip to the health facility amounted to Rs. 1000/- for the residents in the Kupza village.
- Hearse vans with dedicated drivers were used to carry corpses in DH, Mokokchung. Additionally, several advertisements for private ambulance facilities were displayed in the facility.
- A centralized call centre for referral transport services needs to be implemented in the state.

Madhya Pradesh

- The state had functional ALS & BLS along with 5 mini ambulances (Tata winger) which were granted from the local panchayat/ Pradhan, and they were utilized for long-distance travel.
- The ambulances were well-equipped with cardiac monitors, ventilators, suction, oxygen, defibrillator, etc.
- Average waiting period in rural areas was 23 minutes and 18 minutes in urban areas.
- 108 toll-free number was in place with adequate ambulances stationed at the District Hospital.
- Beneficiary awareness needs to be strengthened.

Maharashtra

- Ambulances for ALS and BLS are available as per population norms. Regardless, it was observed that the state needs to ensure standard protocol for transporting pregnant women.
- Although regular training was conducted for EMTs and pilots in all ambulances, refresher training also needs to be provided.
- Infection control protocols were not adhered to in the ambulances surveyed.
- Majority of members in the community were aware about the ambulance number.

Meghalaya

- BLS and ALS services were non-functional in the state and only patient transport vehicles were available.
- Each patient transport vehicle provided an average of 70 patients a month. State records

reported that 700 patients had been transported during the year 2022 (January to October).

- There was a need to implement BLS and ALS as per geographical and population norms.

Punjab

- A fleet of 299 BLS and 25 ALS ambulances are available under the dial '108' model. These are functional in OPEX mode and operationalized by Ziqitza Healthcare Limited.
- 25 ALS ambulances were supported by the state and all BLS ambulances were supported by NHM. All vehicles were state owned and staffed by an EMT and a pilot.
- As per the state population, there was a shortfall of 59% of ALS vehicles and 1.3% of BLS vehicles with population saturation of 1,01,337 per BLS and 12,12,000 per ALS vehicle which needs to be improved.
- ALS ambulances were made available in the DH across all districts and BLS ambulances were distributed across the DH, CHCs and PHCs. Inter district transportation was also made available through BLS in case of emergencies.
- 24*7 services were provided through a 30-seated centralized call centre at the state level that dispatches ambulances as per the calls received under the 108 model. 81% of the total calls received at the call center were dispatched an ambulance with an average response time of <30 mins.
- These ambulances were GPS enabled. Additionally, the drivers had an application to indicate the location of the patients and the nearest healthcare facility. Messages were also sent to patients to track the ambulance assigned as per their requirements and type of emergency.
- The approximate percentage of BLS services availed for road accidents was 23% for pregnant women, 22% and 55% for other cases.
- The average performance of these ambulances was roughly 5 trips and 120 km per day. Provisions for monitoring these ambulances include downtime of not less than 1 hour and a monthly audit which includes equipment functionality and medicine availability.

Rajasthan

- The State has outsourced the services to GVK and has integrated 104 and 108 services.
- It was observed that both BLS and ALS ambulances were well equipped and EMTs were available.
- From community interaction, it was found that free transport facility was rarely utilized by pregnant women. Instead, they use their own or hired vehicles to reach the health facilities.

Sikkim

- The State has operationalized both BLS and ALS ambulances. Among them, 8 ambulances were integrated with 102 and 108 services and have been operationalized in PPP mode. The ambulances were well equipped with BP apparatus, Pulse Oximeter, wheelchair, stretcher, Stethoscope, Glucometer, Injection and Medicines.
- The state has a call centre which receives an average of 3,020 calls per month and has an average dispatch of 206 calls. During 2022, the average distance travelled per trip was 50 km with no downtime or denied services. However, OOPE on account of referral transport incurred by patients was high.

Tamil Nadu

- Tamil Nadu had a fleet of 1,353 ambulances which includes 13 ALS ambulances, 1,154 BLS Ambulances, 65 Neonatal Life Support (NLS) Ambulances and 4 VVIP ambulances. Around 41 First Responder Bikes were also plying in the State.
- The State also had 524 patient transport vehicles functioning under 102 helpline, of which 99 were funded through the Tamil Nadu Health System Reform Program (a World Bank-supported project).
- The ambulance services were integrated through the 108 helpline and the average response time was estimated to be 30 minutes.
- According to the State data, over 95% of all emergency calls were attended on the first ring. As soon as the call was received, the operator was expected to intimate the nearest ambulance using geo-tracking within 60 seconds.
- Approximately, one-third of all calls were due to pregnancy-related emergencies, followed by vehicular trauma cases (18%).
- Availability of EMT, oxygen, drugs and consumables was observed in the ambulances.
- Proper signage and SoPs were adequately displayed.
- Refresher training for EMTs was conducted every 6 months by the State.
- Additional efforts were made to coordinate the availability and response of the ambulances during the designated hotspot time of 5 PM-9 PM, when the frequency of accidents was high.
- Dedicated Emergency Management Executives were posted in each district to coordinate the availability of ambulances.
- The community was aware of 108 services and the utilization was observed to be high.

Telangana

- The State has operationalized ambulance services in PPP mode. Services under the 102 and 108 helplines were functional in both districts.
- Ambulances serviced under 108 were well-equipped and were stationed at the HWC PHCs. There were 10 ambulances under 108 in Suryapet and 12 under Asifabad. The ambulances provided an average of 2-4 trips a day. The average turnaround time for referral services was about 20-30 minutes from the facilities.
- However, in Asifabad, availing of ambulance services was a challenge due to the lack of network and connectivity issues. To facilitate the transportation of pregnant women and for ANC services, 'AVVAL ambulances' have been provided by the tribal department. The district has made arrangements for the users to allow inter-district travel from Asifabad to Mancherial without having to change their vehicles.
- In Asifabad, the healthcare facility also displayed advertisements for private ambulance providers.
- Sufficient EMTs were available and were well trained in Basic Life Support. Records and registers were properly maintained. Follow-up of referred patients was lacking.

Uttar Pradesh

- The availability of ambulances was as per the population requirements.

- ALS and BLS were available in both districts for referral transport. Services were availed through 102, 108 and 112 helpline numbers. In Maharajganj, a five-digit number was operational too. There was a need for integration to improve response and service efficiency.
- The average response time was 30 minutes in rural areas, and the average distance travelled varied from 50 to 100 km. This was also due to non-functional FRUs in many districts.
- Referral audits were not being done though there were reported delays in transporting the patients.
- The functionality of the ambulances was challenged by poorly maintained equipment, lack of medicines, and due to knowledge and skill gaps in the EMTs.

CATEGORY 4
PRADHAN MANTRI JAN AROGYA YOJANA (PMJAY)

The Pradhan Mantri Jan Arogya Yojana (PMJAY) is a component of the Ayushman Bharat scheme, which was inaugurated on September 23, 2018. PM-JAY is the world's largest health assurance scheme, aiming to provide a health coverage of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalisation based on households included in the Socio-Economic Caste Census 2011 (SECC 2011). The scheme offers a variety of IPD services, including about 1,929 treatments that cover all treatment costs, such as medications, supplies, diagnostic services, physician's fees, hospital charges, surgeon charges, OT and ICU charges, etc. The scheme's goal is to deliver cashless, free services to the poor, vulnerable, and marginalised population in order to reduce out-of-pocket expenditure when obtaining healthcare services at accredited public and private healthcare institutions.

KEY OBSERVATIONS:

- The PMJAY scheme in Andhra Pradesh has been merged with Dr YSR Arogyashri scheme which is a state specific health insurance scheme. In addition to the cash collected under PMJAY health benefit package 2.2 under this scheme, the state government pays 40% of the funds for the different mentioned treatments.

- With the goal of achieving "Health for All," the state of Bihar has suggested an extra 32 lakh families for inclusion in 'Arogya Raksha' (for above-poverty individuals with a premium of Rs 1200/year/family). Only 18% of beneficiaries in Aurangabad and 21% in Buxar have received PMJAY cards. The policy only applies to persons who held ration cards prior to the 2011 census and majority of ASHAs and MAS did not have a PMJAY card.

- In the last four years, Jharkhand has distributed PMJAY cards to 3,46,066 beneficiaries out of a population of 18.95 lakh, covering the majority of families. Twenty of the 29 hospitals accredited under PMJAY are in the private sector, seven are CHCs, one SDH, and one DH.

- Goa has reported empanelling various facilities under PMJAY and issuing golden cards to some of the beneficiaries.

- Kerala has fully operational help desks. Beneficiaries and health workers at facilities were aware of their KASP entitlement. The state has also ensured that food expenses incurred by recipients will be compensated under the scheme.

- Madhya Pradesh has distributed 3.38 crore Ayushman Cards to beneficiaries, giving inpatient care to around 1.84 lakh patients. The state spent approximately Rs 641.94 crore on these hospital admissions.

  However, institutional capability in terms of human resource and infrastructure was underutilised. It was observed that referrals for surgery and emergency care were being made to hospitals 5-6 hours away.

- Meghalaya has merged PM-JAY with state scheme, Megh Health Insurance Scheme for all the residents.

- Punjab has distributed around 79.55 lakh golden cards to recipients.

- Tamil Nadu has integrated the PM-JAY with its current Health Insurance system, which is now known as the 'Pradhan Mantri Jan Arogya Yojana-Chief Minister's Comprehensive Health Insurance system' (PMJAY-CHIS).

  Approximately 600 public health institutions and 700 private health institutions have been appointed under the scheme to give qualified beneficiaries with a health insurance cover of Rs. 5,00,000 Lakh per family per year.

- Telangana has its own scheme named 'Aarogyashri' that replaces PMJAY and gives coverage of up to 2 lakhs. It covers over 600 treatments in public facilities. However, ASHAs and eligible population were only covered with ration cards till 2011, and the remaining population was not covered under Aarogyashri scheme.

- Uttar Pradesh has issued golden cards through Ayushman Mitra. Recently, ASHAs and Gram Sahayaks were also trained to issue golden cards. Under PMJAY, approximately 25% of golden cards were issued in Maharajganj and Chitrakoot districts. More than 70% of claims submitted in Maharajganj have been paid/ resolved.

- There was no information on PMJAY for Chhattisgarh, Delhi, Nagaland, Rajasthan, or Sikkim.

RECOMMENDATIONS

- PM-JAY awareness needs to be increased (through CHOs, ASHAs, and IEC).

- Standard Operating Procedures (SOPs) should be developed for more efficient and effective use of funds.

- The state health authority and NHM's leadership may collaborate to make a provision for using money received from PMJAY as a top-up payment over and above the regular salary to specialists hired under NHM.

- A record of patients (PMJAY beneficiaries) directed to PMJAY-empanelled private hospitals may be kept and audited on a regular basis.

- Adequate and strategic deployment of IEC materials should be conducted even at railway stations, marketplaces, bus stations, etc.

- To broaden the reach of PMJAY, campaign mode coverage of eligible families may be planned.

- Community outreach camps should be arranged with the assistance of AB-HWC teams, and the PMJAY secretariat at DH could be enhanced.

- States must prepare a plan to enroll or cover the entire population holding ration cards after 2011 in order to reduce OOPE.

CATEGORY 5
IT APPLICATION
FOR SECONDARY CARE

Information technology (IT) has become an integral part of the health system and has revolutionized healthcare in several ways and means. With the increased use of IT solutions and digital technologies, healthcare delivery has become more accessible and affordable. IT solutions (applications) are being used to address various challenges in healthcare delivery through logistic and supply chain management, healthcare delivery data management, evidence-based planning, and decision-making for programme implementation. IT applications are currently being used till the lowest level of healthcare delivery systems and up to frontline healthcare workers.

The country has already successfully designed, launched, and implemented IT solutions including RCH Portal, NCD App / Portal, Nikshay, DVDMS, HMIS 2.0, Nikushth, IHIP, e-sanjeevani, HRMIS, TMIS and many more. All these applications are providing a seamless flow of data and information from lowest level of healthcare system to highest level and vice-versa which has enabled the programme managers and policymakers to take informed decisions on time and has significantly contributed to health system strengthening. Digital reforms in healthcare in the form of ABDM & ABHA will go a long way to realize the goal of universal healthcare.

It is important for the States/UTs to understand the value of these IT systems and analyse the programme outcomes through such portals to make informed decisions to improve the implementation of initiatives under NHM.

KEY OBSERVATIONS

- The states have streamlined important IT initiatives like HMIS, RCH, NIKSHAY, e-Aushadhi, e-Sanjeevani, e-Rakhtkosh, DVDMS, ANMOL and others.
- Some States have introduced their state-specific portals and applications contextualized to state specific requirements to enable the smooth implementation of various programs such as Mother app and ASHA First in Meghalaya, e-Upkaran in Telangana and MaNTrA- Maa Navjaat Tracking App in Uttar Pradesh.
- Poor internet connectivity in some areas was reported from states like Telangana, Nagaland and Goa, which was as a barrier for the successful implementation and use of IT initiatives.
- Need for capacity building, training, availability of IT equipment, ensuring internet connection and regular supervision and monitoring was a common observation to strengthen the IT systems.
- Newer reforms in Teleconsultation in the form of Tele MANAS was launched on 10th October' 2022 to address the mental health related concerns in the country. Majority of the States were yet to operationalize the initiative and was functional only in few states.

OVERALL RECOMMENDATIONS

- The availability of IT systems and use of analytical tools for decision-making should be in place for a robust and dependable data ecosystem for better programme monitoring and policy decision.
- Data Validation committee needs to be formed at all levels to improve the quality of data.

- There is a need for the integration of data reporting systems to address all issues of IT-based health data systems and infrastructure. State-specific applications should be integrated with the national level systems for interoperability to ensure data sharing and programme monitoring at national level.
- All States/UTs must ensure 100% creation and seeding of ABHA IDs as one-stop single solution which will uniquely identify the citizen in India's digital healthcare ecosystem. It will also establish a strong and trustable identity for citizens that will be accepted by healthcare providers and payers across the country.
- It is also recommended that the IT systems should function in an organically integrated manner to avoid data duplication and ensure data quality.
- Regular capacity building of ASHAs, ANMs and data entry operators and program officers at the State and District needs to be institutionalized along with regular monitoring and supportive supervision.
- The states need to ensure internet availability and improve internet connectivity through the facilities to improve the daily entry of data especially in tribal areas.

STATE- SPECIFIC FINDINGS

Andhra Pradesh

- e-Aushadhi, Nikshay, and e-sanjeevani applications were being used upto rural PHC and sub centre level. In UPHC, MO was using EHR, MO application and e-sanjeevani portal.
- MO application has modules such as Anaemia Mukt Bharat tracking, missed Pregnant and child tracking and IFA tablet stock alert.
- Due to lack of unique ID like ABHA IDs, duplication of data and overlapping of the portal information was observed.

Bihar

- The state had adopted all applications, i.e., HMIS, ANMOL, RCH, HWC e-Sanjeevni, NCD, e-Aushadhi/ DVDMS etc.
- Integrated Health Information Platform (IHIP) training under IDSP had been initiated and ongoing. Till Nov 2022, a total of 17,684 healthcare workers were trained.
- Proper Internet facilities were available at most of the health facilities. Internet facility within the premises of PHC, Dumraon, SDH, Dumraon, and DH Buxar was poor and was not available at Kharahatand Health and Wellness -Sub Centre and Badaka Rajpur HWC APHC. Staff were using their own mobile phones and internet for entering data.

Chhattisgarh

- All the records of NCD screening were being recorded in the NCD MO Portal. The portal also reflects the patients who were being referred from peripheral institutions.
- DH had been established as a hub for HWCs and providing regular Tele-consultation services. Daily roster of doctors (GDMO and Specialist) was in place and teleconsultations were held as per roster. Records were maintained in the eSanjeevani software and separate physical registers were not maintained. Upward Tele-consultations with Medical Colleges and AIIMS was not yet started.
- A State specific software has been prepared with support from NIC in which the line-listing of the patients visiting "Sparsh Clinic" (Mental health Clinic) in DH was being maintained.

Delhi

- The state is utilizing FPLMIS, HMIS, e-VIN, NCC-MIS cold chain management and Mera Aspataal applications.
- Various IT softwares implemented under the national programmes were not integrated and referral linkages for the beneficiaries through IT platform within the programmes was not in place.
- Digital OPD registration (Health Management System) was not functional throughout the state. Data entry on HMIS was up to date and entries were being done at district level.
- IT-enabled inventory management system was present at the State level by the name of 'Nirantar Portal' and implemented only at the district level.
- ANMs had Anmol tablets and they were trained for its use, though some of them were using their own smartphone for data entry as Tablet works slowly.
- e-Sanjeevani was found active in DH but underutilized with only 5-6 calls per day.
- Nikshay portal and Nikshay-Aushadhi were being used effectively by District Hospitals.

Goa

- The State had streamlined important IT initiatives like HMIS, RCH, HWC, NCD, NIKSHAY, FPLMIS, e-Raktkosh, IHIP, e-Vin, e-Sanjeevani etc. and state-specific portal for inventory management system (DHS-IMS)
- Nikushth Portal, e-Rakhtkosh, and e-Aushadhi were found to be non-functional or not implemented throughout the state.
- Internet connectivity issues were observed in every facility which is necessary for seamless implementation of the various IT applications.

Jharkhand

- The State has implemented most of the central IT applications. RCH portal, HWC portal, NCD portal, ANMOL, Nikshay, DVDMS (E-Aushadhi), e-Sanjeevani, HMIS, Nikshay, E-Raktkosh were operational. Tele-medicine services were used for specialist consultation.
- Additionally, the State has instituted additional IT applications like ODCT (Open Data Collection Toolkit), Blood Management System and HRIS (Employee Management Portal).
- The state, in addition to the central applications, was also planning to implement other apps like "VHSND app" and "Sahiya app".

Kerala

- RCH Portal has been implemented and was well-functional in all facilities. Data was uploaded regularly in HMIS Portal and used during monthly review meetings for monitoring.
- State has implemented e-Sanjeevni, e-Raktkosh, Nikshay, HWC portal, LDMS (Lab diagnosis management system).
- IT infrastructure was available at all levels (PHC, CHC SDH and DH).
- FPLMIS, Nikshay Aushadi and Nikushth portal were non functional.
- Other State specific applications operational in the state include e-Health, Shaili app for ASHAs, ECMAN for ASHA Incentives, COVID Jagratha Portal for COVID management.
- FPLMIS portal training and implementation needs to be expedited.

Madhya Pradesh

- The state has implemented programmatic dashboards such as RCH, HMIS, AB-HWC, NCD, Nikshay, e-Aushadhi, and DVDMS.

- The State has rolled out e-Vittapravaha portal and has linked it to ASHA portal ensuring online fund transfers.
- A data management portal "DASTAK" to track child health and identify and help management of malnourished and anemic children and "NRC MISA" in NRCs to track the progress of malnourished children admitted to NRCs.

Maharashtra

- NCD-portal, ANMOL, and e-Raktkosh were found to be functional at the facilities visited.
- IT-enabled inventory management system was well functional.
- The district hospital, sub-district hospital and rural hospital (Dhule, Shirpur and Pimpalner) was integrated with Mera-Aspataal (MA); however, integration with lower-level facilities was yet to established.
- All the secondary care facilities were providing teleconsultation services; however, the uptake was very less.

Meghalaya

- HMIS is functional, state specific Mother app was available for maternal health.
- ASHA facilitators were using ASHA first app and the disbursement of payments of ASHAs were being done on a regular basis.
- Teleconsultation services were being provided daily through e-Sanjeevani, by two doctors hired by the State.

Nagaland

- HMIS data entry was being done online at the Block level and data entry in HWC, NCD portal was not done regularly.
- Internet was not available at all facilities and Staff was using their personal mobile internet to access the portals for data entry.
- ANMOL application was not rolled out in the state yet.
- DVDMS not rolled out universally and training of staff needs to be conducted for the use of DVDMS portal.

Punjab

- RCH portal, NCD portal, IHIP (IDSP), Nikusth, NIKSHAY, e-Sanjeevani, e-VIN, HMIS, e-Sushrut, e-RaktKosh, e-Aushadhi [functional in Ferozepur (up to PHC) and Rupnagar (up to CHCs)] and other IT systems available at all levels of the facility. However, due to server issues real time data entry was not observed into e-RaktKosh, Pradhan Mantri National Dialysis Program Portal and Mera Aaspatal application.
- The state has implemented DVDMS for online drug procurement and logistics management systems.

Rajasthan

- PCTS is one of the best practices observed during the CRM Visit in Rajasthan State and was being used for tracking Pregnant women and Child for the MCH Services instead of the RCH portal.
- The state has implemented e-RaktKosh and needs to be updated properly to know the exact availability of Blood.
- Nikshay, NCD, and HWC Portal were implemented by the state.

Sikkim

- Nikshay Portal was not seen functional across all facilities. Nikshay Mitra scheme was also not implemented in the state. Recording and reporting mechanism was not well established.

- Mera aspatal were not initiated in DHs.

Tamil Nadu

- Tamil Nadu is in the initial stage of integration of all portals with the help of the Tamil Nadu Population Health Registry Portal (by expanding GoI's CBAC formats and including other programme's requisitions) modelled after ABHA IDs.
- In Tamil Nadu, almost all GoI Portals were mirrored to state-specific data collection portals. SMIS to HMIS, PICME to RCH/ANMOL, State NCD to National NCD. Appropriate applications (APKs) were in place to push the data to the corresponding GoI Portal resulting in no duplication of online data entry.
- Tamil Nadu is a front-runner among the States in India in ICT-enabled Governance, by successfully implementing various e-Governance programs of the State Government and the schemes under the National eGovernance Plan. The State currently is considering how multiple applications/portals/ software could be integrated to make data capture and analysis more efficient.
- The State launched the TeleMANAS Helpline as the digital arm of DMHP for addressing the mental health challenges faced by the population.
- PICME web portal is used to capture the details of pregnant women starting from the eligible couple registration till 16 years age of the child through VHNs. Each registered pregnant woman is given a unique ID which can be tracked at all levels of health facilities, including tracking of migrant mothers. The software is linked to several other state software such as birth and death registration software and the Muthulakshmi Reddy Maternity Benefit Scheme.

Telangana

- e-Upkaran - for Bio - medical Equipment Maintenance is initiated in Suryapet Medical College.
- T-Hub: Telangana diagnostics service is an in-house initiative for quality diagnostics services to reduce out of pocket expenditure incurred by patient. It was introduced in March 2020 in Asifabad district. T- Diagnostics portal is working through MIS and LMIS at hub and spoke respectively. Patients receive SMS through this portal when their diagnosis report is generated.
- State has implemented various portals such as HMIS, AB- HWC, e-Aushadhi, Nikshay, e-RaktKosh, e-Sanjeevni, e-Upkaran, and eVin portal.
- All entries in AB-HWC portal were updated in all visited facilities. Daily report and monthly service delivery is regularly reported in the AB-HWC portal in both the visited district.

Uttar Pradesh

- The state has its application called "MaNTrA- Maa Navjaat Tracking App," Labour Room Online MIS, wherein online real-time data of deliveries and referrals from delivery points were captured.
- State has implemented programmatic portals such as RCH, HMIS (Data from health facilities were uploaded to the HMIS portal every month), AB-HWC (Data of all HWCs updated in the portal with an average of 5 minutes per entry per day), DVDMS, e-Sanjeevani, and eVin portal.
- State has rolled out "e-Kavach" application as a step towards integration of all IT based solutions.

TOR-3
CROSS CUTTING AREAS

HUMAN RESOURCES FOR HEALTH

NATIONAL OVERVIEW

Health workforce is one of the key input elements needed to achieve desirable outcomes and sustaining the progress of National Health Programmes. Human Resources for Health has always been an important aspect of National Health Mission. NHM has been emphasising the need for addressing the shortage of HRH since its inception. Over the years, various strategies have been supported under NHM for improving HRH availability, accessibility, acceptability and utilization to provide quality of care at public health facilities across the country.

NHM supplements Human Resources for Health who are directly engaged in healthcare service delivery as well as the ones who are engaged in administering various programmes. The 15th CRM teams observed the situation of HRH across the states, documented the strategies adopted to address HRH challenges and assessed the steps taken for improving their availability, strengthening HR management and reviewed the status of capacity building.

KEY OBSERVATIONS

AVAILABILITY OF HRH

- Gap in the availability of HRH was observed across the states and cadres. Given the recent launch of IPHS 2022, states are still in initial stages of mapping and planning the facilities for IPHS revised norms.
- With AB-HWC being operationalized, it was observed that HRH in upgraded facilities was being prioritized with low number of vacancies. For instance, in Uttar Pradesh, the upgraded HWC-PHC had a lab technician (LT) posted, while there was no post of LT at non-HWC PHCs.
- Vacancies in the Specialist posts, Medical Officers and paramedical staff were observed in the states. The specialist vacancies varied across the states i.e. 68% in Sikkim, 66% in Madhya Pradesh, 65% in Bihar, 64% in Uttar Pradesh, 45% in Goa, 39% in Kerala and 37% in Tamil Nadu. In Jharkhand, the visited Districts had specialist vacancies as high as 90% & 74%. Lack of specialists was also reported as a challenge for care coordination role of secondary care facilities. For e.g., lack of Specialists in the secondary care facilities in Maharashtra has resulted in overburdening of the Medical Colleges.
- High number of vacancies for the post of Medical Officers were also reported in some of the states, like UP and Madhya Pradesh, where almost one in three posts of MO was reported to be vacant; and this was further higher in Jharkhand. Positioning of Staff Nurses also varied, where states like Tamil Nadu and Kerala reported low vacancies, while it was high in other states like Andhra Pradesh, Delhi, MP, Bihar, and Chhattisgarh.
- Among the other key cadres, i.e., the Lab Technicians (LTs), Pharmacists and Multi-Purpose Workers (MPWs), in the states of Bihar, Jharkhand and MP reported higher vacancies as compared to the southern states of TN and Kerala.
- The HRH shortfall was attributed to several factors spanning frequent deputation of staff to other facilities to state specific reasons like high concentration in urban areas (Punjab) and presence of abundant private sector (Kerala). Additionally, absenteeism, and leave for higher studies were reported as other reasons for the unavailability of staff in facilities visited during CRM.
- A major hindrance to filling up of posts at district and block level was the centralized recruitment process prevailing in some states, and there has been a long gap in the recruitment cycle, including that of CHOs.

- Addressing the HRH gaps, states have adopted varied measures such as localised recruitment through Hospital Management Committees in Kerala, reservation for post-graduation for in-service candidates in Andhra Pradesh and TN, and provisions for incentives to HRH posted in difficult areas. To bridge the HRH gaps, UP has recently conducted a large recruitment drive.

- The enabling provision of "You quote, we pay" under NHM was being leveraged by Kerala, and Andhra Pradesh, especially for the Tribal districts, while Sikkim was in the planning stage for the same.

- Decentralised recruitments were noted as an enabling mechanism in Andhra Pradesh, Jharkhand, Kerala, Sikkim, Telangana to improve the availability of human resources. The Medical Education Recruitment Board (MERB) of Tamil Nadu fast tracks recruitments within 2-3 months. The centralization of recruitment in Rajasthan, MP and UP were cited to be bottlenecks in filling HRH gaps at or below the district level.

- Irrational deployment of HRH was observed in Goa, where Specialists were deputed to facilities without complementing cadres or sufficient equipment and infrastructure to optimally utilize their surgical skills.

- The states are yet to integrate the HRH cadres. During the field visits, it was observed that Medical Officers, Staff Nurses, Lab Technicians, and other service delivery staff under NHM were posted at the facilities under specific programs. They were only performing program-specific activities.

- The teams also came across many motivated and dedicated healthcare personnel serving in the public facilities, who despite the tough terrain, (Northeastern States) and other challenges were providing services to the community. Of special mention are the committed and enthusiastic personnel from Tamil Nadu (TN), Kerala and Nagaland, who were shining examples of hard work and the spirit to serve their communities.

MANAGEMENT OF HRH

- One of the prerequisites for effective HRH Management is to have a team of qualified professionals managing HR in the states. Dedicated HRH cells at the state level were functioning in Punjab, Sikkim, Tamil Nadu, and Telangana.

- The states are also nudged towards developing and implementing a comprehensive HRH policy including policies for transfer and posting, contract renewals, performance appraisal etc. Some states like Uttar Pradesh, Madhya Pradesh and Bihar have developed HRH policies for contractual HR.

- Performance appraisal mechanism was observed at different stages across states, where Kerala and MP have developed a system for performance appraisal, while it is still under process for states of Goa and Jharkhand. States of Bihar, Punjab and Telangana do not have any such system in place.

- Moving beyond programmatic verticals to a health systems approach, integration of HRH is a supportive paradigm shift that was observed in the states of Kerala, Tamil Nadu and Telangana. However, HR integration was not done in Andhra Pradesh or UP.

- Timely disbursement of remunerations had played an important role in encouraging Health care providers to become the driving force for health systems. It was observed that for states of Bihar, Goa and Sikkim, salaries are being disbursed timely, whereas Bihar alone reported delay in disbursements of programme specific or team-based incentives. In Nagaland, CHOs reported that they have not received their salaries/ incentives for almost seven months and were protesting for timely release of salary till the day of the CRM visit.

- The states of Sikkim, UP and Tamil Nadu are utilising the NHM provisions of hard area allowance and differential pay to attract and retain HRH serving in difficult areas.
- Some welfare initiatives have been adopted by some states such as Health Insurance for NHM staff in Chhattisgarh and UP. A commendable initiative was seen in one of the districts of Telangana where children's park, and entertainment area for the families of healthcare providers have been created using the District Collector's funds.
- Unavailability of staff quarters in the proximity of rural facilities was reported to be a demotivating factor for CHOs in Nagaland.
- In Tamil Nadu, the primary care and field staff were observed to be overworked as the HWC-SHCs were staffed with only 1 ANM along with CHO and the state doesn't have ASHAs (except in the tribal areas). On the other hand, Sikkim had surplus HRH, particularly dental surgeons in most of the facilities at PHC and above, due to the policy of 'One Family, One Government Job'.
- HRMIS is being used in many states. In Andhra Pradesh, it aided in recording attendance and generating salary slips of NHM employees, while in Chhattisgarh it is used in disbursing salaries and in Punjab, the e-HRM'S is being used for keeping employee details. Tamil Nadu has separate systems in place for NHM and regular HRH. HRMIS was in varying stages of development in Delhi, Sikkim, Jharkhand and UP. In Kerala, software upgradation was needed. HRMIS had not been implemented in Telangana.
- Grievance redressal mechanism was in place in Uttar Pradesh at the State and District Level, but were not available in other states.

CAPACITY BUILDING

- Capacity building efforts in most of the States were in need of strengthening, and a holistic, evidence-based approach towards training programs and training methodology was lacking.
- Most of the states were conducting programmatic trainings in verticals, and very few states were conducting induction Training for their HRH. Andhra Pradesh and Telangana were among the exceptions, conducting induction training for their HRH. States like Maharashtra were focussing on RMNCAH+N or NCD related trainings only.
- Noteworthy innovative initiatives in trainings were reported from Bihar where an MoU with IIM Ahmedabad and Bangalore has been undertaken for motivation and behavioural skills training. TN had entered in an MoU to support Meghalaya in training the HRH, especially doctors.
- There was a felt need and an observed need for conducting training on Program Management Skills for all Programme Management staff across the States. Some specific training needs which came to the fore are holistic training of ANMs in Nagaland, IPC practices for all cadres, and refresher trainings for EMTs in Maharashtra and systematic training programs in Tamil Nadu and Uttar Pradesh.
- At the State level, functional SIHFW was found in Bihar, Punjab, Telangana, UP and Kerala. Goa had an SIHFW, however. it was not functional yet. Training institutes in Madhya Pradesh, Meghalaya, Delhi, Sikkim and Jharkhand needed development.
- Training Calendars were being adhered to in Andhra Pradesh, Goa, Jharkhand, Meghalaya, and Kerala. However, Sikkim, Telangana and UP did not have a systematic training calendar in place. Training Needs Assessment had not been carried out in Bihar, Punjab, Telangana and Rajasthan.
- DNB courses have been initiated in the District Hospitals in some of the States to facilitate the production of Specialists, these include Goa, Punjab, Telangana and UP.

GOOD PRACTICES OBSERVED ACROSS STATES

- For attracting Human Resources by providing opportunities for career progression, Andhra

Pradesh is providing reservations for in-service candidates in 30% of clinical and 50% of non-clinical post-graduation seats from the state quota. After completion of post-graduation, the candidates have to mandatorily serve for 5 years in government facilities. The state has also started a separate course for the ANMs to pursue a GNM course. ANMs from contractual as well as regular cadre are eligible to apply for the course.

- Decentralization of Recruitment Process - Recruitments have been decentralized and recruitment processes are undertaken at the state/ zonal/district level in Andhra Pradesh, Jharkhand, Kerala, Sikkim, and Telangana. In Kerala the recruitments are done through LSG funds and Hospital management committee (HMC) and panchayat level.

- Use of Digital Technology to support healthcare workers to perform better. The primary healthcare workers in the field have been provided smartphones where they can access and use applications that are tailor-made to their roles and responsibilities. Healthcare workers use these applications to report programmatic data. It also helps them to manage their work including monitoring the stocks of key consumables at their facilities.

- Medical Recruitment Board (MRB) in Tamil Nadu has helped the state to fast-track its recruitments. Almost all recruitments are done within 2-3 months.

- Differential remuneration and incentive for difficult areas. Tamil Nadu provides higher salaries to HRH working in difficult areas. The State also provides differential grading in PG entrance, i.e., more marks for doctors who have served in hilly and difficult areas, less for plains and none for urban. Sikkim provides incentives for serving in difficult areas especially for North Sikkim district (Rs. 10,000/-) and South Sikkim (Rs. 5,000/-); and an annual increment as per "loyalty" is also given to NHM employees. Also, Sikkim followed a practice where local applicants were preferred in state to avoid attrition & transfer requests.

- Interstate MoUs between States- Meghalaya has signed MoU with Tamil Nadu in training of the HRH especially doctors which is encouraging to note that one State is leveraging the expertise of other state in skilling HRH and this would also provide them with the additional workforce during the training period.

- Specialist cadre in Sikkim - In Sikkim GDMOs were recruited at the base level while Specialists were recruited at higher grade with increased remuneration. For specialist cadre, the state has defined performance allowance to be given to super specialists; however, indicators for the same have not yet been defined.

- Village councils in Nagaland have supported and facilitated the accommodation arrangements at some health facilities, which is suggestive of strong community ownership. The possibilities of adopting such measures at other facilities and States with proper support and guidance can be explored.

RECOMMENDATIONS

- An HRH policy and strategy that is futuristic and more focused on Primary healthcare so that escalating costs of secondary and tertiary care could be reined in. The futuristic policies should seek to resolve challenges like uneven workload, inadequate numbers of reserve staff, access to mental health counselling, and issues such as lack of accommodation facilities for HRH in remote and rural areas.

- The States need to undertake comprehensive planning for HRH, which should be contextual as well as futuristic. They also must formulate an appropriate action plan to address their unique needs.

- Creation of State HRH cells with competent staff necessary to undertake HRH assessments,

planning, drafting policies and implementing initiatives is paramount towards strengthening HRH practices. Dedicated HRH cells may also push for the formulation of transparent transfer and posting policies, measures for staff welfare such as health insurance, salary rationalization, grievance redressal mechanisms, performance appraisals and adopt initiatives that best suit their local needs. States may refer to 'Guidelines for Human Resources for Health for NHM' 2022 for practices that may be adopted to streamline and strengthen HRH management.

- Rational Deployment of HRH to be ensured with a comprehensive plan for HRH in the states. Transfer of staff should be minimal and critical specialist positions should be filled at the earliest.
- States should create sufficient posts, as per the IPHS following principle of HRH integration, as well as implement measures to expedite the process of filling vacancies. As per the capacity of the district and blocks, the States may consider empowering them with the authority to recruit talent locally, and pool resources to create adequate housing and infrastructure to attract HRH, especially in the aspirational and high priority districts.
- The States can innovate HRH-friendly policies, and also utilize the enabling provisions under NHM such as "You quote, we pay", hard area allowances and providing a supportive environment beyond staff welfare, to their families to attract and retain HRH, especially in the difficult, hilly and tribal areas.
- Creation of the Specialist Cadre could motivate the Specialists for serving in the public health system. Simultaneously, rational deployment of Specialists already within the system by deputing them at facilities with adequate infrastructure and complementing cadres of HRH is imperative to optimally utilise their special skill sets.
- Holistic bridging initiatives, derived from understanding the training needs of different cadres of HRH are a prerequisite to provide quality services. These initiatives could range from induction training to refresher or skill-based training programs documentation and assessment of the training.
- Capacity Building needs strengthening across the thematic areas and for all cadres of service providers as well as managers. Along with capacity building, the bigger picture also needs to be communicated to the Healthcare providers at each level, so that they are clearer about their roles and tasks in the overall system.
- States need to develop and strengthen training infrastructure for conducting localised, high-quality trainings, and make HRH competent to meet the requirement of different health programs.
- States should have a holistic or integrated database for both regular and NHM staff and use it for evidence-based decision making. Training management information system (TMIS), if available, it must be integrated with the HRMIS.
- Adopt a Health Systems approach while planning and setting HRH norms for the facilities. At present, HRH integration, for human resources being posted under various programs, is necessary for the optimum utilization of human resources.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- The state has prepared staffing norms for all levels of health facilities which is being followed instead of IPHS. Disparity was observed in required posts between state norms and IPHS essential norms in critical service delivery cadres like Medical Officers - MBBS, Staff Nurses and Lab Technicians. For instance, as per state norms 2 MOs, 11 Staff Nurses and 2 LTs are required at a 50 Bedded CHC whereas as per IPHS 6 MOs, 58 Staff Nurses and 5 LTs are essential at a 50 Bedded CHC.

- Though vacancy with respect to Sanctioned posts was under 10% for most of the key cadres, it was 44% for Specialists and 19.5% for Staff Nurses when compared with the requirement as per IPHS.
- The state is providing reservations for in-service candidates in 30% of clinical and 50% of non-clinical post-graduation seats. The candidates have to mandatorily serve for 5 years in government facilities post the completion of PG. The state has also started a separate GNM course for the ANMs from both regular and NHM cadre.
- Recruitments have been decentralized and were undertaken at the state, zonal and district level to ensure greater availability in tribal and aspirational districts.
- The state had started conducting walk-in-Interviews for recruiting specialists in tribal regions since August 2022 and has adopted the strategy of 'You Quote, We Pay' to attract more specialists. The state also provides hard-to-reach area allowances to the Specialists in tribal regions.
- With the present capacities, the state was in a good position to meet the requirement of MBBS-MOs, Specialists, and Staff Nurses. The state had also planned to increase the number of Medical Colleges by 2023-24, targeting to upgrade 17 District Hospitals into Medical Colleges.
- Four separate Directorates/Commissionerate are responsible for managing the HRH recruited under specific domains (National Health Programmes & HSCs, Primary care, secondary care and tertiary care). The APCOS (Andhra Pradesh Corporation for Outsourced Services), a corporation established by the AP government, was managing all the outsourced staff across departments, including health.
- The state was yet to integrate the service delivery cadres as the HRH in the same facility were working in silos under separate vertical programmes, performing programme-specific activities.
- HRMIS was in place and was being utilized to manage the HRH under NHM. It was being utilized to manage attendance and generate salary slips but it did not include HRH data from the regular cadre.
- Training calendars were available at district level and there were nodal officers responsible for organizing training for the Medical Officers and the Staff Nurses. However, no training calendars were being made at the state level.
- The state had created a pre-service/induction training module for the Medical Officers along with separate training on Finance Management, to address the training needs of the Medical Officers.

Bihar

- The State has not conducted any gap analysis on Human Resource availability as per the IPHS.
- Shortage of HRH, especially Specialists, Staff Nurse, Pharmacist and Lab Technician, was noted at all levels. The State reported a vacancy of 65% Specialists, 5% MOs, 37% for Staff Nurses, 45% for LTs, 32% for MPWs and 67% for Pharmacists. The HR shortfall was attributed to vacant positions, higher study leaves, absence without any information, deputation to other facilities - within or outside the district etc.
- Thirty-eight positions of HR Co-ordinators, Clinical Establishment at District level were lying vacant. Since there was no person designated for HR at District level, the additional charge of HR related tasks was assigned to other staff posted at the District level.
- At some of the Health Facilities, despite sufficient HRH, caseload was very low, thus existing HRH was under-utilized as observed at APHC-HWC Rajpur Kala.
- Despite the low vacancy among MOs, it was observed that UPHC in Aurangabad was being run by an AYUSH doctor.

- Recruitment for regular cadre was being done by Bihar Technical Services Commission and for the contractual staff under NHM was done by the State Health Society, Bihar (except for the contractual posts of MBBS Medical Officer at Additional Primary Health Centre (APHC)).
- NHM staff at block and facility levels were not aware about the HR Policy of the State.
- No Performance Appraisal system was in place for NHM HR. All NHM HR gets a 5% annual increment.
- State had not adopted the additional incentive policy to attract Service Delivery HRH for hard-to-reach or difficult areas.
- Salaries were disbursed on time, but disbursement of individual incentives or team-based incentives, FP incentives, PM-JAY incentives were delayed.
- As per the state health officials, HRMIS was in place for the regular cadre, but the CRM team found that regular cadre staff was not aware of it. HRMIS was not functional for the NHM staff.
- The State had an MOU with IIM Ahmedabad and IIM Bangalore for Motivation and Behavioural training.
- The State Institute of Health and Family Welfare (SIHFW), Patna was the apex body for training, where Training of Trainers (ToTs) were conducted.
- Total 13 types of trainings had been proposed for FY 2022-23 with a total of 44 batches, out of which 27 batches were completed with 1080 participants.
- Need based assessment for training of the staff had not been carried out, especially for technical training.

Chhattisgarh

- The State was facing 70% (566/1,840) vacancies in the medical specialist cadre and 32% (5,960/8,706) in the Staff Nurse cadre.
- The mandate of representation of tribal (Native people) in the recruitment board, and transfer of hiring manager were challenges impeding the recruitment process in the visited districts.
- The District Human Resource Cell (HR) was established in the visited district, and HR policy was in place.
- HRMIS was functional, and the salary of the HRH was linked to data entry on HRMIS, which led to an increased value of HRMIS and thus getting the staff data entered. Salary and other payments were released timely.
- Staff welfare schemes were in place like term insurance. Staff were also provided with identification cards.
- The utilization of staff could be improved as the average OPD per doctor per day was 30 patients.
- In-service training mechanisms were observed to be well established.

Delhi

- In the State, the sanctioned posts were not as per IPHS norms. Vacancies of Specialists and Medical officers were 69.8% and 35.3% under NHM, and 24.4% and 20.2% under regular posts.
- In the visited districts, 95% of the posts of doctors in the Mohalla Clinics were filled. Doctors were recruited based on merit list. They have on an average 75-80 candidates in the merit list. As and when vacancies arise, the doctors were contacted for their availability and walk-in interview was done.
- Among the other SD staff, vacancies under NHM ranged from 5% for MPWs, 19% for LTs, 24.6% for pharmacists to as high as 63.8 for Staff Nurses. Vacancies for the regular posts of Staff Nurses and Pharmacists were lower at 10.6% and 1.8% respectively.

- As reported by the state officials, many contractual posts had been vacant for the past 2 years as there has been no recruitment since then.
- All 12 sanctioned posts in the City Programme Management Unit were vacant. In the SPMU and DPMU, around 25 % and 19% of the positions were vacant under NUHM. The shortage of program management staff affected the overall implementation of health programs.
- Among the visited districts, the south district had a vacancy of 39.80 percent of the total posts in DHS, while in the North-West District, around 17 per cent of the total posts were vacant.
- There was no dedicated HR cell or HR policy in the State.
- As mentioned by the state officials the average time taken for filling vacancies was 5-6 months approx. and average time taken from advertisement to onboarding (recruitment cycle) was 3-4 months. However, some of the posts were observed to have been lying vacant for 2 years.
- HRMIS for contractual as well as regular staff has been under process since long but is yet to be made operational/functional.
- For remuneration of staff in the Mohalla clinics, a minimum assured guarantee of 75 patients per day is calculated on a monthly basis. However, if the Doctor is not available or on leave, the other staff (MCA, MTW and Pharmacist) does not receive any remuneration.
- The State does not have SIHFW. HFWTC is the only State training institute for training. There were no functional training institutes at the district level. The trainings were being conducted at the DPMU / conference hall of Safdarjung or AIIMS hospital. Knowledge & Skill based training were conducted by HFWTC.
- The training was conducted as per the physical & financial guidelines of GoI, from the funds approved in RoP.

Goa

- In Goa, the HRH falls under the Department of administration in Directorate of Health Services which is headed by Director of Administration.
- Among service delivery staff, the percentage vacancies were - Specialist (45%), ANM (18.9%), MPW (M) (16.9%), Paramedical Staff [Lab Technicians & pharmacists] (19.4%) and AYUSH physicians (14%).
- Key vacant program management posts were State quality consultant, Training consultant and RCH consultant.
- The state had proposed CHOs in the PIP, wherein 100 posts were sanctioned. The state was in the process of onboarding and 70 CHOs were likely to join by December.
- The state has unit called Rural Medical Dispensary for primary care services which was headed by MO MBBS. These centres were now being converted into Health and Wellness Centres.
- For NHM cadres, recruitment was last done by the DHS in April 2022. The total time from advertisement to recruitment takes 3 months, including advertising in the local newspapers and the DHS website, followed by an application time of one month.
- For Regular Cadres, the state has divided the HR into 3 groups - Group A, B, and C. The recruitment process for Group A and Group B is undertaken by Public Health Department of Goa. The last recruitment was carried out in December 2021. The process of recruitment for Group C is undertaken by DHS.
- The state was in the process of instituting Performance appraisal for the staff.
- Irrational deployment of HRH was observed, resulting in sub-optimal utilization of Specialists. The CRM team came across gynaecologists posted

at PHCs and ophthalmologists who were unable to perform surgeries due to lack of equipment. Even though some of the facilities had functional operation theatres, no surgeries were conducted due to unavailability of anaesthetists.

- State has an SIHFW in place but was not yet fully functional, thus the trainings were not being conducted there.

Jharkhand

- The Recruitment process in the state had been decentralized, yet shortage of HR and lack of trained HR was observed across all healthcare facilities visited.
- The vacancies of Specialists in the visited districts were as high as 74% and 94%, while for MOs it was 40% and 71%.
- While primary care staff (ANM and CHOs) vacancies were less in one district (26% and 34% respectively in Deogarh), it was high in the other district (43% and 71% in Garhwa District).
- Vacancies in LTs and Pharmacist positions were also high in Garhwa district (77% and 92% respectively).
- Human Resource Information System (HRIS-online management system) has been developed in the state for all levels of human resources but was not effectively used.
- HRH policies exist in the state but were weak with respect to contract renewal, transfer and posting and minimum performance benchmark.
- The State was in the process of launching performance linked payment for staff.
- There was also no policy on hard area allowance/ differential pay, etc.
- State does not have SIHFW. Training calendar for the capacity building of the available HR was available.

Kerala

- The State has a policy to refer to State norms for Health HR instead of IPHS norms. As against the required strength as per State norms, 83 % of ANM/MPW, 94 % of SNs, 88% of Lab Technicians, 89% of MOs, 93% of Pharmacists and 91% of Specialists were in position.
- However, requirements as per State norms are compromised as compared to IPHS norms. The requirement in MPW /ANM is 19% less as per State norms compared to IPHS, 39% less for SNs, 38% for Lab Technicians, 39% less for Specialists. Hence as per IPHS, there was considerable shortfall in HR (SNs/ANMs/MPWs etc). 1/3rd of sanctioned ANM posts were observed to be vacant in Wayanad.
- State had a well-established Specialists cadre in place.
- It was also noted that there were facilities with considerable load but shortage of staff such as PHC Mullankolly, Wayanad was having only one MO, who was available only on alternate days. Daily OPD was around 150.
- Key posts like State Urban Health Manager, State Quality Assurance Officer, Chief Engineer were lying vacant. All the key posts were filled on deputation basis only. Recruitment process for the above posts had been completed; however, formal orders of the Government were awaited.
- Certain key posts were found to be vacant in Aspirational district Wayanad. The district team has attempted to fill these posts utilizing the provision of flexibility measures such as "You quote we pay" for specialists. One of the reasons cited by the State for specialists/doctors for not joining at these positions is the abundance of private sector with lucrative packages and career advancement scope.
- The State had an HRH cell with 139 staff members. As per State HRH policy, the health staff are

appointed on a temporary basis, with contract renewals based on performance appraisals.

- The performance appraisal of employees working in the districts are done by the concerned District Programme Managers in the districts. The staffs who have more than 80% attendance in the financial year will be given appointment for the period upto 31st March. Those who scored between 60%-79.99% will be given appointment for a period of 3 months. After completing 3 months, there performance will be evaluated for further extension.

- The recruitment for NHM position was decentralized up to the district level. Each rank list was valid for 2 years. There is no separate board for medical recruitment. Decentralised recruitment of HR at health facilities through Local self-Governance (LSGs) funds and Hospital Management Committee (HMC) at panchayat level with usually higher salary slabs.

- Irrational deployment of HRH was observed in a few facilities with respect to the case load (e g., Specialists posted as GDMOs at PHCs).

- The HRMIS application was available and used for generating pay slips. However, the software was made in 2015 and it has now become outdated. State was going to replace the existing HRMIS by a new software.

- It was observed that districts visited had adequate and quality infrastructure for training. It was also noted that State and the district adjered training plan and the calendar.

Madhya Pradesh

- As per the availability of secondary data from the state level, it was estimated that there was vacancy of 34% of Medical Officers, 20.5% Staff Nurses, 40% Lab technicians, 18% MPW (Male & females) and 45% vacancies of Pharmacists.

- At the State level, 66% of Specialists post were vacant, while in the visited districts, the vacancy of Specialists was slightly lower at 54 % in Sidhi and 38% in Singruali.

- NHM has outsourced all HR recruitments to a private consultancy firm.

- Most of the recruitments are centralised affecting the program implementation at district level.

- The State Program Management Unit was adequately staffed, but District Program Management Units across districts were not strengthened optimally.

- Under National Health Mission, the State has guidelines for recruitment and performance appraisal, for contractual HR.

- Provision of inter-and intra-district mutual transfer policy was not in place, as well as comprehensive planning of HR in consultation with Directorate was lacking.

- Although circular had been issued and few Medical Officers had been selected for creation of Public Health Management Cadre (PHMC), it was yet to be implemented.

- It was observed that the District Training Infrastructure needed strengthening and the field staff was in need of refresher trainings.

Maharashtra

- The available staff was found to be highly motivated and technically proficient in deputed service delivery areas.

- The lack of Specialists at or below the District Hospital resulted in overburdening of the Medical Colleges, especially for emergency and critical care services.

- In Washim district, 65 positions including 19 Specialists and 9 MOs were vacant under NHM. 6 MO and two important admin positions under State cadre were also vacant.

- The state was conducting a number of program specific trainings for the key service delivery cadres, mainly pertaining to RMNCAH+N, such as BEmONC, SBA, PPIUCD, NSSK, NCD trainings, training on expanded packages of services under CPHC.
- The CRM team observed the need for training in Infection Prevention and Control practices for all cadres at all levels, and periodic refresher trainings for EMTs and drivers of ambulances.

Meghalaya

- The State did not have any comprehensive, documented plan for HRH. Sanctioned positions were less as per IPHS 2022.
- There was no specialist in one of the visited Districts (South West Khasi District).
- Various Positions in the visited facilities including MO, SN, Lab technician, were lying vacant.
- There was also a need to improve the competency of staff in clinical and soft skills.
- The State had a training calendar, based on which trainings were organized at the State level. However, the training infrastructure was limited, with a state skill lab capacity of only 16.
- The available HR lacked competence for providing emergency and PPIUCD services.
- Training modules were not available for the teaching faculty at State training centre.
- State Midwifery Institute (NMTI) had also not yet been identified.

Nagaland

- Most of the staff was motivated towards work and there was good team spirit, despite challenging conditions, including a difficult terrain. Some of the staff had also been awarded for their exemplary performance at work.
- The HWC visited were adequately staffed with 1 CHO, 2 ANMs, 1 MPW male. Overall, there was no shortage of the front-line health workers but there was an acute shortage of Specialists across all facilities.
- Many of the programmatic responsibilities were handled by Clinical specialists without proper orientation or trainings. District officials expressed concern that they are posted from the clinicals to programs without any trainings and it was a challenge to understand the intricacies of the programme without training and they rely on the staff to understand everything initially.
- The knowledge and skill levels of majority of the contractual staff like ANMs and ASHAs was found to be limited especially. about the newer programmes and most of them reported a need for extensive trainings, to improve service delivery.
- The vacancies were not filled at most facilities as per the IPHS standards.
- Village councils have supported and facilitated the accommodation arrangements at some health facilities, which is suggestive of strong community ownership.
- The CHOs had not received their financial incentives and salary for several months and 103 CHOs had been on strike, as a result of which the service delivery at the HWCs was severely affected.
- The CHOs were unaware about the exact criteria for the incentives, and expressed that their incentives were reduced due to unavailability of pregnant women in their areas, resulting in less ANC or no delivery services.
- The lack of staff quarters for the staff who did not belong to the same village was also a demotivating factor.
- Many of the programmatic responsibilities were handled by Clinical specialists without proper

orientation or trainings. There was a felt need of at least a 7-day training on the details of the programme, indicators, portals, documentation, etc.

- The knowledge and skill levels of majority of the contractual staff like ANMs was found to be limited especially about the newer programmes and most of them reported a need for extensive trainings to improve service delivery.

Punjab

- In the State, approx. 22% of total regular and contractual positions were vacant. Proactive measures were being taken to fill the vacancies by revisiting the salaries as per 7th Central Pay Commission, providing incentives to specialists, medical and paramedical staff for posting in difficult areas.
- In both the districts, the vacancy of specialists was approx. 50%, however 'You Quote, We Pay' was not being implemented as the state has recently revised the pay band as per 7th Central Pay Commission.
- The main reasons for limited availability of Specialist were reportedly their concentration in urban areas, migration to foreign countries, higher studies/joining academics institutes, and lack of retention strategies.
- The recruitment process in the state was centralized; however, flexibilities like empanelment of specialists at the district level was available.
- Recruitment of contractual staff Nurses was done under NHM and in regular cadre recruitment was done by Medical Education and Research.
- Recently, the state empanelled 142 MOs, 79 Pharmacist and 65 Clinical Assistants for 109 Aam Aadmi Clinics, with the support of Baba Farid University of Health Sciences, Faridkot. The empanelment of staff is valid for one year and staff were be given appropriate fee as per patient basis.
- For pre-services trainings like ANM/GNM/B.Sc. Nursing, there are 9 training institutes offering these courses and the state has 23,029 registered ANMs, 76,680 RN & RM and 2,584 LHVs.
- The State had an HRH cell for processing the recruitments of various posts under NHM. Yet, it was observed that HRH policies for selection, retention, transfer and posting of NHM staff in the state were not in place.
- It was also observed in the field that Term of References were not available with the staff and mechanisms to monitor and assess training needs of the staff were lacking.
- The State was in the process of salary rationalization. Presently, an increment of 6% was being given to staff every year. There was no delay in release of salary observed at any level.
- There was no specific established mechanism to ascertain the monthly performance of the staff in the facilities. Since 2013, performance monitoring was done through ACR only. The performance of service providers was assessed on the basis of OPD/IPD, number of surgeries, diagnostics, etc.
- Details of all the employees of the health department in the visited districts had been entered in iHRMS Portal.
- The State has not provisioned for any health policy to ensure regular health check-up for the staff.
- State had an SIHFW functional in a rented building in Mohali, and the overall administration was done by the Medical Education and Research department.
- Trainings were being conducted by different program divisions, and were being coordinated by the SIHFW.
- State had initiated DNB courses at District Hospitals in 2019, 6 (Amritsar, Bathinda, Jalandhar, Ludhiana, Patiala & Faridkot) districts were running

the courses with a total of 42 seats (17-DNB and 25- Diploma). The State was planning to expand the implementation to 10 new districts and add more specialities in the existing District Hospitals providing DNB course.

Rajasthan

- Recruitment for 8,827 service delivery and PM staff positions were in process.
- Vacancies were as high as 62% for the Medical and paramedical service delivery staff, and 31% for CHOs, while vacancies in the managerial positions were lower at 26%.
- A major hindrance to filling up of posts at district and block level was the centralized recruitment process prevailing in the state, and there has been a long gap in the recruitment cycle, including that of CHOs.
- Positions of State Finance Manager, District and Block Accounts Managers have been vacant for the last couple of years.
- Lack of staff welfare practices like insurance, and low salaries were cited as challenges towards attracting and retaining HRH.
- It was observed that trainings and refresher trainings were not being properly done on a regular basis resulting in lack of skills across all major cadres.
- The visited district lacked an availability of a training plan and calendar along with lack of resource persons.

Sikkim

- Specialist cadre is available in the state. GDMO recruited at the base level. Specialists are recruited at higher grade with increased remuneration. For specialist cadre, state has defined performance allowance to be given to super specialists; however, indicators for the same have not yet been defined.
- The State is yet to plan HRH as per IPHS 2022. Most facilities had only NHM Staff and none from regular cadre.
- Recruitment was decentralized at CMO level and local applicants are preferred to reduce attrition & transfer requests. Average recruitment cycle does not take more than 1.5 months from advertisement till onboarding of the personnel.
- Surplus staff was witnessed at many of the visited facilities, which was reported as a result of the State government's policy of 'One Family One Job'.
- The state faced some challenges in terms of HRH planning and deployment, as no separate Admin/ technical wing was present, which is also reflected in postings of workforce with no planning. For example at DH level, MPHW were also posted directly without discussions with NHM team, thus found undertaking the activities of assisting Medical Officers at the facility.
- The state has an HRH cell that handles postings of NHM HRH. Sikkim has transfer policy that balances home postings and distant postings across a cycle of 3 years.
- Hard Area allowance was provided to MOs serving in North Sikkim and South Sikkim district. The state was in the process of providing the same for MLHPs at AB-HWCs.
- To mitigate the paucity of surgeons, the state was also planning to leverage NHM flexibility of "You quote We pay".
- The state was in process of establishing HRMIS for NHM. The software had already been developed and HRMIS was expected to come into force by March 2023.
- Job Descriptions for HRH were not available.
- The State has a unique HR Policy of converting the contractual post to regular after completion of 08 years of service. State has also extended the maternity leave from 06 months to 01 year.

- Hard area allowance is currently for NHM MOs, but now state is expanding the process to include MLHPs from AB-HWCs in the state.
- Deficiency of surgeons was observed across facilities. State was planning for implementing "you quote, we pay" for the same.
- No state specific training institutes were available to support capacity building initiatives.
- There was no training calendar at the state or district level. Trainings were conducted at the district level as per programme needs and directions from the state level.

Tamil Nadu

- As per the data shared by the state, overall, 75% of the posts in 6 key service delivery cadres- required as per IPHS have already been sanctioned. However, there were vacancies ranging from 5% among Lab technicians and Staff Nurses to 32% for MPW(F)/(M)/ Village Health Nurses (VHNs). However, only 62% of the HRH were in place as compared to IPHS norms, and the gap in staff nurses, lab technicians and VHNs was especially worrisome.
- The Medical Recruitment Board (MRB) has helped Tamil Nadu fast-track its recruitments. Almost all recruitments were done within 2-3 months, which was commendable.
- In terms of accessibility, the tribal areas had an almost equal number of HRH as in other areas because of good policies of better salaries in hard-to- reach areas and higher marks in PG exams for doctors serving in tribal/hilly districts.
- While for every 5000 population other states have 5 ASHAs, 2 MPW /ANMs/VHN and one CHO/MLHP, Tamil Nadu had one VHN, and one MLHP who were supported by one Women Health volunteer (who looked after DM and HT) and an MPW-M who generally looks after 3 HWC-SC. The VHN and MLHP had clearly distributed their areas of work and were functioning cordially to supplement each other's role.
- City Health Officers belonging to the public health cadre, served as a bridge between Health and Municipal corporation and resolved most of the challenges pertaining to inter-departmental co-ordination.
- There was an urban and rural divide and unlike other states, in Tamil Nadu, urban facilities were fewer. Hence, the HRH providing services through the existing facilities were not sufficient to cater to the needs of the urban population.
- The State has an HRH cell at State level led by a Deputy Director and supported by consultants. There is a need to transform HRH practices, incorporating HR development activities to motivate the HRH and ensure decent work.
- HR integration, especially in service delivery was seen. It was heartening to see lab technicians taking up responsibilities as a team and not restricting themselves to a particular program. The teams have also managed to overcome the regular and contractual divide and work together.
- Being a front runner in health, Tamil Nadu has made various policies for HRH over the years pertaining to public health cadre, transfer, career progression, etc. All these need to be put together and reassessed with a futuristic perspective.
- Tamil Nadu has one of the strongest directorates in the country, and also has an HRH cell at State level led by a Deputy Director and supported by consultants. However, a lot can be done to transform HRH practices, incorporating HR development activities to motivate the HRH and ensure decent work.
- The state was providing higher salary to HRH working in difficult areas, and differential grading in PG entrance, i.e, more marks for doctors who have served in hilly and difficult areas, less for plains and none for urban.

- Despite the high caseload in many facilities, the monitoring of productivity was not a common practice. The average caseload in the PHC per day ranged between 35 to 60 cases.
- There was mismatch between the HRH data that was available in e-Samiksha portal and the data gathered from State and Districts during the visit.
- Human Resources Management Information System (HRMIS) for NHM staff and regular staff was being maintained separately. If these separate data sets could not be used for any analysis, evidence generation and policy decisions, it fails in its objective.
- As validated HRH data is at the core of any analysis on availability, HRH distribution and productivity, conclusive observations could not be drawn in its absence.
- Systemic support and initiatives in capacity building were very low across the thematic areas in all the facilities.
- Tamil Nadu has entered in an MoU to support Meghalaya in training of the HRH especially doctors. It was encouraging to note that the State was leveraging its expertise to assist other states in producing skilled HRH and this would also provide them with additional workforce during the training period.

Telangana

- State has three different directorates and a Commissionerate or structures overseeing the HRH at different levels of care. There were high vacancies in regular cadre at all levels, across the directorates. Most of the facilities had under-sanctioned posts and were working on almost half of the sanctioned strength.
- The State has a decentralized system for recruitment of service delivery NHM staff at the district level. On the other hand, Recruitment of the district level Programme Management positions is done at the state level.
- Practice of deputations led to frequent unavailability of ANMs, Staff Nurses, Lab Technicians, MOs and Specialists.
- The State has a specialist cadre. However, the District Hospitals still did not have all the required specialities.
- Irrational deployment of Specialists, and other cadres was observed in the state. The CRM team noted instances of Gynaecologists and General Surgeon being deployed without an Anaesthetist, 5 Lab technicians in one facility and none in the other.
- The attraction and distribution of the HRH produced is extremely skewed. NHM Flexibilities like "You Quote We Pay" additional hard area allowance or top-ups for regular cadre were not being utilized to attract HRH to the distant and remote areas.
- There was a State HRH Cell at the SPMU. Since the State has separate directorates for separate levels of care, the management of HRH working in those facilities was also a responsibility of those directorates.
- New joinees were given ToRs after joining and receive a verbal communication from their in-charges regarding their roles and responsibilities.
- The state has adopted Health Systems approach and HR integration was apparent as most staff did not identify with any single programme.
- In Asifabad, a theatre, children's park and entertainment activities had been initiated from District Collector's fund, to encourage HRH to stay in the district and provide services. However, staff quarters were not available in many of the other facilities, hindering staff retention in the tribal belt. Other provisions such as additional incentives or allowances for the HRH working in the distant, remote, and tribal areas were also not being practiced.

- The contract renewal of NHM staff was not based on any performance appraisal, and in one of the districts, the PM staff had not received any increment for the past couple of years.
- State had a decentralized system for recruitment of service delivery NHM staff at the district level. Recruitment of the Programme Management Posts of district level: programme officers, data managers, account officers, quality assurance managers, was done at the state level.
- HR integration was apparent in case of service delivery as most staff did not identify with any single programme. Under Programme Management, different programmes were being handled by different officers.
- The state did not have a functional HRMIS.
- The state has a nodal training centre called the Indian Institute of Health and Family Welfare (IIHFW) in Hyderabad. Trainings come under the purview of respective programme officers, but records were not being uniformly managed as the state did not have a functional HRMIS. Some district level training records were being maintained in one of the visited districts.
- Induction or orientation training had been conducted for most HRH in the field. MLHPs were trained and posted at the Sub-Health centre level. All ASHAs on the field and at least one ANM and/or Staff Nurse from a given facility had undergone the training on AB-HWC expanded package of services. Nevertheless, the provision of NCD services was very limited.
- At the state level or below, training calendars were not being prepared, neither had any Training Needs Assessments been conducted.
- The State has started DNB courses in Sangareddy and Karimnagar District hospitals. However, there was no plan on starting DNB in the visited districts.

Uttar Pradesh

- The state has run 9 recruitment cycles for regular and NHM Posts, and filled 4,583 regular and 4,127 contractual vacancies against the post of Specialist, MO, Staff Nurse, PHN tutor, Midwifery educator etc., in the last year.
- The State has not sanctioned positions as per the IPHS norms. There was no systemic analysis and planning for the identification of gaps as per IPHS 2022 and the sanction of posts accordingly.
- Out of 10,792 sanctioned posts for specialists, 64% seats were vacant. The state had recruited more than 1,200 Specialists through UPPSC recently of which 600 have joined. The initial posting was done through a transparent in-person counselling process.
- Out of 12,527 sanctioned posts for GDMO, 29% of seats were vacant, and of 30,255 sanctioned posts for Staff Nurses, 25% of seats were vacant. Among LTs, 15% of 8,591 seats were vacant, while among PM posts, approx. 2081 key positions were vacant at the state level.
- Usually, the recruitment process was done by UPPSC for the regular cadre and an outsourced agency (EdCIL) for NHM staff. Recruitment was done once a year by the recruitment board, but if any additional posts were sanctioned, then it was done twice a year. Also, some flexibility was there with the District Health Society to conduct the recruitment of contractual staff as per the State guideline.
- The state provides incentives as per norms and TBI (Team- Based Incentives) to the staff for serving in difficult areas/hard-to-reach areas.
- The state had good career progression structures for doctors wherein a specialist cadre and GDMO cadre have a defined pathway for promotion. Specialist joins at a level higher than a GDMO. Transfers and postings have been done since 2019 on pre-fixed criteria through "Manav Sampada".

- HRMIS was in the process of integration with "Manav Sampada". Pay slips were being generated but linkages with FAMS were under process.
- There was no systematic approach nor uniform structure for managing various programmes. Most of the programme would get HR under NHM depending upon the need and priority of activity.
- No human resource and retention policies were available for NHM staff.
- As mentioned by the state officials the average time taken from advertisement to onboarding (recruitment cycle) was 90 to 180 days but from staff interviews, it was found that the average time taken for recruitment was a minimum of 6-9 months.
- A grievance redressal cell has been established at the state, division, and district levels for the quick resolution of staff grievances and 80-90 % resolution of grievances within time limits.
- While interacting with the CRM team members, the cleaning and support staff submitted their grievance regarding the remuneration paid to them by the outsourced agency, which was far lesser than the Minimum Wages Act and also government-approved rates.
- For staff welfare, Group Insurance (accidental and health) for staff was under process.
- The State Institute of Health and Family Welfare (SIHFW) had been conducting some capacity-building programs for higher-level functionaries; however, they did not have the adequate capacity to monitor and mentor various programmes.
- Neither the SIHFW nor the training division had any comprehensive training plan. Training need assessment was being done as per the programmes but a systemic and comprehensive approach was missing. There was no systemic approach for facility-based training needs assessments of the available HRH.
- Induction training for various cadres had not been initiated; however, technical training for 2670 ANMs had recently been conducted.
- Anecdotal evidence of field visits indicated that 50-60% SBA-trained nurses have not received any further orientation beyond their training in 2018-19.
- DNB courses were being offered in eight District hospitals. The total number of DNB seats in DH was 60 in 10 specialities (Departments) in UP. In both the visited districts, (Chitrakoot and Maharajganj), DNB courses had not been initiated in the DH, and there were no nursing colleges either.

INDIAN PUBLIC HEALTH STANDARDS

Indian Public Health Standards (IPHS) were first established in 2007 and revised in 2012. IPHS was further revised in 2022 and launched by the Hon'ble Union Minister of Health & Family Welfare. These standards cover Health and Wellness Centres (HWC) - Health Sub-Centres (HSCs), Urban HWC, Primary Health Centres (PHCs), Urban Primary Health Centres (UPHC), Community Health Centres (CHCs), UCHCs, Sub-District Hospitals (SDHs) and District Hospitals (DHs). These are guiding documents for states/UTs on the infrastructure, human resource, drugs, diagnostics, equipment, quality, and governance requirements for delivering health services at public health facilities. NHM, in an effort to meet the commitment under National Health Policy 2017, has envisaged 50% of the facilities to be IPHS compliant by 2025-26.

KEY OBSERVATIONS

- Given the recent launch of the IPHS 2022, most of the facilities visited across the 17 states, were in initial stages of mapping and planning for IPHS 2022. However, the compliance to the IPHS 2012 was closer in lower-level facilities like HWCs as compared to CHCs and SDH/DH.
- The understanding of IPHS at facility & district levels was limited, ranging from complete lack of knowledge on IPHS to partial understanding of the guidelines. The district level orientation on IPHS was yet to be done by state in most of the visited districts.
- HR, infrastructure, and services norms as per IPHS 2022 were not being adhered to, in many of the facilities visited. Among the non-compliant facilities mostly the issues were related to HR, availability of drugs and diagnostics; however, infrastructure was not reported as an issue in most facilities. There were some issues in the deployment of HR in states like Maharashtra & Goa, where HR is optimal.
- The gap assessment and scoring exercise for IPHS compliance was yet to be initiated in most of the states.
- In state specific examples, Environment Friendly initiatives like herbal gardens and solar water pumps were available in the premises of some facilities visited in Andhra Pradesh.
- States also demonstrated adoption of state specific standards where Delhi and Kerala did not implement Indian Public Health Standards 2022, but follow their own norms/standards for Public Health facilities.

RECOMMENDATIONS

- Orientation of District officials (including architects & engineers) to be expedited on IPHS and preparation of the District Health Action Plan (DHAP), infrastructure planning, and preparing prospective plans with a mechanism to ensure availability of human resources, drugs and diagnostics.
- The initial steps will be scoring facilities for IPHS compliance and accordingly preparing a roadmap, integrated within DHAPs to achieve the target of 50% IPHS compliant facilities by 2025-26.
- States should undertake a detailed gap analysis as per IPHS and develop action plans to make the facilities IPHS compliant. This can facilitate comprehensive planning for the health system of the state.
- The human resource across all facilities needs to be strengthened as per IPHS norms.

PUBLIC HEALTH MANAGEMENT CADRE

The National Health Policy 2017 aims to attain the highest possible level of health and well-being for all ages through a preventive and promotive healthcare orientation in all developmental policies and

universal access to good quality healthcare services without anyone having to face financial hardship. The National Health Policy (NHP) also suggested various strategies to achieve the goal as mentioned above, one of which is the creation of a Public Health Management Cadre (PHMC) in all states. In this regard, the Government of India committed to creating a Public Health Management Cadre (PHMC) as per the mandate of NHP 2017. A booklet as a guidance note for its better implementation across the country was released in April 2022. Implementing these cadres will contemplate rejuvenating and restructuring the health systems design and service delivery, addressing effective management of future outbreaks, robust surveillance, and implementing health programs. As observed during the 15th common review mission visits, the States were at various stages of PHMC implementation.

KEY OBSERVATIONS

- Almost all States have cadres for Medical Officers, but only a few have cadres for public health and specialist cadre. Tamil Nadu's Public Health Cadre dates back to 1923, where the Directorate of Medical Education (DME), Directorate of Medical Services (DMS), and Directorate of Public Health and Preventive Medicine (DPH & PM), are responsible for delivering tertiary, secondary, and primary healthcare services, respectively with adequate career progression, while, Punjab and Uttar Pradesh are still having general medical officers and specialist cadre where the career progression is on seniority basis in the former while no definite channel for career progression exists in latter.

- The MBBS graduates with PG qualifications in Public Health/Community Medicine/PSM were recruited as Health Officers in Tamil Nadu, where they are allowed to progress up to the Director of Public Health and Preventive Medicine level. Conversely, if the MBBS graduate appears for the Medical Recruitment Board (MRB) exam, they can join the Medical Services cadre as Assistant Surgeon.
- Punjab offers medical officers the option to complete their specialization on paid leave with a bond of 10 years to serve the State after completion of specialization. While Tamil Nadu mandates to complete the post-graduation within 4 years of joining the service to get regularized.
- Among other visited States, only Sikkim and Andhra Pradesh have shown some progress toward the implementation by forming a state-level committee, mapping existing public health professionals and diploma/ master's degree in public health holders.

RECOMMENDATIONS

- All the States need to expedite the planning and implementation process of Public Health Management Cadres as per GoI guidelines by 2023, as creating these cadres would greatly strengthen the public health policies and programs' governance, design, and service delivery, monitoring, and accountability.
- States/UTs need to rationalize the existing HR in a time-bound and phased manner to create a 'Public Health Cadre,' 'Health Management Cadre,' 'Specialist Cadre,' and 'Teaching Cadre' as per the guidance note.
- The States also need to explore various in-service public health training and courses for the existing human resources for health and program management unit. An institutional mechanism should be put in place for such training.
- There was a need to streamline the recruitment process by establishing a recruitment board under the Health/ Public Service Commission of all the States.
- The States may also revise the existing cadre structures following the functional requirements as per the local context and regulations of the respective State. Simultaneously, an assessment of the current strength of existing healthcare workers trained in the 'Public Health' stream and 'Health Management' Stream can be done, and options can be explored, absorbing them in the revised structures.

GOOD/REPLICABLE PRACTICES OBSERVED IN TAMIL NADU

- Tamil Nadu Public Health Service ensures a constant inflow of dedicated medical graduates working primarily for public health and primary care administrative functions.
- Initial delegation of the candidates at the field level, while ensuring subsequent career progression, assures a solid foundation of rich experience and learning to help them undertake their duties better throughout their careers.
- Even when the requirements detail a postgraduate degree in public health, induction training on public health ensures a thorough orientation towards public health practice and outlines the expectations from the cadre
- The time scale for promotions is quicker, and the pay scale is higher in the Public Health Services cadre, making the career path more appealing to young graduates. The State has also developed separate training manuals and job descriptions for all public health staff.

QUALITY & PATIENT SAFETY

NATIONAL OVERVIEW

The National Health Mission envisages universal access to equitable, affordable & quality healthcare services that are accountable and responsive to people's needs. In 2013, National Quality Assurance Standards were launched, keeping the specific requirements for public health facilities and global best practices as minimal obtainable standards. Quality Certification program for public health facilities has been found to recognise good-performing facilities and improve the credibility of public hospitals in the community. The CRM teams review the progress of the quality initiative in the country at selected states. The review is based on defined and designed questionnaires or observable points.

KEY OBSERVATIONS

- **Commitment of states to improve the quality of services:** During the CRM visit, it was observed that the states were committed to improving the quality of services with the help of National Quality Assurance Standards. The visited facility staff was keen to know the gaps in their facility and showed utmost interest in improving the processes and outcomes. A few states, like Jharkhand, Punjab, Sikkim, and Bihar, need a drive in this direction.

- **Roadmap to achieve NHM targets for NQAS certification of public health facilities:** NQAS certification targets are given to all the states and UTs by NHM for each financial year. It was observed that all the visited States and UTs had developed their roadmap towards achieving the NHM targets for NQAS certification of public health facilities. The state of Punjab, Goa and Sikkim did not develop the roadmap. There were few states where despite a roadmap, few actions have been taken towards achieving their goals, like Jharkhand and Meghalaya.

- **SQAC / DQAC Mentoring and Supportive Supervision:** The State Quality Assurance Committee and District Quality Assurance Committee are formed and functional in all the states except Rajasthan and Jharkhand, where DQAC was not formed. Almost all the visited states were lacking in rigorous mentoring and supervision.

- **Patient satisfaction surveys:** PSS and integration with "Mera Aspataal" were found in the visited states like Goa, Telangana, Maharashtra, Rajasthan, and Tamil Nadu. In Maharashtra, Rajasthan, and Tamil Nadu, it was observed that primary care facilities were not integrated with Mera Aspataal. In Andhra Pradesh, manual feedback was being recorded. No feedback mechanism was in place in Jharkhand. Despite conducting PSS, the data analysis and decision-making towards improving quality remain challenging.

- **Use of IT to conduct Quality Assessments:** DQAU was aware of using the "Gunak app" for the assessment at most of the visited facilities except Jharkhand, Rajasthan, Sikkim, Andhra Pradesh, Kerala, and Uttar Pradesh.

- **Implementation of National Quality Assurance Standards:**

i. **Patient-centric care:** Display of citizen charter and information about the services, clinical condition, entitlements, etc., were noticed in Andhra Pradesh, Jharkhand, Goa, Kerala, Maharashtra, Tamil Nadu, and Telangana.

   a. There was no well-established grievance redressal system in Goa, Chhattisgarh, Maharashtra, and Telangana.

   b. Adequate and clean basic patient amenities-drinking water, toilets, clean linen, food, etc. was observed in all the visited facilities except in a few visited health facilities in Jharkhand

where shortage of drinking water was a challenge.

c. In Uttar Pradesh, most of the visited health facilities were not disabled-friendly with the absence of railings and ramps.

ii. **Delivery of Respectful Patient Care:** Most visited facilities in Goa, Maharashtra, Telangana, and Tamil Nadu provide respectful patient care. In Maharashtra, it was observed that the curtains were not available between two delivery beds. Birth companion was not allowed in Maharashtra, whereas Tamil Nadu had this provision.

iii. **Training and Capacity Building:** It was observed that ground-level staff requires training on various topics like awareness of NQAS, LaQshya, MusQan, Mera Aspataal, Infection control practices, BMW Management, Quality Tools implementation, SBA, NSSK etc.

iv. **Prescription Audits:** Except in Chhattisgarh, Goa, and Telangana, most of the facilities visited were not undertaking audits (such as prescription audits, medical audits, and death audits).

v. **Patient Safety:** The service providers of Goa, Maharashtra, Tamil Nadu, and Telangana were adhering to a few patients' safety parameters such as adherence to Personal Protective Equipment, moments/steps of hand washing, training on the operationalization of fire extinguishers.

vi. **Recording and Reporting of Key Performance Indicators:** Among the visited states, it was observed few states were reporting the KPI, like Goa and Tamil Nadu, whereas the visited facilities in Maharashtra, Jharkhand, Telangana and Uttar Pradesh were recording their KPIs.

vii. **Statutory & Legal Compliance:** Compliance with the statutory and legal requirements was found to be a foremost challenge in most of the states.

KEY RECOMMENDATIONS

- Institutionalisation of the Quality Assurance Framework at the district and facility level in all the states.
- The states should scale up quality assurance programme implementation through rigorous mentoring and supervision support of State and District Quality Assurance Units.
- The states should expedite the process of NQAS certification as per their roadmap towards achieving the targets by commencing the internal assessments, gap analysis and corrective and preventive actions.
- The states should create awareness and provide implementation training at the ground level regarding the quality assurance programmes like NQAS, LaQshya and MusQan.
- The states are recommended to uptake the NQAS certification of SUMAN-notified facilities as per under "SUMAN guideline" and Guidance note circulated to all States/UTs, i.e., "Roll out Quality Assurance under SUMAN."
- The states are also advised to target Health and Wellness Centres Sub-Centres for the NQAS certification.
- There should be a robust mechanism to capture, measure and report the Key Performance Indicators (KPI) at all healthcare facilities.
- Need-based training should be conducted at the districts and facility levels.
- Implementing the Mera-Aspataal initiative below the District Hospitals (HSC/APHC/Block PHC/ equivalent HCF) to measure patient satisfaction by capturing patient experience in the health facility. The utilisation of analysed data further improves the quality of care and enhances decision-making for patient-centric care.

- Use of the IT-based application "GUNAK app" should be promoted for the NQAS assessments at all levels.
- Ensured adherence to regulatory and statutory rules and Acts for the following:
    a. Bio-medical waste management Authorization
    b. Linkage with CBWTF
    c. NOC for fire safety measures at health facilities
    d. License for Blood Bank/ Blood Storage Unit
    e. Electrical Safety Audit
    f. AERB Authorisation
    g. Calibration of Measuring equipment (calibration)

STATE SPECIFIC FINDINGS

Andhra Pradesh

- SUMAN notified facilities: 239 facilities were SUMAN notified, among which 69 facilities have been taken up for national certification and 86 facilities for state certification under NQAS.
- The State of Andhra Pradesh was committed to improving health facilities' quality of care with a well-thought-out strategy and Action Plan. It has established an institutional framework for Quality Assurance (QA).
- Display of citizen charter, information about the services, clinical conditions, and signages are available in the local language in the state.
- The state was utilizing the GUNAK app for assessment, and there was Real Time Quality Tracking Dashboard (QTD) for monitoring the certification status in the state.
- The utilization of the information received from the Patient Satisfaction Survey for improvement and decision-making was missing.
- It was also observed that there was limited awareness about the MusQan programme in the state.

Bihar

- SUMAN notified facilities: 101 facilities were SUMAN notified, among which two facilities have been taken up for national certification and one facility for state certification under NQAS.
- The District Quality Assessment Committee was established in the state, and meetings were held regularly.
- The secondary care facilities' waiting areas were adequate, with suitable seating. They also had access to basic amenities like running water and electricity.
- All the facilities which were visited did not have proper signages.
- The Labour Room complex, counselling spaces, ANC and PNC wards were all well-designed with unidirectional flow. There was no specific triage space or zoning in the emergency, OT, LDR, and ICU departments.

Chhattisgarh

- SUMAN notified facilities: 328 facilities were SUMAN notified among which 32 facilities have taken up for national certification and 24 facilities for state certification under NQAS.
- The last review meeting of the SQAC and DQAC was held in 2019.
- A robust Complaint Resolution System was absent in most of the visited health facilities.
- None of the visited health facilities was performing Prescription Audits except at DH Surajpur.

- In Chhattisgarh, 77 HWC-SCs were assessed by the district-level team and 20 were assessed by the state-level team.
- In Kondagaon & Surajpur Districts, six (6) health facilities were being shortlisted in each District for NQAS Certification for FY 2022-23. Out of the 12 targeted health facilities, only one PHC (PHC Basdei of Surajpur District) has been NQAS certified.
- State was committed to improving the quality of care and was targeting state certification of 17 healthcare facilities per month along with quality certification under the MusQan programme.

Goa

- SUMAN notified facilities: 33 facilities were SUMAN notified, among which 4 facilities have taken up for state certification under NQAS.
- All the visited health facilities had constituted a quality team to implement quality standards. However, a periodic review of the progress of programs by SQAU was found to be deficient.
- Lack of awareness regarding Quality programmes like NQAS, MusQan, LaQshya, and Mera-Aspatal at ground level.
- Quality Assurance Programmes at the urban health facilities have not been initiated yet.
- There was awareness about infection control practices among the staff.
- All visited facilities maintained patient registers (OPD register, IPD register, Nursing Hand-over register, Labour room, Referral register, etc.).
- Complaint Resolution System was absent in most of the visited health facilities. Also, there was no central grievance redressal system at the state level.
- Reporting and recording of Key Performance Indicators were practiced at all the visited healthcare facilities.
- Compliance with the statutory requirements like authorization for BMW, AERB authorization for radiology set-up, etc., was a common observation across the state. At the same time, NOC for fire safety was unavailable in most healthcare facilities.

Jharkhand

- SUMAN notified facilities: 125 facilities were SUMAN notified out of which 2 facilities have taken up for national certification and 2 facilities for state certification under NQAS.
- The state has established State Quality Assurance Committee. The last SQAC meeting was held in September 2020. District Quality Assurance Unit and Committee were constituted for the district Garhwa only among the two visited districts Deoghar and Garhwa.
- Lack of awareness regarding Quality programmes like NQAS, MusQan, LaQshya and Mera Aspataal at the ground level.
- Citizen charter and information about services and entitlements were displayed across facilities. Grievance redressal boxes were installed.
- SOPs, policies, quality manuals, or work instructions were unavailable in the visited facilities.
- Key Performance Indicators and Outcome Indicators were not recorded in the state.
- At PHC Ramkanda, basic amenities like drinking water, were lacking.
- The DH Sadar- Garhwa had started preparing for the NQAS Certification and completed the facility's

internal assessment. None of the facilities in the visited district Garhwa had integrated with Mera Aspataal.

- Non-compliance to the statutory requirements, viz. Authorization for BMW, AERB authorization for radiology set-up (application was processed), NOC for fire safety, blood bank license (expired at DH Garhwa) etc., was a common observation across the state.

Kerala

- SUMAN notified facilities: 3 facilities were SUMAN notified among which 3 facilities have been taken up for national certification and 3 facilities for state certification under NQAS.
- DQAC meetings were regularly conducted in the Thrissur district, and a Supportive supervision plan for all members was in place. The state had implemented the NQAS, LaQshya, and Kayakalp programmes. The state had not initiated NQAS implementation at the HWC-SC level.
- Gunak App was not in use for assessment of NQAS, LaQshya or Kayakalp.
- Citizen Charters, IEC materials and protocols were displayed in the local language in most of the visited facilities.
- Mera Aspataal initiative was not implemented in all health facilities, but some facilities conducted Patient Satisfaction Survey manually.
- In Thrissur, Dietary services were not provided by the health facilities. Diet was provided with the help of some local NGOs. A standard diet was provided to all clients without considering the nutritional requirements of individual patients at all levels of health facilities. In CHC Perinjanam, only noon meals were distributed due to the disruption of services after the COVID pandemic.

Maharashtra

- SUMAN notified facilities: 196 facilities were SUMAN notified among which 10 facilities have taken up for national certification and 10 facilities for state certification under NQAS.
- After launching the National Quality Assurance Program in 2013, the state made revolutionary progress till 2018 under NQAS certification. Afterwards, the state witnessed a decline in the process of quality certification.
- Lack of awareness regarding Quality programmes like NQAS, MusQan, LaQshya, and Mera-Aspataal at ground level.
- Quality Assurance programmes have not been initiated at urban health facilities, and none of the visited health facilities had constituted quality teams.
- None of the visited health facilities had displayed Citizen Charter at the entrance. However, some places displayed patients' rights and signages in the local language. Patient entitlement under different health schemes was not displayed except at RH Pimpalner.
- Most of the visited health facilities were not allowing birth companions (spouse/family member).
- Privacy and dignity were compromised at most health facilities due to the non-availability of curtains between the delivery tables, and ward beds.
- All visited facilities had thoroughly maintained patient registers (OPD register, IPD register, Labour room, Referral register, etc.). Patient details, including prescribed investigations and the diagnosis was mentioned in the record.
- Most visited health facilities included basic patient

amenities, like separate toilets for men and women, running water, sitting arrangements, etc.

- A robust Complaint Resolution System was absent in most of the visited health facilities.
- Reporting and recording of Key Performance Indicators and conduct of prescription audits were not practised at all visited health facilities.
- Non-compliance to the statutory requirements, viz. Authorization for BMW, AERB authorization for radiology set-up (application was processed), NOC for fire safety, etc., was a common observation across the state.
- The External Quality Assurance Programme for Laboratories was not initiated in any of the visited facilities.
- The policy for the records management in the Medical Record Department was not available. No condemnation policy at the facilities was found at the visited health facilities.

Meghalaya

- SUMAN notified facilities: None of the facility was SUMAN notified in the state.
- The Government of India has rolled out several initiatives to improve the quality of health services, including National Quality Assurance Standards (NQAS), Labour Room Quality Assurance (LaQshya), Kayakalap and Swachh Swastha Sarvatra (SSS), MusQan to ensure child-friendly services, and Mera-Aspatal to capture patient feedback. Meghalaya Government has initiated MHSSP (Meghalaya Health System Strengthening Project) to strengthen and foster health sector development.
- Facilities visited lacked in power backup, appropriate central sterile supplies department, adequate kitchen and dietary services, grievance redressal desk, and fire safety norms.

Madhya Pradesh

- SUMAN notified facilities: 290 facilities were SUMAN notified, among which 6 facilities had taken up for national certification and 16 facilities for state certification under NQAS.
- District Quality Assurance Committees were formed in Sidhi and Singrauli, but no facility was NQAS certified in both the visited districts.
- The state had prepared the SOPs for all the departments of NQAS.
- NQAS Internal Assessors training; NQAS, Kayakalp & MusQan Orientation training; AMR awareness training have been provided to more than 800 Doctors, Nursing Officers, other paramedical Staff, and Quality Nodal Officers/ Monitors/ Mentors.
- The state had developed State AMR Policy and Antibiotic Policy in collaboration with AIIMS, Bhopal, in 2019, and more than 1,000 Medical Officers were trained on AMR Policy.
- In Madhya Pradesh, Fire NOC was received in 49 DHs, 15 CH, 17 CHCs & 10 PHCs. As of the date of review, it was in process in around 40-50 HCFs. AERB authorization was received in 44 DHs, 16 CH, 28 CHCs & 3 PHCs. As of the date of review, it was in process in around 20-30 HCFs. BMW authorization was received in 50 DHs, 16 CH, 8 CHCs & 20 PHCs while it was in process, in around 40-50 HCFs.

Punjab

- SUMAN notified facilities: 3,556 facilities were SUMAN notified, among which 15 facilities had taken up for national certification and 67 facilities for state certification under NQAS.
- The visited facilities had good infrastructure, but none were IPHS compliant regarding services (including drugs, diagnostics), HR, and equipment.

- It was found that the focus on NQAS was low in the state. However, the State has implemented the NQAS, LaQshya, SUMAN, and Kayakalp programmes, but MusQan was yet to be implemented.
- Under the NQAS, the state performance was insignificant against the National target 2021-22.

Rajasthan

- SUMAN notified facilities: 400 facilities were SUMAN notified among which 16 facilities have taken up for national certification and 43 facilities for state certification under NQAS.
- SQAC had been formed in the state. However, it was observed that DQACs were not functional. Even though quality circles were in place, minutes of the meeting or clear-cut action points for quality improvement were not recorded.
- Patient Satisfaction Survey & analysis was being done manually only pertaining to LaQshya certification but interviewed patients denied receiving any feedback.
- Facilities were not doing manual surveys for obtaining patient feedback on services provided by health facilities except for the facilities preparing for NQAS.
- Among the visited facilities, records for quality indicators, departmental SOPs, BMW logbooks, and adverse event records were available at NQAS-certified facilities only.
- A quality team and Infection control committee were not in place at the primary & secondary levels of health facilities.

Sikkim

- SUMAN notified facilities: 2 facilities were SUMAN notified among which none has taken up for NQAS certification.
- State & District Quality Assurance Committee has been established, and meetings were held regularly. The team conducted routine facility visits and encourages staff members to conduct internal Kayakalp and NQAS assessments.
- The state was focussing on the Quality Certification of HWC with the Gap analysis, for which the baseline was completed, and the upcoming visits were scheduled for the two facilities that had been designated in each district.
- Mera Aspataal training was needed for the concerned nodal official at the district level and below. No records were maintained at DH Singtam, whereas at DH Namchi, Mera Aspataal was not initiated. Patient satisfaction scores were not being undertaken.
- Patient satisfaction surveys were only reported in DH Namchi out of all healthcare facilities visited during CRM. At DH Singtam, the process was yet to be established and streamlined.

Tamil Nadu

- SUMAN notified facilities: 3573 facilities were SUMAN notified among which 92 facilities have taken up for national certification and 742 facilities for state certification under NQAS.
- The state has a functional State Quality Assurance Committee and District Quality Assurance Committee. Regular meetings were conducted in the state.
- It was observed that there was a lack of awareness regarding the quality programmes at many visited facilities as the quality teams were not formed at many visited facilities.
- All the visited health facilities had displayed Citizen Charters, OPD timings, and Patient entitlement schemes. Signages were displayed in the local language.

- Birth companions were encouraged in almost all the visited facilities.
- All certified facilities were maintaining Outcome Indicators & Key Performance Indicators under NQAS.
- Except for the facilities that were quality certified, a robust Complaint Resolution System was not found in most of the other visited health facilities.
- None of the visited health facilities was performing Prescription Audits and preparing a corrective and preventive action plan, except at DH Kovilpatti, DH Cheyyar, CHC Eral and UPHC 66 Theresapuram.
- SOP for the care was available and implemented in the DH Kovilpatti, DH Cheyyar, SDH Aarni, CHC Eral, and certified UPHCs only. No condemnation policy was found at the visited health facilities and drug warehouse.
- Compliance with the statutory requirements, viz. Authorization for BMW, AERB authorization for radiology set-up, NOC for fire safety, etc., was a common observation across the state.

Telangana

- SUMAN notified facilities: None of the facility were SUMAN notified in the state.
- A periodic review of the programme's progress by SQAU and DQAUs was present. However, Quality Assurance programmes at the urban health facilities have not yet been initiated.
- Most visited facilities had not constituted quality team for the implementation of quality standards because of the manpower sustenance problem.
- All the visited health facilities had displayed Citizen Charter at the entrance except CHC Kodad, SDH Huzurnagar (Suryapet).
- Fire extinguisher (type ABC) was available at most of the visited health facilities. However, some staff was not trained to use it.
- Basic amenities were available at the visited facilities, like separate toilets for men and women, running water, sitting arrangements, etc.
- Absence of a robust Complaint Resolution System was observed in most visited health facilities.
- All the visited health facilities were performing Prescription Audits except CHC Kodad, SDH Huzurnagar (Suryapet), GGH Suryapet
- Reporting and recording of Key Performance Indicators were practiced at all the facilities except CHC Kodad, SDH Huzurnagar (Suryapet) and GGH Suryapet.
- Non-compliance to the statutory requirements, viz. Authorization for BMW, AERB authorization for radiology set-up, etc., was a common observation across the state. External Quality Assurance Programme for Laboratories had not been initiated in any of the visited facilities.

Uttar Pradesh

- SUMAN notified facilities: 586 facilities are SUMAN notified among which 50 facilities have taken up for national certification and 34 facilities for state certification under NQAS.
- SQAC was held last year, and for this year meeting was scheduled in November. DQAC meetings were held irregularly in the districts.
- The state had implemented the NQAS, LaQshya, and Kayakalp programs, yet the Quality Assurance component was weak in both districts. However, MusQan was yet to be implemented.
- Each district had identified 5 HWC-SC for NQAS assessment, including 1 in Maharajganj. None of

the facilities in the Chitrakoot district had achieved state or national-level quality certification.

- The facilities did not conduct death, fire safety, prescriptions, and electricity audits.
- Key performance and outcome indicators were not monitored in the facilities.
- All facilities had a complaint box, but no one was monitoring it except at DH Maharajganj, where corrective measures were taken systematically to address the grievances received. The grievances were also received from the IGRS portal and addressed by the respective facilities.
- Most healthcare facilities were not disabled-friendly, and ramps/railings need to be constructed at appropriate places for easy access.

KAYAKALP INCENTIVE SCHEME

NATIONAL OVERVIEW

Kayakalp, launched in 2015 aims to promote and maintain Sanitation and Hygiene in public health care facilities. Kayakalp is considered the synonym of "Rejuvenation". It is the steppingstone towards assuring Quality and Safe services to all. It has improved the facade of the public health facilities and made significant effort to mould the behaviour in term of hygiene. This paradigm shift is well reflected in the number of "Satisfied" patients as reported through "Mera Aspataal". It is a scheme under which public health facilities which perform outstandingly are Recognised, Incentivised and are Felicitated at State as well as National level for their efforts. "Kayakalp" has been able to improve the Sanitation, Hygiene, Infection Control and biomedical waste management in public health facilities and has lead the path to the development of Healthy and Fit India leading to Prosperity and Progress.

KEY OBSERVATIONS

- Barcode system for Bio-medical waste collection was lacking at the health facilities at all levels except in Chhattisgarh.
- No smoking policy and no use of single-use plastic were found in most of the visited states except Jharkhand.
- In most visited States/UTs, non-adherence to the current protocol outlined by the Central Pollution Control Board/State Pollution Control Board was observed. Such include intermixing of waste, disposal of PPEs into deep burial pits, and lack of awareness pertaining to changes in BMW Rules 2016 in comparison to BMW 1998 Rules. Though in some places, the BMW storage area was available, it was not as per BMW Rule 2016.
- Liquid Waste Management was not in place. However, pre-treatment of Laboratory & highly infectious waste was being done in a few of the visited facilities.

KEY RECOMMENDATIONS

- Kayakalp winner facilities in FY 2021-22 & FY 2022-23 may be targeted for the NQAS certification.
- Training staff on Bio-medical Waste Management rules 2016 (as amended) and linking peripheral health facilities with the Common Bio-medical Waste Treatment and disposal Facility (CBWTF) for timely transport, treatment and disposal of waste need to be established.
- Regular collection and transport of BMW as per laid norms.
- An appropriate record of BMW generated at each department is essential.
- Various awareness activities like the Rally, Poster competition, and the Swacchta campaign can be conducted to promote Cleanliness & Hygiene.
- The states are advised for the judicious use of Kayakalp funds.

STATE FINDINGS:

Andhra Pradesh

- In FY 2021-22, 3,020 health facilities scored more than 70% under Kayakalp out of 4552 facilities. For FY 2022-23, the assessment of 1,823 facilities were in progress.
- Bio-Medical waste was collected on an alternative day by service providers and disposal was done at CBMWTF.
- Pre-treatment of liquid waste was not practiced in most of the facilities.

Bihar

- In FY 2021-22, 132 health facilities scored more than 70% under Kayakalp out of 2976 facilities.

- BMW management was outsourced, colour-coded bins were available, but records were not maintained, and liquid waste was poorly managed.
- Mixing of biomedical waste was observed at every level of the facility.
- Non-Chlorinated bags are found insufficient and not placed as per colour-coded bins.

Chhattisgarh

- In FY 2022-23, the State has targeted 440 health facilities to be incentivised under Kayakalp.
- A total number of 6,679 health facilities has participated in Internal assessment in FY 2022-23.
- Peer assessment was conducted for selected facilities only in Kondagaon District.
- Authorization of BMW was available with most of the healthcare facilities.
- In Kondagaon District, facilities were using deep/sharp pits, whereas, in Surajpur district, CBWTF had been established, and linkages with HCF (except DH) were in process.
- Waste segregation was done at the point of generation but mixed at the point of disposal (in Kondagaon District).
- Surajpur DH had initiated Bar Coding System to track the Biomedical waste generated from the District Hospital.

Goa

- In FY 2021-22, 18 health facilities scored more than 70% under Kayakalp out of 166 facilities.
- The CRM team observed that the state had extended the Kayakalp scheme to the Health & Wellness Centres and the Rural Medical Dispensaries for FY 2022-23.
- The number of participating facilities under Kayakalp has decreased from 106 health facilities in 2021-22 to 80 in 2022-23. Internal assessment for all 80 facilities and peer assessment was expected to be completed by the end of November 2022.
- Although the state was participating in the Kayakalp scheme every year from DH to SHC level, it was observed that all PHCs/SHCs were still not participating and working towards achieving a minimum 70% Kayakalp score on the external assessment.
- All the visited facilities were found to be neat and clean. Almost all the facilities visited had an herbal garden.
- Most of the visited health facilities followed the no smoking policy and no use of single-use plastic as an initiative under the Eco-friendly thematic area of the Kayakalp scheme.
- In most of the visited facilities, working staff did not have clarity about changes in BMW rules 2016 vis-à-vis 1998 rules. However, they were handling the waste properly.
- Though colour-coded bins were available in all the facilities but mixing of waste was observed at some places.
- Open sewage system was observed in most of the visited health facilities.
- Records of waste generation were maintained at all the facilities monthly and reports submitted to State Pollution Control Board annually.

Jharkhand

- In FY 2021-22, 271 health facilities scored more than 70% under Kayakalp out of 2202 facilities.
- The facilities were not linked with CBWTF facilities across the state.

- Among the visited facilities, UPHC Tandaw has been the winner for the last two Financial years. CHC Majihaun was aspiring for peer assessment.
- The lack of knowledge and awareness about the BMWM was a major concern, with staff unaware of the correct collection method, segregation, and disposal.

Kerala

- In FY 2021-22, 254 health facilities scored more than 70% under Kayakalp out of 1,298 facilities.
- Under Kayakalp, all public health facilities except SC- HWC were participating.
- In FY 2022-23, all facilities had completed the Peer Assessment, and 381 Health facilities scored more than 70%. Kayakalp External Assessment was planned for December 2022.
- In Thrissur district, there was a Progressive increase in number of Kayakalp awarded facilities in 2019-20 (8), 2020-21 (10), and 2021-22 (13). All health facilities (PHC and above) completed the peer assessment. The number of public health facilities having a Kayakalp score>70% had increased compared to last FY (Thrissur - 29 to 60).
- Kayakalp funds were judiciously used. Incentives of the last FY Kayakalp award were received in facilities and were also used to ensure further compliance and also organize facility Staff refreshment and exposure visits to best-performing facilities for cross-learning.
- To decrease energy consumption and to make the facilities eco-friendly, LED bulbs were installed in most of the facilities, and the appliances used were energy efficient. Energy audits were conducted in most of the facilities.

Maharashtra

- In FY 2021-22, 927 health facilities scored more than 70% under Kayakalp out of 12,250 facilities.
- The CRM team observed that the state had extended the Kayakalp scheme to the Health & Wellness centres for FY 2021-22.
- Internal assessment for 1,896 facilities has been completed against a number of 12,250 health facilities (as per RHS 19-20 & HWC Portal), and peer assessment has not yet been initiated.
- In FY 2021-22, one District Hospital and One sub-district hospital were awarded under the Eco-friendly initiative.
- All the visited facilities were found to be neat and clean. However, Chipping of plaster and wall dampening was observed in a few areas of the DH Dhule, RH Pimpalner, and PHC Kudashi.
- Most of the visited health facilities followed the no smoking policy and no use of single-use plastic as an initiative under the Eco-friendly thematic area of the Kayakalp scheme.
- In most of the visited facilities, working staff did not have clarity about changes in BMW rules 2016 vis-à-vis 1998 rules, thereby resulting in non-adherence to current protocols as required under the 2016 rules (& subsequent amendments).
- Colour-coded bins were available in all the facilities, but a mixing of waste was observed in a few facilities.
- Closed sewage system was observed in most of the visited health facilities. Most of the staff reported that they were not given any training on Bio-medical waste management. Pre-treatment of laboratory and highly infectious waste was being done; however, liquid waste management (ETP/STP) was not in place.

- Records of waste generation were not maintained at most of the visited health facilities.

Meghalaya

- In FY 2021-22, 36 health facilities scored more than 70% under Kayakalp out of 355 facilities.
- Kayakalp initiative was being implemented, but biomedical waste disposal was not regular, and laboratory waste treatment was not done due to a lack of ETPs.

Madhya Pradesh

- In FY 2021-22, 394 health facilities scored more than 70% under Kayakalp out of 9,381 facilities.
- Internal assessments were found to be completed in all levels of HCFs (DH, CH, CHC & PHCs). Peer assessments in PHCs were completed. Peer assessment in DH, CH, and CHCs was ongoing as of the review date. External Assessments were planned to be held from 25th November to 25th December 2022, and Kayakalp Awards in different categories were scheduled to be declared in January 2023.
- The state had targeted 50 DHs, 170 CH/CHCs, 300 PHCs, and 500 HWC for FY 2022-23.

Punjab

- In FY 2021-22, 334 health facilities scored more than 70% under Kayakalp out of 2,306 facilities.
- Bio-medical Waste Management Rules, 2016 (BMW Rules 2016), were being implemented in all facilities by the Punjab Health Systems Corporation.
- The SHCs & PHCs in remote areas with less waste generation, transport their waste to nearby Block/CHC for disposal.
- Waste disposal was challenging at DH Ferozepur as the CBWTF was 120 km from the district hospital.
- The daily records of waste generated were being maintained by the visited facilities.

Rajasthan

- Non-compliance with BMW management rules was observed at the facility. Liquid waste management was not being done in visited PHCs and SCs (delivery points).
- The waste was not segregated at the point of generation, though they were aware of the BMW rules.
- Although an MOU had been signed with the CBWTF agency, waste was not collected within 48 hours. The pit for the disposal of BMW was unavailable within the premises in the visited facilities. Hence the BMW was being burnt along with general waste at the back side of the premises.

Sikkim

- In FY 2021-22, out of 87 facilities, 49 health facilities scored more than 70% under Kayakalp.
- Common Bio-Medical Waste Treatment Facility (CBWTF) was not available in the State. All the health facilities had been given permission by the Pollution board for deep burial pits. In the rural area, solid waste was collected by the Gram panchayat vehicle, and red and yellow waste was dumped in the deep burial pits.
- In DH Namchi, the incinerator installed was very old and not equipped to perform waste management of the placenta.
- At CHC/PHC level, the yellow waste is disposed of after treatment in deep burial pits. Some attendants of pregnant women take the placenta

back to their native place, which should be discouraged through effective advocacy and IEC.

Tamil Nadu

- In FY 2021-22, 1,767 health facilities scored more than 70% under Kayakalp.
- Although the state participates in the Kayakalp scheme every year from DH to PHC level, it was observed that all PHCs/HWCs had not been participating and working towards achieving the minimum 70% Kayakalp score on the external assessment.
- The state has outsourced the bio-medical waste management, and all visited health facilities were linked with the treatment facility.
- Records of waste generation were maintained at all visited health facilities. Colour-coded bins were available in all the facilities, and the staff was aware of the waste segregation. However, they did not have clarity about changes in BMW rules 2016 vis-à-vis 1998 rules, resulting in the non-adherence to current protocols as required under the 2016 rules (& subsequent amendments).

Telangana

- It was observed that CHC Kodad, SDH Huzurnagar (Suryapet), and GGH Suryapet were working towards achieving a minimum 70% Kayakalp score on the external assessment.
- Most of the visited health facilities followed a no-smoking policy and no use of single-use plastic as an initiative under the Eco-friendly thematic area of the Kayakalp scheme.
- Though colour-coded bins were available in all the facilities but mixing of waste was observed in a few facilities.
- Most of the visited health facilities were linked with treatment facilities (CBMWTF) except CHC Kodad.
- The Bar code system was not utilized in any visited facilities.
- Portable Liquid waste management was adopted in some visited facilities except CHC Kodad, SDH Huzurnagar(Suryapet), and GGH Suryapet.

Uttar Pradesh:

- In FY 2021-22, 1,075 health facilities scored more than 70% under Kayakalp out of 16,482 facilities.
- Adherence to BMWM protocols was limited to a few facilities.
- There was no liquid waste management/ treatment at any facility. Central biomedical storage rooms were available, but their usage was limited.
- Staff training for handling BMW was lacking.
- Adherence to biomedical waste management guidelines was limited, and effluent treatment plants were not in place. Overflowing safety pits were found at the facilities indicating a lack of appropriate waste management systems and disposal facilities.

LEGAL FRAMEWORK, AND ACCOUNTABILITY FRAMEWORK

The legal framework for health supports health systems through significant contribution, which depends on its implementation and translation in the field. In India, a diverse range of laws and regulations have been enacted to safeguard the rights and interests of its citizens in various aspects of healthcare and related fields.

These legislative measures cover a wide range of areas, including the regulation of clinical establishments, protection of women's rights, management of biomedical waste, prevention of gender-based harassment, reproductive rights, healthcare for persons with disabilities, control of tobacco products, and promotion of mental health. By examining these legal frameworks, insights were gained into the efforts made by the Indian government to ensure accountability, protect individual rights, and promote public health in a rapidly evolving society.

Fifteenth CRM highlights the status and functionality of legal framework across states, with findings and observations derived through visits, engagement with relevant stakeholders, available records and reports and community interactions in the field.

In certain states like Andhra Pradesh, Rajasthan, and Kerala established and streamlined legal frameworks and governance structures were found in place. The Clinical Establishment Act (CEA) has been adopted by most of the states while Kerala has its own Clinical Establishment Act. Almost all states have established an institutional mechanism under the PC&PNDT Act. However, there are inconsistencies in the practice of documenting consent in Form C under the MTP Rules in various facilities, and service providers lack clarity on various legal Acts such as the Mental Healthcare Act, 2017 (MHCA), Bio Medical Waste Management Rules, 2016 (BMW Rules), Atomic Energy Act, etc.

The inadequate or poor awareness on various health related legal Acts was observed largely due to absence of organized training programs for service providers to familiarize them with various health-related Acts contributing to this lack of clarity. Nonetheless, service providers at the facility level appear to have a good understanding of crucial provisions like the issuance of disability certificates, birth registrations, confidentiality provisions, prohibition of sex selection, and mandatory signages under COTPA.

KEY OBSERVATIONS

- The Clinical Establishments (Registration and Regulation) Act, 2010: The Clinical Establishments (Registration and Regulation) Act, enacted by the Central Government, mandates the registration and regulation of all clinical establishments in India to ensure they meet minimum standards of facilities and services. The Act has been adopted by 13 out of 17 states. However, there were inconsistencies in implementation across states. All the public health facilities followed the Clinical Establishment Act, 2010 and were compliant with the rules in Andhra Pradesh while in Meghalaya, the Act only applies to nursing homes and in Goa, the District Registering Authority (DRA) has been formed but districts were not sharing registration data with the state. In Sikkim, a district level committee provides temporary certification every 6 months to facilities and data was still maintained manually. Kerala was implementing the Kerala Clinical Establishment Act 2018.

- Pre-Conception and Pre-Natal Diagnostic Techniques (PC&PNDT) Act, 1994: The act bans prenatal sex determination in order to stop female foeticides and prevent the declining sex ratio in India. All genetic counselling centres, genetic laboratories, or genetic clinics conducting pre-natal diagnostics with the potential for sex selection come under the Act's purview. Good IEC display found in most of the districts. Strong enforcement of PC&PNDT Act was visible in all the facilities visited in Andhra Pradesh.

  While institutional mechanisms and awareness under the Act exist in most states, implementation needs strengthening in Maharashtra, Chhattisgarh,

Jharkhand, and Uttar Pradesh, where knowledge and awareness among staff was inadequate. In Chhattisgarh, there was a lack of proper case filing by the Appropriate Authority.

- Medical Termination of Pregnancy (MTP) Act, 2021: MTP Amendment Act, 2021 came into force, with amendments including, all women being allowed to seek safe abortion services on grounds of contraceptive failure, increase in gestation limit to 24 weeks for special categories of women, and opinion of one provider required up to 20 weeks of gestation. The MTP Rules further prescribe that consent needs to be documented on 'Form C'.

- There was a clarity on the provisions of the amended Act observed this year in the states visited as compared to the last year. In Punjab, despite filling of forms by the private and public facilities under MTP Act, number of cases reported were low. Inconsistent practice related to documentation and reporting was observed in few facilities. The knowledge and awareness about safe abortions and MTP Act was found to be inadequate among the staff in Maharashtra. In Goa and Meghalaya, it was found that the community present at the facility was unaware of any abortion facility available nearby their village as well as MTP kits were also not available in the facilities.

- Rights of Persons with Disability Act, 2016: The Act aims to ensure that people with disabilities have the same rights as everyone else. To achieve this, the act requires the issuance of a disability certificate which indicates the type and severity of the person's disability. Of the States visited this year, Meghalaya, Bihar, Sikkim, Kerala, Punjab and Telangana were issuing disability certificates. However, in Chhattisgarh, the beneficiaries were not aware of the procedure to obtain the certificate, and in Uttar Pradesh, technical issues were causing delay in the issuance of certificates.

- The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 (POSH Act) - POSH Act has been enacted with the objective of preventing and protecting women against workplace sexual harassment and to ensure effective redressal of complaints of sexual harassment. The statute aims at providing every woman (irrespective of her age or employment status) a safe, secure, and dignified working environment, free from all forms of harassment. The Act requires an employer to set up an Internal Committee (IC) and The Local Committee (LC) to ensure redressal of grievances of workplace harassment in a time bound manner.

  This time a mixed response was observed with respect to the implementation of POSH Act. Awareness regarding the POSH Act has increased as compared to the previous year. In states like Tamil Nadu, Rajasthan, Punjab, Kerala, Madhya Pradesh, Chhattisgarh, and Bihar implementation of the provisions of the Act i.e., constitution of Internal Complaints Committee, training and written policy were observed. However, in Uttar Pradesh, Telangana, Nagaland, and Jharkhand there was no written policy and staff was also not oriented on POSH Act. Even the Internal Complaint Committee was also not available. In Sikkim and Andhra Pradesh, the Internal Complaint Committee had been constituted but there was no awareness regarding the act.

- Medico-Legal Care Protocols for Survivors of Rape/ sexual violence - Through these, the Ministry not only proposes to provide clear directives to all health facilities to ensure that all survivors of all forms of sexual violence, rape and incest have immediate access to health care services but also recognizes the need to create an enabling environment for survivors/victims where they can speak out about abuse and receive empathetic support. The guidelines require every hospital to have SOPs printed for management of cases of sexual violence, including informed consent.

- During the visits, it was observed in states like Goa and Tamil Nadu 'One Stop Centres' were available and all protocols along with procedures were being followed. But in certain other states like Sikkim, Kerala, Punjab, and Telangana, although centres were available, but health care providers lacked training on the protocols. Whereas Bihar was yet to establish One Stop Centres. In states like- Chhattisgarh, Andhra Pradesh, Nagaland, and Uttar Pradesh there were no SOPs in place and staff was also not trained.

- Cigarettes and Other Tobacco Products Act, 2003 (COTPA 2003) - The Act prohibits smoking of tobacco in public places, advertisement of tobacco products including cigarettes, sale of tobacco products to minors, and provides for penal provisions for violation of the provisions of the Act.

  Signages and awareness on the Act was observed in most facilities of the visited states except Telangana and Bihar which had very few signages with no monthly review meetings and Tobacco selling shops were seen everywhere. Statutory warnings were found to be in place in hospitals and public places and challans were issued to the violators.

- Registration of Births and Deaths Act - Registration of Births and Deaths, which is mandated by the act, is being carried out in the majority of the visited States. Birth and death reporting forms were available at most of the facilities and certificates were issued. Most of the facilities were using online registration system for Birth & Death registration. In Goa Birth Record cum Child Care Card were being maintained which was a good initiative.

- Bio Medical Waste Management Rules, 2016 (BMW Rules) - The rules were being implemented in almost all health facilities of the states visited. In Kerala and Goa, health facilities visited were also linked to the Common Bio Waste Management Medical Waste treatment facility (CBWTF). In Goa QR code-based scanning system was found in place leading to availability of critical data related to BMW. In Sikkim as CBWTF was not present, so all the health facilities have been given permission by the Pollution control board for deep burial pits. In UP, Maharashtra and Meghalaya dustbins, baskets and transportation of Biomedical waste for disposal were being done but segregation and decontamination were compromised. Also, cleaning staff or housekeeping staff was also not properly trained in the cleaning protocols of BMW. In Tamil Nadu all facilities were covered under BMW and the bins/ bags/ hub cutters for segregation of Biomedical Waste was adequate. However, the Health workers were unaware of major changes in the new rules.

- The Human Immuno Deficiency Virus and Acquired Immuno Deficiency Syndrome (Prevention & Control Bill 2017). Only a few states have issued necessary SOPs on safe working environment. The provisions of the Bill are yet to be implemented in most of the states. Chhattisgarh has established the state body for implementation of this act and the Health Commissioner is appointed as the State-level Ombudsman. In Tamil Nadu- complaint officer is identified (generally facility in charge) in every Facility for handling complaints. Protocols and SOPs were shared and displayed in the facilities.

- The Mental Healthcare Act, 2017 (MHCA) - The 2017 Act seeks to provide mental healthcare and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental healthcare and services. These measures include the necessity of setting up mental health establishments across the country to ensure that no person with mental illness will have to travel far for treatment, as well as the creation of a mental health review board which will act as a regulatory body.

  Most of the states have implemented this act. It was observed that State mental health authority and mental health review board required to be constituted under MHCA 2017, was present in

most of the States like Sikkim, Nagaland, Andhra Pradesh, Kerala, Tamil Nadu. In Uttar Pradesh, the District Hospital mostly provides clinical care but does not systematically take up the implementation of various provisions under the act.

- Atomic Energy Act - The Act seeks to provide standards of controlling radioactive substances and measures to be taken to prevent radiation accidents, retain public safety, assure cautious disposal of radioactive wastes.

  The establishments had limited knowledge about the Atomic Energy Act, 1962. In Meghalaya and Sikkim all units were AERB certified but TLD badges were not available. In Bihar, Jharkhand, Nagaland, Telangana, and Uttar Pradesh there was a gap in AERB certification and TLD badges were also not properly used. Whereas certain states like Goa, Chhattisgarh, Andhra Pradesh, Kerala, Punjab, and Tamil Nadu were compliant with all necessary protocols.

KEY RECOMMENDATIONS

- Awareness on legal framework and related acts and procedures may be included in Health promotion related activities at the primary care and community level.
- Adoption of central clinical establishment act or enacting state specific act where the provisions are inadequate, or the act is not implemented well.
- Robust training programme for capacity building of healthcare workers and stakeholders should be organised related to various health related legal acts.
- Regular monitoring and review at the State level is needed for effective implementation of the legal acts. State/District Health Society (SHS/DHS) to monitor the implementation of relevant acts.
- Workplace related sexual harassment SOPs to be displayed, especially penal consequences of violating the rules, as that would act as a deterrent.
- Including Information, Education and Communication (IEC) materials on the Disability Act in community awareness campaigns can help to raise awareness and understanding of the rights and needs of people with disabilities.
- Orientation is needed on safe practices of reproductive health for adolescents. Parent counselling on dealing with early adolescents is recommended.
- Training doctors on medico-legal care protocols is essential for survivors of rape and sexual violence. This training should cover the unique needs and sensitivities of survivors.
- To develop linkages with Police to include COTPA in Crime Review. Reaching out to hotels for implementation of COTPA guidelines is required.
- There is a need for sensitisation of service providers on various provisions of Acts/Bills such as COTPA, POSH, MTP, Human Immuno-Deficiency Virus & AIDS Prevention & Control.
- MTP kits should be made available at facilities to reduce out-of-pocket expenditure for the patients.
- Routine meetings of the committees formed and documentation of the minutes of meetings and action points to be prioritized should be done.
- Orientation about legal compliance among facility in-charge would enable facility to be prepared for the NQAS.
- Mandatory AERB certification of facilities should be done, and Dosimeters/TLD badges should be provided to all the technicians and doctors.
- Robust and effective supply chain mechanism should be in place for timely procurement and supply of drugs and equipment.

- Ensure implementation of BMW guidelines across all levels. Legal and statutory compliance needs to be ensured. BMW training and awareness should be prioritized in the state. Mock drills should be conducted to sensitize the staff.
- Engineering team may make a quick assessment to convert the existing health facilities disabled friendly. Appropriate changes may be made in the lay out designs also.
- Orientation of nodal officers at district and sub district level must be done.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- In both districts, District and Sub-District level Advisory Committees on Pre-Conception & Pre-Natal Diagnostic Techniques (PC&PNDT) were constituted to address issues related to PC&PNDT.
- Private facilities providing ultrasonography were subjected to random inspections to ensure compliance with regulations.
- PC&PNDT IEC posters were displayed at District Hospital and Area Hospital Level in both the districts to spread awareness about PC&PNDT.
- The state-specific PC&PNDT portal was used for data entries related to various aspects of PC&PNDT such as registration, inspection reports, and submission of forms.
- Pregnant women and family members visiting the facilities received awareness and counseling services on gender equality during ANC visits.
- In the district facilities, the Prevention of Sexual Harassment (POSH) Act was implemented through an internal committee, but there was no policy on sexual harassment at the workplace available. The hospital administration did not conduct any awareness or workshop on sexual harassment among staff.
- A separate reporting system was maintained to manage medico-legal cases, with adequate evidence maintained in a register by the officer-in-charge. Counselors posted under TB Programme were utilized for a specific case of alcohol or tobacco addiction and suicide. The facility maintained medical/clinical examination reports and lab test forensic reports of the medico-legal cases. However, none of the staff received any training on Medico-legal care and protocol for rape and sexual violence cases. In the last three months, the reported medico-legal cases in an Area Hospital were 163, 135, and 148 in August, September, and October 2022, respectively.
- All secondary care facilities had an online system for Birth & Death registration. Under the Registration and Birth and Death Act, 1969, Area Hospital and District Hospitals provide birth certificates to all the births delivered at the facility.
- Andhra Pradesh state notified State Mental Health Authority and Mental Health Review Board in 2020 under the Mental Healthcare Act 2017. However, district counselling centres for mental health did not have professional counselors and services were provided by the officer in charge.
- All health facilities having X-ray facility were AERB certified under the Atomic Energy Act, 1962. TLD badges were available in 90 facilities in the state.
- All the observed facilities displayed IEC messages such as "No Smoking Area" signs to spread awareness about the hazards of smoking.
- In terms of Grievance Redressal System; 104 call centres at state level and help desks at facility level were operational. However, they were not linked.
- Citizen Charter was available in all visited facilities.

Bihar

- The Clinical Establishment Act was enacted, and State Council and District Registration Authorities were constituted in both districts.

- Under PC&PNDT Act state supervisory board had been constituted and regular meetings were conducted. The IEC on Act was displayed across the facilities in both districts. No cases were registered under PC&PNDT in either district.
- Respective committees were formed for all legal framework mechanisms at the state and district levels for the MTP Act, Medico legal cases, and BMW rules. However, the Internal Complaint Committee was not constituted under the POSH Act in any facility in the districts. Meetings were held for some of the committees at the district level.
- The Bio Medical Waste Management Rules, 2016, were implemented in the facilities, and the biomedical waste was being collected by an outsourcing agency.
- Disability certificates were issued as per the Rights of Persons with Disability Act in camp-based mode at DH, and camps were conducted with interdepartmental collaboration.
- Few 'No smoking areas' and signages were observed across all facilities under the COTPA Act. However monthly review meetings were not observed at any facility and tobacco selling shops were seen everywhere.
- Birth & death registers were available across the facilities to record and register births and deaths.
- The State had not yet established "One Stop centre", in the visited districts for the Medico-Legal Care for Rape and Sexual Violence Cases.
- Some radiology units did not had AERB certification under the Atomic Energy Act, 1962. TLD batches were not available in the visited facilities. Even if some of the facilities were AERB certified, the infrastructure was not fit for these services.
- Jan Arogya Samitis (JAS) were constituted at AB-HWCs (APHCs) but were yet to be constituted at UPHCs.
- Although RKS minutes were found in APHC, meetings were not held regularly, and monitoring was not carried out effectively.
- Grievance redressal mechanisms were not established in any of the health facilities.

Chhattisgarh

- The Clinical Establishment Act, 2010 had been implemented in the State and registration certificates were issued to clinical establishments.
- The mapping of blocks with low child sex ratio was not completed and no decoy operations were conducted. During interactions with beneficiaries, it was found that they had the opinion that identification of the sex of the fetus is wrong and were aware of the IEC campaign on PC&PNDT Act.
- At the state level, 14 cases were registered, out of which 8 were disposed off and 6 were under trial. The low conviction rate was attributed to the inappropriate filling of cases by the Appropriate Authority.
- The implementation of COTPA was limited to health facilities and was not implemented in hotels. Currently, challans were issued only on hospital premises.
- Health facilities were issuing disability certificates, but during interactions with beneficiaries, it was found that they were not aware of the procedure to obtain a disability certificate.
- The POSH committee known as "VISHAKHA" was established in the state and district offices.
- The state did not conduct any training on the Medico-legal care protocol for rape and sexual violence cases. One to two POCSO cases per month were being registered in Surajpur District.
- A CBWTF (Common Bio-medical Waste Treatment and Disposal Facility) was established at Ambikapur, which was 45 Km away, and linked with DH and

one CHC. Linking of the rest of the facilities was in process. The establishment of CBWTF was also under process in Kondagaon District.

- The state had established a dedicated body to oversee the implementation of The Human Immuno-Deficiency Virus and Acquired Immuno-Deficiency Syndrome (Prevention & Control) Act 2017 and entrusted the responsibility of the State-level Ombudsman to the Health Commissioner.
- State Mental Health Authority had been constituted for the implementation of the Mental Healthcare Act and drafted mental health care provisions for the State.
- Health facilities providing radiology services were AERB certified.
- Several institutional bodies, including SHS, SHM, DHS, DHM, JDS/RKS, MAA, JAS, MAS, and VHSNC, have been established to ensure accountability.
- A decentralized planning system has been put in place to promote accountability.
- A robust grievance redressal system for both beneficiaries and staff has been established to address any issues that may arise.

Delhi

- The State has not yet implemented the Clinical Establishment Act (CEA) which is crucial for quality control. State has a large number of private hospitals, health facilities, laboratories and private clinics which were being accessed daily by a large numbers of residents, hence implementation of CEA as legal framework needs to be in place on priority basis to ensure that patient rights are protected.
- Regular District Action Committee (DAC) meetings were held in South Delhi for the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, and minutes of the meetings were recorded. From April 2021 to November 2022, 104 inspections were carried out, and one decoy operation was conducted in 2022. A total of 27 USG machines were sealed at 19 centres, and FIRs were lodged against 4 centres.
- In South Delhi hospitals, appropriate "No Smoking/No Tobacco" signages were displayed in English and local language.
- RKS were established in 26 hospitals and 16 maternity homes in the state, providing a framework for accountability and effective management.
- The State has a Grievance Redressal Mechanism in place, which successfully resolved all 88 grievances received in the last financial year. This indicates a strong commitment for addressing public concerns and promoting transparency in governance.

Goa

- The Goa Clinical Establishment Act has been notified and effective from 2021. A state council under the CEA was formed in April 2022. A District Registering Authority (DRA) was formed, but districts were not sharing registration data with the State. Meeting minutes of DRA were not available with the State, nor was district-wise data of CEs registered, which leads to the unavailability of the State Register.
- The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 was being implemented, and IEC on prohibiting sex determination tests were displayed in health facilities.
- The MTP Act has been implemented at District Hospital. In the last 6 months, 43 abortions were carried out, and MTP forms were available and maintained well for records of abortions conducted at the facility. However, MTP drug kits were not available since inception, and patients were required to purchase them from outside. The community present at the facility was unaware of any abortion facility available nearby their village.

- One Stop Centre (OSC) had been established in collaboration between District Hospital and an NGO (SAKHI) in Margao to provide medico- legal care to rape and sexual violence cases.
- High level of awareness in the community for timely registration of Births and Deaths was observed. Gender-wise categorization of births and deaths was not found in the monthly summary sheet in health facilities. However, maintaining the Birth Record cum Child Care Card was observed as a good initiative.
- The Bio Medical Waste Management Rules, 2016 are being followed properly, with a disposal system available that includes segregation of waste at all levels of the health system. An outsourced agency was on-boarded for timely bio medical waste management and QR code-based scanning system was in place, which makes critical data related to BMW available.
- The Mental Health Act 2017 is being implemented, with the State Mental Health Authority (SMHA) and review board notified, and the District Coordination Committee functional. The Institute of Psychiatry and Human Behaviour, Bambolim, Goa, is functioning as the apex organization for promoting mental health.
- The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply And Distribution) Act, 2003, was being followed, with a District Tobacco Control/Cessation center established. School teachers were trained on ToFEI, guidelines. IEC displays were found in the health facilities and fines through challans were collected in 2020 and 2021 against violations of the Act by the enforcement squads.
- Atomic Energy Act, 1962 - The radiology units were found to be AERB certified at all the levels of health facilities, TLD badges were available at DHs & SDHs.

Jharkhand

- Legal and statutory requirements were not met at many of the visited facilities. The blood bank license was expired even for the DH Sadar Hospital, Garhwa.
- The facilities were unable to show any other license or certifications like Fire NOC, BMW authorization certificate, and Licence under PCPNDT Act.
- CAC services along with the relevant documentation and counseling services were available at DH level but IEC was found lacking on PCPNDT Act in both districts.
- Internal Complaints Committee under Sexual Harassment of Women at Workplace (Preventive, Prohibition and redressal) Act, 2013 (POSH Act) were not constituted at either district.
- IEC and awareness were being created under the COTPA Act. Nodal Officer was appointed and details were displayed. Collection of fines for smoking and using tobacco in the hospital premises was duly followed with receipts in place.
- The institutional structures of convergence like DHS, HMC, and VHSNC were established with varying degrees of effectiveness. While the Hospital Management Committee met regularly in Garhwa, it rarely convened in Deoghar.
- MAS meetings were held on a regular basis and the records were well-maintained. There was a strong presence of PLA, and good coordination between the health and ICDS department.
- X-ray and CT scan units of the PP Mode centre at the DH were AERB certified and the certificates were displayed.
- The Rogi Kalyan Samiti was established at the district level, but the members last convened in June 2020.

Kerala

- In Kerala, instead of the Clinical Establishment Act, 2010, the state has implemented the Kerala Clinical Establishment Act 2018. A senior officer has been appointed to monitor the implementation of the state act, with regular visits and cross-checking of documents.
- The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (PCPNDT Act) was being implemented in the state, with over 3200 registered institutions. Regular meetings of the State Supervisory board and State Advisory committees were held on a half-yearly and quarterly basis, respectively, with the Health Minister and Health Secretary chairing the meetings.
- Various awareness activities were conducted in both districts, such as displaying Gudda-Guddi boards in health institutions to raise awareness.
- While PHC and higher facilities were deemed to be registered and provide services under the Medical Termination of Pregnancy Act (MTP Act), doctors required training to provide these services. The MTP forms were not being filled.
- The Rights of Persons with Disability Act, 2016 had been implemented in the state, with a committee being constituted and services for persons with disabilities being displayed at the Disability board in GH/TH in the districts.
- The Sexual Harassment of Women at Workplace (Prevention, Prohibition & Redressal) Act, 2013 (POSH Act) had been implemented, with Internal Complaint Committee in place. Members of the committee at facilities were trained in POSH Act, and a written policy on sexual harassment was available.
- The state government had implemented an initiative supported by NHM named "Bhoomika", providing medical and psychological care for victims of gender-based violence/social abuses.
- The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 (COTPA) was being implemented across the state. Regular meetings at the district level were conducted under the DDC, with representatives from police, health, and excise departments. No tobacco shops were found near schools.
- Bio Medical Waste Management Rules 2016 (BMW 2016) were reported to be followed at all facilities and copies of the same were also available with many facilities. Health facilities visited had BMW authorization and were linked to the Common Bio Waste Management Medical Waste Treatment Facility (CBWTF). It was informed that the CBWTF agency visits the facilities daily at DH and SDH, twice in a week (>48 Hours) in CHC and PHC level. It was observed that BMW was often kept more than 48 hours below SDH level. It was noticed that there was only one weekly visit in PHC Vettilapara (Trissur) by CBWTF.
- The Human Immuno Deficiency Virus and Acquired Immuno Deficiency Syndrome (Prevention & Control Act.), 2017, The Mental Healthcare Act, 2017 (MHCA), Atomic Energy Act, 1962, Registration of Births and Deaths Act, 1969 [RBD ACT] have been implemented in the State.
- As a compliance with regulatory and statutory requirements, AERB certificates were available.
- The effective coordination between the directorate and rural/urban local bodies has enabled regular VHSNCs to be held. This coordination has also been observed in hospital management activities.
- The involvement of PRIs/LSGs was evident in the HMC minutes. The LSG actively monitors health facilities and supports their development, including infrastructure, provision of referral transport, special schemes and services for tribal populations, emergency procurement of drugs, and engagement of health HR.

- The Urban LSG in Wayanad district had implemented special geriatric services through mobile clinics.
- Complaint boxes were available at the facilities to address grievances, and complaint registers were also found. However, in some facilities, the Grievance Redressal Committee was formed, but the action taken report was not available, and grievances were kept pending for months.

Madhya Pradesh

- The State has implemented the Clinical Establishment Act, and a revised version of the Act was put in place in 2022.
- A district level committee had been established to enforce the Pre-Conception and Pre-Natal Diagnostic Techniques (PC&PNDT) Act, and regular meetings and inspections were being conducted under the Act.
- The Medical Termination of Pregnancy Act and a Committee for redressal of sexual harassment of women at the workplace were also in place.
- The Cigarettes and Other Tobacco Products Act (COTPA) of 2003 was being enforced in the visited districts, with "No smoking" signage observed at District Hospitals, CHCs and PHCs. A district-level enforcement squad had been constituted.
- VHSNC & MAS were formed but funds were not utilized properly.
- Decentralized planning was not happening since last 4-5 years.
- No supportive supervision plans available at district level.

Maharashtra

- The implementation of the PC&PNDT Act in the state needs to be strengthened due to inadequate knowledge and awareness about safe abortions and the MTP Act among staff.
- Priority should be given to training specialist doctors, medical and paramedical staff on the PC&PNDT and MTP Acts and protocols. Streamlining reviews at all levels of public health facilities is crucial to achieving this.
- Irregular and unsegregated collection and storage of biomedical waste were reported. Most facilities were not visited by the vehicle for collecting biomedical waste for over 15 days.
- No records were found at the facilities visited regarding training on BMW management, infection control procedures, and fire safety protocols
- Proper records of birth and death must be maintained and reasons for deaths should be regularly analyzed.
- The MLC protocol was followed at the facilities visited.
- Although no smoking areas were demarcated, compliance was continuously monitored.
- The RKS meetings were being held regularly and the district-level funds were being utilized according to the minutes of the RKS meetings.

Meghalaya

- State has Meghalaya Nursing Home (Licensing and Registration) Rules, 2010 for the purpose of registration of private clinical establishments in place, however, the scope of these rules is limited to registration of nursing homes only and do not cater to other clinical establishments. Moreover, implementation of these rules was also poor as at the district level no register of facilities registered under the rules were found.
- The Rights of Persons with Disabilities Act 2016 is being effectively implemented in healthcare facilities throughout the state, with provisions for ramps, wheelchairs, and walkers to create a disabled-friendly environment. Furthermore,

disability certificates were being issued to persons with disabilities at the district level to ensure access to necessary resources and services.

- Implementation of birth and death registration: Birth & Death certificates were being issued by the facilities (CHC, DH) in both the districts. Birth and death reporting forms were available at the facilities.
- PC&PNDT Act was being implemented in the state. IEC on the prohibition of child sex determination was available in the health facilities. All health facilities (70) providing ultrasonography services were registered under PC&PNDT Act & no case had been registered in last 1 year. Last meeting of the State supervisory board was conducted in April 2021.
- The COTPA act was being implemented in the state and 1,582 challans had been done in last 6 months preceding the visit. Tobacco-Free Educational Institute (TOFEI) guidelines were being implemented in the state in all districts, 85% of schools in the state were implementing TOFEI guidelines.
- X-ray units were AERB certified in both districts. However certificate for the X-ray unit at Bhoirymbong CHC had expired and X-ray units did not have TLD (Transluminescence dosimeters) badges to monitor radiation exposure to healthcare workers.
- Colour-coded dustbins were available, Waste segregation at point of generation was being done but disposal was not done as per BMW rules at all the facilities visited. Hospital general waste and biomedical waste was found lying in the open area in hospital premises.
- Internal Complaints Committees were in place at state directorate office as well as in health facilities in Ri Bhoi and South West Khasi Hills district. However, no complaint had been registered in last 1 year.
- State Mental Health Authority has been notified in the state. District Mental Health counselling centre with a helpline number was functional in both visited districts.
- Rogi Kalyan Samitis were functional at District & Block level
- Jan Arogya Samitis have been constituted at operational Health & Wellness centres in the state. District-level trainers have been trained. However, JAS members were yet to be trained.
- Village Health Councils (VHCs) were being constituted in the state both in rural and urban (Local health councils) localities as nodal community institution to mobilize action on health and nutrition and serve as a link between the health system and the community.

Nagaland

- Although the SHS and DHS were functioning well for achieving the goals of NHM, the State Health Mission and District Health Mission lacked clear guidance and direction.
- While a district plan document was available, its implementation as a tool was found to be limited. Grievance redressal nodal officers were designated at the state/district and health facility level, and a supportive supervision plan was in place, but planned visits and action planning were not yet in place
- Information about DLVMC and the POSH committee was not available at the district level, and awareness about these committees was limited. Even in the district hospital, the POSH committee was yet not formed.
- The state had adopted the central legislation for regulating Clinical Establishments and hospital registrations were ongoing.
- Mapping of institutions with USG facilities as part of PC&PNDT was observed in Mokokchung.

Doctors were aware of the 2021 amendments to the MTP Act, but safe abortion services were available only at the district hospital.

- The disability certificates were being issued only at DH level.
- Implementation of COTPA was essential as tobacco use was rampant in Nagaland. Statutory warnings were found to be in place in hospitals and public places, and violators were issued challans.
- Birth certificates were issued for institutional deliveries before discharge, and necessary coordination was made for issuing certificates for home deliveries.
- AERB license and TLD badges were found in only at few health facilities.
- Medico-legal protocol and SOPs regarding care and services for survivors of sexual offense was largely not in place.
- The state had notified the Mental Health Authority and Review Board under the Mental Health Act, and rules (2022) had been notified with requisite formats for nominated representatives, advance directives, etc. Eleven out of twelve districts had constituted DMHA.

Punjab

- Compliance with the PCPNDT Act, MTP Act, Mental Health Act, COTPA Act, Right to Person with Disability Act, Registration of the Birth and Death (RBD) Act, and BMW Rules was observed in the state.
- Although the Clinical Establishment Act was not implemented in the state, private clinics and hospitals shared data related to treatment under blindness control program and NTEP.
- The PC&PNDT Act was implemented in the state, and the community was aware of sex determination, with 'F-form' being filled at the facilities. However, the sex ratio was still low, indicating possible underreporting.
- The Medical Termination of Pregnancy Act (MTP Act) was being implemented, and forms were being filled by both private and public facilities. MTP up to 12 weeks were being conducted at DH and SDH, but the number of reported cases was low.
- Regarding COTPA, there was a defined monitoring mechanism, with a district tobacco cell available, signages displayed in the facilities, and no individuals found smoking in public places during the visit. IEC material, such as "No Smoking" signs, were displayed in all visited facilities.
- Under Medico-legal protocols, a One-Stop Center was available in DH, and the blood bank had a license. The X-ray units visited were certified under the AERB Act.
- Under the Sexual Harassment at Workplace Act, Internal Complaints Committees were available, but no registers and complaints were registered for many years.
- Under the Right to Person with Disability Act, camps were being organized by the district in collaboration with Red Cross society. The community was aware of the process, and disability certificates were issued at District level.
- Birth and death registration facilities were available and ASHAs were supporting the community in registering vital events. Online registration for births and deaths was available in all secondary care facilities. Community awareness of birth and death registration was high.
- Bio-medical Waste Management Rules, 2016 (BMW Rules 2016) being implemented in all facilities by the Punjab Health Systems Corporation. The SHCs & PHCs in remote areas generating less waste transport their waste to nearby Block/CHC for disposal.

- It was observed that for District Hospital Ferozepur, CBWTF connectivity was within the range 120 km. Adherence to rules as per the guidelines (within 75 kms) needs to be ensured. The daily records of waste generated were being maintained by the visited facilities.
- SHM/SHS and DHM/DHS were established, but irregularity was observed in holding meetings. All facilities had Rogi Kalyan Samiti (RKS), but the frequency of meetings was inconsistent. For instance, in SDH Ferozepur, no meetings were held in the past two years. The committees in almost all facilities did not receive untied funds from the state.
- Despite the lack of untied funds, VHSNC, MAS, and JAS were functional with active bank accounts and regular monthly meetings were being conducted. However, health promotion activities under these platforms were limited.
- MAS and VHSNC members received training to implement community-based activities.
- Convergence with other departments was limited to organizing 'Mamta Diwas' or VHND.
- Grievance redressal mechanisms were lacking at the CHC and DH level. Although complaint boxes were installed near the registration counter, no register or records were found during the visit. At the state level, a 104-call centre has been established for registering complaints, which was utilized as a health helpline.

Rajasthan

- Legal framework and accountability of Clinical Establishment Act, 2010, PC&PNDT Act, MTP Act, POSH Act, COTPA, Registration of Birth & Death (RBD) Act, MHCA & Atomic Energy Act were implemented.
- The BMW Management at secondary level facilities was very poor. Healthcare staff was not segregating waste at the point of generation, though they were aware about the same.
- Although an MOU had been signed with the CBWTF agency, waste collection within 48 hours was not taking place. In the visited facilities, the pit for disposal of BMW was not available within the premises, hence the BMW was being burnt along with general waste at the back side of the premises.

Sikkim

- Clinical establishment act had been enacted in the state. State Council and District Registration Authorities were constituted, and CEA was re-notified on 13 Oct 2022. An online system for registration of Clinical establishments was being developed by the state.
- Under the act the district level committee provides a temporary certification for 6 months for the functioning of any facility and according to satisfactory performance, permanent licenses were issued. Data was still maintained manually, and no digitization has been started yet. State was yet to develop a mechanism for online reporting.
- The PC&PNDT Act was being implemented in the State. The state supervisory board had been constituted and regular meetings were recorded. State had 35 USG clinics registered under the act and there had been no case of violation or conviction reported in the last year.
- Committees had been established at both state and district levels to oversee the legal framework mechanisms of the MTP Act, POSH Act, Medico-legal cases, and BMW rules. Some of the committees have already held meetings at the district level.
- The MTP Act was first notified in the state in 2010 and then re-notified in 2014 and again on 1 August 2019, with the state-level committee comprising eight members and the district-level

committee comprising seven members. In addition, a permanent Medical Board with seven members, headed by STNM Hospital in Gangtok, had been established to examine MTP cases referred by the courts.

- An Internal Complaints Committee was constituted by written order dated 6 April 2016 to enforce the POSH Act 2013. However, no written policy or list of committee members was displayed at DH Namchi, and there was a lack of awareness regarding the Act at DH/CHC/PHC levels.
- The emergency ward at DH level had a separate designated room to ensure confidentiality of the victims during examination and treatment. MOs had received training on the Medico-Legal Care Protocol for Rape and Sexual Cases at the State level to ensure proper handling of cases.
- Disability certificates were being issued at the DH after validation by medical experts. The certificates were issued by the CMO office and necessary facilities for the disabled person were provided by the Social Welfare Department.
- The COTPA act was notified in the state in 2008 with amendments in the enforcement section as per the state rules. Routine raid activities were being undertaken, challans for violations were done by the district level team, but tobacco selling shops were seen everywhere. The state was currently a no smoking state, and public smoking was not allowed. However, very minimal IEC was available at the CHC/PHC and HWC level.
- Birth and death registration registers were available at all healthcare facilities, and were responsible for issuing birth and death certificates upon completion of the respective forms. Computer systems had been provided for real-time updation of the registers. However, if a birth or death is reported after 21 days, permission needed to be obtained from the SDM, and a fee of Rs. 50 was to be paid.
- The Mental health act was implemented in the State from 2 January 2018 along with the Central Mental Health Authority rules 2018. The State Mental Health rules 2020 were notified in 2020 and the State Mental Health Authority had been established. District Counselling Centre (DCC) was established at DH and the State had its own 24x7 crisis helpline centre with a helpline number (18003453225/202111) for counselling. Tele MANAS was still not rolled out, and as a first step Tele MANAS cell had been identified in the state.
- CT scan and Digital X Ray units at DH Namchi were AERB certified but PHC Temi and Ravlanga did not had visible certifications. However, TLD badges were not observed with any X-Ray technician in any of the facilities.
- Under the Bio-Medical Waste Management Rules 2016, a Common Bio-Medical Waste Treatment Facility (CBWTF) was not present in the State. Instead, all health facilities had been granted permission by the Pollution Board for deep burial pits. In rural areas, solid waste was being collected by the Gram Panchayat vehicle and biomedical waste was disposed in the deep burial pits. At DH Namchi, the installed incinerator was outdated and not equipped to manage placenta waste. Additionally, some attendants of pregnant women take the placenta back to their native place, which needs to be discouraged through effective advocacy and IEC.
- The state/District Health Mission and State and District Health Society had been established, with regular meetings being held. Micro plans were available for conducting VHSNCs and VHNDs, and were being conducted as per schedule. However, ASHAs reported that the untied funds received by the VHSNC committee have decreased over the last few years, with only Rs. 2,600-3,000 being received as mentioned during interactions.
- The MAS was operational, with regular meetings taking place. While the RKS functionality was

available at CHC and DH levels, meetings were not held regularly.

- Although supportive supervision plan had been found to be available at the state level, field-level experiences indicated need for a stronger plan at the state, district, and sub-district levels.
- Citizen Charters were available in all the facilities visited, providing information on services available, OPD timings, and the nearest referral centre.
- The state had managed the procurement and supply of drugs and consumables through the government agency named the "Central Health Store Organization (CHSO)." The agency procures drugs for both state-supplied and NHM drugs, with the contract year for state procurement being three years. The NHM fund was primarily used for procurement from DH to SC levels, with the agency itself procuring from registered vendors under the GeM portal.

Tamil Nadu

- In the Thoothukudi District, the Clinical Establishment Act (CEA), 2010 was being implemented with 740 registered facilities, which were categorized under various establishment categories. An online portal had been set up for CEA implementation, and bi-monthly committee meetings were being held.
- The Pre-Conception and Pre-Natal Diagnostic Techniques (PC&PNDT) Act, 1994 was being implemented with 167 registered sonography centres , and no cases of violation had been reported during the current year.
- The MTP Act was being implemented with the Head of OBGY serving as the head of the District Committee. The facilities had the necessary formats, drugs, and equipment for providing MTP services. VHNs accompany patients to nearby facilities when needed.
- The Rights of Persons with Disabilities Act, 2016 was being implemented, with a separate washroom available for differently-abled patients in the PHC Mappillaiurani.
- The Sexual Harassment of Women at Workplace (Prevention, Prohibition & Redressal) Act 2013 (POSH Act) had been implemented in the Thoothukudi District, with an all-female Internal Complaints Committee, including an NGO representative. Although a written policy had been circulated, IEC was not displayed in the facility. Two workshops were held, and one complaint was received under the Act during the financial year.
- The Medical-Legal Care Protocol for Rape and Sexual Violence Cases had been implemented in the State/district, with a One-Stop Centre established under the Act in DH and MC. 72 cases were reported during the year, which were attended with all protocols and procedures being followed.
- The Cigarettes and Other Tobacco Products Act (COTPA) was being implemented in the state, with signages regarding no-smoking areas observed in almost all health facilities. However, the school opposite the PHC in Thoothukudi did not have such signages.
- The Registration of Births and Deaths Act, 1969 was being implemented, with PICME being linked with the CRS Portal for efficient birth and maternal death registration. For community deaths, the Village Administrative Officer was informed. It was found that the staff had been trained in filling registers and using portals, with IEC being done via VHNs.
- The Biomedical Waste Management (BMW) Rules, 2016 were being implemented, with all facilities covered under BMW. Bins, bags, and hub cutters are being used for segregation of biomedical waste, although health workers were unaware of the major changes in the new rules. Staff had been

vaccinated and provided with PPE, and annual health check-ups were completed for all staff.

- The HIV Prevention and Control Act, 2017 was being implemented, with a complaint officer identified in every facility for handling complaints. Protocols and SOPs were shared and displayed in the facility.
- The Mental Healthcare Act, 2017 was being implemented, with District Counseling Centres established in both districts. Psychiatrists, clinical psychologists, social workers, and DMHP teams were providing dedicated services. The TeleMANAS helpline was expanding the availability of mental health services for patients.
- The Atomic Energy Act, 1962 was being implemented, with all new facilities certified with AERB and all technicians having TLD Badges.
- The District Magistrates were well aware of the health issues of the districts and were taking initiatives to act on the social determinants of health. In Tiruvannamalai, the DM had established a 'Model PHC' with a massive, lush park, a walking path and even a big enclosure for wellness activities. The Thoothukudi DM had initiated a drive in the villages where officials visited door-to-door to understand the requirements of each household, be it Ration card, or health needs or agricultural schemes. Appropriate inter sectoral action was then initiated to provide the community with the benefits of various schemes as per their requirements.
- Grievance Redressal Mechanism was implemented via the Suggestion Box, 104 CM Helpline, and CM Cell (Portal). In Thoothukudi District, citizens could register their complaints directly with the DM via WhatsApp.
- All facilities had well-displayed citizen charter in the local language along with the display of available amenities, timings of the facility, and service provider's contact details for an emergency.

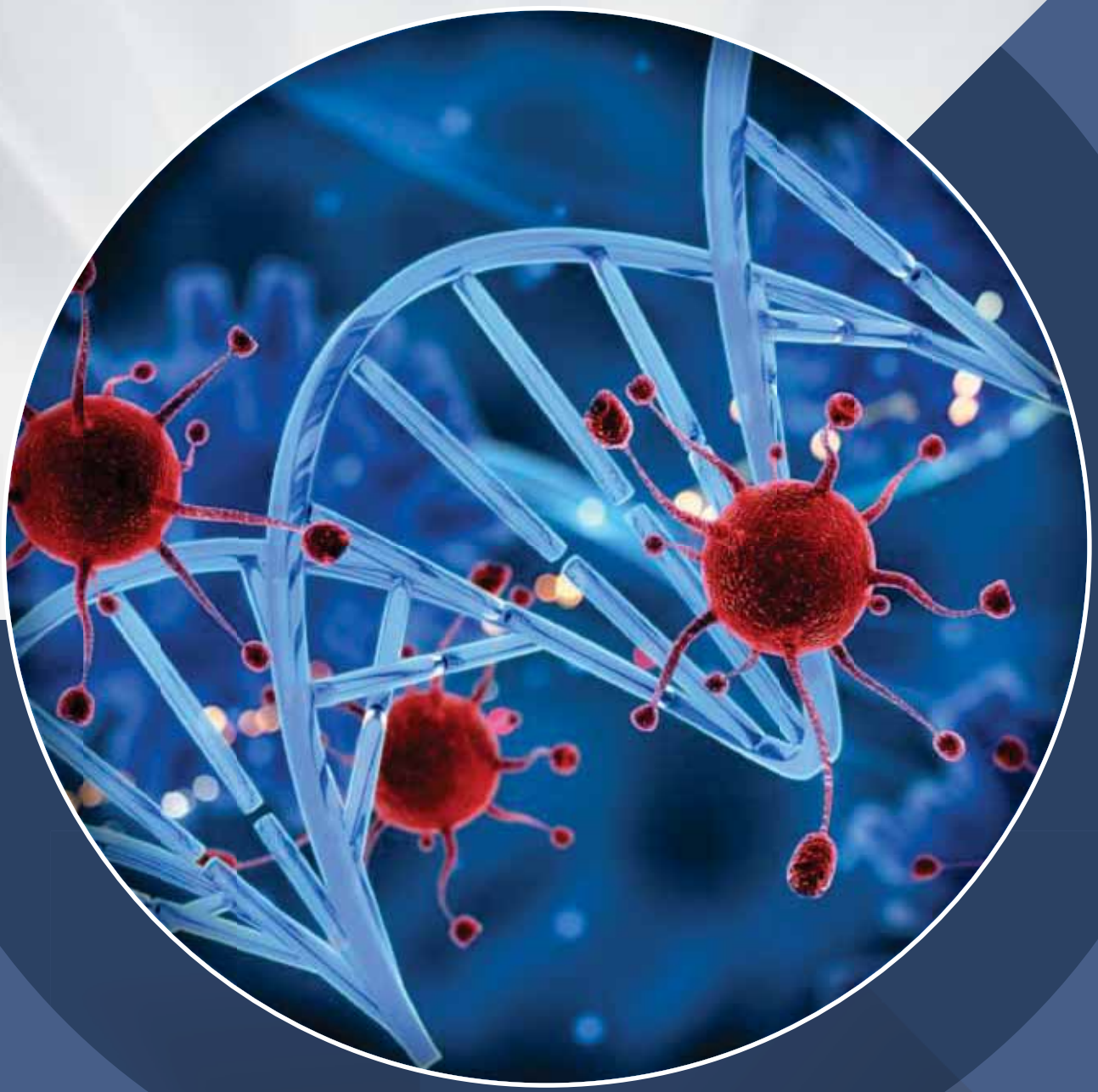
Telangana

- The Clinical Establishment Act had been enacted, and State Council and District Registration Authorities were constituted in both districts.
- PC&PNDT Act was implemented in the state and IEC was displayed across facilities in both districts. Supervisory board had been constituted, and regular meetings were being held. An action plan for visiting private facilities was available in the district of Suryapet, but not in Asifabad.
- Respective committees were formed for all legal framework mechanisms at state and district levels. Meetings were also held for some of the committees at the district level.
- The Internal Complaint Committee under POSH Act had not been constituted yet in any of the districts visited.
- Biomedical waste from the facilities was being collected by an outsourcing agency for disposal.
- Disability certificates were issued through camp-based modes at DH after being validated by respective medical experts and certificates were issued. Camps were being conducted with interdepartmental collaboration.
- Very few 'No smoking area' signages were observed across all the facilities. Monthly review meetings were not observed at any facility. Tobacco selling shops were seen everywhere.
- Birth & Death registers available across facilities for registration of births and deaths.
- A standalone one stop centre was available as "Bharosa centre" in Suryapet district for Medico-Legal Care of Rape and Sexual Violence Cases.
- The Radiology Unit at DH, Asifabad did not have AERB certification for one X-Ray. TLD badges were not found in the visited facility.

Uttar Pradesh

- Although the State had adopted the CEA Act under clause (1) of article 252 of the Constitution, its implementation was not being followed in the state or the districts.
- Despite 6,966 clinics being registered under the PC&PNDT Act, state-level meetings were not regularly held.
- While the monthly crime review meeting included COTPA, awareness was only through IEC posters, and there were no capacity building activities being undertaken for service providers
- Although district hospitals were issuing certificates under the Disability Act, the transparent procedures for application and the time-bound issue of certificates were not available in the public domain.
- The POSH Act was not being implemented properly, as there was no training or written policy available in the facilities visited, and the internal complaint committee was not formed. There was a lack of designated room, written SOPs, or capacity building of service providers for medico-legal care for Rape and Sexual Violence cases.
- Although certificates were being issued under the Registration of Births and Deaths Act, information on the process for issuing certification was not available.
- Although bins, baskets were available and transportation for disposal of BMW was being done but segregation and decontamination were compromised. Cleaning staff and housekeeping staff were not trained in cleaning protocols of BMW, and district Cleaning staff at Chitrakoot were only receiving a monthly remuneration of Rs. 6,500, and PPE for concerned cleaning staff was not available.
- Radiological services were being provided by AERB-certified and non-certified health facilities. TLD badges were not being used wherever available and were often expired.
- Although DH was mostly providing clinical care under the Mental Health Act, it did not systematically take up the implementation of various provisions under the act.
- Although a licensed blood bank was in place, the total number of blood bags stored was only 5, despite having a capacity of 80-90 bags. In Maharajganj, the blood bank's license was expired since 2016, and despite several attempts, the approval had not yet been received.
- In district Chitrakoot, the MAS members were active and working together with ASHA.
- DHAP was not available, neither any prospective plan for the layout designs, expansions etc. was available.
- District ROPs were being received but districts were not actively involved in their need assessment.
- Grievance Redressal: No proper systematic mechanism for grievance redressal was available.

COVID19-
PREPAREDNESS, RESPONSE AND CHALLENGES WITH REFERENCE TO ECRP-II



NATIONAL OVERVIEW

COVID-19 posed a multitude of challenges to the health systems globally. The Indian health system too faced multiple challenges concerning, but not limited to, governance, infrastructure, and human resources. Despite the challenges India's health system constructively responded to the COVID-19 pandemic through data and evidence based scientific planning, strategic infusion of funds, and successful implementation of initiatives to mitigate the catastrophic impact of pandemic on communities.

Government of India had been swift in taking actions to contain COVID-19 and bolstering the preparedness of the health system. To respond to all aspects of COVID-19 management provision of additional financial support to the States/UTs in the form of "India COVID-19 Emergency Response and Health System Preparedness Package" Phase I and II was made.

The ECRP-I, a 100% Centrally Sponsored Scheme, provided support for preparedness and prevention related functions that would address not only the COVID-19 pandemic but also any such emergencies in future.

The ECRP-II is being implemented with an aim to strengthen the district and sub district capacity for an effective and rapid response to the pandemic. It has Central Sector (CS) as well as Centrally Sponsored Scheme (CSS) components. The CSS components flow through the National Health Mission to leverage the existing implementation framework for executing the proposed activities and to avoid any duplication. Only the CSS components being implemented in the States were assessed as per the ToR by the CRM teams.

Under ECRP II, states/UTs are being supported in ramping up health infrastructure including establishing paediatric care units in all the districts of the country under the technical guidance and mentorship of State level Paediatric Centre of Excellence, augmenting additional beds at the facilities including those in rural, tribal and peri-urban areas closer to the community, augmenting ICU beds capacity of the country.

Furthermore, the Government of India pushed for increased vaccination to achieve the goal of full vaccination of the eligible beneficiaries. The 'Har Ghar Dastak' vaccination campaign aimed at awareness, mobilization and vaccination of all eligible beneficiaries with 1st dose and all due beneficiaries with 2nd dose of COVID-19 vaccines through house-to-house visits in all States/UTs. This resulted in an appreciable jump in COVID-19 vaccination coverage during the campaign.

KEY OBSERVATIONS

- The states visited are at various stages of implementation of activities supported under ECRP II. However, the expenditure reported by many States was much below the desired levels.
- Pediatric care units have been established in most of the district hospitals and are functional. However, establishment of Pediatric Centres of Excellence in most of the states visited were at nascent stages.
- Paediatric centres of excellence were constructed in some States like Bihar, Rajasthan, Telangana, Sikkim, Kerala, Maharashtra, Tamil Nadu whereas the mapping and tender was finalised in other visited States.
- ECRP II has accentuated the availability of oxygen and ventilator supported beds across all States. However, training of healthcare staff on usage, maintenance and upkeep was sub-optimal.
- Pressure Swing Adsorption (PSA) oxygen generating plants and Liquid Medical Oxygen tanks have been installed at DH and SDH levels in all the states visited.
- Medical gas pipeline system under ECRP-II had been established in most of the health facilities.
- Liquid medical oxygen was under different stages of installation and lying unused and/or non-operational in some facilities.
- Oxygen concentrators, cardiac monitors, ventilators were available in adequate numbers/

abundance without exception, though the equipment were not rationally distributed across the health facilities.

- Tenders were floated and construction of prefabricated structures started in majority of the visited States. Some States such as Bihar raised concerns over creation of prefabricated units under ECRP and instead proposed reinforced concrete structures for long term sustainability owing to the weather condition in the state and land constraints.
- Construction of 50/100 bedded field hospital was in progress in few states while the agency and space were identified in other states.
- RT-PCR labs were found functional in most of the States.
- Average expenditure of funds allocated under ECRP-II was approximately 30-50% in the visited States.

KEY RECOMMENDATIONS

- ECRP-II funds to be utilised in timely manner and all activities need to be expedited on priority and completed by 31st December 2023.
- Systematic plan for parallel actions such as layout plans, selection of agency for construction, and gap assessment against available equipment need to be initiated and accomplished on priority.
- The states should regularly update the physical and financial progress on the NHM PMS portal of the budget sanctioned under ECRP along with the capacity building of district and block officials for the same.
- The hub and spoke network for paediatric care should be established which can also be used for capacity building of paediatricians and medical officers on topics other than COVID-19 as well.
- Devices like oxygen concentrators, ventilators, cardiac monitors, and other devices must be allocated rationally. Each of these equipment requires installation, and staff must be acquainted on how to use and maintain it.
- Capacity building is of utmost important so that, the public health care facilities are resilient and responsive to the needs of both programmatic and future pandemics/emergencies. Regular training and hands-on practice on oxygen devices is one such area.
- Community needs to be sensitized about the availability of these services at concerned hospitals so as to decongest higher facilities.
- Training and capacity building of medical officers is recommended for effective utilisation of the paediatrics centre of excellence established under ECRP-II.
- Mock drills to be carried monthly to check the functionality of the LMO plants and MGPS installed under ECRP-II.
- States to expedite completion of the under-construction projects on fast track basis.

STATE-SPECIFIC FINDINGS

Andhra Pradesh

- 79.99 % of the funds have been allocated to districts and health facilities out of which 100% expenditure has been made by the State under ECRP-ll
- The remaining funds approved by MoHFW need to be disbursed to the districts for timely completion of activities under ECRP II.

Bihar

- Oxygenated beds were available at all level of facilities.
- Paediatric care unit and oxygen plant at District Hospital was functional in both the districts.
- State should ensure timely execution of all the activities under ECRP II and simultaneously updating the physical and financial progress in the PMS portal for availability of real time status.

Chhattisgarh

- Utilization of ECRP funds in the State was 29.13% (Rs.182.63 Crores out of the approved funds of Rs.626.60 crores).

- CGMSC has been selected by the State Health Society for civil and procurement works under ECRP.
- The program activities were not carried out at the District and Block level in FY 2022-23 while waiting for RoP approvals from the State level. Various ongoing activities such as procurement of drugs, hiring of HR, etc. had not been executed.
- Further, there was a delay between the execution of the activity and the receipt of bills, which resulted in a delay in the booking of expenditure at the facilities (Surajpur District).
- The State to hold regular meetings for review of the progress of works awarded to CGMSC or explore alternatives for utilization of funds before 31st December 2023.

Delhi

- Out of Rs.787.91 Crores, an expenditure of an amount of Rs.775 Crores had been incurred and booked (98%) under ECRP I and Rs.12 Crores balance available with agencies pending for settlement.
- Under ECRP II, 100% expenditure had been incurred to date by the State.
- State should ensure that all the activities completed under ECRP II are operationalized and regular capacity building of the staff for the same.

Goa

- A 150 bedded COVID hospital was established during second wave having medical gas pipeline system. At present, screening, testing, vaccination, and symptomatic treatments are being provided. Patients with severe symptoms were referred to Goa Medical College.
- Recruitment of AYUSH practitioners were observed as an alternate practice in Goa, where they were involved in OPD, Vaccination, and ICU Care for COVID cases. State had incurred an expenditure of 100% under ECRPI, which was utilized for purchasing of Ventilators, oxygen concentrator parts, COVID Kits (Thermometer, Pulse Oximeter, Mask, Sanitizer, Medicines, and AYUSH Kits).
- Oxygen Plants have been installed in the State and Engineers have been recruited on contractual basis for providing 24x7 services.

Jharkhand

- The district hospital at Garhwa had a dedicated COVID care facility with a recently installed RT -PCR machine; which was not bring utilized as the Lab Technician was untrained and the procurement of reagents and consumables was not done.
- Oxygen supported beds were available in all the facilities visited.
- One PSA plant with generation capacity of 500 LPM was installed at district hospital, Garhwa.
- COVID vaccines were available and properly stored. However, some near expiry vaccines were also found.

Kerala

- Out of the total 66 institutions where sanctions were accorded under ECRP II, work had been completed in 58 facilities.
- Though the work had been completed in most of the facilities but they were not yet operationalised and awaiting formal launch.
- Although civil works were mostly completed, the fund utilization/Booking or payments with respect to COVID Essential Diagnostics and Drugs, IT Interventions, Capacity Building and Training was lagging behind.
- Operationalization of completed activities need to be expedited.

Madhya Pradesh

- The State had established dedicated pediatric unit at District Hospital level. Liquid medical oxygen plants were also installed in the districts.

Maharashtra

- State had a total allocation of Rs.1367.95 Crores, out of which 100% amount was released

(including 100% central & state share). However, State reported an expenditure of Rs.652.52 Crores i.e., only 46.92%.

- Paediatric ICU was under construction and the procurement was also under process.
- A 100 bedded field hospital was approved for DH Washim which was under construction and a 10 bedded PICU approved was ready to be functional.
- Medical gas pipeline system were in place in the DH and Women's hospital. The DH Washim had 1 PSA plant, 1 LMO tank and cylinder bank in the facility. The W0omen's hospital had excess of oxygen sources- 2 PSA plants, 1 LMO and 30 Dewar flasks.

Meghalaya

- 97.84 % of the funds had been allocated to districts and health facilities whereas only 61.82 % expenditure against the total approved fund under ECRP-II had been made by the state.
- The funds flow mechanisms between State treasury and State Health Society (SHS) were not strengthened. Thus, hampering timely disbursement and utilization of the funds to undertake activities under ECRP II.

Nagaland

- An amount of 62.46 Crores was approved for the state under ECRP II. However, the expenditure for the same had been approximately 38% only.
- Despite of approval of ECRP II components, the activities were not initiated in any of the visited facilities.
- Some activities like setting up of a 35 bedded pre-fabricated isolation ward, LMO tank, oxygen concentrators distribution to peripheral facilities were observed in Mokokchung district. However, as understood from interactions with state officials, they were funded through CSR initiatives and not under ECRP.
- It was also reported that during second wave of COVID majority of the patients were under home isolation and were not admitted. Those requiring admissions were shifted to TB hospital for the purpose of isolation. However, the infrastructure of the building was old and cleanliness at the facility was compromised at time of the visit.
- Only two ALS ambulances were proposed under ECRP II provision. However, the availability was not seen in the districts visited.

Punjab

- Through support provisioned under ECRP-II, state has augmented the bed capacity by 466 ICU/HDU beds, established 324 paediatric units, 17 Liquid Medical Oxygen tanks, 26 MGPS, 8 tele-consultation hubs & 230 spokes, 4,390 medical beds are oxygen supported and also strengthened 20 RT-PCR Labs across the State.
- State reported 98% expenditure under ECRP-II.
- Though the funds had been utilized but there was a need for rational distribution of the equipment and beds. This was corroborated by the presence of beds in a PHC with vacancy of MO for the last 1.5 years due to which the beds were not utilized.

Rajasthan

- Most of the activities under ECRP II were either not completed or were under construction and were non-functional. This was substantiated by the under construction dedicated Paediatric care unit at DH Jaisalmer, Centre of Excellence (CoE) was not established at AIIMS Jodhpur and J K Loan medical college Jaipur, additional ICUs beds not established in Jaisalmer, under construction LMO in Jawahir District Hospital Jaisalmer and non-functional MGPS system at SDH Pokhran.
- Only 44% expenditure against the total approved fund under ECRP-II had been made by the state.
- In District Jaisalmer, expenditure was only 40% against approved funds whereas in District Kota expenditure was about 70% against approvals.

- HMIS portal was not being used for real-time reporting of patients on ventilators.
- The state is required to ensure that all ECRP II initiatives are carried out on schedule and that the PMS portal is updated in real time to reflect both physical and financial progress.

Sikkim

- Paediatric Centre of Excellence was being established at Sir Thutob Namgyal Memorial (STNM) Hospital, Gangtok.
- All 4 districts and STNM hospital had Medical Gas Pipeline System in place. LMO tank installation was under process.
- The expenditure of funds sanctioned under ECRP II was reported to be slow across the districts.

Tamil Nadu

- The State has managed the COVID-19 situation very effectively. However, the State had not fully utilized the ECRP-II grants.
- Two Paediatric CoEs were being established in the State. A Hybrid PICU had been established in Thoothukudi Medical College. However, the linkages of Paediatric CoE, PICU and other facilities in hub and spoke model were yet to be established.
- While Medical Gas Pipeline Systems were available, major source of oxygen in several facilities was still manifold. PSA plants and LMO tanks were in different stages of installation and were unused. The PSA plants and LMO with MGPS were not operational at most of the facilities visited.
- Ventilators under PM Cares funds were available in DH and Oxygen Concentrators were available till PHC level, and staff nurses were trained for its effective utilization.

Telangana

- Paediatric CoE at GGH Suryapet and oxygen supported beds were at DH, Medical Hospital and other secondary care facilities were being established under ECRP. Although, Paediatric wards had been established under ECRP II and Paediatrician was also available at Area Hospital Suryapet but the utilisation rate was almost nil.
- Liquid Medical Oxygen (LMO) & MGPS were available in both districts.
- The COVID vaccination coverage was commendable and it was more than 100% across different age groups in both the districts owing to the active involvement of Government, healthcare teams & citizens and availability of doses, awareness through IEC and district specific implementation strategies to roll out the program.
- Gap identification and operationalization plan for completed ECRP II activities, was not observed during the visit.

Uttar Pradesh

- Funds under ECRP II were being utilized in District Maharajganj and District Chitrakoot for the creation of 20 and 6 bedded COVID wards at Community Health Centre level. Agency was identified and work has been started.
- 32-bedded Pediatric care Unit was approved in both District Maharajganj and Chitrakoot. Agency has been identified for the same in District Chitrakoot.
- The number of functional oxygen-supported beds in District Chitrakoot was 550 and in Maharajganj 206 whereas the number of hybrid ICU beds in District Chitrakoot and Maharajganj are 55 and 26, respectively.
- Liquid Medical Oxygen (LMO) tanks have been installed at 67 District hospitals in the state. 3 LMO tanks have been installed at DH Maharajganj whereas in District Chitrakoot, LMO has been installed in MCH wing Khoh and CHC Nautanwa.

HEALTHCARE FINANCE

NATIONAL OVERVIEW

Healthcare financing is an important element of the health system to reach the desired health outcomes. The Ministry of Health and Family Welfare under the National Health Mission has released a total amount of Rs. 2.7 lakhs crores[2] since its inception in 2005-06. The effective management and utilization of these resources are critical to ensure the efficient provision of health services. States have been encouraged to build and develop their financial management capacities to provide accurate and timely funds at district, block levels and healthcare facilities through the implementation of the Single Nodal Agency (SNA). This step is undertaken for better monitoring of the availability and utilization of financial resources by the States.

NHM provides financial support to states through annual budget provisions based on the Program Implementation Plans (PIPs). The PIPs spell out the strategies to be deployed, budgetary requirements and health outcomes aimed based on their population-specific needs, providing states/UTs more power to plan interventions. Both Central and State governments contribute to implementing programmes under NHM in the ratio of 60:40 for all States and Union Territories (UTs) with the legislature, 90:10 for hilly and the Northeastern States and 100% for UTs without the legislature. Post pandemic, with an objective to establish a resilient health system, Government of India has included more resources and additional financial allocations to NHM specific components. These are routed through India's largest pan India Infrastructural scheme Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PMABHIM) and fifteenth finance commissions health sector grants which focus on decentralized approach by strengthening local bodies in rural and urban areas. Under PMABHIM Rs. 64,180 crores and under Fifteenth finance commission health sector grants Rs. 70,051 crores have been recommended to strengthen public health sector. The additional resources are also focused on strengthening primary health care, thus complementing the NHM through establishing AB-HWCs in both rural and urban areas.

As per the National Health Accounts (NHA) Estimates for India 2018-19, for the visited CRM states, spending by the state government expenditure on health ranged between 4.9% and 19.9% of the General Government Expenditure (GGE). More than 8% of the budget is being spent on healthcare by states like Delhi and Meghalaya. In Goa, Kerala, and Tamil Nadu more than 6.5% of the state budget is allocated for healthcare. In general, even though the government expenditure on healthcare is showing a rising trend in the country, the states need to make additional efforts to increase their spending on healthcare as per the targets of the National Health Policy 2017.

[2] https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1782603

Table 1: Government Health Expenditure across the States in 2018-19

Government Health Expenditure			
State	GHE as % of GSDP	GHE as % of GGE	Per Capita TGHE in Rs.
Andhra Pradesh	0.9	5.5	1,576
Bihar	1.5	5.5	674
Chhattisgarh	1.3	5.7	1,433
Delhi	1.1	19.9	4,001
Goa	1.4	7.6	5,055
Jharkhand	1.2	6.1	1,005
Kerala	1.1	7.4	2,479
Madhya Pradesh	1	4.9	1,031
Maharashtra	0.7	5.9	1,470
Meghalaya	3.5	9.7	3,787
Nagaland	2.4	5.1	3,180
Punjab	0.8	5.2	1,361
Rajasthan	1.4	7	1,696
Sikkim	1.5	6.4	4,150
Tamil Nadu	0.9	6.9	2,022
Telangana	0.7	5.2	1,687
Uttar Pardesh	1.2	5.3	863
India	1.28	4.81	1,815

Source: National Health Systems Resource Centre (2022). National Health Accounts Estimates for India (2018-19), New Delhi, Ministry of Health and Family Welfare, Government of India.

The Out-of-Pocket Expenditure (OOPE) in the country has consistently declined over the years. The schemes and programmes under NHM such as free essential drugs and diagnostics, free ambulance services, free blood services, and free diet and transportation for the patients directly target to reduce the OOPE make public health services universal and affordable. As per the National Health Accounts Estimates for India 2018-19, among the states visited, most of the states have OOPE more than 50% of the Total Health Expenditure. Chhattisgarh, Maharashtra, Rajasthan, Tamil Nadu, and Telangana are the only states with OOPE of less than 50% while Uttar Pradesh has more than 70% of OOPE.

Table 2: Out of Pocket Expenditure across the states in 2018-19*

Out of Pocket Expenditure (OOPE)			
State	Per Capita OOPE in Rs.	OOPE as % of GSDP	OOPE as % of THE
Andhra Pradesh	3140	1.9	63.2
Bihar	811	1.8	53.5
Chhattisgarh	1175	1.1	38.3
Jharkhand	1915	2.3	63.9
Kerala	6772	3	68.6
Madhya Pradesh	1409	1.4	55.7
Maharashtra	2644	1.3	48.4
Punjab	3065	1.8	65.5
Rajasthan	1745	1.5	44.9
Tamil Nadu	1909	0.9	44.3
Telangana	1982	0.9	48
Uttar Pradesh	2481	3.5	71.3
India	2155	1.52 (% of GDP)	48.21

Source: National Health Systems Resource Centre (2022). National Health Accounts Estimates for India (2018-19), New Delhi, Ministry of Health and Family Welfare, Government of India.
*Estimates for Northeastern states and Goa is not reported due to the small sample size of the household at the state level.

KEY OBSERVATIONS

- The Single Nodal Agency (SNA) was implemented and operational in all CRM states visited. The SNA was integrated with PFMS and State Treasury. However, in many states, the process was completed up to the district level. In states like Chhattisgarh, Bihar, Goa, Sikkim, Kerala and Rajasthan, the system was not operational at the block and levels below.
- It was highlighted by the findings that with the implementation of SNA, the delays in fund transfer have considerably reduced compared to previous years. In states such as Sikkim, Tamil Nadu, Jharkhand, Punjab, Kerala, Chhattisgarh, Goa and Meghalaya the delay of fund transfer was within 45 days. In a few states where delays were observed it ranged from 50 to 90 days.
- The utilization of the NHM funds at the state level was observed to be low in many of the states visited. In Sikkim utilization was 53%, in Rajasthan it was 34% and in Chhattisgarh, it was 22%. The main reason for underutilization was procedural delays due to the delay in release of funds, inefficiencies of the system owing to the dearth of health personnel and lack of information about routine activities in the district.
- Compliance with accounting mechanisms at the state level has improved as highlighted in the previous report. The statutory audits for 2021-22

were observed to be completed by most of the states and were in process for a few states. However, for the states such as Telangana, Rajasthan, Punjab, Nagaland, Jharkhand and Chhattisgarh the Statutory Audit Report was not submitted to the GoI. The compliance on the concurrent audit report at the district and block levels needs to be improved. There is still scope for improvement of accounting measures at district and facility levels in most of the states.

- The availability of human resources for the management of the financing varied across the states visited. The dearth of finance personnel was reported at various levels across states, especially at district and block levels. Vacancies for accounts and finance staff were reported in states like Bihar, Uttar Pradesh, Nagaland, Jharkhand, Delhi and Maharashtra. It is pertinent to fill the human resource gaps in terms of finance and accounts staff for proper utilization and monitoring of the funds. Adequate training is required for finance personnel at different levels of health care.

- The utilization of untied funds varied across states, and it was found to be underutilized in states like Arunachal Pradesh, Bihar and Uttar Pradesh. The untied fund at the level of health care facilities was reported to be mostly utilized for procurement of medicines, maintenance, payment for sanitation workers, purchase of drinking water, storage water tank, support to outreach activities, etc. States like Kerala and Meghalaya reported of health facilities not receiving any untied funds. The inability of the facilities to utilize the funds was reported due to a lack of clarity in terms of areas of spending for these funds.

- In most of the CRM visited states, the information for dissemination of District ROPs and funds utilization as per ROP was not clearly reported. The utilization of funds under PM-ABHIM grants was found efficient in states such as Tamil Nadu and Meghalaya. However, utilization under PM-ABHIM was reported to be pending in some states such as Telangana and Punjab.

- A substantial decrease in delays was observed with the use of Direct Benefit Transfers (DBT) under JSY, JSSK, NTEP and payments to ASHA. In comparison to the previous year, the delay in JSY payments has been substantially reduced. In states like Tamil Nadu, Jharkhand, Maharashtra, Sikkim, Andhra Pradesh, Rajasthan, Kerala and Madhya Pradesh the disbursal of funds to beneficiaries and all payments were done through DBT. The payments in most of these states were made on time.

- The Out-of-pocket expenditure was reported in the visited states for medicines, diagnostics and transportation to healthcare facilities. The districts with robust implementation of various government programmes such as JSY, JSSK, free drugs and diagnostics reported lower cases of OOPE with no expenses in government facilities. The information on OOPE for patients covered under Ayushman Bharat PMJAY or any state-specific scheme was not adequately captured.

KEY RECOMMENDATIONS

- The implementation of SNA at the district and block level needs to expedited to make financial resources efficiently available to the bottom levels and smooth implementation of healthcare programmes.

- The vacancies for finance and accounts staff should be filled at all levels in the states. The adequacy of staff should be monitored and supervised at regular intervals. This should be supplemented by capacity building of finance and accounts staff at state and district level on regular basis through training for reporting, managing expenditures, monitoring and maintaining effective financial records.

- The delays in the release of funds should be addressed at the state level. The funds from the State Treasury to the SNA should be transferred appropriately without delays. Measures should be undertaken to ensure that funds are available timely below the district at the block and facility level. This is necessary to ensure the effective utilization of funds.
- The financial activities across various levels in the state should be coordinated effectively. The State needs to focus on mitigating the communication gap between district, block and state finance teams. A proper channel must be established to coordinate financial activities at various levels.
- The state should focus on improving the process of maintaining the account records in facilities at all levels. Steps should be undertaken to monitor and settle advance outstanding. Periodic bank reconciliation may be done to ensure balance as per the bank and balance as per books of accounts at facilities are matched. Proper vouchers should be maintained against the expenditure and utilization certificates should be obtained.
- States should undertake necessary measures to further strengthen the accounting mechanisms. Proper planning should be done in order to make appointments for conducting statutory and concurrent audits at state, district and block levels and timely availability of reports that should be laid to the Governing Body for acceptance and submission to the GoI.
- The budgeting for health activities should incorporate involvement from district and block levels to ensure decentralised planning which can enhance the effective utilization of funds at the grass-root level.
- Regular monitoring should be done at the district and block levels for financial performance and utilization. The state should ensure effective implementation of the Progress Monitoring System w.r.t NHM finance (FMR and SFP). The reasons for the underutilization of funds should be identified and examined to provide supportive supervision for taking corrective actions.
- The States must ensure that there is no duplication of activity from various grants i.e., 15th Finance Commission and PMABHIM grants.
- States that reflected delays in DBT payments should identify the constraints for timely transfers. Proper follow-up actions are needed in case of failed payments.
- Higher funds should be allocated to High Priority Districts as per the GoI norms. RoPs and District Health Action Plans should be timely disseminated to all the districts for efficient planning, allocation and utilization.
- To address the issue of out-of-pocket expenditure (OOPE) at public health facilities the states should ensure the effective availability of drugs and diagnostics at all facilities which comprise the major proportion of the OOPE. The implementation of programmes and schemes such as JSSK, Free Drugs & Diagnostics services, Ambulance and PTV service with improved response time must be strengthened which have a direct impact on the reduction of OOPE.

STATE FINDINGS AND OBSERVATIONS

Andhra Pradesh

- The state had implemented the Single Nodal Agency (SNA) and Single Nodal Account in the state and has integrated with the PFMS. DBT payments were being done in the state using the SNA system. However, gaps were observed in disbursal of DBTs under Janani Suraksha Yojana (JSY) and Nikshay Poshan Yojana (NPY).
- The corresponding state share from the State Treasury in financial year 2022-23 were transferred

within 2 months of release of the Central share. Rigorous follow-ups and efforts were made by the SNA to expedite the release of funds from the State Treasury, which resulted in the release of funds within 2 months.

- The districts were sending monthly fund utilization reports to the state level, where monitoring of utilization of funds was being done.
- Poor utilization of funds by Hospital Development Societies was reported across the districts. Inability to ensure participation of all members of Hospital Development Societies in HDS meetings and fear of audits has led to less utilization of HDS funds.

Bihar

- SNA had been implemented in the State of Bihar with ICICI Bank at State and both the visited Districts.
- The concurrent Auditor appointment for the FY 2021-22 and FY 2022-23 and statutory Audit for the FY 2021-22 was still pending whereas the due date was 31st July 2022.
- It was observed that there were Vacant position of Finance and Accounts at different levels.
- Monitoring and supervision for the Finance and Accounts Staff was not done by the State Team on a regular interval. There was no Financial Training and Review by the Finance and Accounts team at the State level.
- Ledger Account was not maintained at District Level in both the Districts. Expenditure reported in FMR was not tallied with books of Accounts in both districts.
- The unspent balance of Rs.4.52 Crore of FY 2020-21 was still pending under RCH-A, MFP-B, IDSP, NUHM, NHM Main Account with District Health Society- Aurangabad. Though no balance certificate under this was submitted by the state to MoHFW.
- In Buxar Rs.18.85 Cr reported expenditure against the district approval of Rs.46.19 Cr i.e. only 41%.
- The health facilities reported a major proportion of the untied funds was not utilized. There was a difference in the payment as per Cash Book and the voucher entry. The utilization certificates were not obtained against the payments.

Chhattisgarh

- The Single Nodal Account has been implemented only up to the district level. However, the Block and the PHC level were still managing the payments by RTGS transfers and cheques. The time taken for fund transfer to SNA may vary for each release instalment. The delay in fund transfer from State Treasury to the SNA of State Health Society has been considerably reduced, from maximum 53 days to minimum 31 days.
- The State had been able to utilize only 22% of funds under NHM for FY 2022-23 at the time of the visit. Lower utilization is reported under almost all the activities. Disease controls programmes such as IDSP, NVBDCP, NLEP, NTEP, PMNDP, NPHCE, NVHCP etc had shown much low utilization of less than 10% upto the end of second quarter of FY 2022-23.
- It was observed during the visit that the DBT payment was being made through cheque and there was some delay in payment of JSY incentive to beneficiaries. However, the major delay was observed at DH Surajpur where 67 cheques were made but was not disbursed to the beneficiaries (time lag 2 months).
- The Statutory Audit was due to be submitted by 31st July, 2022 as per instructions issued by the Ministry for FY 2021-22. However, the State was yet to submit its Statutory Audit Report. There was

a delay of more than 3 months in submission of Statutory Audit Report. The Audit Report for FY 2021-22 was under finalization at the District level even after more than 6 months since the end of Financial Year.

- For FY 2022-23, concurrent auditor was appointed for 23 Districts. The concurrent auditor had not yet been appointed for both Surajpur and Kondagaon Districts for FY 2022-23. Besides, Surajpur and Kondagaon, concurrent auditor was yet to be appointed for Bastar, Kawardha and Korba which was under process.
- Compliance on the observations of the concurrent audit report issues was not being undertaken at the district level and Block level.

Delhi

- ICICI Bank had been selected for the implementation of SNA under NHM, Delhi on Model 1 system on PFMS. All the payments were being made through the SNA system at the state, district and below the district level. Both the districts' were working 100% on "Digipay portal" under SNA.
- Approximately 85% below district-level agencies have been mapped and training were being continued for the payment process. File for refund of interest for the year 2021-22 was under submission.
- All the central releases along with state share received in the FY 2021-22 had already been received in the Single Nodal Account of State Health Society Delhi.
- Final audited books of accounts for the FY 2021-22 had been submitted to the Govt. of India, Finance Division, NHM.
- Around 46% out of the total 199 codes/schemes/ activities in the FMR of DSHM shows an expenditure in the range of 0 - 10% as on September 2022.
- Finance-related issues observed were High PFMS Balance, Pending Interest Deposit, ASE and UC under Infrastructure Maintenance for the FY 2019-20 to 2020-21.
- There was no allocation of funds under FC-XV for Delhi state. PM-ABHIM was yet to be implemented as the receipt of the MoU was awaited from the State Society. Hence, there was no release of the 1st tranche of GIA.
- Very few of the interviewed registered TB patients received the Direct Benefit Transfer (DBT). The incentives for ASHA transferred through PFMS reported a delay in the Northwest district due to a delay in the enrolment process with a new bank.
- Management HR is short, and recruitments were not done against vacancies for the last 3 years. The district accounts manager post in North West was vacant since July 2021. There was no District Programme Manager and Quality Consultant (State) in South District.
- Due to absence of Block accounts managers/ assistants, the doctors and other staff in facilities were doing accounting work without formal training resulting in extremely delayed UC responsible for reflecting accumulated expenditure at the end of the financial year.
- The funds to the existing four RKS were released between 2010 and 2016. Since then, no other funds had been released as the utilization rates were poor. No regular meetings were being held.

Goa

- The Single Nodal Account (SNA) had been implemented at the State Level. However, there was no such clarity about SNA at the district and below levels.

- The time taken in receiving funds from State Treasury to Single Nodal Account was around 40 days. However, this delay does not lead to delay in salary of employees at any level, but delay in programme implementation and delays in training, monitoring and supervision could be seen at various levels.
- Only 10% of JSY beneficiaries were identified. The Direct Beneficiary Transfer (DBT) for those identified under JSY was delayed for more than 6 months due to the poor internet connectivity and non-linkage of the beneficiary with PFMS in both districts.
- The State had issued funds to districts for faster implementation of the programmes. The financial funding to facilities should be differential (as per need, area and population) for Untied Funds as per GOI guidelines.
- The books of accounts were not maintained properly at any of the health facility.
- The Out-of-Pocket Expenditure on the Drugs and Diagnostics was on higher side due to shortage of drugs in hospitals.
- Also, non-domiciliary patients need to pay for drugs, diagnostics, bed charges per day and all other care related charges.

Jharkhand

- Single Nodal Account (SNA) had been implemented up to the district level. Implementation started September 2021 and appropriate training for the programme was given. Average time taken by the SNA to receive funds from State Treasury was 45 days.
- Block account managers Positions were filled in all CHCs/SDH of Garhwa. However, the post of District Accounts Manager was vacant from June 2020. The District Account Assistant was performing the financial & Accounting work.
- In Deoghar district, out of the 8 sanctioned posts, 2 blocks had no Block Account Manager and 5 Blocks had no Block Programme Manager.
- Recruitment for these positions was under process and was expected to be completed by November 2022.
- Statutory Auditor had been appointed timely and appointment of the concurrent auditor was also been done by the district Garhwa.
- Internal Auditor for the current financial year (F.Y. 2022-23) was not yet appointed in Deoghar and Audit Report for the F.Y. 2021-22 was yet to be completed.
- In Deoghar, training required for the new format of FMR at district level to allay confusion about the heads to book expenses.
- Monthly SFP not submitted with the monthly FMR by District Hospital, Sadar.
- Direct Beneficiary Transfer (DBT) under JSY, JSSK and NTEP was being done in a timely manner. The PFMS portal was implemented well in the district Garhwa.

Kerala

- Single Nodal Account (SNA) had been implemented. However, switching fully to Single Nodal Account at peripheral level was still pending. Further down the district level Implementing Agencies started opening separate accounts and mapping started in March 2022.
- Out of 1317 institutions at the district level, SNA was active in 1288 institutions.
- The Direct Beneficiary transfers under JSY and NTEP were done through DBT only. DBT report up to September 2022 was uploaded in GOI DBT Portal.

- Through SNA, all the payments were being done directly to the beneficiary whether it was an employee, contractor, vendor or agency either by DBT/NEFT/RTGS.
- The number of days delay for transferring the different tranche of central and state funds ranges from 14 days to 32 days.
- Frequent follow ups were being done with the Finance Department for getting the funds in time.
- Statutory Auditor had been appointed for 2019-20 after due tendering process and reappointed for 2020-21 and 2021-22. All Statutory Audit reports up to 2019-20 had been placed in the Governing Body.
- Concurrent Auditor had been appointed by SHS for state level and by the districts for district level. Audit was completed for FY 2021-22.
- Delay had been observed in case of utilization of funds in the case of procurement of equipment and drugs. Kerala Medical Service Corporation is entrusted with the procurement and after issuing the administrative sanction.
- On account of availability of ultrasound in only two public facilities in Wayanad, only JSSK beneficiaries could avail free of cost services.

Madhya Pradesh

- The State of Madhya Pradesh had implemented the single nodal agency (SNA) account for financing. The State had rolled out e-Vittapravaha portal, ensuring full online fund transfers.
- State PIP fund flow (visible as allocated grants) from the State to direct Block level was through one mother account opened in HDFC bank. E-Vittapravaha was linked with PFMS system and used for DBT purpose as well.
- BPMUs were well staffed with accountants, headed by one District Account Manager and District Program Manager.
- Overall expenditure at State level noted was 38%. Joint signatory procedure for expenses was noted. The expenditure report was being jointly validated and signed by the Chief Medical Health Officer, District Account Manager and District Program Manager.
- Mukhyamantri Shramik Seva Prasuti Sahayta Yojana was rolled out in Sidhi. As part of this initiative, Rs. 16000 for delivery was given to beneficiaries by the State government of MP.
- Incentives of CHOs and ASHAs were paid through DBT in their bank accounts through E-Vittapravaha, and linkages of E-Vittapravaha with ASHA portal and RCH portal had been instituted.
- Internal controls were found to be adequate for issuing payments. 77% of direct benefit payment was noted in visited districts. Major reasons noted for the delayed payment were data entry in RCH portal not validated, issues in bank account confirmation, issues of Samagra ID linkages.
- The statutory audit at state-level was completed. The statutory audit in visited district of Sidhi was also completed and presented before the district committee.
- Issues were noted in maintenance of advance registers, fixed asset registers, and journal books by district.
- State was undertaking concurrent audits for all districts at the time of visit.

Maharashtra

- Single Nodal Accounts (SNA) system of DOE had been implemented in Districts. Concurrent Auditor had been appointed for FY 2022-23.

- PFMS was functional till Block-PHC, CHC level. DBT system was used for payment to beneficiary of JSY, JSSK, contractual staff payment, NTEP and FP.
- Books of accounts were maintained at sub district level manually as well as computerized and the same was authenticated by the MO. Bank Reconciliation Statements were prepared at State, DHS and Block level.
- It was observed that there was some time lag for payment of JSY and JSSK and FP beneficiary.
- Long period taken by the units for procurement process/ civil construction project from approval to payment.
- One position of State Account Manager was vacant at the State level. Two Position of DAM at the District level and Eleven Block Account Manager were vacant at the Block level.
- Internal control system needs to be strengthened for keeping of vouchers, payment process of Asha incentive, JSY JSSK and TA claim settlement.
- Need for Re-orientation training was felt on Financial Management at State & Districts level for strengthening the internal control system for better financial management.

Meghalaya

- State had implemented SNA up to the block level and its integration with PFMS and State Treasury has been completed. All Implementing Agencies (IAs) have deposited 100% of the balances in the SNA Account & Separate Budget Lines have been created for Central and State Share for both the SNAs (NHM & PM-ABHIM).
- Expenditure Filing for SNAs was being done using the Digital Signature Certificate (DSC) Mode. All Implementing Agencies had been registered in PFMS as per PFMS Guidelines.
- State mapping & District Allocations as per RoP had been completed. However, the state was yet to update the same along with expenditure in the NHM-PMS portal. Central and State Share from the State treasury was transferred to SNA.
- Statutory Audit Report for FY 2021-22 was available and was tabled in Governing body of SHS.
- For FY 2022-23, all implementing agencies had opted for the reappointment of the Concurrent Auditor for the second year.
- Utilization certificates were available at the block and district level. Monitoring of funds released against approved activities under NHM was being done by the state through review meetings.
- All sanctioned posts under NHM finance at state, district & block level were in position and no vacancies were reported.
- Average Delay Days in releasing of Central Share from state treasury to SNA was 40 Days. There was a delay of 41 days in the transfer of Rs. 49.06 crores and in receiving of funds from State treasury to the SNA account. File was pending with Planning Department, Meghalaya since 1 November 2022.
- Backlog in DBT was observed under JSY, JSSK & Nikshay Poshan Yojana in Southwest Khasi hills district.
- Untied funds were not available in any of the facilities visited as the State had not proposed the same in the PIP for FY 2022-24.

Nagaland

- State had implemented SNA from October 2021 and the account was integrated with PFMS and State treasury. All parameters of SNA were implemented except the time taken to transfer Central and State share.

- The 1st tranche of central grants for FY 2022-23 was received in the SNA account after 45 days, but the State share was still pending.
- DBT payments for JSY, JSSK and NPY was ongoing.
- At the State and district level, the positions were filled. However, at the block level, vacancies exist due to frequent resignations. To address this challenge available Block Accounts Managers were pooled at district level re-designating them as District Accounts Assistant, who serves 2 to 3 blocks each, ensuring coverage of all blocks.
- During 2021-22 the time taken for the central share fund to be transferred from State treasury to SNA account was about 90 days while for State share it was 150 days.
- Concurrent audit was held up to 2021-22 but the report was submitted till 2020-21 only.
- Other observations include not keeping track of advances, actual bills not being attached with expenditure statements etc., the corrective actions for which were initiated by the State.
- Regarding PMS portal, state had given feedback that, though one virtual meeting was held by MoHFW, a detailed orientation was required to clarify various points.

Punjab

- SNA had been implemented in the State, funds to various facility level DH/SDH/Block level were transferred within one to two days of receipt of funds from State Head Quarter.
- The payments through DBT mode made only after confirmation of beneficiary particulars through automated system (PFMS).
- Statutory Audit Report for the FY 2021-22 had to be submitted under NHM. For PM-ABHIM: FMR and SFP was pending.
- The funds disbursement to the entitled societies needs to be streamlined for committees at all levels.

Rajasthan

- The Single Nodal Agency implementation process is completed up to the district level. The percentage utilization for the year 2022-23 till September was 34%. The state's matching share was not yet transferred. State Share of Rs. 819.13 crore was pending with the state treasury related to FY 2021-22.
- The Statutory Audit report for the FY 2021-22 had not been submitted to the GoI. State was not able to share the action taken report on observation shared by GoI on statutory audit report for FY 2020-21.
- Concurrent Audit report for the FY 2021-22 was not provided in Jaisalmer, while Kota had not shared the action taken on observation of the concurrent audit report. Manual books of account were maintained at DHS Jaisalmer
- The use of ASHA software for payment was present up to the PHC level. ASHA incentives and salaries of staff were being paid timely. Use of OJAS software was observed for payment of the JSY beneficiaries.
- It was also observed that there were very low payment of transport under JSY in Jaisalmer. Due to vacancy of Accountants one Block Accountant was assigned to maintain the DHS accounts including other blocks of the district Jaisalmer.

Sikkim

- SNA implementation and integration with PFMS was streamlined.
- For FY 2020-21 statutory audit findings were acted upon and Statutory Audit for FY 2021-22 was in the final stage of completion.

- Concurrent audit report for first quarter of FY 2021-22 was not yet prepared. The process was expected to start post completion of Statutory Audit of FY 2021-22.
- Payments to beneficiaries under JSY, JSSK & NIKSHAY are being done through DBT.
- It average number of days for funds to get transferred from State Treasury to SNA was 15-20 days and thus no significant delays in fund disbursal was found.
- 53% of the NHM funds for FY 2022-23 were utilized by the State by October 2022.
- OOPE was high for medicines, diagnostics, and transport to health facilities. For higher level of diagnosis/treatment, community members prefer to visit private facilities, leading to high OOPE expenses and under-utilization of public health facilities.
- The community shared that the monthly OOPE for hypertension and diabetes medicines was approx. Rs. 500-1000 per month if procured from the private sector. The private cab fare from a South district PHC to Namchi DH ranges from Rs. 1200-1500 per trip. Diagnostics costs in the private sector were high as well.

Tamil Nadu

- All payments were being done using Public Finance Management System (PFMS)/Single Nodal Account (SNA) at all levels. The State was disbursing funds to the districts through the new SNA system along with instructions for its utilization in parts, and was yet to synchronize it with the quarterly frequency. As a result of this, the districts were unable to implement activities in a holistic manner.
- Overall, in comparison to the previous year, the delay in JSY payments had been substantially reduced as direct benefit transfers (DBT) were being utilized for crediting payments to the beneficiaries.
- Manual books of accounts and cash books were up to date, but were not being maintained on a daily basis. The internal control mechanisms were not planned timely. The internal control report or the FY 2022-23 was not available.
- The transfer of withdrawal limits from the State treasury to SNA/DHS was being done. Monthly MIS report of expenditure at CHC/PHC/UPHC and DH level was available. Compilation of annual expenditure report through SNA system was being complied with in both districts.
- Regular meetings of Rogi Kalyan Samiti (RKS) to decide expenditures at the facility were conducted. The minutes of the meeting and account of the expenditure of the funds were maintained at most of the facilities. However, the amount approved by the Committees was not mentioned in the Minutes of the Meeting.
- Poor maintenance of accounts and records was reported in the City PMU Office visited. For many expenditures, the utilisation certificates were not collected and submitted. Payment vouchers for many expenditures were reported missing by the Asst. Accountants.
- Utilization of ASHA incentive fund 94.43 % against the approved limit as per RoP 2020-23. The utilisation of funds under the PM-ABHIM grants for the FY 2022-23 up to October 2022 was 99.90 %.

Telangana

- The State has implemented a Single Nodal Account up to the sub-centre level. There has been timely updating of all the accounts books. Direct Benefit Transfer (DBT) for various government programs had been fully implemented. There has been timely release of ASHA's salaries.

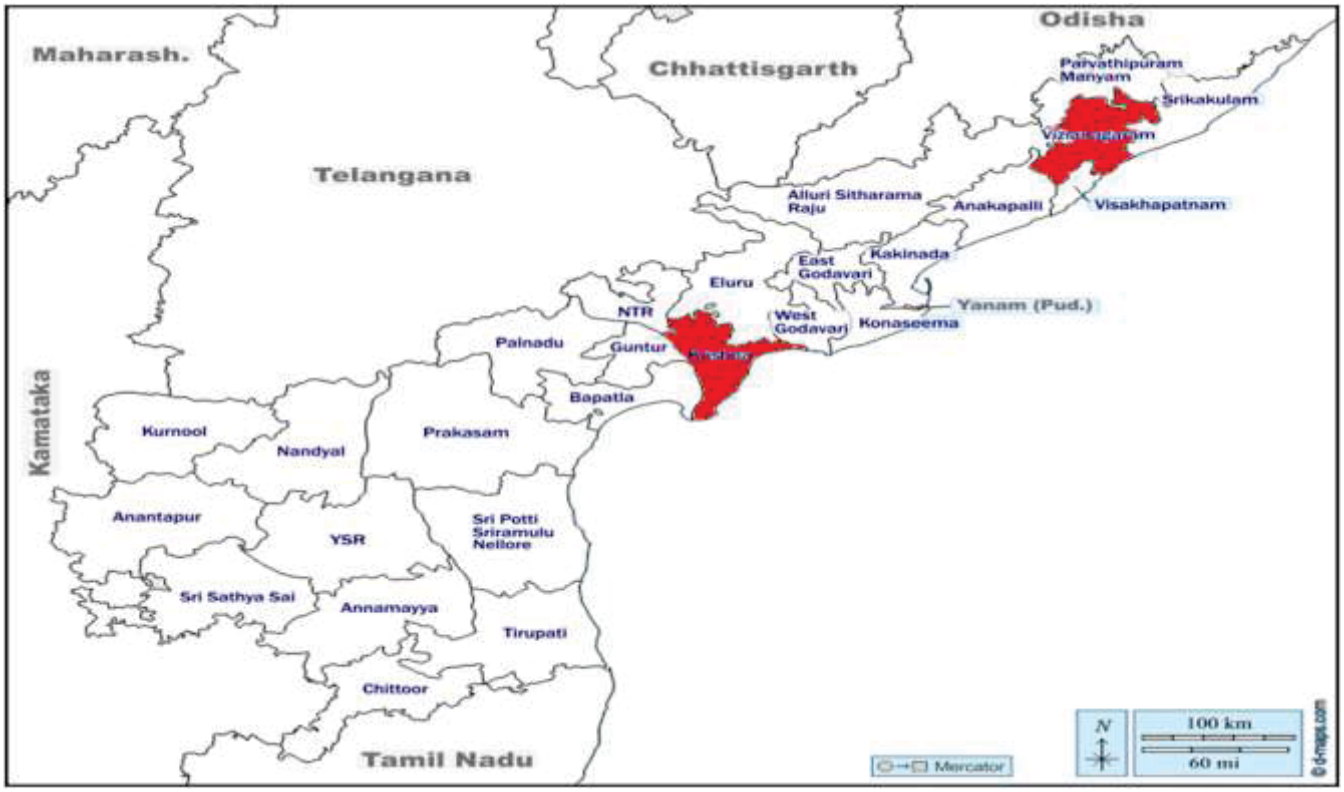
- Some lacunae on different fronts that were observed were that TDS was deducted timely but deposited very late.
- Progress Management System (PMS) portal was not fully functional. Central share was pending under the scheme of NHM.
- Statutory Audit for the financial year 2021-22 was yet to be submitted by the SHS Telangana.
- Both the State share and Central share was pending under the scheme of PM ABHIM.
- Training/Orientation programme about finance related issues/portals/incentives was not being provided.

Uttar Pradesh

- The State has implemented a single Nodal Account up to the block level. PFMS and FAMS reporting were also being done. The major findings of the statutory audit in FY 2020-21 quotations were not there, GST bills, and ASHA payments were maintained online through the BCPM MIS portal but no hard copies were being maintained.
- The appointment of Concurrent Auditors for the FY 2022-23 and the Statutory audit for the FY 2021-22 is under process.
- The delay in the transfer of Central Share from the State Treasury to the State Health Society for the FY 2021-22 is 3 months (approx.) and for the FY 2022-23 delay of 45 days has been noticed
- There were delays in JSY payments by 3 months, reportedly due to incorrect beneficiary details. ASHA incentives were unspent last year, and the reasons were ASHA vacancies, pending payments of JSY beneficiaries, etc.
- The accounting procedure and record keeping were sub-optimal in both the districts visited, e.g., noting/approval, the work order was missing from the vouchers, the cashbook was not stamped, etc.
- It was noticed that some payments were being made by cheque instead of PFMS. A matching State Share of Rs.627.61 Cr was also pending. The overall utilization of RKS untied funds against the allocation for the FY 2021-22 was 47.46 %.
- The overall utilisation of RKS untied funds against the allocation for the FY 2021-22 was 47.46 %.
- It had been observed that no untied funds were utilised at sub-centre and VHSNC level for the FY 2021-22 in both Districts.
- Presently, the State has not yet started the process of updating/feeding the financial progress of NHM at the PMS portal
- An internal control mechanism should be at all levels for monitoring. Presently, no such mechanism was available at Districts and below level.
- The district needs to monitor and train the Accounts Personnel at the block level.

STATE TEAMS AND FACILITIES VISITED

ANDHRA PRADESH

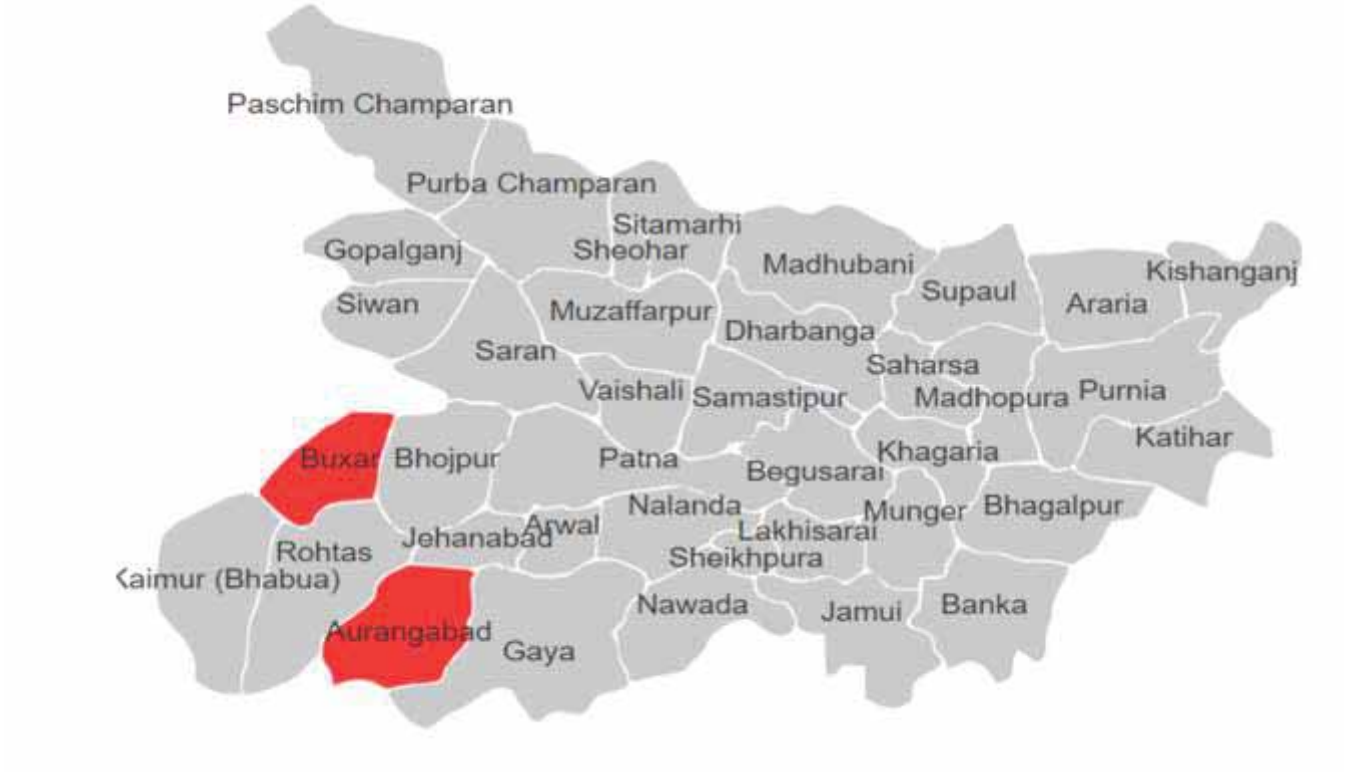


Vizianagaram District Team	Krishna District Team
Air Cmdre (Dr) Ranjan Kumar Choudhury, NHSRC	Ms. Preeti Upadhyay, SHSRC MP
Dr Ankur Nair, NHSRC	Dr Aashima Bhatnagar, NHSRC
Mr. Vishal Kataria, MoHFW	Dr Rashmi Wadhwa, MoHFW
Dr Vijay Rajana, Jhpiego	Ms Chinmaee Pawar, NHSRC
Dr Shweta Sharma, WHO	Dr Aniket Chowdhury, WHO
Dr Monika Saini, NIHFW	Mr. Subodh Jaiswal, Consultant
Dr K Srinivasa Rao, PRC - Vishakhapatnam	Mr. Abhishek Dadhich, MoHFW

Health Facilities Visited

Facility Type	Type of Facilities	
District Hospital	GGH and MCH Hospital	Machilipatnam
Area Hospital	S. Kota	Gudiwada
CHC	CHC - Cheepurapalli	Avanigadda, Kankipadu
PHC	PHC Dendaka, PHC Alamanda, PHC Pusapatirega, PHC Mopada, PHC Gurla	Gudlavalleru, Nagayalanka, Kruthivennu, Tallapalem, Moturu
UPHC	UPHC-Phoolbaug Colony	Varrigudem, Chilakalapudi
Sub-Centre/HWC	HWC - Kumli, HWC -Attada HSC- Savaravilli, HWC- Gurla	Lingavaram, Bhavadevarapalli
Others-Community Interactions, and FGD	Kumli Village	Nagayalanka, Bhavadevarapalli, Beachpakalu, YSR fisherman community

BIHAR

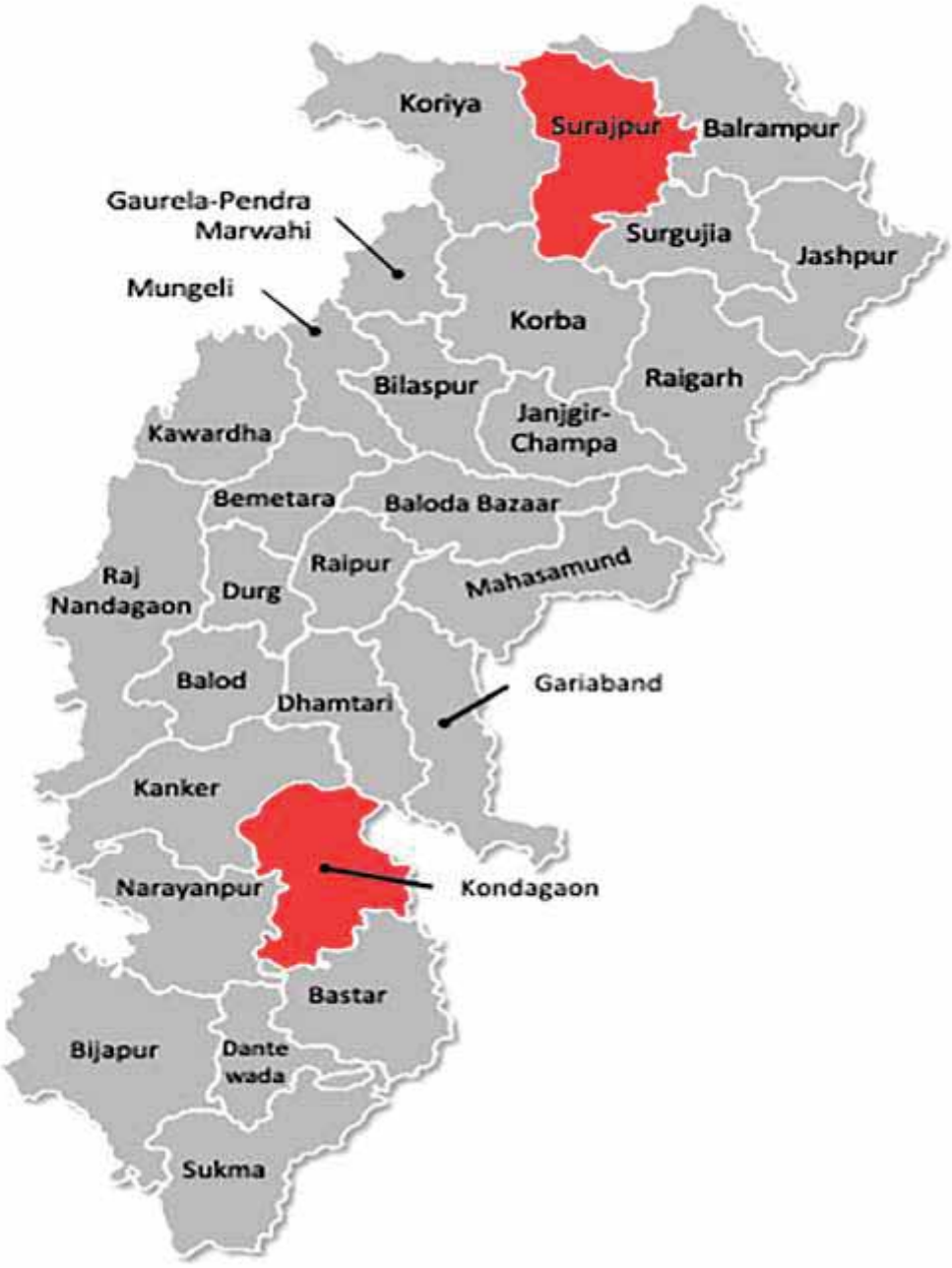


Aurangabad District team	Buxar District team
1. Dr Jyoti Rawat, MoHFW	1. Dr. Divya Valecha, MoH&FW
2. Mr. Sharad Singh, MoHFW	2. Mr. Divya Prakash, NHSRC
3. Mr. Shishir Biswas, NUHM	3. Dr. Sucharita Pujari, MoRD, GOI
4. Dr Christine Ho, CDC	4. Dr. Navin Vijay Kamble, NHSRC
5. Dr. Abhishek Yadav, NIPI	5. Dr. Ranjeet Prasad, MoHFW
6. Dr.Jitesh Kuwatada, Jhpiego	6. Ms. Sonal Gawande, PATH
7. Mr Sumanta Kar , NHM	7. Dr. Harshad Patel, (MCH), Gujrat
8. Dr. Balaji Potbhar, Regional Ayurveda Research Institute, Patna	8. Dr.Ravi Shankar Singh,CMO(NFSG) of RoHFW(GOI)
9. Ms. Neelam Tirkey, NHSRC	9. Mr. Sumanta, NHM

Health Facilities Visited

Type of Facility	Aurangabad	Buxar
DH	Sadar Aurangabad	Sadar Buxar
SDH	Daudnagar	Dumraon
CHC	Barun, Obra	Simri, Barhampur
PHC/UPHC	Aurangabad	Dumraon, Buxar
APHC	Kudwa, Siris	Rajapur Kala, Barki Naini Jor
SHC-HWC	Sarsauli, Dhuriya	Kharahatand, Gaighat
Others-Community interaction	Personal interview and focus group discussion: ASHA, ANM, AWW, PRI, School, Adolescent, Elderly etc.	

CHHATTISGARH



Kondagaon District Team	Surajpur District Team
Mr. Elangbam Robert Singh, (MoHFW)	Dr. B. S. Charan, MoHFW
Dr. Sandip Jogdand ,Regional office of Health & Family Welfare	Mr. Anil Kumar Gupta , MoHFW
Dr. Pranjal Tamuli ,WHO	Ms. Isha Rastogi, NUHM
Dr. Sudhanshu Kumar Meher , CCRAS, Ministry of AYUSH	Mr. Anup Jyoti Basistha , RRC-NE
Dr. Deepika Sharma,NHSRC	Dr. Quazi Toufique Ahmed , CDC
Mr. E. Lokesh Kumar,NHSRC	Dr. Tukaram Khandade,Technical Officer-Health Systems
Mr. Dhruv Kumar, MoHFW	Mr. Mahesh Jakati, SHSRC

Health Facilities Visited

Type of Facilities	Kondagaon District	Surajpur District
District Hospital	District Hospital, Kondagaon	DH Surajpur
Community Health Centre	MCH Kondagaon CHC Pharasgaon	CHC Pratappur CHC Bhaiyyathan
Primary Health Centre	PHC (HWC) Adenga PHC (HWC) Lanjoda	PHC (HWC) Dharampur PHC (HWC) Baisdehi PHC (HWC) Batra PHC (HWC) Songara
Urban Primary Health Centre		UPHC Rajatalab, Raipur
HWC - SC	HWC (SHC) Kabonga HWC (SHC)Sodma	HWC (SHC) Palada HWC (SHC) Kewara HWC (SHC) Kopa
AYUSH Health Facilities	AYUSH H&WC, Borgaon AYUSH H&WC, Singanpur AYUSH Speciality Clinic, Kondagaon AYUSH Dispensary, Mungapadar AYUSH Dispensary, Bahamni	AYUSH HWC, Kalyanpur AYUSH HWC, Jaynagar AYUSH Specialised therapy center, Surajpur AYURVED DISPENSARY, Krishanpur AYURVED DISPENSARY, Gangoti
Others-Focus Group Discussions	ASHA, PRI members, Community members	ASHA, PRI members, Community members

DELHI

	South District Team	Northwest District Team
1.	Dr. Ashoke Roy, RRCNE	Dr Anuradha Jain, USAID
2.	Dr Rajesh Deshmukh, CDC India	Col (Dr) Arun Yadav, Ext. Consultant (Public Health)
3.	Dr Trupti Shende, NCDC	Dr Divya Taneja, Ministry of Ayush
4.	Dr. Adil Shafie,MoHFW	Dr Gudakesh, PRC Delhi
5.	Dr. Surajit Choudhury, RRCNE	Md Latif, MOHFW
6.	Dr. Anjana,UNDP India	Dr Vineeta Sharma, NHSRC
7.	Dr.Nidhi Tiwari, MoHFW	Dr Athira KR, NIHFW
8.	Ms. Kalpana, NHSRC	Dr Paayal Bose, NHSRC

Health Facilities Visited

Facilities/ villages visited	South district (18)	Northwest district (13)
District Hospital	Pt Madan Mohan Malviya hospital	Bhagwan Mahavir District Hospital
MCW hospitals (MCD)	Mehrauli, CU PHC Mehrauli	Maternal Child Health Centre, S Block Mangolpuri
Aam Aadmi Mohalla Clinic	Sheikh Sarai, Malviya Nagar	Aam Aadmi Mohalla Clinic, Avantika
Delhi Government dispensary	Jonapur and Chirag Delhi	Delhi Government Dispensary, Sector 21
Seed UPHCs	Ayanagar	Seed PHC, Belgaonpur
Maternity Home	Nil	Maternity Home, Shakurpur
Aam Aadmi Polyclinic	Nil	Aam Aadmi Polyclinic, Sector 4

AYUSH facility	1. AYUSH unit (Ayurveda, Homoeopathy), polyclinic (Chattarpur) 2. Homeopathy dispensary and 3. Unani dispensary (Mehrauli)	AYUSH Unit (Ayurveda, Homoeopathy, Uniani) Bhagwan Mahavir Hospital 2. AYUSH Unit at Sector 21 (Unani, Homoeopathy), Polyclinic, Rohini 3. AYUSH Unit at Sector 4 (Ayurveda, Homoeopathy), Polyclinic, Rohini 4. Panchkarma Ayurvedic Hospital, Prashant Vihar
Others-School	Sarvodaya Kanya Vidyalaya.	Community Government Girls Senior Secondary
AWC	4 AWCs	School, AP Block Shalimar Bagh
Villages	Three	Nil
FGD	Community members, ASHAs & AWWs, adolescent, pregnant & lactating mothers	Nil Community members, ASHAs & AWWs, Adolescents, Pregnant & lactating mothers

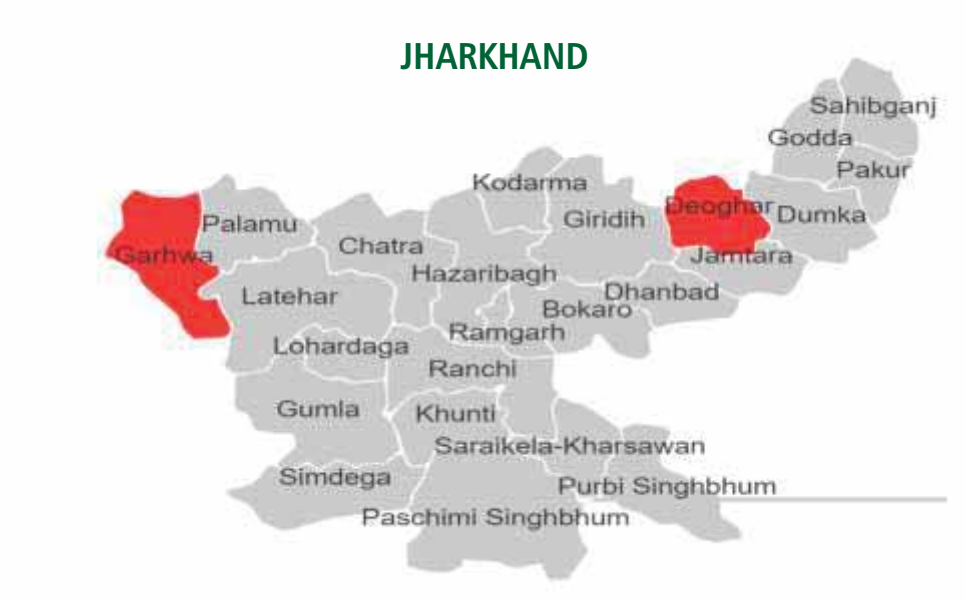
GOA

Districts Team Members	
Dr J N Srivastava, NHSRC	
Dr Srinibash Sahoo, RARIM & MR	Mr Muniraju SR, MoHFW
Ms Taijshee, Consultant, NITI Aayog	Mr Angshuman Moitra, UNDP
Ms. Manisha Verma, MoHFW	Dr Nadeem Akhtar, National Programme Officer
Dr Devaki A, NHSRC	Dr Harshad P. Thakur, TISS Mumbai
Dr Aman Sharma, NHSRC	Dr Varsha Tanu IIHMR Jaipur
Dr Aakanksha Verma, HRH HPIP	Dr Manju Madhavan,SHSRC

Health Facilities Visited

Type of Facility	North Goa	South Goa
District Hospitals (DH)	Asilo Hospital, Mapusa	Hospicio Hospital, Margao
Sub District Hospital (SDH)		Ponda
Community Health Centre (CHC)	Sankhali Valpoi, Sattari	Canacona
Primary Health Centres (PHC)	Siolim Colvale	Pilliem - Dharbandora Marcaim
Urban Primary Health Centres (UPHC)	Panjim	Margao
Rural Medical Dispensaries (RMD)	Revora Chapora	Agapur
Sub Health Centres (SHC)	Moira Gurim	Sacorda
Others- Villages including FGDs	Goa Medical College Anganwadi Centre Siolim Gudem	Medical Store Depot Ponda, Anganwadi Centre Pratapnagar Schools Sacorda, Gulem

JHARKHAND

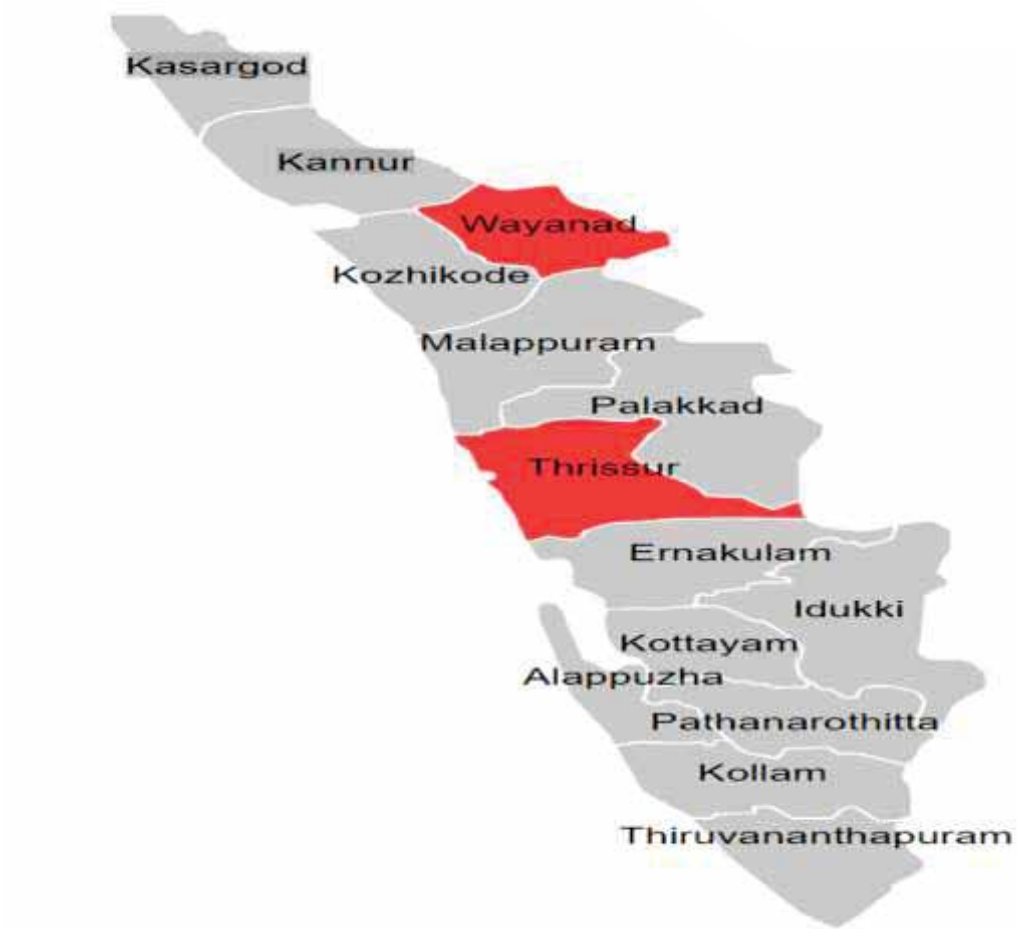


Deoghar District Team Members	Garhwa District Team Members
Team Lead- Dr. Zoya Ali Rizvi, Deputy Commissioner (AH), MoHFW	
1. Dr Zoya Ali Rizvi , MoHFW	1. Dr Purbasa Bera, Director, NCDC
2. Dr Agrima Raina, MoHFW	2. Dr Sunil Prasad, MoAYUSH
3. Mr. Nikhil Bhatia, MoHFW	3. Mr Shatrughan Thakur, MoHFW
4. Ms Haifa Thaha, NHSRC	4. Dr Pallavi Singh, NHM, MoHFW
5. Ms Anisha Singh, NTSU, ACSM	5. Dr Vineeta Dhankhar Shah, NHSRC
6. Dr Ritesh Kumar, Jhpeigo	6. Dr DK Yadav, NIHFW
7. Ms Shyamashree Das, BMGF	7. Dr Osama Ummer, WHO
	8. Dr Priyanka Agarwal, Wadhwani AI

Health Facilities Visited

Type of Facilities	Deoghar	Garhwa
District	Sadar Hospital	District Hospital
	Blood Bank	
Block	CHC- Sarwan	CHC Meral
	CHC- Palojori	CHC Majhioan
	CHC- Sarath	CHC Bhandaria
		PHC Ramkanda
SHC-HWC	Chithra,Block-Sarath	Peska
	Bandajori, Sarwan	Kharsota
	Madhuwadih	Bishrampur
	Chatnadangal, Palojori	Saraidih
	Tapovan	Bargarh
		Kharjiya
Urban	UPHC- Kalyanpura	UPHC-Tandwa
Others	Community Interactions/ AWC/Atal Mohalla Clinic/Schools/VHSNCs/MAS	

KERALA

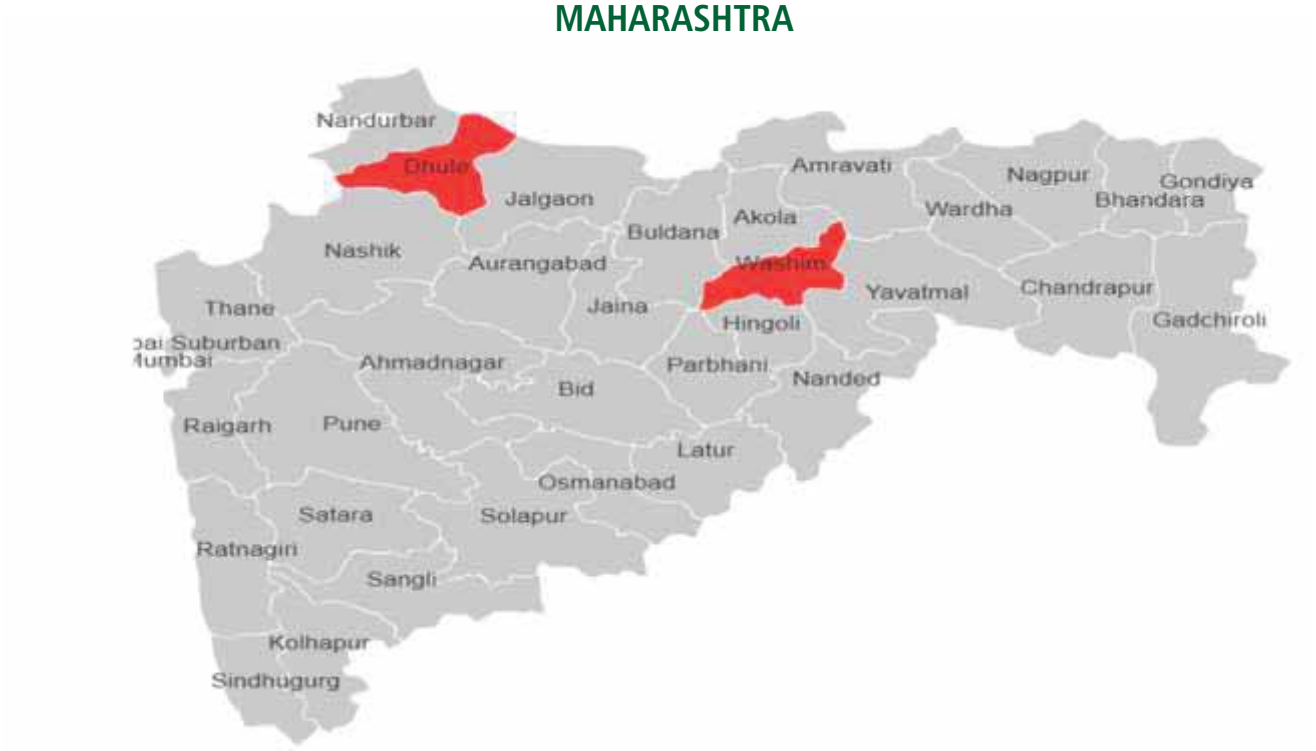


Wayanad District Team	Thrissur District Team
Dr Sumita Ghosh, Additional Commissioner , MoHFW	Dr Ramchandra Rao Sathuluri, NIHFW
Dr K.C Muralidharan, Assistant Director (Homeopathy)	Dr Satish Pawar,SHRC Maharashtra
Ms. Asmita Jyoti Singh, MoHFW	Mr. Anjaney Sahi,NHSRC
Dr Abhishek Nautiyal, ADU MoHFW,	Mr. Mohammad Saeed,MMP Cell
Dr Kalpana Pawalia, NHSRC	Dr Manisha Chawla, UNICEF Health officer
Dr Oommen P. Mathew, Research investigator	Mr. Ajay Arya, Consultant CP RRC, NE
Dr Ali Manikfan Abdullage, RoHFW	Dr Sampada Sahu, MoHFW
Mr Suresh K, NHM	Ms Navneet Kaur Manchanda,World Bank
Dr Shreehari M. SNO Child Health	Dr Bipin Gopal,NPCDCS
Dr. Amar Fettle, SNO AH	Ms Seena K M, NHN
Dr. Lipsy Paul, SNO MH	Dr Laxmi GG, Epidemiologist
Smt. Anishakumary M C, NHM	Ms Sujatha, NHM
Sri. Prakash C P, NHM	

Health Facilities Visited

Type of Facilities	Wayanad District	Thrissur District
District Hospital	District Hospital Mananthavady	Taluka Hospital Chalakundy
Sub-district Hospital	Taluka/SDH Sultan Bathery	General Hospital Thrissur
CHC	CHC Meenangadi	Community Health Centre, Perinjanam
UPHC	Urban Primary Health Centre Munderi	Urban Family Health Center, Gosayikunnu
Others	DEIC Wayanad NRC Sultan Bathery Family Health Centre, Noolphuza Tribal Mobile Medical Unit and Tribal Colonies Government UPS School, Kampalikkd Visit at Family Health Centre-Mullankolly and Main Sub Health centre Mullankolly AWC Varadoor Community interaction-Village Interaction with ASHAs and community members	Family Health Centre, Vetilapara Family Health Centre, Kodakara Primary School, Vetilapara AWC Vazhachal

MAHARASHTRA



Dhule District Team	Washim District Team
Dr A. M. Kadri, SHSRC	Dr Bal Rakshase,TISS
Dr Nidhi Shrivastava,MoHFW	Mr. Sanjeev Gupta,NHM
Dr Vikas Gupta, WHO	Ms. Vertika Agarwal, NHSRC
Dr Arpita Agarwal, NHSRC	Dr Abhishek Gupta, Piramal Swasthya
Mr. Ankur Sharma, Senior consultant Immunization	Dr Vinay RSL, RRC- NE
Ms. Annie Sushma Suchiang, JHPIEGO	Dr Manisha Mandal, UNDP Senior Project Officer,
Mr. Mandar Randive, PATH	Dr Bal Govind, IIPS
Dr Ramesh Bawaskar, Research Officer	Dr A.G Alone, Sr. RD

Health Facilities Visited

Type of Facilities	Dhule District	Washim District
District Hospital	Dhule	DH-Washim, Women's Hospital, Washim
Sub-district Hospital	Shirpur, Dondaicha	Karanja (Lad)
Rural Hospital	Sakri, Pimpalner	Mangrulpir
Primary Health Centre-HWC	Kudashi, Shirsole, Dahiwel, Rohini, Nardana, Vikharan, Wadi, Betawad, Kusumba	Shirpur, Pardi Takmo, Selubazar,
Urban PHC HWC-SC	Prabhat Nagar UPHC, Dhule City Pankheda, Amli, Kuruswade, Ghodade, Sule, Waghadi, Nardana, Varud	Kumbhi, Falegaon, Wasari, Dongarkinni-Malegaon,
Others-Focus Group Discussion	HWC-SC-Sule (ASHA, ASHA Facilitator, AWW, Beneficiaries), PHC Wadi (ASHA, ASHA Facilitator), SC-Amli (ASHA, ASHA Facilitator, AWW, Beneficiaries)	MAS at SDH Karanja (Lad), JAS at HWC Falegaon, Female and Male FGD at HWC Wasari

MEGHALAYA

South West Khasi Hills District Team	Ri Bhoi District Team
Dr. Sushil Kr. Vimal, MoHFW	Dr L. Somorendra Singh, RoHFW
Dr. Harsavardhan Nayak , NCD	Dr. Masram Pravin R, Ministry of AYUSH
Dr Mamta Chauhan, IIHMR, Jaipur	Mr. Vikas Sheemar, MoHFW
Dr Rajnesh Kumar, NHSRC	Dr. Smita Shrivastava,NHSRC
Ms Sandhani Gogoi, RRC NE	Dr Rekha M, SHSRC
Dr L Prabhakaran, FIND	Mr. Kingson Kamkara, UNDP
	Mr. Linto Andrews, Jhpiego

Health Facilities Visited

Facility Type	South West Khasi Hills District	Ri Bhoi District
District Hospital	DH Mawkyrwat	DH Nongpoh
CHC	CHC Ranikor	CHC Patharkhmah & CHC Bhoirymbong
PHC	PHC Rangthong	PHC Warmawsaw & PHC Mawlasnai
SHC-HWC	SHC-HWC Phlangkynshi,	SHC-HWC Umsong & Iapngar
	SC-Nongnah	
Others	Community Process: ASHAs, AWW, CHO, Elderly, Pregnant Women, Newly delivered/lactating mother, community members, VHC Ngunraw Village, VHND Anganwadi Sankwang, Liarbang	

MADHYA PRADESH

Team Lead - Dr. (Flt Lt).M.A.Balasubramanya Advisor, CP-CPHC NHSRC, MoHFW

Sidhi District	Singrauli district
Dr M A Balasubramanya, NHSRC	Ms Rangoli Pathak,MoHFW
Dr. R. S Rawat, Sr. RD	Ms. Saranga Panwar, MoHFW
Dr Balu Mote, NHSRC	Dr. Vijaya Shekhar Salkar, CP CPHC
Mr. Gulam Rafey, NHSRC	Dr. Surendra Kumar, Research Officer (Ayurveda) Regional Ayurveda Research Institute
Ms Sugandha Suman, RCH	Dr Vikas Nariyal, NITI Ayog
Dr Sandeep Bharaswadkar, BMGF	Prof K C Das, IIPS Mumbai
Mr. Gaurav Kumar, NIPI Bihar	Dr. Mayank Mittal TB-MoHFW
Mr Sribash Chandra Saha, Jhpiego	Mr Kumar Gaurav, WHO
Mr Kamlashankar Carpenter	Dr. Ranganai Matema , UNICEF
Dr. Sanjay Pandagale , RIE Bhopal	Dr. Nikhilesh Parchure
Ms Manju Dhami, NHSRC	Dr Monika, NHSRC

NAGALAND

District Zunheboto Team	District Mokokchung Team
Dr. Sila Deb, In-Charge, Nutrition Division, MoHFW	Mr. Prasanth KS,NHSRC
Dr. Archana Patil, SHSRC	Dr. Shraddha Verma, MOHFW
Dr. Ashish B. Chakraborty, MoHFW	Dr. Amit Lokhande, UNDP
Dr. Vilas Gangurde, AYUSH, MoA,	Ms. Dharmishta Nanavati, Prog. Manager, Saksham Pravah
Mr. Prakamya Gupta,NHSRC	Dr. Aditi Joshi, NHSRC
Mr. Eshwar Sai Tipirisetty, MOHFW	Arpita De, MOHFW

Health Facilities Visited

Facility Type	District Mokokchung	District Zunheboto
District Hospital	Dr.Imkongliba Memorial District Hospital (IMDH), Mokokchung Naga Hospital, Kohima State Mental Health Institute, Kohima	Zunheboto District Hospital, Zunheboto
CHC	Changtongya CHC	Phugoboto CHC
PHC	Mongsenyimti PHC Yimyu UPHC	Satakha PHC, Suruhoto PHC, Akuluto PHC (HWC)
SC	Longkong HWC, Sungkomen UHC Kupza, AYUSH HWC	Asukiqa- HWC, Sapotimi- HWC
Others	AWC, Longkong Community Interaction and Household visits at Longkong and Sungkomen, Govt. School, Mongsenyimti	Others-VHND at Sutemi and Suruhoto, Community Interaction and Household visits at Sapotimi, Sutemi and Suruhoto Village

PUNJAB

District Ferozepur Team	District Rupnagar Team
Dr A Raghu, DDG (AYUSH), MoHFW	Dr. Amarjeet Kaur, Sr. RD, Chandigarh
Ms. Amita Chauhan, MoHFW	Dr. Harbans Singh, Central Ayurveda research Institute, Patiala (Punjab)
Dr. Priyanka Bharti, MoHFW	Dr. Reneej K B, RCH, MoHFW
Dr Abu Sarkar, WHO	Dr. Rudra Prasad Pradhan, Jhpiego
Mr. Sukhwinder Singh, World Health Partners	Dr. Sathish, Senior Project officer, Tamil Nadu
Dr. Deepika Anand, World Bank	Dr. Manmohan Singh, PRC, Punjab
Dr. Poonam, NHSRC	Mr. Jatin Bhat, NHSRC
Dr. Anjali Krishnan R, SHSRC Kerala	CA Saurav Gupta, ACFA (state officials)

Health Facilities Visited

Facility Type	Ferozepur	Rupnagar
District Hospital	Civil Hospital, Ferozepur	DH Rupnagar
Sub-district Hospital	Zira	Anandpur Sahib
Community Health Centres	Ferozshah and Guruharsahai	Bharatgarh
Primary Health Centre	Mudki UPHC Tankan Wali FZR city 1, UPHC, FZR Cantonment- 2	Purkali, Kiratpur Sahib UPHC Kotla Nihang
Health & Wellness Centre-Subcentre/ SHCs	Thaturrana wala, Megla Panj Grain, Dulchi, Sur Singh wala	Takhatgarh, Nurpur Khurd, Makaurikala, Bada Pind, Singh
Community	Dulchi Ke, Nihale wala and Kalu wala	Singh
Others	De-addiction Centres, Aam Admi Clinics, Aam Admi Clinics, MMU, State training Institute, Call centres- 108 and 104	

RAJASTHAN

District Jaisalmer Team	District Kota Team
Dr Indu Grewal, MoHFW	Dr Deepak Saxena, Sr. RD, Jaipur
Dr Santosh Kumar Ojha, MoHFW	Dr. Abhishek Shrivastava Advisor IT, NHSRC
Ms. Ritu, NHSRC	Dr Gaurav Thukral, Jhpiego
Dr Khanindra Bhuyan, UNICEF	Mr Srivinas D, SHSRC , Karnataka
Dr Abhishek Joshua, UNDP	Dr Annapurna K N, NHSRC
Dr Radhay Shyam, MoHFW	Dr Abhishek Dixit, NIHFW
Dr B R Meena, RARI, Jaipur DGHS	
Mr Prem Kumar, MoHFW	
Mr Satendra Singh, Finance Analyst, MoHFW	

Health Facilities Visited

Facility Type	District Jaisalmer	District Kota
District Hospital	Shri Jawahir Hospital, DH	JK Lon Hospital, Kota
Sub District Hospital	Pokhran	Sulthanpur
Community Health Center	Sankada	
Primary Health Center	PHC Devikot & UPHC Gafur Bhatta	PHC-HWC Morak and UPHC-HWC Nanta
Sub center	SC- Sanvada, SC - Dabala	SC-HWC Kalyanpura, SC-HWC Kukda Khurd, SC-HWC Kudyala
Community	AWHC Barhat Ka Gaon, Sanvada, Dabala, Pannasar, Modak gaov, Sultanpura, Kalyanpura	
Other facilities visited	Drug Warehouse, MMUs,	

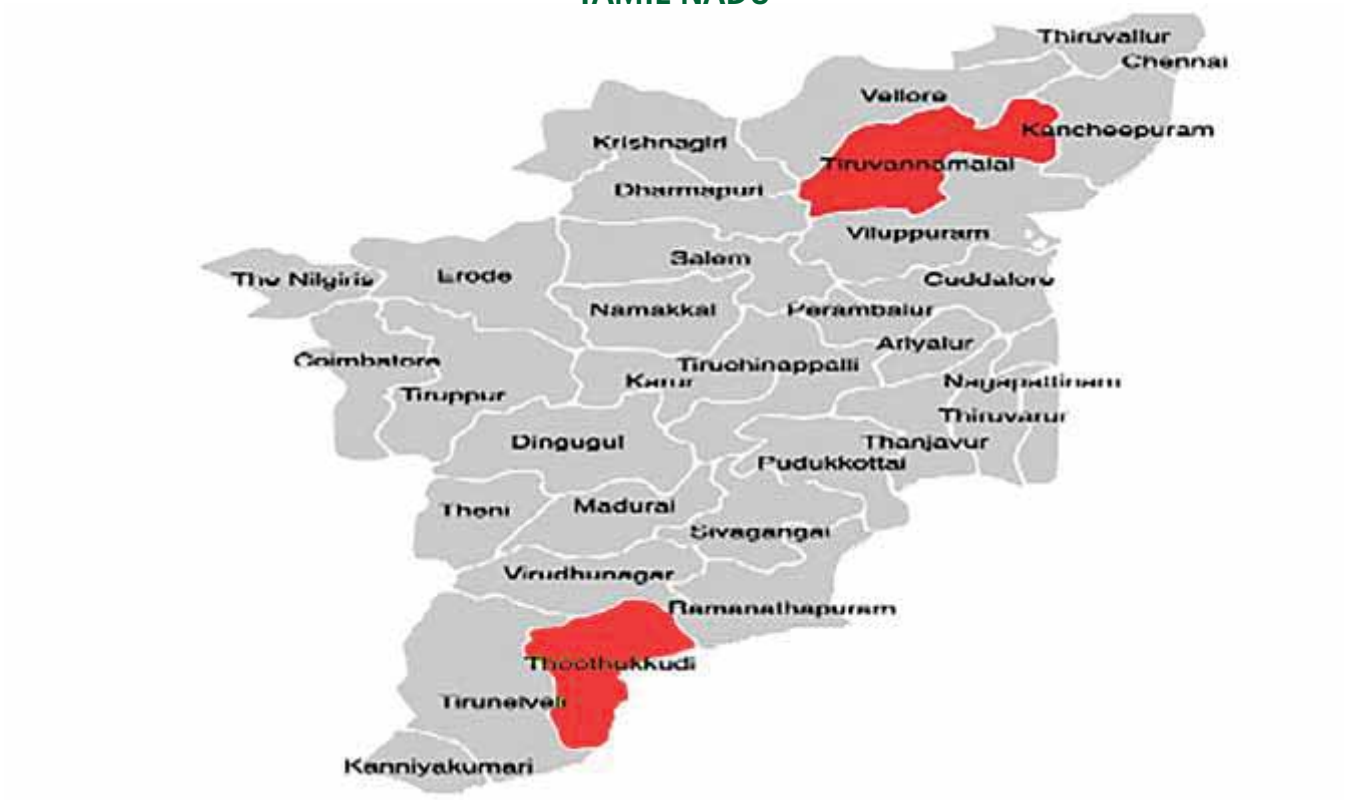
SIKKIM

East District (Gangtok) Team	South District (NAMCHI) Team
Dr Govind Bansal, MoHFW	Dr Divya Valecha, MoHFW
Dr Neha Dumka, NHSRC	Dr Taruna Janeja, NHSRC
Dr Shipra Verma, MoHFW	Dr Moiz Uddin Ahmed, MoHFW
Dr Devajit, Bora, RRC NE	Dr Priyanka Bajaj, MoHFW
Dr Sarita Verma, UNICEF	Dr Bhavna Sethi, BMGF
Dr Rinky Thakur, WCD Vertical, NITI Aayog	Mr Vishnu, SHSRC Chhattisgarh
Dr Manas Pradhan, IIPS	Dr Shri Prakash, Ministry of AYUSH

Health Facilities Visited

Facility Type	District East (Pakyong/Gangtok)	District Namchi
District Hospital	District Hospital Singtam	District Hospital Namchi
CHC	CHC Rhenock	CHC Jorethang
PHC	PHC-HWC Sang PHC-HWC Samdong UPHC Gangtok	HWC-PHC Ravangla HWC-PHC Namthang HWC- PHC Temi
SHC-HWC	(SHC) HWC-PHSC - Martam, Makha, Aritar Urban HWC Siche	(SHC) HWC-PHSC - Kabrey, Damthang, Maniram Bhaniyang, Sadam
Community	Communities under visited HWCs ICDS - centre-Church line & Upper Amba	Communities under visited HWCs ICDS centre Sukrabarey
Others	STNM, Gangtok, CAM, Chuwatar, Mobile Village Van State office, DMPUs and BPMU	

TAMIL NADU

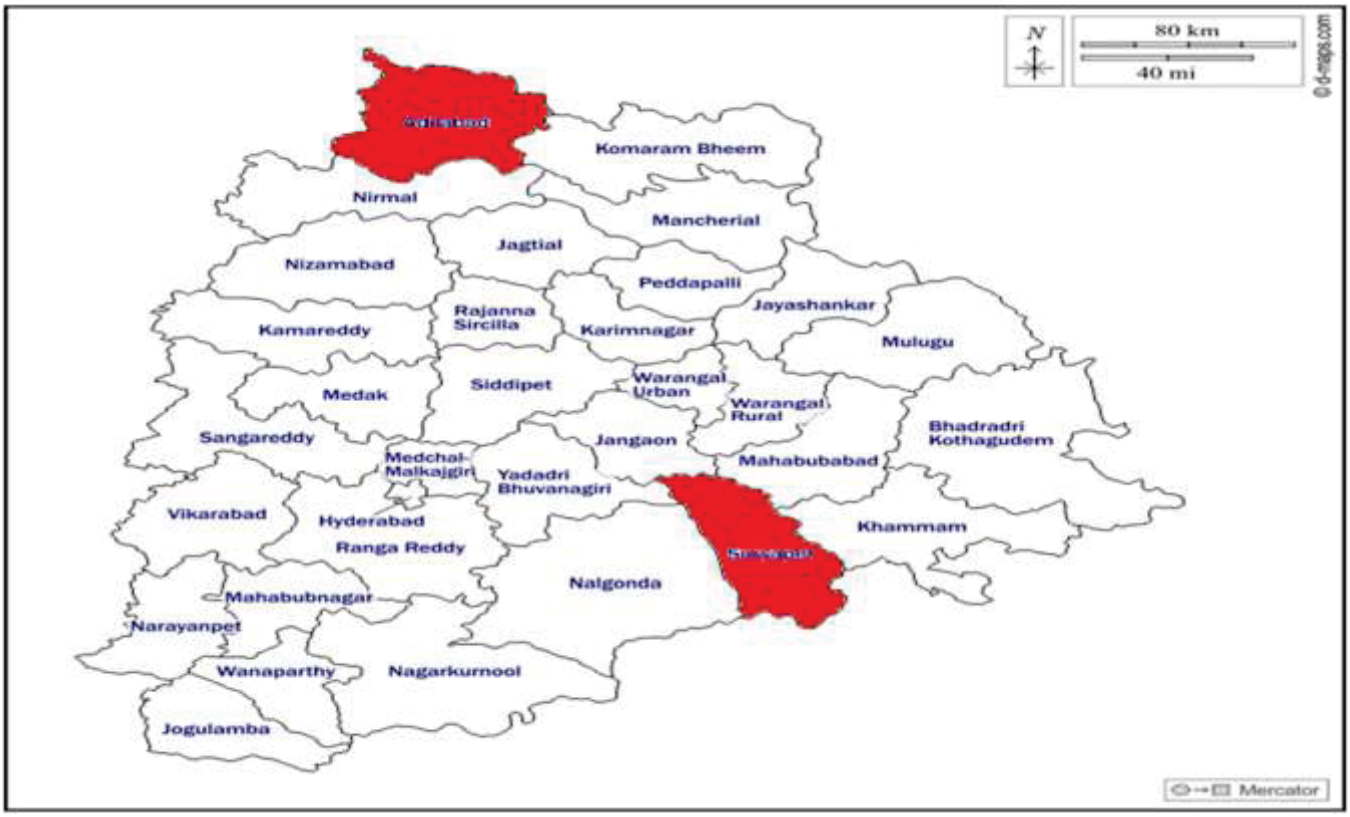


District Tiruvannamalai Team	District Thoothukudi Team
Ms Mona Gupta, Advisor, NHSRC	Dr Nirmal Joe
G.S. Krishnan Dr	Shri Aravind Kumar Pandian
Mushtaq Ahmed Dar	Prof. Nanthini Subbiah
Dr Sheen Job	Dr Senthilvel
Mr Vigneshwaran	Dr Surabhi Sethi
Dr Quincy	Mr Shazi Iqbal
Mr Shahid Ali Warsi	Ms Prachi Singh
Ms Vaishnavi Akanksha	Mr Anand Yadav
	Dr Monika Talegaonkar

Health Facilities Visited

Facility Type	District Thoothukudi	District Tiruvannamalai
Medical College	Thoothukudi Medical College	Medical College Tiruvannamala
Sub-District/ District Hospitals	DH Kovilpatti	GH Arani, DH Cheyyar
Block PHC/ Community Health Centres	Block PHC Era	Block PHC Jamnamarunthur (Tribal block) Block PHC Kattampoondi, Block PHC S V Nagaram
Primary Health Centres/ Urban PHCs	PHC Sebathaiyapuram, PHC Mapillaiurani UPHC Therisapuram, UPHC Ganesh Nagar	Addl PHC Namiyampattu, UPHC Central Tiruvannamalai, UPHC Arani
Health & Wellness Centres- SC	HWC Kovangaadu	HWC Thoppur, HWC Paiyur
Villages and Health Sub-Centres	SC Veppaladai, SC Ramdass Nagar	SC S V Nagaram

TELANGANA

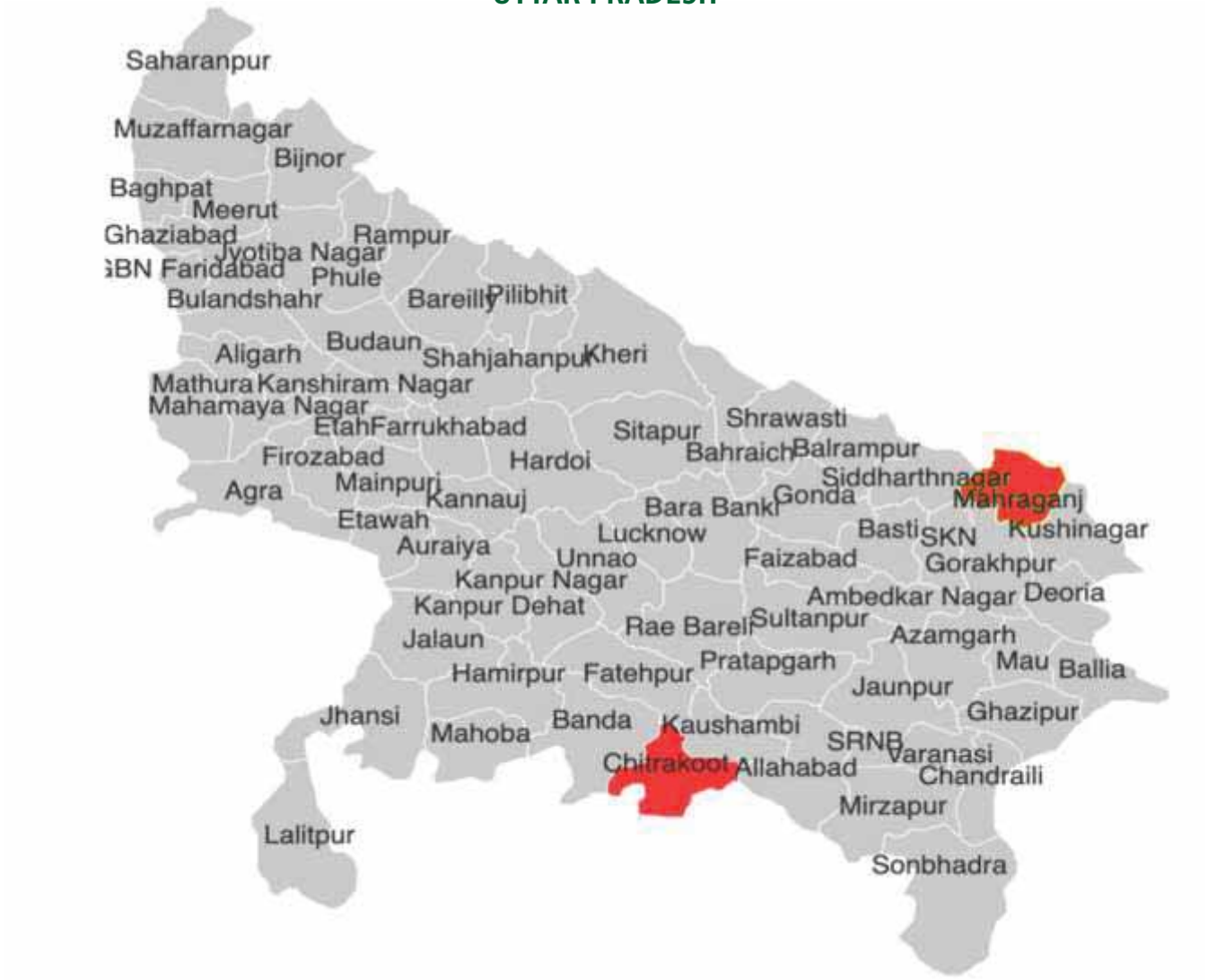


District Suryapet Team	District Asifabad Team
Dr Jyoti Rawat	Prof Viswanathappa
Dr Tapas	Mr Mahipal
Mr Sundaram	Dr Rajesh Ranjan
Dr Bhupinder	Dr Kapil Joshi
Dr Ameena	Dr Sampan
Dr Gaurav	Dr Ekta
Mr Hari Krishan	Ms Sagarika
	Ms Isha Sharma

Health Facilities Visited

Facility Type	District Asifabad	District Suryapet
Medical college		GGH Medical College & Hospital
District Hospital	DH Asifabad	SDH Huzurnagar
Community Health center	CHC- Sirpur T, Kagaznagar	CHC- kodad
Primary Health Center	PHC- Rompally, Kowtala, UPHC- Navegaon Basti	PHC- Penpahad, UPHC- Rajeev Nagar
SC-HWCs/ Sub centers	Sub Centre- Gambiraopet, Gundaipet	SC-HWC-Singireddypallem SC- HWC- Balemla
Community	Manakyapuri Village	Singireddypallem village

UTTAR PRADESH



District Maharajaganj Team	District Chitrakoot Team
Dr Himanshu Bhushan NHSRC	Dr Padmini Kashyap, MoHFW
Dr Sanjay Kumar, Regional Ayurveda Institute Lucknow	Dr Arun Aggarwal, PGIMER, Chandigarh
Mr Guru Rajesh Jammy, World Bank	Dr Yogita Sharma, UNDP
Dr Hardik Solanki, WHO	Dr Upma Sharma, CDC
Mr Gunjan Gaurav, PATH	Dr Ananth Kumar Srinivasaiyer, NHSRC
Dr Abhishek Kumar Bhagat, SHSRC Madhya Pradesh	Dr Sutirtha Mazumder, MoHFW
Dr Nischay Keshri, RoHFW, Lucknow	Ms Charu, MoHFW
Dr Jyoti Rai, MoHFW	Dr Payal Das, MoHFW
Dr Siddharth Maurya, RRC NE	Mr Bhartendu Sharma, Jhpiego
Dr Ashutosh Kothari, NHSRC	Dr Harioum Sharma, NHSRC
Dr Kushagr Duggal, NHSRC	
Dr Tahseen Kulsum, NHSRC	

Health Facilities Visited

Facility Type	District Majarajaganj	District Chitrakoot
DH	DH Maharajganj	DH Karwi MCH Wing
CHC	CHC Mithaura, Brijmanganj, Dhani, Siswa, Ghugli	CHC Mau, Pahadi, Sitapur, Manikpur, Ramnagar
PHCs	PHC-HWC- Kolhui, Nausagar, Chowk, Nausagar, Kulhuirsoni	PHC Tikra, Biyawal, Hatwa, e-PHC Manikpur UPHC Sankalpganj Kurdana, Karwi
SC-HWCs/ Sub centers	SHC-HWCs- Sikandarjitpur, Munderi, Pakri, Pipra Rasoolpur, Gopalpur Shahu, Koriya	SHC-HWCs Bhauri, Murkha, Puranpur
Others	Government Primary Schools, Community Interactions in urban and rural areas, MAS, AAA meetings, Anganwadi Centres (Mankuwar, Bhauri), Medical Mobile Units	AYUSH Centre Murkha, Karwi Government Primary School, Bhauri, Community Interactions in urban and rural areas, MAS, AAA meetings, Anganwadi Centres (Mankuwar, Bhauri), Primary Vidhyala Mankuwar, private USG clinics, Medical Mobile Unit

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